US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in Consult Management in the Endocrinology Service at the VA Fayetteville Coastal Healthcare System in North Carolina

Healthcare Inspection | **24-02634-229** | **September 23, 2025**

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection, including a site visit September 9 through 12, 2024, after receiving allegations regarding internal endocrine consult management, endocrine clinic utilization, and patient access to gender-affirming hormone therapy (GAHT) at the VA Fayetteville Coastal Healthcare System (system) in North Carolina. The OIG further evaluated leaders' awareness of and response to these concerns.[1]

Deficiencies in Internal Endocrine Consult Management

The OIG substantiated that the chief of medicine (COM) did not effectively manage internal endocrine consults.[2] Specifically, the COM

- did not communicate endocrine consult management process changes to key stakeholders,
- did not process consults within Veterans Health Administration (VHA) timeliness requirements,
- canceled a large volume of consults without communicating to sending providers,
- converted face-to-face consults to e-consults without providing a mechanism for sending providers to communicate concerns as required by VHA, and
- delayed implementation of a required service line agreement.

These actions resulted in delays in patient care and provider-created workarounds, which circumvented the formal consult process required by VHA.

Communication About a Consult Process Change

The OIG learned that in June 2023, the COM changed the endocrine consult management process by routing all consults through the COM rather than the endocrine providers for initial

[1] The OIG received additional allegations pertaining to endocrine consult management regarding employee relations issues and administrative actions, which will not be included in this inspection report.

[2] Consults are "used as two-way communication on behalf of a patient consisting of a physician or provider (sender) request seeking opinion, advice, or expertise regarding evaluation or management of a specific problem answered by a physician or other health care provider (receiver)." VHA Directive 1232(5), *Consult Processes and Procedures*, August 24, 2016, amended December 5, 2022. This directive was in place during the time of the events discussed in this report. VHA Directive 1232(5) was rescinded and replaced by VHA Directive 1232, *Consult Management*, November 22, 2024. Unless otherwise specified, the 2024 directive contains the same or similar language as the rescinded 2022 directive. The OIG acknowledges the new directive was issued outside the time frame of this inspection but expects system leaders to comply with the new requirements effective November 22, 2024.

review.[3] One essential component for implementing change successfully in the healthcare setting is gaining buy-in from those involved, which requires "communicating with stakeholders, motivating impacted individuals to accept the change, and encouraging cooperation among the team."[4] In 2018, VHA implemented high reliability organization (HRO) concepts to promote a culture of safety. Clear bidirectional communication and respect for people are two of seven VHA HRO values.[5] In changing the endocrine consult management process, the COM assumed the process change was communicated to staff by the endocrine section chief. However, two endocrinologists previously responsible for managing consults reported the change was not communicated to them until "much later" by the COM at a team meeting.

Timeliness of Consult Processing

VHA requires that consults are acted on within two business days after being placed by a sending provider.[6] One exception relates to e-consults, which must be completed within three business days.[7]

The OIG reviewed consult data for internal endocrine consults ordered (and not originally ordered as e-consults) and found that the COM did not act on the consults timely. The OIG also reviewed completed e-consult data and found a majority of the e-consults were not completed within three days as required. The OIG learned that, despite the COM and executive leadership team members receiving multiple alerts about delays in consult actions, which resulted in delays in patient care, no actions were taken to determine the cause.[8]

[3] The COM could not provide a date for the process change; however, endocrine providers told the OIG that the change occurred in June 2023.

[4] Maxamillian Solow and Tjorvi E. Perry, "Change Management and Health Care Culture," *Anesthesiology Clinics* 41, no. 4 (December 1, 2023): 693-705, https://doi.org/10.1016/j.anclin.2023.05.001.

[5] VA, *VHA High Reliability Organization (HRO) Reference Guide*, September 2024. "High reliability means evidence-based, exceptional care is consistently delivered for every patient, every time, at any facility across VHA." The seven HRO values are: It's About the Veteran, Support a Culture of Safety, Commit to Zero Harm, Learn, Inquire and Improve, Duty to Speak Up, Respect for People, and Clear Communications.

[6] For this section of the report, a "day" means a business day. VHA Directive 1232(5); Business days exclude weekends and Federal holidays. 31 C.F.R. § 800.203 (2024).

[7] VHA Directive 1232(5). An e-consult is ordered when a provider is seeking the advice or expertise of a specialist in order to provide diagnostic and medical management to a patient. The specialist reviews the patient's medical record and provides a documented response to the sending provider. An e-consult does not involve a face-to-face visit between the specialist and the patient. Other exceptions include prosthetic and pathology consults.

[8] For purposes of this report, executive leaders include the System Director, Chief of Staff, Deputy Chief of Staff, and Associate Director of Access and Clinical Business Operations.

Consult Cancellation and Conversion to E-Consults

Consults may be canceled when staff responsible for consult management have determined a consult is no longer needed.[9] When consults are canceled, VHA requires that the reason for cancellation is documented. In cases when further work-up is required before a consult can be acted on, VHA "highly" recommends e-consults are utilized to provide recommendations to the sending provider instead of canceling the consult.[10] A receiving provider can convert a face-to-face consult to an e-consult, however, VHA specifies sending providers should have the ability to refuse if they feel the needs of the patient cannot be met through an e-consult.[11]

The OIG learned that the COM's decision to cancel endocrine consults was made during the review process if the type of care being requested did not require an endocrinologist. Additionally, the COM said when canceling endocrine consults, "the intent is to include a comment as to why endocrine consultation is not needed." Primary care providers (PCPs) communicated concerns regarding canceled consults to the COM and Chief of Staff (COS); however, PCPs reported not consistently receiving responses back from the COM.

The OIG reviewed internal endocrine consult data and found that the COM canceled 43 percent of consults. Further, the OIG reviewed the COM's comments and found that 19 percent of the consults included recommendations for further work-up such as diagnostic laboratory tests, which was contrary to VHA's recommendation that e-consults be utilized to provide requests to sending providers for further action "if a work-up is incomplete."

The OIG found that the COM converted 12 percent of face-to-face consults to e-consults. A PCP and an endocrinologist told the OIG of concerns related to not having autonomy in the e-consult decision-making process. Endocrinologists said that as a result of endocrine consult delays, cancellations, and conversions to e-consults, PCPs did not feel they could safely manage patients and workarounds were developed to get the patient care management support needed.

The OIG is concerned that despite PCPs voicing concerns to the COM and the COS about the volume of canceled endocrine consults, no sustainable attempts were made to address the issue.

Service Line Agreement Implementation

Service line agreements (SLAs) are written documents that outline an understanding between two services, one of which sends consults to the other, defining rules and expectations for

[9] VHA Directive 1232(5).

[10] VHA Directive 1232(5); VHA Directive 1232. VHA Directive 1232 updated and now indicates to facilities that "e-consults must be used to provide further recommendations in place of cancelling a consult …"

[11] VA Office of Veteran Access to Care, *Electronic Consultation (E-Consult) Implementation Guide Version 3.0*, May 2019.

services sending and receiving consults.[12] VHA requires that SLAs are established and include consensus between the involved services and signatures of involved service chiefs.[13]

The OIG learned that despite multiple attempts to develop an SLA between the endocrine section and primary care services (endocrine SLA), an endocrine SLA had not been approved and implemented. The Referral Coordination Initiative (RCI) nurse manager reported receiving an endocrine SLA from the COM in August 2024; however, it was missing required signatures. Despite two missed deadlines imposed by the System Director in July and September 2024, the RCI nurse manager confirmed that an approved endocrine SLA had not been implemented as of late January 2025.

Impact of Deficient Endocrine Consult Management on Fayetteville Health Care Center Clinic Utilization

The OIG substantiated that the COM's deficient management of endocrine consults had a negative impact on endocrine clinic utilization at the Fayetteville Health Care Center (FHCC). Specifically, the OIG found that due to consult cancellations, conversions, and delays, the supply of new patient (consult) and established patient (follow-up) appointments did not match patient demand. As a result, follow-up patients did not get timely endocrine appointments.[14]

VHA requires that service chiefs work collaboratively with group practice managers to provide oversight of clinic scheduling including "the mix of appointment types, length, and quantity" of clinic profiles.[15]

Two system endocrinologists told the OIG that as the COM canceled consults, the number of new patients being referred to the FHCC endocrine clinic diminished, leaving consult appointments unused but there were not enough follow-up appointments to meet patient demand.

The OIG reviewed scheduled appointment utilization data for the FHCC endocrinologists' consult and follow-up appointments and found that after the COM took over the endocrine consult management process, scheduled consult appointments declined while follow-up appointments were consistently utilized higher than the target rate of 85 percent. The OIG learned that the clinic profiles of endocrinologists 1 and 2 had been changed to allocate more

[12] VHA Directive 1232(5). Examples of rules and expectations include diagnoses that are appropriate for consultation, and lab tests or other diagnostics that should be completed before a consult is ordered. VHA uses the term *care coordination agreement*, which is synonymous with *service line agreement*. For purposes of this report, the term *service line agreement* will be used.

[13] VHA Directive 1232(5).

[14] VHA Office of Integrated Veteran Care, "VHA Office of Integrated Veteran Care Clinic Profile Management Business Rules," May 24, 2023. VHA defines a new patient as a patient who has not been seen by the specific service in the past 36 months, and an established patient as a patient who has been seen by the specific service within the past 36 months.

[15] VHA Directive 1231(4), *Outpatient Clinic Practice Management*, October 18, 2019, amended February 7, 2024.

follow-up appointments and fewer consult appointments with all changes in place by late November 2024.

VHA requires specialty care patient appointments be scheduled within 28 days of the provider's return-to-clinic date—the requested date for the patient's next appointment.[16] VHA also requires service chiefs to identify clinics with appointment wait times exceeding VHA wait time standards.[17]

The OIG learned that follow-up patients had to wait months to be seen, although the return-to-clinic date was sooner. The OIG reviewed Medicine Service data and found that from October 2023 through June 2024, endocrine follow-up appointment wait times were less than 28 days. However, the OIG confirmed the metric combined data for FHCC and the Wilmington Health Care Center (WHCC) endocrine clinics. The OIG reviewed follow-up appointment wait-time data for endocrinologists 1 and 2. Except for one month, wait times ranged from 29 to 77 days.

The OIG concluded that FHCC endocrine follow-up patients experienced wait times longer than the VHA target of 28 days. Although system leaders reviewed appointment wait-time data, the data included WHCC and FHCC combined. The OIG expects that given the awareness of the low utilization at WHCC due to low patient demand, leaders should have analyzed utilization for FHCC independent of the WHCC data to track and trend supply and demand issues at FHCC.

Delays in Patient Access to Gender-Affirming Hormone Therapy

The OIG substantiated that for about eight months, from February 2024 through early October 2024, patient access to GAHT was delayed as a result of the COM's actions, resulting in adverse clinical outcomes.[18] The OIG considers an adverse clinical outcome to be a delay in diagnosis or treatment, a progression of disease, worsening prognosis, suboptimal treatment, or a need for higher level care.

At the time of the OIG's inspection in June 2024, VHA's policy was to "provide care or pay for care in the local community" for transgender patients, which includes "hormonal therapy, mental

[16] VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393 (2018); 38 C.F.R. § 17.4040 (2019); VHA Office of Integrated Access Operations, "Standard MISSION Act Guidance: Patient Eligibility and Scheduling Reference Sheet," February 26, 2023; VHA Directive 1230, *Outpatient Scheduling Management*, June 1, 2022.

[17] VHA Directive 1230.

[18] GAHT is prescribed to transgender patients "who want [their] gender-related characteristics … to match the gender with which they identify." "Gender Affirming Hormone Therapy," Duke Health, accessed October 22, 2024, https://www.dukehealth.org/treatments/adult-gender-medicine/gender-affirming-hormone-therapy.

health care, preoperative evaluation … and long-term care following gender-affirming surgery."[19]

The COM told the OIG of learning, in August 2023, that the endocrine section chief, the only endocrinologist at the system providing GAHT at that time, was retiring in early 2024. The three remaining endocrinologists voiced concerns to the COM about providing GAHT, citing a lack of experience and expertise, or a personal objection. However, the COM communicated an expectation that the patients would receive GAHT by system endocrinologists. Between March and June 2024, the three endocrinologists separately submitted requests for accommodations to not provide GAHT.[20]

The COM reported learning in February 2024 that the endocrinologists had placed Care in the Community (CITC) consults for all GAHT patients, but the COM instructed CITC staff to cancel the CITC consults and have the patients rescheduled with the system endocrinologists.[21] The OIG found some patients had their CITC consults repeatedly canceled and were rescheduled multiple times with system endocrinologists, who were not providing GAHT.

The OIG also reviewed the electronic health record of five patients who were identified by the complainant and found multiple concerns.[22] The OIG requested that executive leaders complete a review of the care provided to GAHT patients to ensure timely treatment, consults, and medications were provided. The OIG found the system reviews were not thorough and noted they lacked an analysis of medication management, patient care delays, and identification of adverse clinical outcomes. As a result, the OIG asked Veterans Integrated Service Network (VISN) leaders to review the GAHT care provided to patients to identify and address quality of care concerns.[23] The VISN-level review identified that of the 100 patient records reviewed, four patients experienced delays in obtaining GAHT, one of whom was identified as encountering

[19] VHA Directive 1341(4), *Providing Health Care for Transgender and Intersex Veterans*, May 23, 2018, amended August 19, 2024. This directive was rescinded on March 17, 2025, noting that patients already receiving GAHT through VA Health Care at the time of recission remain eligible to receive this therapy. VHA Notice 2025-01(1), "Rescission of VHA Directive 1341(4), Providing Health Care for Transgender and Intersex Veterans," March 17, 2025.

[20] The requests for accommodation involve an internal VA administrative process and action. The OIG does not investigate complaints addressed in other legal or administrative forums. As such, the OIG will not further discuss the administrative actions in this report. Instead, the OIG focused on ensuring patients were, and are, receiving the care needed notwithstanding the accommodation requests.

[21] "VA provides care to [patients] through community providers when VA cannot provide the care needed." Care in the community must be approved before a patient can access care from a community provider. "Community Care Overview," Community Care, accessed September 25, 2024, https://www.va.gov/communitycare/. "Community Care," Veteran Care Overview, accessed November 5, 2024, https://www.va.gov/communitycare/programs/veterans/#types.

[22] The complainant provided the OIG with a list of 22 GAHT patients whose CITC consults were canceled multiple times to which the OIG reviewed the first five patients.

[23] The OIG requested that VISN leaders "ensure [the] review is independent and completed by VISN identified endocrinologists at other facilities ..."

potential harm. The review also noted that all patients ultimately received the GAHT they were entitled to according to VHA policy.

The OIG concluded that the COM executed a plan for continued GAHT care that failed to ensure access to GAHT and caused delays in patient care, and adverse clinical outcomes.

Leaders' Awareness and Response to Interpersonal Communication Concerns

The OIG identified concerns related to the COM's interpersonal communication skills from staff and leaders in various services. VHA emphasizes the HRO values of clear communication and respect for people because miscommunication is a leading cause of medical errors.[24]

The OIG learned that the System Director, COS, and Deputy COS were aware of the COM's lack of responsiveness. As a result of this awareness, the COS and System Director stated that a new interim chief of primary care was selected to allow the COM to focus strictly on the Medicine Service.[25] The System Director also directed the COS to provide the COM with additional support for leadership development.

Leading an effective service requires strong interpersonal skills and the ability to collaborate with others in a team setting. The OIG is concerned that the COM's interpersonal communication skills did not reflect the HRO values of clear communication and respect for others and negatively affected system staff across multiple services. Further, the OIG expects executive leaders to closely track and monitor the COM's leadership performance once learning and observing firsthand the extent of the COM's interpersonal communication deficiencies.

The OIG made one recommendation to the Veterans Integrated Service Network Director to review the leadership performance of the COM related to communication and collaboration.

The OIG made six recommendations to the System Director related to reviewing the endocrine consult management process and ensuring compliance with policy, reviewing patients affected by delayed endocrine consults and evaluating whether harm occurred and the need for institutional disclosures, ensuring a service line agreement between endocrine and primary care services is developed and monitoring implementation, confirming effective utilization of endocrine clinic appointments for timely access to care, ensuring a process is in place for monitoring and tracking clinic profile modification requests, and evaluating communication gaps between leaders of primary care and the Medicine Service to ensure consistency with VHA HRO goals.

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[24] VA, *VHA High Reliability Organization (HRO) Reference Guide*; VA, "HRO Clear Communications Fact Sheet," January 2024; VA, "HRO Respect for People Fact Sheet," January 2024.

[25] The OIG was told the COM served as the interim chief of primary care from March 5, 2024, through August 24, 2024, while maintaining concurrent duties as the COM.

VA Comments and OIG Response

The Under Secretary for Health and the Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided an acceptable action plan (see appendixes A, B, and C). Based on the information provided, the OIG considers all recommendations open. The OIG will follow up on the planned actions until they are completed.

JULIE KROVIAK, MD
Principal Deputy Assistant Inspector General,
in the role of Acting Assistant Inspector General,
for Healthcare Inspections

Contents

Abbreviations

CITC	care in the community
COM	chief of medicine
COS	Chief of Staff
EHR	electronic health record
FHCC	Fayetteville Health Care Center
GAHT	gender-affirming hormone therapy
GPM	group practice manager
HRO	high reliability organization
OIG	Office of Inspector General
PCP	primary care provider
RCI	Referral Coordination Initiative
RCT	referral coordination team
SLA	service line agreement
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WHCC	Wilmington Health Care Center

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection, including a site visit from September 9 through 12, 2024, after receiving allegations regarding internal endocrine consult management, endocrine clinic utilization, and patient access to gender-affirming hormone therapy (GAHT) at the VA Fayetteville Coastal Healthcare System (system) in North Carolina.[1] The OIG further evaluated leaders' awareness of and response to these concerns.

Background

The system, part of Veterans Integrated Service Network (VISN) 6, operates a VA Medical Center in Fayetteville; two healthcare centers—Fayetteville Health Care Center (FHCC) and Wilmington Health Care Center (WHCC); and seven outpatient clinics across North Carolina.[2] The Veterans Health Administration (VHA) classifies the system as a level 1c complexity.[3] From October 1, 2023, through September 30, 2024, the system served 95,469 patients and completed 826,919 outpatient visits. The system provides primary care, general medicine, surgery, mental health, and specialty care services, including endocrinology.

Endocrinology

Endocrinology is a field of medicine that focuses on hormones, endocrine glands, and organs such as the pancreas, ovaries, and testes.[4] Hormones are developed and released through certain glands and organs in the body that make up the endocrine system. Hormones play a key role in many bodily functions such as growth, sleep, sexual function, and reproduction.[5] An endocrinologist specializes in medical conditions related to hormones, including sexual development and reproductive health, and can diagnose and treat various endocrine conditions such as diabetes, thyroid disease, and cancers related to the endocrine system.[6]

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[1] For purposes of this report, internal consults refer to those that are routed to specialties within the system and do not include consults routed to care in the community.

[2] The system's community-based outpatient clinics are located in Hamlet, Lee County, Brunswick County, Robeson County, Goldsboro, Jacksonville, and Wilmington. FHCC and WHCC are multi-specialty outpatient clinics.

[3] VHA Office of Productivity, Efficiency, & Staffing (OPES), "Data Definitions VHA Facility Complexity Model," October 1, 2023, accessed June 14, 2024. The Facility Complexity Model classifies VHA facilities at levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex and level 3 being the least complex.

[4] "A hormone is a chemical messenger that travels from one endocrine gland or organ in your body to another part of your body through your blood." "Endocrinologist," Cleveland Clinic, accessed July 2, 2024, https://my.clevelandclinic.org/health/articles/22691-endocrinologist.

[5] "Glands are special tissues in your body that create and release substances." Endocrine glands include the adrenal glands, parathyroid glands, pineal gland, pituitary gland, and thyroid gland. "Endocrinologist," Cleveland Clinic.

[6] "Endocrinologist," Cleveland Clinic.

Endocrinology is a component of the Medicine Service at the system. The system provides outpatient endocrine services at the FHCC and WHCC. As of January 2024, the system's endocrine section included a nurse practitioner and three endocrinologists located at the FHCC—(endocrinologist 1), (endocrinologist 2), and the endocrine section chief.[7] One endocrinologist (endocrinologist 3) and one physician assistant were located at the WHCC.[8] The OIG was told the chief of medicine (COM), also an endocrinologist, was located at the Fayetteville VA Medical Center and did not provide outpatient care.[9]

Consult Management

Consults are "used as two-way communication on behalf of a patient consisting of a physician or provider (sender) request seeking opinion, advice, or expertise regarding evaluation or management of a specific problem answered by a physician or other health care provider (receiver)." Consult requests are routed through the electronic health record (EHR) and can be ordered as face-to-face consults or e-consults. An e-consult does not involve a face-to-face visit between the receiving provider and the patient and is ordered when the sending provider is seeking the advice or expertise of the receiving provider in order to perform diagnostic and medical patient management. The receiving provider reviews the patient's medical record and provides a documented response to the sending provider.[10]

The receiving provider can take various actions on a consult including

- receive, indicating efforts are being made to complete the consult;
- cancel, if the consult is no longer needed;
- forward, to another service, as appropriate; or
- convert to an e-consult or face-to-face, if deemed appropriate.[11]

In 2019, VHA mandated the Referral Coordination Initiative (RCI), which "transition[ed] [consult] scheduling from multiple clinical employees to referral coordination teams (RCT),

[7] The endocrine section chief retired from the system in early 2024; as of November 2024, the role remained vacant.

[8] Endocrinologist 3 resigned in mid-summer 2024.

[9] The OIG was told the COM is a board-certified endocrinologist and did not provide direct patient care in the outpatient setting until October 2024.

[10] VHA Directive 1232(5), *Consult Processes and Procedures*, August 24, 2016, amended December 5, 2022. This directive was in place during the time of the events discussed in this report. VHA Directive 1232(5) was rescinded and replaced by VHA Directive 1232, *Consult Management*, November 22, 2024. Unless otherwise specified, the 2024 directive contains the same or similar language as the rescinded 2022 directive. The OIG acknowledges the new directive was issued outside of the time frame of this inspection but expects system leaders to comply with the new requirements effective November 22, 2024.

[11] VHA Directive 1232(5); VA Office of Veteran Access to Care, *Electronic Consultation (E-Consult) Implementation Guide Version 3.0*, May 2019.

comprised of administrative and clinical staff" with a goal to improve scheduling timeliness and patient involvement in healthcare decisions.[12] Under the RCI, once the sending provider orders a consult, the clinical members of the RCT can triage the consult and complete the consult management process through scheduling.[13]

Prior OIG Reports

In August 2023, the OIG published a report, *Deficiencies in Echocardiogram Interpretation Timeliness, Facility Policies, Patient Safety Reporting, and Oversight at the Fayetteville VA Coastal Health Care System in North Carolina.* The report addressed delays in echocardiogram interpretation, deficiencies in patient safety reporting, and system leaders' oversight.[14] The OIG made six recommendations including one related to the COM's evaluation of provider performance. As of November 14, 2024, this recommendation remained open.

Allegations and Related Concerns

In March 2024, the OIG received a confidential complaint alleging that the COM did not

- manage internal endocrine consults,
- utilize endocrine clinic appointments to meet patient needs, and
- ensure transgender patients received timely and appropriate GAHT.[15]

The OIG opened a hotline inspection in June 2024. During the inspection, the OIG identified an additional concern related to system executive leaders' (executive leaders) awareness and response to concerns regarding the COM's interpersonal communication with staff and leaders in various services at the system.[16]

[12] VHA Office of Integrated Veteran Care, *Referral Coordination Initiative (RCI) Guidebook*, November 2023.

[13] VHA Office of Integrated Veteran Care, *Referral Coordination Initiative (RCI) Guidebook*.

[14] VA OIG, *Deficiencies in Echocardiogram Interpretation Timeliness, Facility Policies, Patient Safety Reporting, and Oversight at the Fayetteville VA Coastal Health Care System in North Carolina*, Report No. 22-01230-185, August 30, 2023.

[15] At the time of the OIG's inspection in June 2024, VHA's policy was to "provide care or pay for care in the local community" for transgender patients, which includes "hormonal therapy, mental health care, preoperative evaluation … and long-term care following gender-affirming surgery." VHA Directive 1341(4), *Providing Health Care for Transgender and Intersex Veterans*, May 23, 2018, amended August 19, 2024. This directive was rescinded on March 17, 2025, noting that patients already receiving GAHT through VA Health Care at the time of recission remain eligible to receive this therapy. VHA Notice 2025-01(1), "Rescission of VHA Directive 1341(4), Providing Health Care for Transgender and Intersex Veterans," March 17, 2025.

[16] For purposes of this report, executive leaders include the System Director, Chief of Staff, Deputy Chief of Staff, and Associate Director of Access and Clinical Business Operations.

Scope and Methodology

The OIG conducted a site visit from September 9 through 12, 2024, and conducted virtual interviews through October 1, 2024.

The OIG interviewed VHA Office of Specialty Care leaders, the VISN Chief Medical Officer, and system leaders and staff. The OIG reviewed relevant VHA and system policies and procedures, Joint Patient Safety Report data, organizational charts, committee meeting minutes, electronic communications, and patients' EHRs.[17] The review also included endocrine clinic utilization, patient appointment wait-time data, and endocrine consult data. The OIG did not independently verify VHA data for accuracy or completeness.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

1. Deficiencies in Internal Endocrine Consult Management

The OIG substantiated that the COM did not effectively manage internal endocrine consults. Specifically, the COM

[17] The OIG reviewed patient examples provided by the complainant, other interviewees, and from joint patient safety reports.

- did not communicate endocrine consult management process changes to key stakeholders,
- did not process consults per VHA timeliness requirements,
- canceled a large volume of consults without communicating to sending providers,
- converted face-to-face consults to e-consults without providing a mechanism for sending providers to communicate concerns as required by VHA, and
- delayed implementation of a required service line agreement.

These actions resulted in delays in patient care and provider-created workarounds that circumvented the formal consult process required by VHA.

Communication About a Consult Process Change

Change management in the healthcare setting "focuses on the process of implementing and maintaining change in order to improve quality of care, reduce costs, and ensure the delivery of safe and effective care."[18] One essential component for implementing change successfully is gaining buy-in from those involved, which requires "communicating with stakeholders, motivating impacted individuals to accept the change, and encouraging cooperation among the team."[19] In 2018, VHA implemented high reliability organization (HRO) concepts to promote a culture of safety. Clear bidirectional communication and respect for people are two of seven VHA HRO values.[20]

The COM told the OIG of changing the endocrine consult management process by routing all consults through the COM rather than the endocrine providers for initial review.[21] The COM explained the process change was made to decrease the number of endocrine consults being sent to the community when they could be addressed by system endocrinologists, and to create "a forwarding pathway for e-consults." In addition, the COM stated the new process (1) reduced the amount of consult alerts received by endocrine providers, (2) decreased the endocrine provider's administrative workload, and (3) allowed the COM to learn more about the

[18] Maxamillian Solow and Tjorvi E. Perry, "Change Management and Health Care Culture," *Anesthesiology Clinics*, 41, no. 4 (December 1, 2023): 693–705, https://doi.org/10.1016/j.anclin.2023.05.001.

[19] Solow and Perry, "Change Management and Health Care Culture."

[20] VA, "VHA High Reliability Organization (HRO) Reference Guide," September 2024. "High reliability means evidence-based, exceptional care is consistently delivered for every patient, every time, at any facility across VHA." The seven HRO values are: It's About the Veteran; Support a Culture of Safety; Commit to Zero Harm; Learn, Inquire and Improve; Duty to Speak Up; Respect for People; and Clear Communications.

[21] The COM could not provide a date for the process change; however, endocrine providers told the OIG that the change occurred in June 2023.

endocrine clinics. The COM told the OIG of assuming the process change was communicated to staff by the endocrine section chief at a staff meeting.

In OIG interviews, two endocrinologists previously responsible for managing consults confirmed that the consult management process changed but reported the change was not communicated to them. Rather, the endocrinologists noticed they had suddenly stopped receiving consults in June 2023. The OIG reviewed relevant email correspondence and found endocrinologist 2 emailed the medical service administrative staff, with the COM copied, alerting to a concern of a possible technical issue that could be hindering receipt of consults. Endocrinologist 2 told the OIG that a response to the email was not received, and it was not until "much later" at a team meeting that the COM told endocrine staff of the process change.[22]

The OIG also reviewed email correspondence from mid-August 2023, about two months after the process change was made, and found the RCI nurse manager sent a notification to endocrinologists about lack of consult timeliness. The endocrine section chief replied that the COM had taken over consult management and copied the COM on the email.[23] In interviews, the Chief of Staff (COS) and Deputy COS told the OIG of being unaware that the COM was receiving all endocrine consults for review and first action.

The OIG expects the COM to ensure clear communication to all involved, including system leaders, of a process change affecting endocrine providers and other system staff. Implementing a process change without advanced communication does not reflect HRO values, as lack of communication can decrease stakeholder buy-in, cause confusion among those directly impacted, and decrease trust between staff and leaders.

Timeliness of Consult Processing

VHA requires that consults are acted upon within two business days after being placed by a sending provider.[24] One exception relates to e-consults, which have no time requirement for first action, but must be completed within three business days.[25] VHA identifies that the receiving

[22] The OIG could not confirm the date or substance of discussion at the team meeting as the chief of quality and safety reported confirming with the COM that endocrine section meetings were not scheduled regularly, and minutes were not recorded.

[23] After not receiving a reply from the COM, the RCI nurse manager sent another email about the delayed endocrine consults to the COM six days later.

[24] For this section of the report, a "day" means a business day. VHA Directive 1232(5); Business days exclude weekends and Federal holidays. 31 C.F.R. § 800.203 (2024).

[25] VHA Directive 1232(5). An e-consult is ordered when a provider is seeking the advice or expertise of a specialist to provide diagnostic and medical management to a patient. The specialist reviews the patient's medical record and provides a documented response to the sending provider. An e-consult does not involve a face-to-face visit between the specialist and the patient. Other exceptions include prosthetic and pathology consults.

provider is responsible to ensure timely consult review and response and service leaders are responsible for compliance with consult performance measures.[26]

A former primary care provider (PCP) and two endocrinologists told the OIG of challenges related to delays in endocrine consult processing after the COM took ownership of endocrine consult management. The PCP shared frustration that a patient reported not having "heard from endocrinology yet and it had been months" after an endocrine consult had been placed. Two endocrinologists reported receiving messages from PCPs about consults that had not been addressed. One endocrinologist stated, "We've had patients come up to endocrine clinic because their [PCP] told them, 'I put in an endocrine consult,' so [the patients] come up here and they say, 'why are [endocrinologists] not answering our consults?'"

In an OIG interview, the COM reported instances of delays in endocrine consult review. The COM explained, "I look at all of them but had not triaged them … I can think of about three episodes last year where I got behind … later than I would have wanted to be on those." When asked about the cause for delays, the COM cited "administrative burden and [a] system issue."[27]

The OIG reviewed consult data for 1,601 internal endocrine consults ordered (and not originally ordered as e-consults) from June 2023 through June 2024 and found that the COM did not act on 197 (12 percent) of consults within two days. Of the 197 consults, 123 (62 percent) were not acted on for more than 7 days and 54 (27 percent) were not acted on for 50 days or more. Thirty consults remained pending for more than 100 days. Of those, 3 consults remained pending for over 200 days.

The OIG also reviewed completed e-consult data from the same period and found of 141 e-consults, 88 (62 percent) were not completed within 3 days.[28] Of the 88 e-consults not completed within 3 days, 44 (50 percent) took between 90 and 164 days to complete.

The OIG reviewed multiple communications that alerted the COM and the executive leadership team of endocrine consults that required action. The system group practice manager (GPM) told the OIG that a system data team sends daily emails to service chiefs, including the COM, which include lists of consults not acted on or completed within VHA requirements.[29] In addition, the GPM told the OIG that the executive leadership team receives a weekly brief on consult data,

[26] VHA Directive 1232(5).

[27] The COM reported the system issue was a change in the consult alert system, which was not communicated widely throughout the system.

[28] The OIG found that as of November 2024, three e-consults remained incomplete. The OIG defined incomplete e-consults as consults that did not have a terminal action of *canceled*, *discontinued*, or *completed*. One of these e-consults was ordered in February 2024, and two in June 2024.

[29] The GPM confirmed this practice started prior to 2023.

including those not acted on or completed consistent with VHA requirements.[30] The OIG also reviewed correspondence provided by the RCI nurse manager and an associate GPM and found 11 additional email reminders sent to the COM from July 2023 through June 2024, regarding consults that were overdue for action or completion; two of which included a copy to a member of the executive leadership team. One email, sent to the COM in late February 2024, included a list of 121 overdue endocrine consults, including 61 e-consults.

The COM told the OIG that due to workload capacity, endocrinologist 3 was assigned to complete all e-consults. Endocrinologist 3 told the OIG about not receiving e-consult alerts during a period in early 2024, which resulted in a backlog of incomplete e-consults. The OIG reviewed correspondence between the COM and endocrinologist 3 and found that the COM provided partial lists of the overdue e-consults to endocrinologist 3 in batches from mid-March through early June 2024 for completion.

Every pending consult or incomplete e-consult is associated with a patient waiting to see a specialist or a PCP awaiting guidance on medical management. The OIG is concerned that despite multiple alerts to the COM and executive leadership team members about delays in consult actions and resulting delays in patient care, no actions were taken to determine the cause. The OIG expects the COM or executive leaders would have reviewed the endocrine consult management process for efficiency or patient impact. In addition, the OIG would have expected the COM to disperse a backlog of e-consults to all available endocrine providers for immediate action, rather than tasking one endocrinologist to address them in intervals over a three-month period, resulting in further patient care delays.

Consult Cancellation and Conversion to E-Consults

Consults may be canceled when staff responsible for consult management have determined a consult is no longer needed.[31] When consults are canceled, VHA requires that the reason for cancellation is documented. In cases when further work-up is required before a consult can be acted on, VHA "highly" recommends e-consults are utilized to provide recommendations to the sending provider instead of canceling the consult.[32] A receiving provider can convert a face-to-face consult to an e-consult, however, VHA specifies the sending providers should have the ability to refuse if they feel that the needs of the patient cannot be met through an e-consult.[33]

[30] The GPM provided the OIG with examples of the daily emails and weekly briefings, which identified endocrinology as a service with consults not being acted on or completed consistent with VHA requirements.

[31] VHA Directive 1232(5).

[32] VHA Directive 1232(5); VHA Directive 1232. VHA Directive was 1232 updated and now indicates to facilities that "e-consults must be used to provide further recommendations in place of cancelling a consult …"

[33] VA Office of Veteran Access to Care, *Electronic Consultation (E-Consult) Implementation Guide Version 3.0*.

Canceled Consults

In an OIG interview, the COM explained that the decision to cancel endocrine consults was made during the review process if the type of care being requested did not require an endocrinologist.[34] The COM further stated that when canceling endocrine consults, the intent is to include a comment as to why endocrine consultation is not needed.

PCPs told the OIG of concerns regarding the volume of endocrine consults that were being canceled and the rationales provided for the cancellations. A former PCP told the OIG,

> every time I would put a consult in, they were just immediately canceled and it's frustrating … because I felt the work-up was done, but they say … further work-up or this can be managed by primary care, but I feel that if we're asking for help, it's because we've got to the point that we can't do anything more from our end. This is why we're consulting this specialist … I don't feel like we were getting enough support.

In OIG interviews, PCPs reported communicating concerns regarding canceled consults to the COM but did not consistently receive responses. One PCP reported receiving a response from the COM that suggested a need for PCPs to receive further clinical training, which the PCP characterized as "disrespectful." PCPs explained to the OIG that, as a result of continued consult cancellation, they stopped ordering endocrine consults for their patients. The COS told the OIG of being unaware that some PCPs had stopped entering endocrine consults.[35] The COM affirmed knowledge that some PCPs were upset by the volume of canceled consults and told the OIG in September 2024, of a "goal" to speak at a future primary care service line meeting to discuss the clinical scenarios appropriate for placing endocrine consults.[36]

The OIG reviewed internal endocrine consult data from June 2023 through June 2024 and found that of the 1,601 consults, the COM reviewed 1,153 and canceled 491 (43 percent).[37] The COM forwarded 448 consults to WHCC endocrine providers for review and the WHCC physician

[34] The COM provided examples of consults that did not require an endocrinologist, including a consult for thyroid dysfunction for a patient with normal thyroid hormone lab results, and a consult requesting a continuous glucose monitor for a patient when a clinical pharmacist is responsible for that function.

[35] On January 3, 2025, the COS responded to the OIG via email and further reported being "alarmed that the PC team was frustrated, and it was not brought up to our attention." The COS also reported taking steps to address clinical expectations between primary care and endocrine providers.

[36] In response to follow-up correspondence on January 8, 2025, the COM told the OIG that a presentation about endocrine consults had not been delivered at a primary care service line meeting.

[37] The OIG opined that the number of canceled consults is higher than expected, however, the OIG did not review the individual canceled consults to determine whether cancellations were appropriate.

assistant canceled 92 (21 percent).[38] The OIG found that consults canceled by all providers generally had corresponding comments as required by VHA.[39] Further, the OIG reviewed the COM's comments and found that 19 percent included recommendations for further work-up such as diagnostic laboratory tests. However, this was contrary to VHA's recommendation that e-consults are utilized to provide requests to the sending provider for further action "if a work-up is incomplete," instead of canceling the consult.[40]

The OIG also reviewed six emails that a PCP sent to the COM from September 2023 through July 2024, expressing concerns about specific canceled endocrine consults. The COS was copied on three of the emails and responded to one, encouraging the PCP to attend an upcoming Town Hall meeting to discuss the concerns. The PCP responded to the COS stating, "Of course we will attend this meeting … [h]owever … [w]e have been saying the same things for years and I am not sure what voicing it yet again in a meeting will impact change." The OIG found one response from the COM offering to provide clinical training for PCPs.[41]

Conversion to E-Consults

Of the 1,153 internal endocrine consults that the COM reviewed from June 2023 through June 2024, the OIG found that the COM converted 139 (12 percent) of face-to-face consults to e-consults. In an OIG interview, a PCP shared concerns related to face-to-face consults getting converted to e-consults without having the ability to refuse in cases where they felt the needs of the patient could not be met through an e-consult. The PCP gave an example in which this occurred and told the OIG of not feeling that an e-consult was appropriate for the patient.[42]

Endocrinologist 3, who was responsible for completing e-consults, told the OIG that it was common to receive e-consults from the COM that PCPs originally ordered as face-to-face consults. Endocrinologist 3 expressed concerns about not having autonomy in the e-consult review process, stating,

[38] Of the 448 consults that the COM forwarded to WHCC providers, 114 consults were acted on by providers other than the WHCC physician assistant whom the COM identified as the only other endocrine provider who performed consult triage: 103 consults were acted on by endocrinologist 3 (9 percent of those consults were canceled); the COM acted on 9, including 2 cancellations; non-endocrinologist providers acted on 2 consults, including 1 cancellation. Endocrinologist 3 told the OIG of triaging consults as a backup when the physician assistant was out of the clinic.

[39] The OIG did not perform EHR reviews to assess the quality of the comments provided. The OIG found that of all canceled consults, only one did not have an associated comment.

[40] VHA Directive 1232(5).

[41] Of note, the OIG was told the COM served as the interim chief of primary care from March 5, 2024, through August 24, 2024, while maintaining duties as the COM concurrently, and therefore had a more substantial role in managing the consult traffic between the services. The former chief of primary care was also a recipient of the emails sent prior to March 2024.

[42] The OIG confirmed that the COM converted this face-to-face consult to an e-consult.

> I would get [e-consults], and I would review them, and I would in many of them say "wow, this is really complicated. I … need to see this person …" And I was not able to kind of facilitate that … I didn't have the ability to convert a consult. That was turned off … I didn't feel like an e-consult was gonna serve them. But I did not feel like I had ultimate decision-making about that.[43]

Consult Workarounds

Workarounds are behaviors that bypass an apparent or perceived workflow obstacle in order to achieve a goal.[44] Workarounds can undermine patient safety by going outside safety mechanisms or masking deficiencies that can jeopardize patient care.[45] A common healthcare workaround is informal consultation, also known as curbside consultation, whereby a provider seeks input from other providers through phone, email, face-to-face, and other means.[46] VHA requires providers to use the EHR to document all consults.[47]

Endocrinologists told the OIG that as a result of endocrine consult delays, cancellations, and conversions to e-consults, PCPs did not feel they could safely manage patients and workarounds were developed to get the patient care management support needed. The endocrinologists explained that the use of curbside consultation was a common workaround whereby the PCP contacted an endocrinologist through Teams messaging or via phone to request assistance in managing patients and resulting in an informal consult that was not documented in a patient's EHR.[48] The complainant provided the OIG with multiple examples of Teams messages sent from PCPs to endocrinologists that included requests for informal consults. One message sent from a PCP to endocrinologist 2 voiced frustration about multiple canceled consults. The PCP stated, "I DON'T KNOW EVERYTHING [*sic*] … I don't have time to educate myself on specialty all day long when I'm seeing [patients]." Endocrinologist 2 replied,

> you would not believe how many curb side [*sic*] consults we get via teams … we have mentioned this to our chief … and [the COM's] answer was for us not to

[43] The OIG could not confirm that Endocrinologist 3's ability to convert a consult had been disabled as Endocrinologist 3 was no longer a VHA employee at the time of the OIG interview.

[44] Debono, D. et al., "Nurses' Workarounds in Acute Healthcare Settings: A Scoping Review," *BMC Health Services Research* 13, no. 175 (May 11, 2013), https://doi.org/10.1186/1472-6963-13-175.

[45] Debono, D. et al., "Nurses' Workarounds in Acute Healthcare Settings: A Scoping Review."

[46] Zacharias, R., Feldman, E., Joffe, S., and Fernandez Lynch, H., "Curbside Consults in Clinical Medicine: Empirical and Liability Challenges," *The Journal of Law, Medicine, and Ethics 49,* no.4 (2021): 599-610, https://doi.org/10.1017/jme.2021.83.

[47] VHA Directive 1232(5).

[48] Teams is a Microsoft messaging application used for communication and meetings. "What is Microsoft Teams?," Microsoft Support, accessed June 27, 2024, https://support.microsoft.com/en-us/topic/what-is-microsoft-teams-3de4d369-0167-8def-b93b-0eb5286d7a29.

> answer the curb side [*sic*], but we should tell the PCP asking to contact [the COM] instead, I chose not to do that, this is a very serious issue …

Endocrinologist 3 told the OIG of another workaround created to address consults that the COM converted to e-consults, but that endocrinologist 3 felt needed to be converted back to face-to-face. Endocrinologist 3 arranged to have PCPs resubmit the consult, at which time endocrinologist 3 would locate the consult in the EHR and immediately move it forward to scheduling; thus, bypassing the COM's review of the consult.[49]

The OIG expects that open lines of communication between sending and receiving providers are built into the consult management process and are a standard aspect of clinical practice. The OIG is concerned that despite PCPs voicing concerns about the volume of canceled endocrine consults to the COM and the COS, no sustainable attempts were made to address the issue, or to implement VHA's recommendation to use e-consults to provide suggestions for further work-up rather than cancel a consult. In addition, the OIG is concerned that despite VHA guidance, no mechanism is in place for the sending provider to object to the conversion of a face-to-face consult to an e-consult based on the clinical needs of a patient. PCPs and system endocrinologists established workarounds, which resulted in consultations not being documented in the EHR as required by VHA and potentially compromising patient care and safety.

Service Line Agreement Implementation

Service line agreements (SLAs) are written documents that outline an understanding between two services, one of which sends consults to the other, defining rules and expectations for services sending and receiving consults.[50] SLAs are also used by clinical members of the RCT to review consults before scheduling.[51]

VHA requires that SLAs are established and include consensus between the involved services and signatures of involved service chiefs. Service chiefs are responsible for establishing and using SLAs "with a goal of optimizing referral relationships, establishing clear processes, and reducing the need for inspection and rework."[52]

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[49] This workaround was done outside the formal consult review process whereby the endocrinologist would locate the consult by actively searching through the patient's EHR, rather than receiving an alert.

[50] VHA Directive 1232(5). Examples of rules and expectations include diagnoses that are appropriate for consultation, and lab tests or other diagnostics that should be completed before a consult is ordered. VHA uses the term *care coordination agreement*, which is synonymous with *service line agreement*. For purposes of this report, the term *service line agreement* will be used.

[51] VHA Office of Integrated Veteran Care, *Referral Coordination Initiative (RCI) Guidebook*, November 2023. During this inspection, system staff and leaders informed the OIG that the RCT was managing consults for multiple services, however, endocrine consult management had not yet transitioned to the RCT because an endocrine section SLA was not complete.

[52] VHA Directive 1232(5).

Staff and leaders told the OIG that despite multiple attempts to develop an SLA between the endocrine section and primary care services (endocrine SLA), an endocrine SLA had not been approved and implemented.[53] System leaders opined that the delay was due to the COM's hesitancy to utilize the RCT for endocrine consult management. The RCI nurse manager reported receiving an endocrine SLA from the COM in August 2024; however, it was missing required signatures.[54] The RCI nurse manager told the OIG of twice offering to route the SLA for additional signatures on behalf of the COM, but the COM did not respond.

In an OIG interview, the COM attributed the delay in implementing an endocrine SLA to difficulty getting the SLA signed by primary care as the former chief of primary care required all PCPs to review and approve the SLA before signing. The COM explained this was resolved when the COM became the interim chief of primary care and chose to only have primary care section chiefs review the SLA. An OIG document review showed the COM signed the SLA as the interim chief of primary care and the deputy chief of medicine signed as the acting COM.[55]

The OIG was told that the System Director provided two separate deadlines for the endocrine SLA to be completed: July 15, 2024, and September 20, 2024. As of late January 2025, the RCI nurse manager confirmed that an endocrine SLA had not been approved nor implemented.

The OIG found that the COM did not establish an endocrine SLA as required per VHA. The absence of an SLA can (1) negatively affect relationships between services that order and receive consults, (2) result in unclear consult management processes, and (3) increase the need for inspection and rework. The OIG opines that had an endocrine SLA been implemented, thus placing responsibility for endocrine consult management with the RCT rather than the COM, timeliness of consult processing and communication between primary care and endocrine providers could have been improved.

2. Impact of Deficient Endocrine Consult Management on FHCC Clinic Utilization

The OIG substantiated that the COM's deficient management of endocrine consults had a negative impact on endocrine clinic utilization at FHCC. Specifically, the OIG found that due to consult cancellations, conversions, and delays, the supply of new patient (consult) and

[53] System staff and a member of the executive leadership team reported the endocrine SLA had been worked on for at least two years.

[54] The RCI nurse manager told the OIG that additional required signatures included members of the executive leadership team and the acting chief of primary care.

[55] The COM and deputy chief of medicine signed the SLA on August 29, 2024.

established patient (follow-up) appointments did not match patient demand. As a result, follow-up patients did not get timely endocrine appointments.[56]

Endocrine Clinic Appointment Utilization

To assist in managing access to care, accurate clinic profiles are necessary to understand the supply of appointments needed to meet the demand for care.[57] A clinic profile sets capacity (number of appointments) for the clinic and defines scheduling parameters for available appointments.[58] Accurate clinic profiles result in improved patient access and optimal clinic appointment utilization.[59]

VHA requires that service chiefs work collaboratively with GPMs to provide oversight of clinic scheduling including "the mix of appointment types, length, and quantity" of clinic profiles.[60] Services are to maintain accurate clinic profiles by reviewing capacity and making changes routinely.[61] System policy states that service chiefs are responsible for identifying a need for clinic profile changes, reflecting "long-range needs of the patient population."[62]

According to VHA, clinic utilization data provide insight to supply and demand for services, and analysis of this data can "identify potential barriers and, more importantly, trend improvements."[63] VHA requires the Clinic Practice Management team to review key metrics, such as clinic utilization, for continuous assessment of clinic performance, at minimum

[56] VHA Office of Integrated Veteran Care, "VHA Office of Integrated Veteran Care Clinic Profile Management Business Rules," May 24, 2023. VHA defines a new patient as a patient who has not been seen by the specific service in the past 36 months, and an established patient as a patient who has been seen by the specific service within the past 36 months.

[57] VHA Office of Integrated Veteran Care, "VHA Office of Integrated Veteran Care Clinic Profile Management Business Rules." Supply refers to the number of appointments available, whereas demand refers to the number of appointments scheduled or requested.

[58] VHA Directive 1231(4), *Outpatient Clinic Practice Management*, October 18, 2019, amended February 7, 2024.

[59] VHA Office of Integrated Veteran Care, "VHA Office of Integrated Veteran Care Clinic Profile Management Business Rules."

[60] VHA Directive 1231(4).

[61] VHA Office of Integrated Veteran Care, "VHA Office of Integrated Veteran Care Clinic Profile Management Business Rules."

[62] VA Fayetteville Coastal Healthcare System, "Clinic Profile Management" (standard operating procedure), September 2023.

[63] VHA Office of Integrated Veteran Care, "VHA Office of Integrated Veteran Care Clinic Profile Management Business Rules."

monthly.[64] VHA business rules state, "[u]tilization that is too high or too low signals the need for additional review and modification."[65]

Endocrinologists 1 and 2 reported to the OIG that as the COM canceled consults, the number of new patients being referred to the endocrine clinic diminished, leaving consult appointments unused. Further, endocrinologists 1 and 2 reported there were not enough follow-up appointments to meet patient demand.

Endocrinologist 2 told the OIG that "there will be many days that we will not have any consults to see … [but yet] we don't have enough follow-up [appointments]." Endocrinologist 1 explained that the clinic profile had four hours of consult appointments in the morning, but they would have no patients to see, although there were patients in need of follow-up appointments.

The OIG reviewed a July 2023 email from the COM, which included the GPM and Deputy COM, recommending changes to the endocrinologists' clinic profiles by decreasing the number of consult appointments and replacing them with follow-up appointments. The OIG was informed that requested clinic profile changes did not become effective until late November 2024.[66]

Endocrinologists 1 and 2 told the OIG of continued concerns about the inability to schedule follow-up appointments and reported reaching out to medical support assistants, requesting follow-up appointments be scheduled into underutilized consult appointments. The OIG reviewed an email sent by the supervisory medical support assistant to the endocrinologists, the endocrine section chief, COM, and the Deputy COM in December 2023, listing follow-up patients who needed to be scheduled. Endocrinologist 1 responded that consult appointments were open and that they should be used to schedule patients in need of follow-up; however, the COM responded that this practice was not allowed.[67]

The OIG reviewed an email sent by the endocrine section chief to the COM in February 2024 requesting that consult appointments be converted to follow-up appointments, further adding that, due to retirement, the endocrine section chief's patient panel "rapidly overflowed [the remaining endocrinologists'] [f]ollow up visit [appointments] to beyond October." The COM replied that "we keep close eye on utilization and availability of clinics." However, contrary to

[64] VHA Directive 1231(4). The Clinic Practice Management team is responsible for patient access and using resources effectively. The team consists of the GPM and service line clinical and administrative leads.

[65] VHA Office of Integrated Veteran Care, "VHA Office of Integrated Veteran Care Clinic Profile Management Business Rules." Systems can select target rates for clinic utilization; "[s]ome sites have elected to use 80% – 120% as a local target." VISN 6 uses a target of 85 percent utilization for Medicine Service.

[66] Despite inquiring as to why the request was not implemented, the OIG was unable to get a clear explanation from the GPM.

[67] The endocrinologists' consult appointments were set at 60 minutes, and follow-up appointments were set at 30 minutes and could not be changed.

the COM's response, the OIG reviewed clinic profiles and profile auditing data and found no changes were made in response to the endocrine section chief's request. Endocrinologist 2 confirmed during an OIG interview that being assigned the endocrine section chief's patients made it even more difficult to schedule follow-up appointments.

In OIG interviews, the GPM reported making attempts to have weekly meetings with the COM to discuss issues such as consult management and clinic utilization; however, the COM did not attend. With only administrative staff attending, the meetings were not productive in that decisions were not made or were not supported by the COM. The GPM stated the COM is the "only service chief that does not meet with us."[68]

The associate GPM told the OIG of attempting to communicate with the COM through Teams messaging and email but not receiving responses. The associate GPM sought assistance from the GPM, who requested to be added to communications with the Medicine Service. The COM told the OIG of reviewing clinic utilization at least weekly and having administrative staff attend meetings with the GPM to discuss clinic profiles. The Medicine Service administrative officer confirmed that the COM does not typically attend the meetings and that administrative staff work as liaisons between the COM and the GPM.

The GPM told the OIG that the GPM's team completes an annual review of clinic utilization and clinic profiles for each provider and further stated that FHCC endocrinology clinic utilization was not the focus, rather the focus was the WHCC clinic. The GPM explained that the WHCC endocrine clinic utilization was low, as was the demand in the geographic area to support a full-time endocrinologist. The COM reported awareness of the low utilization at WHCC. The OIG reviewed endocrine utilization data provided by the GPM and identified that data reflected overall underutilization. To better understand endocrinologist 1 and 2's availability, the OIG reviewed consult and follow-up appointment utilization data from January 2023 through May 2024 (figure 1).[69]

[68] The COS told the OIG of being aware that the COM was not attending the meetings with the GPM team and was not concerned as long as the administrative officer was attending, further stating, the administrative officer does not have authority to make decisions, including clinic profile changes.

[69] "Clinic Utilization Dashboard," Power BI VSSC Access Team, https://app.powerbigov.us/groups/me/apps/057a6693-7190-4fd4-9491-f8a038913689/reports/70332590-e0b9-445d-a014-81bbc410b497/ReportSectionfe1e32a2efea11b87c4e?ctid=e95f1b23-abaf-45ee-821d-b7ab251ab3bf. (This website is not publicly accessible.) VHA Office of Integrated Veteran Care, "Clinic Profile Management Business Rules," updated May 24, 2023. The Clinic Utilization report can be used to track number of appointments used and number of appointments remaining unused as a method to monitor clinic capacity on an ongoing basis. To clearly understand how the change in consult process effected clinic scheduling, the OIG extended the data from January 2023 through May 2024. June 2024 data was excluded as one endocrinologist was on extended leave.

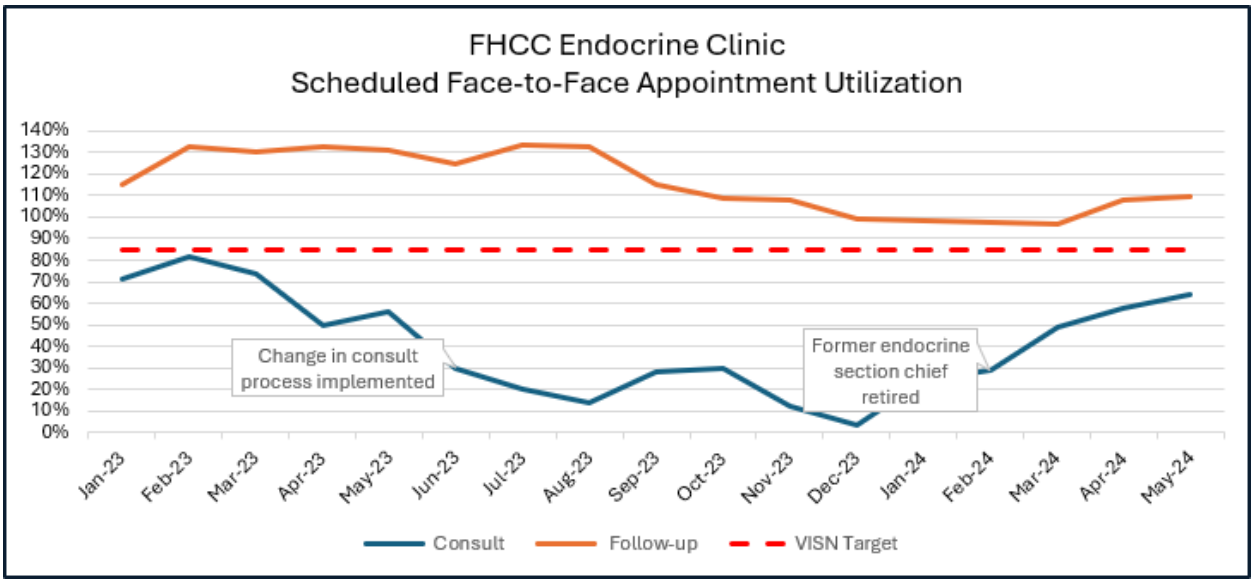

Figure 1. FHCC Endocrine Clinic scheduled face-to-face endocrine consult and follow-up appointments utilization from January 2023 through May 2024.

Source: OIG analysis of VHA Support Service Center Access team data of scheduled endocrine clinic utilization at the FHCC. Specifically, the percentage of face-to-face scheduled consult and follow-up appointments compared to target clinic capacity.

The OIG noted face-to-face follow-up appointment utilization was higher than 100 percent for the majority of the 17-month period, while the face-to-face consult appointment utilization rate was below 60 percent of the capacity for the same period, never meeting the VISN target of 85 percent utilization. The OIG found that after the COM took over the endocrine consult management process, scheduled face-to-face consult appointments declined to lower than 30 percent, meaning 70 percent of the appointments were not being utilized, while follow-up appointments were consistently utilized higher than the target rate of 85 percent. The OIG also noted that just prior to and after the endocrine section chief's retirement in February 2024, it was reported patients were assigned to the remaining endocrinologists as consult appointments rather than follow-up, resulting in an increase in consult appointment utilization.

The OIG reviewed endocrinologists 1 and 2's clinic profiles and confirmed that the morning appointment times were allotted primarily to consult appointments. The OIG learned that endocrinologists' clinic profiles had been changed to allocate more follow-up appointments and fewer consult appointments, with changes going into effect by late November 2024.[70]

The OIG concluded that while FHCC endocrine consult appointments had low utilization, the endocrinologists had challenges in scheduling follow-up appointments. Although the COM

[70] The facility completed the annual clinic profile review for the endocrine providers on May 15, 2024, which identified a need for clinic profile changes.

requested an adjustment to the endocrinologists' clinic profiles, the COM failed to confirm the changes were implemented and to take timely actions to minimize the discrepancy in supply and demand of the clinic. Additionally, the OIG concluded that system leaders, including the COM and GPM, did not take steps to utilize endocrine clinic data to identify opportunities for improving utilization despite continued complaints from endocrine providers and staff.

Delays in Established Patient Follow-Up Appointments

VHA requires specialty care patient appointments be scheduled within 28 days of the provider's return-to-clinic date—the requested date for the patient's next appointment.[71] VHA also requires service chiefs to identify clinics with appointment wait times exceeding VHA wait-time standards.[72]

Endocrinologists 1 and 2 told the OIG that follow-up patients had to wait months to be seen, although the return-to-clinic dates were sooner. In response to the COM disapproving of scheduling follow-up patients into consult appointments, the OIG learned that endocrinologists started placing follow-up patients in the endocrine nurse clinic, bypassing the provider clinics. The endocrinologists placed return-to-clinic orders for the nurse clinic where patients were seen by the nurse who communicated with the provider as to the patients' status and to receive further instructions. Endocrinologist 1 stated this process was like "virtually doing the medical management" but not getting workload credit for the visit.[73]

In an interview, the GPM confirmed the system's target to see patients within 28 days and stated that endocrine follow-up wait times did not exceed the metric, although there may have been exceptions when the endocrine section chief retired, and the remaining endocrinologists took over those patients. The OIG also learned that the GPM was more concerned with the endocrine consult management process than endocrine follow-up appointment access. The OIG reviewed the Medicine Service report card and found that from October 2023 through June 2024, wait times for completed endocrine follow-up appointments were less than 28 days.[74] However, the

[71] VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393 (2018); 38 C.F.R. § 17.4040 (2019); VHA Office of Integrated Access Operations, "Standard MISSION Act Guidance: Patient Eligibility and Scheduling Reference Sheet," February 26, 2023.

[72] VHA Directive 1230.

[73] In addition to workload credit issues, the OIG is concerned that this practice may result in providers delivering care that is not documented in the EHR. It would be difficult to determine which patients were subject to this work-around; therefore, the OIG was unable to conduct EHR reviews on relevant patients.

[74] According to VHA, completed appointment wait times are calculated using appointments that were not canceled or not attended by patients (that is, a patient was a no-show), appointments with a checkout date and time (that is, a patient completed the appointment), and appointments that occurred in the past. "Appointments Cube Dashboard" data definitions, accessed November 26, 2024, https://vssc.med.va.gov/VSSCMainApp/products.aspx?PgmArea=48. The GPM told the OIG the service report card is reviewed monthly by the GPM and contains a number of data elements including wait times, clinic utilization, and consults.

OIG confirmed the metric combined data for FHCC and WHCC endocrine clinics. The OIG reviewed follow-up appointment wait-time data for endocrinologists 1 and 2. Except for one month, wait times ranged from 29 to 77 days.[75]

The OIG concluded that FHCC endocrine follow-up patients experienced wait times longer than the VHA target of 28 days. Although system leaders, including the COM and GPM, reviewed appointment wait-time data, the data included WHCC and FHCC combined. The OIG expects that given the awareness of the low utilization at WHCC due to low patient demand, the GPM and COM should have analyzed utilization for FHCC independent of the WHCC data to track and trend supply and demand issues at FHCC.

3. Delays in Patient Access to Gender-Affirming Hormone Therapy

The OIG substantiated that for about eight months, from February 2024 through early October 2024, patient access to GAHT was delayed as a result of the COM's actions, resulting in adverse clinical outcomes.[76] The OIG considers an adverse clinical outcome to be a delay in diagnosis or treatment, a progression of disease, worsening prognosis, suboptimal treatment, or a need for higher level care. At the time of the OIG's inspection in June 2024, VHA's policy was to "provide care or pay for care in the local community" for transgender patients, which includes "hormonal therapy, mental health care, preoperative evaluation … and long-term care following gender-affirming surgery."[77]

The COM told the OIG of learning, in August 2023, that the endocrine section chief, the only endocrinologist at the system providing GAHT at that time, was retiring in early 2024. There were three other endocrinologists in the system and the COM planned to reassign the endocrine section chief's patient panel, including patients receiving GAHT, to those providers. The three endocrinologists voiced concerns to the COM about providing GAHT; two noted that they felt they did not have the necessary experience and expertise and the third identified a personal objection to providing GAHT. The COM told the OIG that, although the remaining endocrinologists had not provided GAHT at the system previously, the COM informed them that providing GAHT "is a core [duty]" of an endocrinologist and the expectation was that the patients would receive GAHT by system endocrinologists. Between March and June 2024, the

[75] "Appointments Cube Dashboard," VHA Support Service Center (VSSC), accessed July 10, 2024, https://pyramid.cdw.va.gov/direct/?id=f34c65f5-6998-4d2a-b850-d35f84b4cdbc. (This site is not publicly accessible.)

[76] GAHT is prescribed to transgender patients "who want [their] gender-related characteristics … to match the gender with which they identify." "Gender Affirming Hormone Therapy," Duke Health, accessed October 22, 2024, https://www.dukehealth.org/treatments/adult-gender-medicine/gender-affirming-hormone-therapy.

[77] VHA Directive 1341(4). This directive was rescinded on March 17, 2025, noting that patients already receiving GAHT through VA Health Care at the time of recission remain eligible to receive this therapy; VHA Notice 2025-01(1).

three endocrinologists separately submitted requests for accommodations to not provide GAHT.[78]

The COM reported learning in February 2024 that the endocrinologists had placed Care in the Community (CITC) consults for all GAHT patients. In response, the COM told CITC staff that community care was not approved for these patients and instructed CITC staff to cancel the CITC consults and have them rescheduled with system endocrinologists. [79] The OIG learned that when patients presented to in-person appointments for GAHT, system endocrinologists informed them that GAHT was not provided at the system. While the employee relations issue of whether the COM could require the endocrinologists to provide GAHT was being worked out, the endocrinologists reported continuing to resubmit CITC consults for GAHT patients, and the COM continued instructing CITC staff to cancel the CITC consults. As a result, some patients had their CITC consults repeatedly canceled and were rescheduled multiple times with system endocrinologists who were not providing GAHT.

Although the OIG reviewed correspondence that showed the COM's prior awareness that endocrinologists were not providing GAHT, the COM reported being unaware of the extent of the issue until July 2024, when one of the endocrinologists copied the COM on an EHR note in which the endocrinologist documented telling a patient that they would not provide GAHT. As a result, the COM subsequently began to approve CITC consults. Additionally, the OIG was told the COM began providing GAHT on October 3, 2024.

Through a document request, the OIG became aware of seven patient safety reports and two patient advocacy complaints related to GAHT concerns and patient care delays from February through August 2024. The OIG also reviewed the EHRs of five patients who were identified by the complainant, and found multiple concerns:

- Expired GAHT prescriptions
- Repeat cancellation of CITC consults
- Patients presenting to appointments and endocrinologists informing them that GAHT was not provided

[78] The requests for accommodation involve an internal VA administrative process and action. The OIG does not investigate complaints addressed in other legal or administrative forums. As such, the OIG will not further discuss the administrative actions in this report. Instead, the OIG focused on ensuring patients were, and are, receiving the care needed notwithstanding the accommodation requests.

[79] "VA provides care to [patients] through community providers when VA cannot provide the care needed." Care in the community must be approved before a patient can access care from a community provider. "Community Care Overview," Community Care, accessed September 25, 2024, https://www.va.gov/communitycare/; "Community Care," Veteran Care Overview, accessed November 5, 2024, https://www.va.gov/communitycare/programs/veterans/#types.

- Adverse clinical outcomes including exacerbation of mental health symptoms[80]

As a result of care delays and adverse clinical outcome concerns, the OIG requested that executive leaders complete a review of the care provided to GAHT patients to ensure timely treatment, consults, and medications were provided. The OIG found the system reviews were not thorough and noted they lacked an analysis of medication management, patient care delays, and identification of adverse clinical outcomes. As a result, the OIG asked VISN leaders to review the GAHT care provided to patients to identify and address quality of care concerns.[81]

In March 2025, the OIG received the completed VISN-level review that identified that, of the 100 patient records reviewed, four patients experienced delays in obtaining GAHT, one of whom was identified as encountering potential harm. The review also noted that all patients ultimately received the GAHT they were entitled to under VHA policy at the time. For this reason, the OIG made no associated recommendations.

The OIG concluded that the COM's plan between February and October 2024 to continue GAHT care resulted in a failure to ensure transgender patients' access to GAHT and caused delays in patient care and adverse clinical outcomes.

4. Leaders' Awareness and Response to Interpersonal Communication Concerns

As demonstrated throughout this report, the OIG consistently heard concerns related to the COM's interpersonal communication skills from staff and leaders in various services.[82] The OIG evaluated executive leaders' awareness and response to these concerns.

VHA emphasizes the HRO values of clear communication and respect for people because miscommunication is a leading cause of medical errors, and when staff do not feel respected or valued, they are less likely to share information and collaborate to allow for exceptional patient care.[83] VHA identifies that executive leaders' commitment to HRO is critical and

[80] The complainant provided the OIG with a list of 22 GAHT patients whose CITC consults were canceled multiple times; the OIG reviewed the first five patients. The OIG found some patients experienced multiple events as described above. An example of an adverse clinical outcome was identified when a patient sent a secure message to endocrinologist 2 stating, "I have been without my medication for two weeks … it is causing me mental health issues and anxiety."

[81] The OIG requested that VISN leaders "ensure [the] review is independent and completed by VISN identified endocrinologists at other facilities..."

[82] Examples include but are not limited to the COM (1) changing the endocrine consult management process without communicating change to stakeholders, (2) not allowing a mechanism for PCPs to refuse conversion of a face-to-face consult to an e-consult if they had patient care concerns, and (3) not responding to the RCI Nurse Manager, who offered to route the draft SLA for required signatures.

[83] VA, *VHA High Reliability Organization (HRO) Reference Guide*; VA, "HRO Clear Communications Fact Sheet," January 2024; VA, "HRO Respect for People Fact Sheet," January 2024.

requires "… support and participation of highly visible and vocal leaders to promote and demonstrate their sustained commitment to HRO transformation through their actions."[84]

In OIG interviews, the Deputy COS and COS reported awareness of the COM's lack of responsiveness."[85] The Associate Director of Access and Clinical Business Operations described directly observing challenges with the COM collaborating in a team setting and attending meetings, and reporting concerns to the COS. The System Director affirmed awareness of interpersonal communication issues with the COM by stating,

> … this was an issue that was raised to me when [the COS] became our Chief of Staff in March and [the COS's] concern was there was a lack of responsiveness to [the COM's] staff. There's a lack of responsiveness even to [the COS]. There is a lack of responsiveness to VISN leadership when things are being asked.

The System Director also reported knowledge of concerns related to the COM making unilateral decisions and leadership competencies, including teamwork.

When asked about actions taken as a result of this awareness, the COS and System Director told the OIG that a new interim chief of primary care was selected to allow the COM to focus strictly on the Medicine Service, and as the COS further explained, to "… focus on communicating with people."[86] The System Director told the OIG of directing the COS to provide the COM with additional support for leadership development.

Leading an effective service requires strong interpersonal skills and the ability to collaborate with others in a team setting. The OIG is concerned that the COM's interpersonal communication skills did not reflect the HRO values of clear communication and respect for others and has negatively affected system staff across multiple services. These deficiencies resulted in the COM being an ineffective leader, as demonstrated by unilaterally changing the endocrine consult processes without deference to colleagues' input and expertise. Ultimately, these failures undermined the access to and quality of health care for a vulnerable population of patients (transgender patients seeking GAHT).

While the OIG recognizes that the COM was responsible for managing two large services for a period of almost six months, the OIG heard of related concerns both before and after the COM took on the additional role. The OIG expects executive leaders to closely track and monitor the COM's leadership performance upon awareness of the extent of the COM's interpersonal communication deficiencies.

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[84] VA, *VHA High Reliability Organization (HRO) Reference Guide*. The other HRO pillars include culture of safety and continuous process improvement; VA, "HRO Training and Resource Guide for VA Facility Executive Leaders."

[85] The OIG was told the COS is the COM's direct supervisor.

[86] The OIG was told the COM served as the interim chief of primary care from March 5 through August 24, 2024, while maintaining duties as the COM concurrently.

Conclusion

The OIG substantiated that the COM did not effectively manage internal endocrine consults. Specifically, the COM did not communicate consult management process changes to key stakeholders, did not process consults in accordance with VHA timeliness requirements, canceled a large volume of consults without communicating to sending providers, converted face-to-face consults to e-consults without providing a mechanism for sending providers to communicate concerns, and delayed implementation of a required service line agreement. These actions resulted in delays in patient care.

The OIG substantiated that the COM's deficient management of endocrine consults had a negative impact on endocrine clinic utilization at FHCC. Specifically, the OIG found that due to consult cancellations, conversions, and delays, the supply of consult and follow-up appointments did not match patient demand. As a result, follow-up patients did not get timely endocrine appointments.

The OIG substantiated that for about eight months in calendar year 2024, patient access to GAHT was delayed. The COM developed a plan for patients to receive care with system endocrinologists, despite endocrinologists' unavailability to provide GAHT. The COM's actions resulted in a failure to ensure patient access to GAHT as well as adverse clinical outcomes.

The OIG learned of concerns related to the COM's interpersonal communication skills from staff and leaders in various services. The COM's interpersonal communication skills did not reflect the HRO values of clear communication and respect for others and has negatively affected system staff across multiple services. System leaders reported awareness of the concerns, including the COM's lack of responsiveness to staff and leaders. Although actions such as leadership development occurred, executive leaders did not track and monitor the COM's leadership performance as expected.

Recommendations 1–7

1. The VA Fayetteville Coastal Healthcare System Director reviews the endocrine consult management process and takes actions as needed to ensure compliance with current Veterans Health Administration directives and guidance.

2. The VA Fayetteville Coastal Healthcare System Director implements a strategy to review patients affected by delayed endocrine consults to evaluate whether harm occurred and the appropriateness of institutional disclosures.

3. The VA Fayetteville Coastal Healthcare System Director ensures a sustainable and effective service line agreement between endocrine and primary care services is developed and agreed upon by both services, and monitors implementation.

4. The VA Fayetteville Coastal Healthcare System Director confirms effective utilization of endocrine clinic appointments to ensure timely access to care.

5. The VA Fayetteville Coastal Healthcare System Director ensures a process is in place for monitoring and tracking clinic profile modification requests.

6. The VA Mid-Atlantic Health Care Network Director reviews the leadership performance of the chief of medicine related to communication and collaboration and takes action as necessary.

7. The VA Fayetteville Coastal Healthcare System Director evaluates communication gaps identified in this report between leaders of primary care and the Medicine Service and takes action to ensure consistency with Veterans Health Administration High Reliability Organization goals.

Appendix A: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: August 15, 2025

From: Acting Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report, Deficiencies in Consult Management in the Endocrinology Service at the Department of Veterans Affairs (VA) Fayetteville Coastal Healthcare System in North Carolina

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on OIG's draft report on Deficiencies in Consult Management in the Endocrinology Service at the VA Fayetteville Coastal Healthcare System in North Carolina. The Veterans Health Administration (VHA) concurs with recommendations 1–7 provided to the VA Mid-Atlantic Health Care Network Director and the VA Fayetteville Coastal Healthcare System Director. An action plan is provided in the attachment.

2. The VHA greatly values OIG's assistance in ensuring that all stakeholders are unified in supporting VHA's vision of providing all Veterans with access to the highest quality care. Your collaboration is instrumental in helping us achieve our commitment to excellence in health care services for Veterans.

3. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at vacovha10oicoig@va.gov.

(Original signed by:)

Steven L. Lieberman, M.D., MBA, FACHE

[OIG comment: The OIG received the above memorandum from VHA on August 19, 2025.]

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: August 19, 2025

From: Interim Director, Department of Veterans Affairs (VA) Mid-Atlantic Health Care Network (10N6)

Subj: Office of Inspector General (OIG) Draft Report—Deficiencies in Consult Management in the Endocrinology Service at the VA Fayetteville Coastal Healthcare System in North Carolina

To: Director, Office of Healthcare Inspections (54HL07)
Chief Integrity and Compliance Officer (10OIC)

1. We appreciate the opportunity to work with the OIG's Office of Healthcare Inspections as we continuously strive to improve the quality of health care for the Nation's Veterans. We are committed to ensuring Veterans receive quality care that utilizes the high reliability pillars, principles, and values. I concur with the report findings and recommendations of the OIG Draft Report— Deficiencies in Consult Management in the Endocrinology Service at the VA Fayetteville Coastal Healthcare System in North Carolina.

2. I have reviewed the documentation submitted by the Medical Center and concur with the response as submitted.

3. Should you need further information, contact the Veterans Integrated Services Network Quality Management Officer.

(*Original signed by:*)

Kevin P. Amick MBA, MHRM, SES

[OIG comment: The OIG received the above memorandum from VHA on August 19, 2025.]

VISN Director Response

Recommendation 6

The VA Mid-Atlantic Health Care Network Director reviews the leadership performance of the chief of medicine related to communication and collaboration and takes action as necessary.

_X _Concur

____Nonconcur

Target date for completion: October 2025

Director Comments

The VISN 6 Network Director will collaborate with the VISN Organizational Development (OD) Psychology team to evaluate the Chief of Medicine's leadership performance, particularly in the areas of communication and collaboration. To build on efforts already taken by the Medical Center Director, the OD Psychology team will provide additional recommendations to improve the COM's interpersonal communication and ensure conduct aligns with High Reliability Organization (HRO) principles to foster a respectful, collaborative, and safe health care environment. Active engagement in OD psychology interventions will be monitored by VISN Leadership. Additionally, it has been reported that the Chief of Medicine will be resigning from the facility.

Appendix C: System Director Memorandum

Department of Veterans Affairs Memorandum

Date: August 18, 2025

From: Director, Department of Veterans Affairs (VA) Fayetteville Coastal Healthcare System (565)

Subj: Office of Inspector General (OIG) Draft Report—Deficiencies in Consult Management in the Endocrinology Service at the VA Fayetteville Coastal Healthcare System in North Carolina

To: Interim Director, VA Mid-Atlantic Health Care Network (10N6)

1. We appreciate the opportunity to review and comment on the OIG Draft Report—Deficiencies in Consult Management in the Endocrinology Service at the VA Fayetteville Coastal Healthcare System in North Carolina. VA Fayetteville Coastal Healthcare System concurs with the recommendations and will take corrective action.

2. I have reviewed the documentation and concur with the response as submitted.

3. Should you need further information, please contact the Chief of Quality Management & Patient Safety.

(*Original signed by*:)

Marri Fryar, MBA, MHA, BSN, NE-BC, VHA-CM

[OIG comment: The OIG received the above memorandum from VHA on August 19, 2025.]

System Director Response

Recommendation 1

The VA Fayetteville Coastal Healthcare System Director reviews the endocrine consult management process and takes actions as needed to ensure compliance with current Veterans Health Administration directives and guidance.

_X _Concur

____Nonconcur

Target date for completion: February 2026

Director Comments

The Department of Veterans Affairs (VA) Fayetteville Coastal Healthcare System (FHCC) Director will conduct a comprehensive review of the endocrine consult management process. This review will include an audit of current compliance rates with VHA directives and guidance. As part of the review, 10% of endocrinology consults will be reviewed by the Clinic Operations team each month, using a review tool that incorporates guidance provided by VA Directive 1232. Based on the results, the Director will then develop and implement an action plan to address any identified deficiencies. Compliance will be monitored with a target of 90%. Progress will be tracked through the Clinical Business Operations Executive Council.

Recommendation 2

The VA Fayetteville Coastal Healthcare System Director implements a strategy to review patients affected by delayed endocrine consults to evaluate whether harm occurred and the appropriateness of institutional disclosures.

_X _Concur

____Nonconcur

Target date for completion: Request Closure

Director Comments

The VA Fayetteville Coastal Healthcare System Director directed a full review of all patients affected by delayed endocrine consults, which were completed in November 2024. Those that were identified with delays were further reviewed for potential institutional disclosure. It was determined after the review that none of the cases met criteria for institutional disclosure. We request closure of this recommendation based on the evidence provided.

OIG Comments

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 3

The VA Fayetteville Coastal Healthcare System Director ensures a sustainable and effective service line agreement between endocrine and primary care services is developed and agreed upon by both services, and monitors implementation.

_X _Concur

____Nonconcur

Target date for completion: February 2026

Director Comments

The VA Fayetteville Coastal Healthcare System Director will ensure the development of a sustainable and effective service line agreement (SLA) between the endocrine and primary care services. This process will involve key stakeholders from both services to ensure mutual agreement and alignment with VHA guidelines. Once the agreement is finalized and signed by all parties, the Clinic Operations team will perform a monthly audit of 10% of endocrinology consults submitted by primary care to verify adherence to the parameters outlined in the SLA. Compliance will be monitored with a target of 90%. Progress will be tracked through the Clinical Business Operations Executive Council.

Recommendation 4

The VA Fayetteville Coastal Healthcare System Director confirms effective utilization of endocrine clinic appointments to ensure timely access to care.

_X _Concur

____Nonconcur

Target date for completion: February 2026

Director Comments

The VA Fayetteville Coastal Healthcare System Director has instructed the Group Practice Manager and the Chief of Medicine to implement a structured process. This process will involve routinely assessing clinic utilization metrics at each clinic location. The goal is to ensure that clinic-specific utilization data is analyzed independently and regularly, enabling more effective management and optimization of resources across the healthcare system. Specifically, FHCC

data will be tracked and trended independently of the Wilmington Healthcare Center to ensure timely identification of access barriers and resource imbalances. This analysis will be conducted monthly and reported to the Clinical Business Operations Executive Council to guide proactive decision-making and ensure alignment with patient care demands. Compliance will be monitored with a target of 90%.

Recommendation 5

The VA Fayetteville Coastal Healthcare System Director ensures a process is in place for monitoring and tracking clinic profile modification requests.

_X _Concur

____Nonconcur

Target date for completion: February 2026

Director Comments

The VA Fayetteville Coastal Healthcare System Director will implement a monitoring and tracking system for clinic profile modification requests. This system will be managed by the Group Practice Manager, who will generate monthly reports for the Clinical Business Operations Executive Council. These reports will include tracking and trending of the modification requests for actions as recommended by the Clinical Business Operations Executive Council. The Associate Director Clinical Business Operations, or designee, will ensure the Clinical Business Operations Executive Council provides oversight of the recommended actions for clinic modification. Compliance will be monitored with a target of 90%.

Recommendation 7

The VA Fayetteville Coastal Healthcare System Director evaluates communication gaps identified in this report between leaders of primary care and the Medicine Service and takes action to ensure consistency with Veterans Health Administration High Reliability Organization goals.

_X _Concur

____Nonconcur

Target date for completion: February 2026

Director Comments

To address identified communication gaps between the Primary Care and Medicine Service leaders, the VA Fayetteville Coastal Healthcare System Director will implement a structured communication strategy consistent with Veterans Health Administration HRO goals. Primary

Care and Medicine Service Leadership teams will participate in weekly interdisciplinary huddles using facility-implemented digital huddle boards. These huddles will serve as a platform for documenting and elevating concerns, fostering open and transparent communication.

Training will be conducted for 100% of the designated leadership team members from both services before the implementation of the huddle boards to ensure effective utilization and understanding of the process. The effectiveness of these huddles will be continuously monitored, with the goal of sustained participation by maintaining at least 90% attendance by both services on a weekly basis. Compliance and the impact of these huddles will be reviewed monthly by the HRO Workgroup, and adjustments will be made as needed to ensure continuous improvement in communication and alignment with HRO principles.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Alison Loughran, JD, BSN, Director Debbie Davis, JD Tabitha Eden, MSN, RN Michelle Ernzen, MSN, RN Dannette Johnson, DO Zaire Smith, MSW, LCSW
Other Contributors	Alicia Castillo-Flores, MBA, MPH Christopher D. Hoffman, LCSW, MBA Michelle Kamel, MBA, RN Sarah Mainzer, JD, BSN Larry Ross Jr., MS Natalie Sadow, MBA

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