US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Leaders' Actions Affecting Clinical Services at the Syracuse VA Medical Center in New York

Healthcare Inspection | **25-02192-39** | **January 15, 2026**

OUR MISSION

To conduct independent oversight of the Department of Veterans Affairs that combats fraud, waste, and abuse and improves the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, their families, caregivers, and survivors.

CONNECT WITH US

Subscribe to receive updates on reports, press releases, congressional testimony, and more. Follow us at @VetAffairsOIG.

PRIVACY NOTICE

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Executive Summary

The VA Office of Inspector General (OIG) initiated a healthcare inspection on April 1, 2025, at the Syracuse VA Medical Center (facility) in New York, to assess allegations regarding reduced availability of clinical services, poor communication from leaders, and staff resignations. The OIG conducted virtual interviews from April 24 through August 4, 2025, and performed a site visit June 24 through 26, 2025. During the inspection, the OIG identified additional concerns related to patient transfers and oversight of infrastructure requirements.

The OIG substantiated that reductions in clinical services occurred. Specifically, the former Facility Director closed the neurosurgery program, and facility leaders allowed contracts for infectious disease and endocrinology services to lapse. The OIG found that facility leaders did not complete the administrative actions as Veterans Health Administration (VHA) Directive 1043, *Restructuring of Clinical Programs,* requires when (1) closing a clinical program or (2) communicating the clinical service reduction to physicians as expected in a high reliability organization (HRO).[1] The OIG also substantiated multiple physicians resigned due to the clinical service reductions and the deficient communication that followed. During the review, the OIG determined facility leaders lacked a process to monitor patient transfer timeliness as required by VHA Directive 1094(1), *Inter-Facility Transfer Policy*. Additionally, Veterans Integrated Service Network (VISN) and facility leaders did not provide the VHA Directive 1102.01(2), *National Surgery Office* required oversight of facility infrastructure requirements.[2]

Neurosurgery Program Closure

According to VHA Directive 1043, *Restructuring of Clinical Programs*, a clinical restructuring request (CRR) is required when a major clinical program closure is proposed. Medical center and VISN leaders are responsible for reviewing a CRR to ensure the proposed closure does not affect patient care. The CRR is then routed to the Under Secretary for Health for review and approval.[3] The facility's neurosurgery program operated through a contract scheduled to expire in June 2024. In April 2024, the former Facility Director did not renew the contract due to cost, unmet productivity, and availability of community care. While the OIG did not have concerns about the decision to close the neurosurgery program, the OIG found VISN and facility leaders were unaware of CRR requirements and did not submit a CRR before the program's closure. Closing a

[1] VHA Directive 1043, *Restructuring of Clinical Programs*, November 2, 2016.

[2] VHA Directive 1094(1), *Inter-Facility Transfer Policy*, January 11, 2017, amended June 24, 2024; VHA Directive 1102.01(2), *National Surgery Office*, April 24, 2019, amended April 19, 2022.

[3] VHA Directive 1043; "Clinical Restructuring Request Process," VHA Office of Clinical Services, updated September 2023.

major program without formal review and approval circumvents required national oversight intended to ensure the continuity of patient care.[4]

The OIG learned staff expressed concerns about the neurosurgery program's closure during a May 2024 medical staff meeting. Concerns included not being involved in the decision-making process to terminate the program. Although the former Facility Director and facility leaders knew the closure negatively affected morale, no further action was taken following the meeting to address concerns.

Clinical Service Contract Lapses

VA Directive 1663, *Health Care Resources (HCR) Contracting – Buying Authority Under 38 U.S.C. 8153* states that facility leaders may request healthcare resource contracts (contracts) to ensure the availability of clinical services.[5] VHA's, *Health Care Resource (HCR) Acquisition Team Planning Guide* outlines that VISN and medical center directors are responsible for ensuring contract milestones are met.[6] Further, VHA's Medical Sharing/Affiliate National Program Office (MSO) provides guidance to facility leaders and staff throughout the contracting process. If contracted services are interrupted, facility leaders must implement established contingency plans to ensure continuity of patient care.[7]

The OIG learned contracts for infectious disease and endocrinology services lapsed in 2024, causing the loss of inpatient consultation. Infectious disease services were unavailable from August 1 through October 31, 2024, and endocrinology services have remained unavailable since November 1, 2024. The OIG determined facility leaders did not manage the contracts timely, despite multiple reminders from MSO staff.

Both the former VISN Director and former Facility Director denied knowledge of contracting issues until after the contracts lapsed.[8] The OIG found that both former Directors did not provide adequate oversight of the contracting process, which resulted in gaps in critical clinical services. Additionally, facility leaders did not communicate established contingency plans when the

[4] VHA Directive 1043.

[5] VHA Directive 1101.04, *Medical Officer of the Day*, February 14, 2024; VA Directive 1663, *Health Care Resources (HCR) Contracting – Buying, Title 38 U.S.C. 8153,* May 10, 2018. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VA Directive 1663, *Health Care Resources (HCR) Contracting – Buying Authority Under 38 U.S.C. 8153,* July 30, 2025. Unless otherwise specified, the 2025 directive contains the same or similar language regarding contracts as the rescinded 2018 directive. Healthcare resource contracts for clinical services may be requested under certain circumstances, for example, when a "qualified clinician cannot be recruited."

[6] VHA Medical Sharing/Affiliate Office (MSO), *Health Care Resource (HCR) Acquisition Team Planning Guide*, February 2, 2018.

[7] VHA Directive 1660.07, *Medical Sharing/Affiliate National Program Office,* February 21, 2023.

[8] The OIG learned the contracting officer representative started in the role in January 2024 and the chief of medicine started in the role in May 2024.

contracts lapsed. To determine whether patients suffered adverse clinical outcomes related to these service gaps, the OIG reviewed patient safety reports dated April 1, 2024, through March 31, 2025, and did not identify any reported concerns.

Physician Resignations

Following reductions in clinical services and lack of associated communication, eight specialty physicians in cardiology, gastroenterology, hematology-oncology, and neurology resigned.[9] Due to the substantial loss of physicians and the facility's designation as "inpatient complex," the OIG evaluated whether the availability of consultative services met requirements outlined in VHA Directive 1220(1), *Facility Procedure Complexity Designation Requirements to Perform Invasive Procedures in Any Clinical Setting*.[10] The OIG determined multiple specialties did not meet coverage requirements of the facility's complexity designation, which reduced the availability of clinical services. In June 2025, facility leaders told the OIG of plans to leverage community care and hire more physicians to address coverage gaps. However, coverage gaps remained as of August 2025. The OIG is concerned about the potential risk to patient care when required specialty physician consultative coverage is not available.

Additional Concerns

Physicians told the OIG about an increased reliance on patient transfers to community hospitals and concerns with delays associated with those transfers. The OIG found facility leaders did not have a process for monitoring and evaluating the timeliness of patient transfers as VHA Directive 1094(1) requires; therefore, the OIG was unable to determine whether delays occurred.[11]

The OIG also found that VISN and facility leaders did not oversee the VHA process for identifying and reporting infrastructure deficiencies, which resulted in not submitting required waivers.[12] Facility and VISN leaders' inadequate oversight allowed the facility to retain an "inpatient complex" designation and provide associated invasive procedures without the required resources, which placed patients at risk. Further, the VISN Chief Surgical Consultant's lack of oversight allowed inaccurate reporting of infrastructure deficiencies and long-term noncompliance with waiver requirements.

---

[9] Physician resignations occurred from April 30, 2024, through March 7, 2025.

[10] All VA medical centers are assigned an invasive procedure designation, which reflects the facility's capacity to safely perform specific procedures. The facility's complexity designation of "inpatient complex" requires that certain specialty services be "available 24/7." VHA Directive 1220(1), *Facility Procedure Complexity Designation Requirements to Perform Invasive Procedures in Any Clinical Setting,* May 13, 2019, amended February 11, 2020.

[11] VHA Directive 1094(1).

[12] VHA Directive 1220(1).

The OIG made one recommendation to the Under Secretary for Health related to establishing a timeliness expectation for procedural complexity designation infrastructure waiver submissions.[13] The OIG made two recommendations to the Veterans Integrated Service Network Director related to ensuring leaders' compliance with clinical restructuring and procedural complexity designation requirements. The OIG made five recommendations to the Facility Director related to adherence to HRO communication principles, evaluating contracting processes and distributing contingency plans, monitoring patient transfers, and ensuring annual procedural complexity designation infrastructure reviews are accurately completed.

The OIG is aware of VA's transformation in VHA's management structure. As we monitor the implementation, our oversight remains focused on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

VA Comments and OIG Response

The Senior Advisor Performing the Delegable Duties of the Office of the Under Secretary for Health and the Interim Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided acceptable action plans (see appendixes B, C, and D). The Senior Advisor shared plans for communicating expectations for infrastructure deficiency waivers. The Interim Veterans Integrated Service Network Director committed to evaluating circumstances that led to facility leaders not following clinical restructuring requirements as well as ensuring accurate infrastructure reviews. The Facility Director also outlined plans to verify accurate infrastructure reviews, enhance communication strategies, and examine contracting and patient transfer processes. 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

[13] The recommendations addressed to the Under Secretary for Health and the Veterans Integrated Service Network Director are directed to anyone in an acting status or performing the delegable duties of the position.

Contents

Abbreviations

CMO	Chief Medical Officer
COR	contracting officer representative
COS	Chief of Staff
CRR	clinical restructuring request
FY	fiscal year
HRO	high reliability organization
MSO	Medical Sharing/Affiliate National Program Office
OIG	Office of Inspector General
VCSC	Veterans Integrated Service Network Chief Surgical Consultant
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) initiated a healthcare inspection on April 1, 2025, and conducted an on-site visit June 24 through 26, 2025, to assess allegations regarding reduced availability of clinical services, poor communication from leaders, and staff resignations at the Syracuse VA Medical Center (facility) in New York.

Background

The facility is part of Veterans Integrated Service Network (VISN) 2—the New York/New Jersey VA Health Care Network—and consists of one inpatient hospital with 120 acute care beds and seven outpatient clinics throughout central New York.[1] The facility provides comprehensive health care, including medical, surgical, and specialty services, and operates an on-site emergency department. The Veterans Health Administration (VHA) classifies the facility as level 1c.[2] There are four community hospitals within a five mile radius of the facility.

Allegations and Related Concerns

In September 2024, the OIG received an anonymous complaint alleging facility leaders reduced clinical services at the facility and did not adequately communicate these changes to physicians. Additionally, the complainant alleged the reduction in clinical services and poor communication resulted in multiple physician resignations. On December 3, 2024, the OIG reviewed the allegations and notified VISN leaders on December 9 to review and take action as appropriate with no response required. In March of 2025, the Office of Accountability and Whistleblower Protection referred a similar complaint to the OIG. The OIG opened this healthcare inspection in April 2025. During the inspection, the OIG identified additional concerns related to patient transfers and oversight of procedural complexity infrastructure requirements.

Scope and Methodology

The OIG conducted virtual and on-site interviews from April 24 through August 4, 2025.[3] The OIG interviewed the former VISN Chief Medical Officer (VISN CMO) and former VISN Director.[4] The OIG also interviewed the VISN Chief Surgical Consultant (VCSC) who held a

[1] The clinics are in Auburn, Binghamton, Ithaca, Oswego, Potsdam, Rome, and Watertown, New York.

[2] VHA Office of Productivity, Efficiency and Staffing. The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, and educational and research missions. Complexity levels include 1a, 1b, 1c, 2 or 3. Level 1a facilities are considered the most complex and level 3 facilities are the least complex.

[3] On-site interviews were conducted from June 24 through 26, 2025.

[4] The former VISN Director left the role in June 2025. The former VISN CMO left the role in March 2025.

dual role as the former facility associate chief of staff of surgical services (chief of surgery).[5] Additionally, the OIG interviewed select former facility leaders, facility leaders, physicians, and staff who had knowledge of the availability of clinical services and related facility processes.[6] The OIG also provided an email questionnaire to physicians who resigned from April 1, 2024, through March 31, 2025.

The OIG reviewed relevant VHA and facility policies and procedures, quality reviews, organizational charts, committee meeting minutes, electronic communications, on-call schedules, contracts, electronic health records, physician resignation data, and patient transfer data.[7] 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 that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that 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

The OIG substantiated reductions in clinical services occurred and facility leaders did not adequately communicate these changes to physicians. Specifically, the OIG found that the former Facility Director closed the neurosurgery program and facility leaders allowed clinical

[5] The VCSC held a dual role as the chief of surgery from March 31, 2019, through November 30, 2024. The VCSC holds a dual role as a surgery attending at the facility.

[6] Former and current facility leaders included, but are not limited to, the former Facility Director who left the role on February 28, 2025, and the interim Facility Director who assumed the role on March 3, 2025, and had previously served as the Associate Director since January 31, 2021.

[7] The OIG reviewed on-call schedules for services included in the complainants' allegations. However, the OIG only included references in this report to on-call schedules for services with specific VHA requirements.

service contracts for infectious disease and endocrinology to lapse.[8] Additionally, the OIG determined that when the neurosurgery program closed and the contracts lapsed, facility and VISN leaders did not perform administrative actions. Further, facility leaders did not communicate information to physicians as expected in a high reliability organization (HRO). The OIG also substantiated that multiple physicians resigned because of the reduction in clinical services and the deficient communication that followed.

Recognizing that the reduction of clinical services may affect facility leaders' ability to meet other VHA requirements, the OIG assessed processes related to patient transfers and procedural complexity designation infrastructure requirements. The OIG determined facility leaders did not have a process to monitor the timeliness of patient transfers as required and that VISN and facility leaders did not provide oversight of facility infrastructure requirements.

1. Neurosurgery Program Closure

VHA Directive 1043, *Restructuring of Clinical Programs*, and VHA Office of Clinical Services "Clinical Restructuring Request Process," outline requirements and steps needed for a major clinical program closure.[9] Proposed closures are captured through a clinical restructuring request (CRR).[10] Medical center directors, chiefs of staff, and VISN CMOs are responsible for reviewing CRRs and ensuring "the provision of clinical care for these services are no longer required, or are adequately provided for by community care, contract services, or agreements with another VA facility."[11] VISN directors are responsible for confirming the request does not "adversely affect the delivery of patient care and that alternate [plans] for care [delivery] have been identified" and submitting the CRR to the VHA Office of Clinical Services.[12] The CRR is then

[8] Neurosurgery is the medical specialty that focuses on the diagnosis and treatment of conditions that affect the brain, spinal cord, and nerves. *Merriam-Webster.com Dictionary*, "neurosurgery," accessed September 2, 2025, https://www.merriam-webster.com/dictionary/neurosurgery; Infectious Disease is a medical specialty focusing on the diagnosis and treatment of infections "caused by bacteria, viruses, fungi, and parasites." "Infectious Disease," Upstate University Hospital, accessed September 4, 2024, https://www.upstate.edu/id/healthcare/index.php; Endocrinology is "a branch of medicine concerned with the structure, function, and disorders of the endocrine glands." *Merriam Webster.com Dictionary*, "endocrinology," accessed September 2, 2025, https://www.merriam-webster.com/dictionary/endocrinology.

[9] VHA Directive 1043, *Restructuring of Clinical Programs*, November 2, 2016; "Clinical Restructuring Request Process," VHA Office of Clinical Services, updated September 2023, https://dvagov.sharepoint.com/sites/VHAClinSvcs/SitePages/-Under-Construction-(i.e.,-content-structural-updates-pending).aspx. (This site is not publicly accessible.)

[10] VHA Directive 1043, *Restructuring of Clinical Programs*; "Clinical Restructuring Request Process," VHA Office of Clinical Services; A VHA Office of Clinical Services leader confirmed that neurosurgery is considered a major clinical program.

[11] VHA Directive 1043. In support of VA's commitment "to providing Veterans access to timely, high-quality health care … VA Medical Centers (VAMCs) may purchase care in the community for eligible Veterans, after VA options to render care have been considered."

[12] VHA Directive 1043; "Clinical Restructuring Request Process," VHA Office of Clinical Services.

routed to the relevant program offices and the Under Secretary for Health for review and approval.[13]

The facility's neurosurgery program operated through a contract scheduled to expire in June 2024.[14] Contracted elements included one board-certified spine physician, on-site surgical services, on-call neurosurgery services, and outpatient spine clinics.[15] The OIG learned that in August 2023, the former Facility Director evaluated the need for the neurosurgery program due to the contract's high cost, unmet service workload expectations, and availability of neurosurgery services in the community. The former Facility Director also told the OIG of consulting stakeholders prior to the program's closure and verbally discussing the decision with the VISN Director and VISN CMO.[16] The Facility Chief of Staff (COS) stated that in April 2024, the former Facility Director decided not to renew the contract. The program closed effective July 1, 2024.

On May 1, 2024, the COS emailed clinical leaders about the decision to close the neurosurgery program. The email stated that following the program's closure, patients would receive neurosurgery care in the community. Although the former Facility Director closed the neurosurgery program, reducing the availability of clinical services at the facility, patients continued to access neurosurgery care within the community. Therefore, the OIG did not have concerns about the decision to close the neurosurgery program.

The OIG reviewed patient safety reports dated from April 1, 2024, through March 31, 2025, and asked during interviews about instances of adverse clinical outcomes related to the neurosurgery program's closure. The OIG did not learn of any instances of adverse clinical outcomes.[17] However, the OIG found the former Facility Director and VISN leaders did not perform the required administrative actions for clinical restructuring before the former Facility Director closed the program. Additionally, the former Facility Director and facility leaders did not engage in continued communication related to physician concerns regarding the program's closure.

Facility and VISN Leaders Did Not Submit a Clinical Restructuring Request

The former Facility Director reported being unaware of the VHA Directive 1043 CRR requirements and confirmed with the OIG that a CRR was not submitted.[18] "My thought process

[13] VHA Directive 1043; "Clinical Restructuring Request Process," VHA Office of Clinical Services.

[14] The contract began July 1, 2023, with an end date of June 30, 2024.

[15] The clinics rotated through VA medical centers within the VISN.

[16] Stakeholders included the chief of community care, the interim Facility Director who was in the role of associate director at the time, and the VCSC who was in dual role also serving as facility chief of surgery at the time.

[17] 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.

[18] VHA Directive 1043.

[was] I would speak with the [VISN CMO], [the VISN Director] … and if they had questions or any direction on … how we need to proceed that they would give that direction." The COS told the OIG of being aware of CRR requirements but thought a CRR was not needed since neurosurgery was a contracted service.

The former VISN CMO, although familiar with CRR requirements, told the OIG a CRR was not needed stating, "you can pause a program without a restructuring, but you can't really close it without the restructuring … they only really pause[d] the program. I don't think they officially closed the program." The former VISN Director told the OIG of being notified of the neurosurgery program closure during a conversation with the former Facility Director. The former VISN Director also reported familiarity with CRR requirements, however, stated a CRR was not completed as neurosurgery services were provided through a contract.

The OIG confirmed with the VHA Office of Clinical Services that a CRR is required regardless of whether services are provided through a contract. Therefore, facility and VISN leaders should have submitted the CRR and received approval from the Under Secretary for Health prior to closing the neurosurgery program.

The OIG concluded facility and VISN leaders did not follow VHA policy when closing the facility's neurosurgery program. Closure of a major program without a formal review and the Under Secretary for Health's approval circumvents the national-level oversight requirement. The CRR process ensures patient needs are addressed and care is not adversely affected.

Facility Leaders Did Not Engage in Continued Communication

A system shock is an event that disrupts an organization's usual daily operations and may result from planned or unplanned events that have lasting effects on an organization's focus and culture. Negative impacts of system shocks can be reduced when leaders communicate directly and are transparent with staff about the event that occurred.[19] Clear communication "helps remove ambiguity and uncertainty" and supports a culture of safety.[20] VA, *VHA High Reliability Organization (HRO) Reference Guide,* discusses that in 2018, VHA began to implement HRO principles to promote leadership commitment to support a culture of safety.[21] This requires a

[19] Valerie M. Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies," *BMJ Quality & Safety* 28, no. 1 (2019): 74-84, https://doi.org/10.1136/bmjqs-2017-007573.

[20] VA, *Leaders Guide to Foundational High Reliability Organization (HRO) Practices*, July 2024; VA, "Clear Communications," January 2024.

[21] "High reliability means evidence-based, exceptional care is consistently delivered for every patient, every time, at any facility across VHA." There are three HRO pillars: leadership commitment, culture of safety, and continuous process improvement. VA, *VHA High Reliability Organization (HRO) Reference Guide*, September 2024; Culture of safety means that "throughout our organization, safety values and practices are used to prevent harm and learn from mistakes." VA, *VHA High Reliability Organization (HRO) Glossary of Terms*, September 2024.

culture transformation that empowers staff to openly raise concerns "because they [staff] trust that leaders want to know."[22]

The OIG learned that during a May 9, 2024, quarterly medical staff meeting, staff expressed significant concern regarding the neurosurgery program's closure.[23] Staff told the OIG that their concerns included (1) staff's perception that the termination of the program was arbitrary and sudden and (2) staff had not been included in the decision-making process. During an OIG interview, the COS characterized the participants in the meeting as having a sense of grief but further explained that every question and concern was addressed before adjourning. Despite that impression, one service chief shared that staff felt they were not given context about the program's closure. The former Facility Director reported awareness that providers communicated displeasure about the decision to close the program. When asked how leaders should respond to staff dissatisfaction in such circumstances, the former Facility Director stated it would be appropriate to meet with individuals to address concerns.

The OIG found that although facility leaders knew the program's closure negatively affected employee morale, neither the former Facility Director nor the COS took any further action following the meeting to address the concerns. The COS acknowledged the need to improve communication and described recent actions such as providing frequent updates to staff and meeting regularly with service chiefs. The interim Facility Director recognized the absence of communication as "a major issue" and reported, especially in times of change, communication is important.

2. Clinical Service Contract Lapses

VHA Directive 1101.04, *Medical Officer of the Day,* sets the expectation that medical center directors and chiefs of staff are responsible for ensuring necessary healthcare services are available to meet patient care needs.[24] As detailed in VA Directive 1663, *Health Care Resources (HCR) Contracting – Buying, Title 38 U.S.C. 8153,* healthcare resource contracts (contracts) for clinical services may be requested under certain circumstances; for example, when a "qualified clinician cannot be recruited or it is determined that recruitment of VA staff is not appropriate."[25] Pursuant to VHA Directive 1660.07, *VHA's Medical Sharing/Affiliate National Program Office* (MSO) "provides administrative oversight and guidance when … medical facilities buy or sell

[22] VA, *VHA High Reliability Organization (HRO) Reference Guide*, September 2024.

[23] The COS told the OIG the quarterly staff meeting occurred on May 9, 2024.

[24] VHA Directive 1101.04, *Medical Officer of the Day*, February 14, 2024.

[25] VA Directive 1663, *Health Care Resources (HCR) Contracting – Buying, Title 38 U.S.C. 8153,* May 10, 2018. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VA Directive 1663, *Health Care Resources (HCR) Contracting – Buying Authority Under 38 U.S.C. 8153,* July 30, 2025. Unless otherwise specified, the 2025 directive contains the same or similar language regarding contracts as the rescinded 2018 directive.

services under … contracts … to ensure continued delivery of high-quality health care to Veterans."[26] Additionally, medical center and VISN directors are responsible for managing contracting requirements and taking corrective action for noncompliance with VHA policy.[27] Further, VHA's *Health Care Resource (HCR) Acquisition Team Planning Guide* indicates medical center directors must also ensure that planning for contract milestones, such as submission of required documentation, is initiated timely.[28]

Contracting processes are complex and require continuous collaboration between the MSO and a contracting officer representative (COR) to meet milestones.[29] Therefore, the VHA Procurement Office recommends that facility leaders allow adequate processing times for various types of contract actions such as renewals.[30] VA Directive 1663 and the *HCR Acquisition Team Planning Guide* state that in the event that contracted services are interrupted, the COS is required to establish an alternate source plan (contingency plan) with specific steps providers should take to ensure continuity of patient care.[31]The OIG learned through document review and correspondence that the infectious disease contract lapsed from August 1 through October 31, 2024, and the endocrinology contract lapsed on November 1, 2024. The chief of medicine informed the OIG that the endocrine contract had not been reinstated as of August 2025.

Facility and VISN Leaders Did Not Manage Clinical Service Contracts

The OIG determined facility leaders, and the former VISN and Facility Directors, did not address pending actions for the infectious disease and endocrinology contracts timely, which resulted in the loss of both clinical services. Contracts included board-certified infectious disease and endocrinology providers on-site at the medical center in addition to 24-hour on-call consultation.

The OIG reviewed communication between MSO staff, former and current VISN and facility leaders, and a facility COR that occurred from March through December 2024. The OIG found that MSO staff made multiple attempts to obtain information from facility leaders to facilitate contract approvals. When the information was not provided, MSO staff repeatedly warned the

[26] VHA Directive 1660.07, *Medical Sharing/Affiliate National Program Office,* February 21, 2023.

[27] VHA Directive 1660.07.

[28] VHA Medical Sharing/Affiliate Office (MSO), *Health Care Resource (HCR) Acquisition Team Planning Guide*, February 2, 2018.

[29] A COR is a medical center staff member who assists with contracting processes. VHA MSO, *Health Care Resource (HCR) Acquisition Team Planning Guide*.

[30] According to the VHA Procurement Office, which provides administrative oversight of the MSO, processing times for contract renewals can vary widely.

[31] VA Directive 1663; VHA MSO, *Health Care Resource (HCR) Acquisition Team Planning Guide*.

COR and the COS of impending service gaps that would require implementation of contingency plans (see appendix A).[32]

The COR told the OIG of knowing when the contracts would expire but, due to being new to the role, receiving minimal guidance, and having no prior contracting experience, "didn't realize how long the process was" or "what it all took to be able to get a contract awarded."[33] When asked about the contract lapses, the associate chief of staff of acute and specialty services (chief of medicine) stated the lapses occurred as a result of "process issues" and "unnecessary delay[s]" in obtaining the former Facility and VISN Directors' approval. The COS attributed the lapses to staff turnover and delays receiving the former Facility Director's approval. The COS also stated that no facility process existed for tracking anticipated milestones.

The former Facility Director acknowledged awareness of contracting milestones and requirements but denied any knowledge of the delays or the impending lapses. The former VISN Director told the OIG of being unaware of the facility's contracting delays prior to the lapses and explained the VISN is not responsible for the management of contracts and reported that "every facility does their own contracts and has their own CORs." The VISN Director also shared the expectation that medical center directors would communicate if contracting issues were affecting patient care.

Additionally, the former Facility Director and the COS attributed the responsibility for managing the infectious disease and endocrinology contracts to the chief of medicine. However, the OIG reviewed documentation that showed the chief of medicine was newly hired when the contract lapses occurred. The chief of medicine assumed the role on May 28, 2024. From January 2024 through when the chief of medicine started, the position was filled through a rotation of physicians assigned in an "acting" capacity. Therefore, the OIG would have expected increased engagement from the former Facility Director and COS to ensure timely completion of contracting steps to avoid reductions in clinical services.

The OIG reviewed patient safety reports from April 1, 2024, through March 31, 2025, and asked during interviews with facility leaders and staff about instances of adverse clinical outcomes related to contract lapses. The OIG did not learn of any instances of adverse clinical outcomes related to contract lapses and subsequent loss of clinical services but did learn staff had concerns about the potential risks to quality of care and patient safety. These concerns included (1) the inability to consult infectious disease physicians for hospitalized patients, (2) the inability to fulfill pharmacy-related requirements for antibiotics without infectious disease services, (3) the risks of caring for hospitalized patients with insulin pumps without endocrinology services, and (4) the absence of contingency plans to ensure continuity of care for patients requiring infectious

[32] The underlined terms are hyperlinks to another section of the report. To return to point of origin, press and hold the "alt" and "left arrow" keys together.

[33] The COR told the OIG of assuming the role in January 2024.

disease and endocrinology services. During an OIG interview, the COS acknowledged staff concerns of potential risk to patients, but minimized their importance, stating "I don't think there's as much risk as sometimes they're [physicians are] worried about."

The OIG concluded that former and current facility leaders did not manage the infectious disease and endocrinology contracts timely, which resulted in the loss of clinical services.

Facility Leaders Did Not Communicate Contingency Plans

The OIG determined that prior and subsequent to the contract lapses, facility leaders did not communicate the established contingency plans for infectious disease and endocrinology services with physicians.

In 2019, the required infectious disease and endocrinology contingency plans were established when the original contracts were implemented. Contingency plans are developed to sustain "services in the event a contract is not reached or if the contract is interrupted during performance" and described transferring all patients requiring infectious disease and endocrinology services to local hospitals for non-VA care.[34]

Infectious Disease

Infectious disease specialists "provide consultation on treatment of patients who may have … infectious conditions, which are often severe and require intensive monitoring to appropriately diagnose and manage."[35] The chief of medicine emailed clinical leaders on July 30, 2024, about the lapse in infectious disease services, stating

> As of August 1 … we will no longer have inpatient [infectious disease] consultation or call available …. Hopefully, we will have [infectious disease] inpatient services available again in October 2024. More to come … I am sorry for the inconvenience of this and I appreciate your extra efforts to mitigate patient impact.

On August 14, 2024, the COS emailed facility leaders with a list of resources being pursued to cover infectious disease services. The list included the use of a fee-basis provider who had limited capacity, support from another medical center within the VISN, electronic interfacility

[34] VHA MSO, "Health-Care Resource (HCR) Acquisition Team Planning Guide."

[35] Steven Schmitt et al, "Infectious Diseases Specialty Intervention Is Associated With Decreased Mortality and Lower Healthcare Costs," *Clinical Infectious Diseases* 58, no. 1 (January 1, 2014); 22-28, https://doi.org/10.1093/cid/cit610.

consults, and telehealth service agreements.[36] Additionally, the email reflected that the details were being finalized.

Email communications reflected that a process to route electronic consults for infectious disease to other medical centers in the VISN started on August 26, 2024.[37] However, an infectious disease specialist who managed the electronic consults expressed concerns to facility leaders about the arrangement, emphasizing that the use of electronic consults is a "stopgap measure" and an infectious disease provider needed to be on-site to provide adequate patient care. The OIG determined that the August 14th email provided a list of potential resources for providers; however, several were not yet available, and such information is not a contingency plan. Further, through a review of email correspondence and interviews, the OIG found that the established contingency plan to transfer patients requiring infectious disease services to non-VA care was not communicated to physicians.

Both the chief of the emergency department and the chief hospitalist confirmed that facility leaders did not formally communicate the established contingency plan and physicians used clinical judgment to manage patients who required infectious disease services during the contract lapse.[38]

Endocrinology

An endocrinology consultation is vital when a patient's endocrine condition is complex as endocrinologists are knowledgeable on specific conditions and the medications used for treatment.[39]

In an October 8, 2024, email, the chief of medicine notified clinical leaders about the impending lapse in endocrinology services (at the end of the month) and stated that an attempt to obtain

---

[36] John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393. When VA facilities cannot provide timely access to care, non-VA providers are reimbursed by VA using a fee-for-service arrangement known as fee-basis care.

[37] An e-consult does not involve a face-to-face visit between the receiving provider and the patient and is ordered when the requesting 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 requesting provider. 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.

[38] A hospitalist is a physician, usually trained in general internal medicine, who specializes in managing the care of hospitalized patients. "General Internal Medicine," American College of Physicians, accessed August 11, 2025, https://www.acponline.org/about-acp/about-internal-medicine/general-internal-medicine.

[39] Cleveland Clinic, "Endocrinologist," accessed September 8, 2025, https://my.clevelandclinic.org/health/articles/22691-endocrinologist.

assistance from other medical centers in the VISN had not been successful.[40] On January 15, 2025, the chief of medicine emailed clinical leaders directing the transfer of patients with "complex endocrine management issue[s]" to a community hospital as endocrinology services remained unavailable due to the contract lapse. Through a review of email correspondence and interviews, the OIG did not find support that the established contingency plan to transfer patients requiring endocrinology services to non-VA care was communicated prior to January.

Similar to the management of patients requiring infectious disease services, the chief of the emergency department and the chief of hospitalists both confirmed that facility leaders did not formally communicate the contingency plan for patients needing endocrinology services, and physicians relied on their clinical judgment. Specifically, the chief of the emergency department reported that for a true endocrine emergency or complex endocrine conditions, the facility would transfer the patient.

The OIG concluded contingency plans ensure the continuity of operations and mitigate risks, particularly for healthcare resources that are vital to patient care. Facility leaders did not follow HRO principles of clear communication regarding established contingency plans prior to and during contract lapses.[41]

3. Physician Resignations

Through interviews, the OIG learned staff were concerned that several physicians resigned due to the reduction in clinical services; subsequently, the OIG asked the former physicians to give their rationale for leaving.[42] Responses reflected concerns about the effect of clinical service reductions on the quality of patient care and the dissatisfaction with how facility leaders communicated these changes. Specifically, the former physicians perceived facility leaders lacked transparency and did not communicate decisions, which resulted in a "chaotic environment" and allowed for "poor patient care."

The COS recognized some physicians resigned because of the neurosurgery program closure, the lapses in contracts, and providers feeling stressed. The former Facility Director reported not knowing why so many physicians resigned. The interim Facility Director told the OIG of taking actions to address culture of safety concerns and recognized improvements were made through the use of open and transparent communication and implementation of safety forums.

[40] The chief of medicine told the OIG that the other medical centers in the VISN did not have resources to assist the facility and that virtual consultation options for endocrinology coverage were not pursued.

[41] VA, "HRO Clear Communications Fact Sheet," January 2024.

[42] The time frame of the physician resignations ranged from April 30, 2024, through March 7, 2025. The OIG emailed nine former physicians on June 11, 2025, to obtain information related to their resignation and to explore their perception regarding the culture of safety at the facility. Six of nine former physicians responded to the OIG email. Five respondents were specialty physicians, and one respondent was a hospitalist.

The OIG reviewed resignation data and found eight specialty physicians who resigned between April 1, 2024, and March 31, 2025.[43] The resignations represented a significant percentage of specialty physicians:

- Cardiology—80 percent physician reduction when four of five physicians resigned
- Gastroenterology—50 percent physician reduction when two of four physicians resigned[44]
- Hematology-Oncology—50 percent physician reduction when one of two physicians resigned[45]
- Neurology—50 percent physician reduction when one of two physicians resigned

Due to the substantial loss of specialty physicians within each identified service, the OIG was concerned about consultative service availability and evaluated whether the coverage met VHA requirements outlined in VHA Directive 1220(1), *Facility Procedure Complexity Designation Requirements to Perform Invasive Procedures in Any Clinical Setting* for the facility's inpatient complexity designation, as the resignations could represent further reduction in clinical services.[46]

Absence of Required Specialty Physician Consultative Coverage

VHA Directive 1220(1), *Facility Procedure Complexity Designation Requirements to Perform Invasive Procedures in Any Clinical Setting,* and VHA National Surgery Office's "Invasive Procedure Complexity" website highlight specialty physician consultative coverage requirements. The VHA invasive procedure complexity model ensures "all surgeries are performed under the safest possible conditions at facilities with the resources to support them."[47] Procedures cannot exceed the infrastructure's capabilities, which include the availability of specialty physician consultation.[48] The Under Secretary for Health assigns each facility an invasive procedure designation (complexity designation) based on infrastructure criteria

[43] Two of the eight resignations were voluntary retirements.

[44] Gastroenterology is "a branch of medicine concerned with the structure, functions, diseases, and pathology of the stomach and intestines." *Merriam-Webster.com Dictionary*, "gastroenterology," accessed September 2, 2025, https://www.merriam-webster.com/dictionary/gastroenterology.

[45] Hematology is "a medical science that deals with the blood and blood-forming organs." *Merriam-Webster.com Dictionary*, "hematology," accessed September 2, 2025, https://www.merriam-webster.com/dictionary/hematology; Oncology is "a branch of medicine concerned with the prevention, diagnosis, treatment, and study of cancer." *Merriam-Webster.com Dictionary*, "oncology," accessed September 2, 2025, https://www.merriam-webster.com/dictionary/oncology.

[46] VHA Directive 1220(1), *Facility Procedure Complexity Designation Requirements to Perform Invasive Procedures in Any Clinical Setting*, May 13, 2019, amended February 11, 2020.

[47] VHA Directive 1220(1); "Invasive Procedure Complexity," VHA National Surgery Office, accessed August 13, 2025, https://dvagov.sharepoint.com/sites/VHANSO/SitePages/VA-Operative-Complexity-Designation.aspx. (This site is not publicly accessible.)

[48] VHA Directive 1220(1).

established by the Specialty Care Service Chief Officer and the National Director of Surgery.[49] According to the National Surgery Office, the facility has held an inpatient complex designation since 2010.[50]

VHA Directive 1220(1) also requires that medical centers designated as inpatient complex must have cardiology and gastroenterology services "available 24/7 within 15 minutes by phone and on-site, within 60 minutes." Similarly, services such as hematology-oncology, neurology, and infectious disease "must be available 24/7 within 15 minutes by phone and on-site, or virtually, via telemedicine, within 60 minutes."[51] The OIG reviewed on-call schedules for the months following the specialty physicians resignations and found the volume of resignations resulted in not meeting VHA specialty consultative coverage requirements for an inpatient complex designation (see table 1).

Table 1. Specialty Service Consultative Coverage

VHA Consultation Requirement	Specialty Service	Months With Gaps in Specialty Coverage*
"[M]ust be available 24/7 within 15 minutes by phone and on-site within 60 minutes."	Cardiology	2025: January, March
	Gastroenterology	2024: October, November, December 2025: January, February, March
"[M]ust be available 24/7 within 15 minutes by phone and on-site, or virtually, via telemedicine, within 60 minutes."	Hematology-Oncology	2024: August 2025: January, February, March
	Neurology	2024: October, November, December 2025: January, February, March

Source: OIG analysis of on-call specialty consultation schedules from July 1, 2024, through March 31, 2025. VHA Directive 1220(1).
Notes: The COS told the OIG that telemedicine services are not used for hematology-oncology or neurology consultative coverage. The OIG reviewed the infectious disease on-call specialty consultation schedules from July 1, 2024, through March 31, 2025, and found coverage gaps occurred from August 1, 2024, through October 31, 2024; however, this was due to the contract lapses as discussed above and not related to physician resignations.
**Of the months with gaps in specialty coverage, the range is from 1 to 22 days without required coverage.*

The OIG also reviewed patient safety reports dated April 1, 2024, through March 31, 2025, and asked during interviews about instances of adverse clinical outcomes related to a lack of consultative coverage. Although none were identified, the OIG is concerned about the potential

[49] VHA Directive 1220(1).

[50] The VA implemented complexity designations for inpatient medical centers in 2010. "Invasive Procedure Complexity," VHA National Surgery Office; Inpatient complex is the highest designation and includes procedures such as open heart surgery and solid organ transplant; VHA Directive 1220(1).

[51] VHA Directive 1220(1).

risk of adverse clinical outcomes when required specialty consultative coverage is not available. Facility leaders acknowledged the absence of required specialty physician consultative coverage and expressed concerns to the OIG.

The interim Facility Director and the COS told the OIG of plans to leverage community care and hire specialty care physicians to ensure specialty physician coverage. As of August 7, 2025, the specialty care administrative officer reported the hiring of one cardiologist and the active recruitment of two gastroenterologists and an advanced practice hematology-oncology provider (licensed independent practitioner).[52] Although a cardiologist was hired in June 2025, cardiology consultative coverage gaps remained in July 2025.

The OIG concluded the reduction in clinical services and lack of associated communication led to physician resignations, further reducing the availability of clinical services. As a result, the facility did not meet VHA requirements for specialty service consultative coverage and continued to perform "inpatient complex" procedures, which increased the risk of adverse outcomes for patients.

4. Additional Concern: Monitoring Patient Transfers

The chiefs of medicine, hospitalists, and emergency medicine, told the OIG that the reduction of clinical services resulted in an increased reliance on patient transfers to community hospitals. Facility physicians told the OIG of experiencing delays with transferring patients and expressed concerns about the risk of adverse clinical outcomes. The OIG found facility leaders did not have a process to monitor the timeliness of transfers; therefore, the OIG was unable to determine whether delays in transfers occurred.

VHA Directive 1094(1), *Inter-Facility Transfer Policy*, states "transfers [to another healthcare setting] are frequently necessary to provide a patient's access to specific providers or services"; however, transfers may "expos[e] the patient to risks."[53] This policy requires the monitoring and evaluation of transfers to ensure appropriateness and "maximum safety for patients." Specifically, medical center directors are responsible for having processes in place to guarantee "the safe, appropriate, orderly, and timely transfer of patients" and chiefs of staff are responsible for ensuring that "[a]ll transfers are monitored and evaluated as part of VHA's Quality Management program."[54]

The OIG inquired about the facility process to monitor and evaluate transfers and learned from the associate director for patient care services that transfers are documented on a nursing report sheet that quality management staff review to ensure accurate notes and appropriateness of

[52] According to the specialty care administrative officer, no neurology positions are under recruitment.

[53] VHA Directive 1094(1), *Inter-Facility Transfer Policy*, January 11, 2017, amended June 24, 2024.

[54] VHA Directive 1094(1).

transfers.[55] When asked about the transfer review process, the associate director of patient care services stated the review is not standardized and timeliness is not tracked. The OIG reviewed patient safety reports from April 1, 2024, through March 31, 2025, and did not find instances of adverse clinical outcomes due to transfer delays.

The interim Facility Director told the OIG of a facility process to escalate concerns about delays in patient care but also reported being unaware of any transfer delays. The former Facility Director, the interim Facility Director, and the chief of quality management reported being unaware if patient transfer timeliness was monitored. The COS explained relying on staff to report concerns about transfer delays and acknowledged, "I don't have a really good sense of how to track that population." The OIG asked the former Facility Director and the COS about the process for monitoring and evaluating the timeliness of patient transfers per VHA requirements and was told no process existed.

Tracking timeliness of transfers may result in opportunities to identify whether patient transfers are delayed. Based on the VHA Directive 1094(1) requirement to monitor and evaluate transfers and the potential increase in transfers due to reductions in clinical services, the OIG would expect facility leaders to evaluate the timeliness of the patient transfer process.[56]

5. Additional Concern: Oversight of Complexity Designation Requirements

The OIG determined VISN and facility leaders did not oversee the VHA required process for identifying and reporting facility infrastructure deficiencies, which resulted in not submitting required waiver requests.

VHA Directive 1220(1) indicates medical center service chiefs are required to complete an annual infrastructure review to ensure the medical center's complexity designation requirements are met.[57] The medical center director, VCSC, VISN CMO, and VISN director must certify the review.[58]Additionally, the VISN CMO and VCSC are responsible for addressing noncompliance with requirements of a medical center's assigned complexity designation.[59]

When medical centers do not meet infrastructure requirements, such as specialty physician consultative coverage, VISN and facility leaders must take steps to either lower the medical

[55] The data elements used to track transfers include verification required transfer documentation was completed, and patient information was communicated to the accepting hospital.

[56] VHA Directive 1094(1).

[57] VHA Directive 1220(1). In an interview, the Chief of Staff told the OIG the chief of surgery is responsible for performing the annual review at the facility. "[I]nvasive procedures are those procedures that require signature informed consent and involve a skin incision or puncture, or endoscopy."

[58] VHA Directive 1220(1).

[59] VHA Directive 1220(1).

center's complexity designation or submit a waiver request.[60] Although VHA does not define waiver request submission time frames (once deficiencies are identified), the medical center must submit a waiver if intending to retain the same complexity designation.[61] Further, VISN surgical workgroups are tasked with "overseeing compliance with VHA surgical … policy across the VISN" and medical center surgical workgroups are tasked with "[o]verseeing compliance with VA medical facility surgical complexity infrastructure requirements." [62]

The OIG examined facility annual reviews from fiscal years (FY) 2020 through 2025 to determine whether VISN and facility leaders accurately reported deficiencies and if so, whether required waivers were submitted.[63]

Fiscal Years 2020–2024 Annual Reviews

Through document review and interviews, the OIG learned that FY 2020 and 2021 annual reviews were inaccurate because the reviews did not indicate the cardiac catheterization laboratory lacked on-call services. The former chief of cardiology told the OIG that the cardiac catheterization laboratory opened in 2010 and had never provided on-call services.[64] The OIG was unable to determine who completed the FY 2020 and 2021 annual reviews.

The OIG also learned that although FY 2023 and 2024 annual reviews indicated the facility did not meet infrastructure requirements for cardiac catheterization laboratory services and nonvascular interventional radiology, no corresponding waivers were submitted until April 2025.[65] When asked why waiver requests were not submitted when cardiac catheterization laboratory and nonvascular interventional radiology coverage deficiencies were identified on the FY 2023 and 2024 annual reviews, the COS stated, "I don't have a good answer." Although the

[60] Service chiefs and facility directors are responsible for notifying facility and VISN leaders of infrastructure deficiencies. VISN directors are responsible for submitting a waiver to the VHA Office of Clinical Services for review and final determination by a committee, which includes members from Specialty Care Services, the National Diagnostics Office, and the National Surgery Office. VHA Directive 1220(1).

[61] VHA Directive 1220(1).

[62] VHA Directive 1102.01(2), National Surgery Office, April 24, 2019, amended April 19, 2022. VISN Surgical workgroups are required within each VISN and at each facility with a VHA surgery program. The VCSC chairs the VISN workgroup and the chief of surgery chairs the facility workgroup.

[63] Fiscal years for federal agencies include an annual period of October 1 of one calendar year through September 30 of the following year. "Common Budgetary Terms Explained," Congressional Budget Office, December 2021, accessed August 12, 2025, https://www.cbo.gov/publication/57660.

[64] In January 2025, all cardiac catheterization laboratory services became unavailable due to staffing vacancies. The OIG reviewed documentation indicating cardiac catheterization laboratory services are expected to resume in January 2026.

[65] The OIG reviewed the facility waiver request, which cited deficiencies for on-call and dayshift coverage in both interventional cardiology and nonvascular interventional radiology. In September 2025, the Office of Specialty Care Services and the National Surgery Office approved waivers for interventional cardiology on-call and dayshift coverage and for nonvascular interventional radiology "weekend and evening coverage," but did not address nonvascular interventional radiology dayshift coverage.

VCSC acknowledged beginning the waiver process in fall 2022, the VCSC reported changes kept occurring with service availability and the waivers were not submitted at that time.

The COS also acknowledged that a lack of familiarity with infrastructure waiver requirements contributed to the delayed waiver submission. The former Facility Director, the former VISN Director, and the former VISN CMO told the OIG of not knowing the absence of cardiac catheterization laboratory and nonvascular interventional radiology coverage would be characterized as a deficiency. The former Facility Director further stated waivers should have been submitted and believed the reporting of deficiencies "should flow up through the chief surgery."

FY 2025 Annual Review

The OIG learned the chief of surgery completed an annual review covering FY 2025 (October 1, 2024–September 30, 2025) indicating neurology consultative coverage requirements were met.[66] However, the OIG found neurology consultative coverage deficiencies began in October 2024 without a corresponding waiver submission.[67]

When the OIG asked about the inaccuracy, the chief of surgery shared that the task of completing the FY 2025 annual review was assigned one week after assuming the position. The chief of surgery requested assistance from the VCSC and was redirected to the COS. The chief of surgery reported the COS's guidance was to complete and submit the infrastructure review "to the best of your ability." The COS confirmed reviewing the FY 2025 annual review and reported that it appeared accurate at the time. However, an October 2024 email revealed the COS characterized the facility as noncompliant with VHA infrastructure requirements, citing deficiencies that included neurology consultative coverage.

Following the chief of surgery's completion of the FY 2025 annual review, the VCSC told the OIG of recognizing the review did not reflect deficiencies in neurology, cardiology, and gastroenterology consultative coverage. The VCSC reported asking the chief of surgery to reassess the annual review responses with the COS. However, despite having direct knowledge of unreported deficiencies, the VCSC deferred to the facility; "… as part of VISN, I go by what they [medical centers] tell me they [medical centers] are deficient in." The OIG confirmed the VCSC took no further action with VISN or facility leaders to ensure noncompliance with infrastructure requirements was addressed.

The interim Facility Director reported an expectation that waivers would be submitted when required, acknowledging that a waiver was needed for the absence of required consultative services. However, the interim Facility Director was not aware whether a waiver was submitted

[66] The chief of surgery completed the FY 2025 annual review in December 2024.

[67] The chief of surgery informed the OIG the alternative action of downgrading the facility's complexity designation was not planned.

for this deficiency. When asked about waivers for infrastructure deficiencies, the COS told the OIG of not understanding the significance of the waivers "until recently" and recognized the need to correct waiver deficiencies. In August 2025, the chief of surgery informed the OIG that no additional waivers had been submitted and that the chief of surgery was working with service chiefs to identify unreported deficiencies, with a plan to correct the annual review and submit corresponding waivers.

Further, the OIG reviewed both VISN and facility surgical workgroup meeting minutes from April 2024 through March 2025 and found that infrastructure deficiencies and corresponding waivers were not discussed until January 2025.[68] Given both workgroups are charged with overseeing compliance, the OIG would have expected that infrastructure deficiencies and the status of corrective actions, such as waiver submission, to be acted upon prior to January 2025. When asked, the VCSC stated waiver submissions were not tracked previously because only a few VISN facilities needed them. However, the OIG reviewed a June 2024 report published by the National Surgery Office that listed the facility and two other facilities within the VISN that reported infrastructure deficiencies without submission of corresponding waivers.[69]

Given that the VCSC had direct knowledge of all facility infrastructure deficiencies discussed within this report, the OIG would have expected the VCSC to communicate deficiencies to the former Facility Director, the former VISN Director, and the VISN CMO so that required actions could have been completed timely.

The OIG concluded VISN and facility leaders' lack of knowledge about infrastructure requirements and inadequate oversight allowed the facility to retain an "inpatient complex" designation and provide associated invasive procedures without the required resources, which placed patients at risk. As a result, procedures exceeded the infrastructure's capabilities without approved waivers for the deficiencies. Further, the VCSC's lack of oversight allowed inaccurate reporting of infrastructure deficiencies and long-term noncompliance with waiver requirements.

Conclusion

The OIG substantiated reductions in clinical services occurred, which included the closure of the neurosurgery program and lapses in infectious disease and endocrinology services contracts. Although the OIG did not have a concern about the former Facility Director's decision to close the neurosurgery program, VISN and facility leaders did not complete the required administrative actions before closing the program. Closing a major program without a formal

[68] The VCSC chaired both the VISN and facility surgical workgroups until December 2024 when the chief of surgery began chairing the facility surgical workgroup.

[69] VA National Surgery Office, *FY24 Q2 National Surgery Office Quarterly Report*, June 10, 2024. Facilities included the East Orange VA Medical Center in New Jersey, and the Brooklyn and Syracuse VA Medical Centers in New York.

review and approval bypasses required national oversight intended to ensure patient care is not compromised. Additionally, the OIG determined that VISN and facility leaders did not maintain adequate oversight of contracting milestones, resulting in lapses in the contracts and loss of clinical services, which posed potential risks of adverse clinical outcomes.

Further, facility leaders did not communicate changes in clinical operations to physicians in alignment with HRO principles. Specifically, facility leaders did not (1) address physician concerns about the neurosurgery program's closure and (2) disseminate formal and timely contingency plans for infectious disease and endocrinology patients, which negatively affected the culture of safety at the facility.

The OIG substantiated that multiple physicians resigned because of the reduction in clinical services and the deficient communication that followed. The resignations resulted in specialty physician consultative coverage gaps, placing the facility out of compliance with VHA inpatient complexity designation requirements. The OIG also learned facility leaders did not have a process to monitor the timeliness of patient transfers as required by VHA. Additionally, VISN and facility leaders lacked sufficient knowledge of infrastructure requirements and did not provide adequate oversight, allowing the facility to retain an inpatient complex designation without the resources to safely perform certain invasive procedures. As a result, procedures were conducted beyond infrastructure capabilities without approved waivers.

The OIG did not identify any adverse clinical outcomes related to the deficiencies identified within this report; however, the OIG is concerned about the potential risk of adverse clinical outcomes related to these issues.

The OIG is aware of VA's transformation in VHA's management structure. As we monitor the implementation, our oversight remains focused on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

Recommendations 1–8

1. The New York/New Jersey VA Healthcare Network Director evaluates the circumstances that led to Network and Syracuse VA Medical Center leaders not following clinical restructuring requirements according to Veterans Health Administration Directive 1043.

2. The Syracuse VA Medical Center Director evaluates the implementation of high reliability organization principles when communicating changes to clinical operations that include stakeholders, service and section leaders, and staff input.

3. The Syracuse VA Medical Center Director evaluates facility contract processes and takes action to ensure leaders maintain adequate oversight of contracting milestones.

4. The Syracuse VA Medical Center Director evaluates the communication of established contingency plans and ensures alignment with high reliability organization principles.

5. The Syracuse VA Medical Center Director ensures the monitoring and evaluation of patient transfers according to Veterans Health Administration Directive 1094(1) and takes action as warranted.

6. The Syracuse VA Medical Center Director ensures annual procedural complexity designation infrastructure reviews are completed accurately and ensures administrative actions are performed as required.

7. The New York/New Jersey VA Healthcare Network Director evaluates fiscal year 2026 procedural complexity designation infrastructure reviews for all Veterans Integrated Service New York/New Jersey VA Health Care Network facilities and takes action to ensure reviews are accurate and deficiencies are addressed as required.

8. The Under Secretary for Health ensures a timeliness expectation for infrastructure waiver submissions pursuant to Veterans Health Administration Directive 1220(1).

Appendix A: Timeline of Contracting Activity

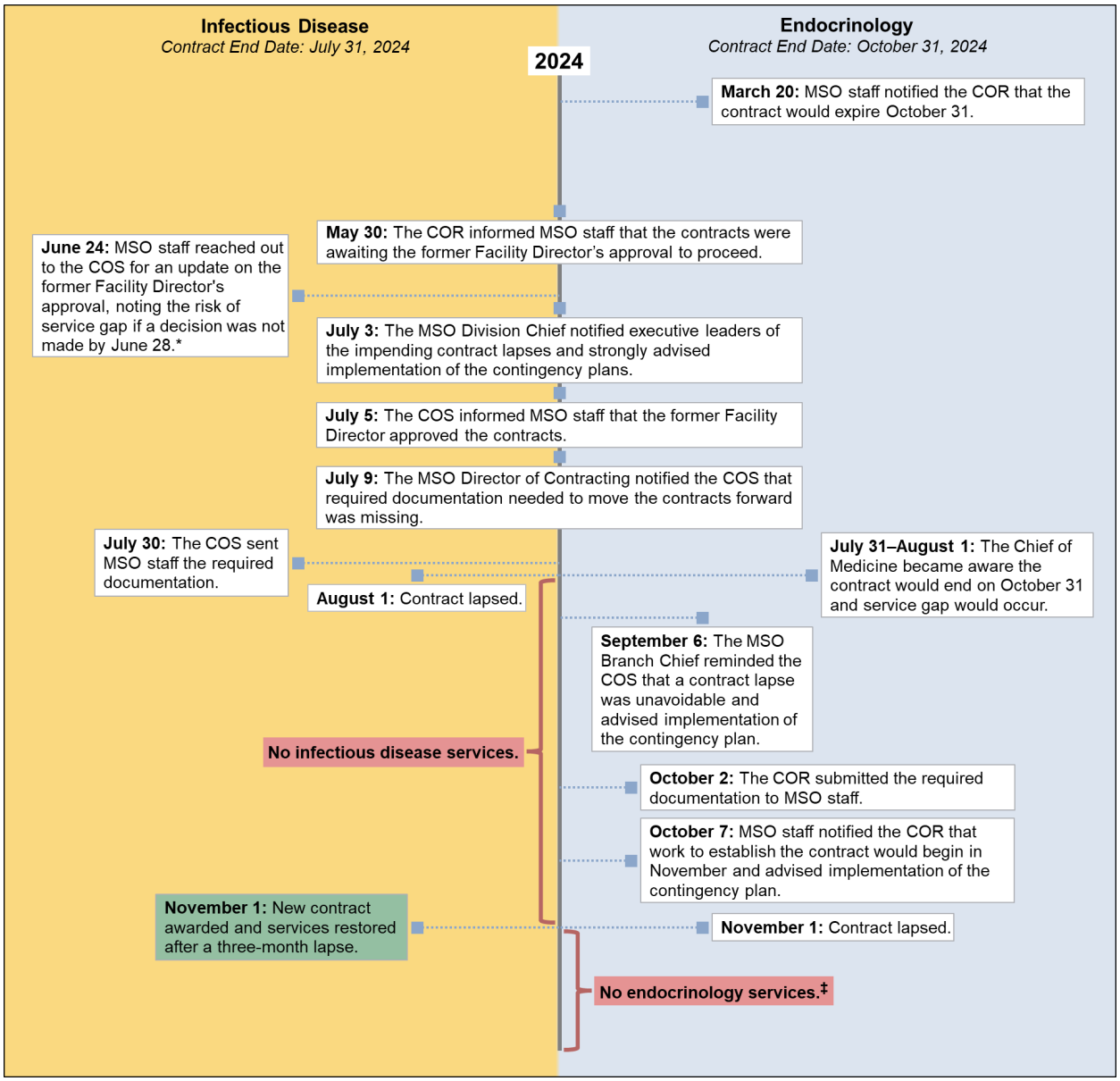

Figure 1. *Timeline of Contracting Activity.*
Source: OIG analysis of email correspondence between MSO staff, facility leaders, and the COR from August 2023 through August 2025.
Note: VHA contract renewals typically take 12–18 months to complete.
**The OIG did not find support that facility leaders responded to the June 24, 2024, email notifying them of the risk of the infectious disease contract lapsing.*
‡As of November 2024, the endocrinology contract lapsed. According to MSO staff, the contract is not expected to be restored until early 2026.

Appendix B: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: December 4, 2025

From: Senior Advisor Performing the Delegable Duties of the Acting Office of the Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Report, Review of Leaders' Actions Affecting Clinical Services at the Syracuse VA Medical Center in New York

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on OIG's draft report on Review of Leaders' Actions Affecting Clinical Services at the Syracuse VA Medical Center in New York. The Veterans Health Administration (VHA) concurs with recommendation 8 made to the Under Secretary for Health and provides an action plan in the attachment.

2. 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:)

John Figueroa

[OIG comment: The OIG received the above memorandum from VHA on December 4, 2025.]

Office of the Under Secretary for Health Response

Recommendation 8

The Under Secretary for Health ensures a timeliness expectation for infrastructure waiver submissions pursuant to Veterans Health Administration Directive 1220(1).

_X _Concur

____Nonconcur

Target date for completion: February 2026

Under Secretary for Health Comments

The Invasive Procedure Waiver Council will determine and formally communicate timeliness expectations and processes to VA Medical Centers and VISNs for requesting waivers for infrastructure deficiencies defined by VHA Directive 1220(1).

Appendix C: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: November 10, 2025

From: Interim Director, New York/New Jersey Department of Veterans Affairs (VA) Healthcare Network (10N02)

Subj: Office of Inspector General (OIG) Report, Review of Leaders' Actions Affecting Clinical Services at the Syracuse VA Medical Center in New York

To: Office of the Under Secretary for Health (10)
Director, Office of Healthcare Inspections (54HL06)
Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review the VA OIG Report: Review of Leaders' Actions Affecting Clinical Services at the Syracuse VA Medical Center in New York. I concur with the report's findings and recommendations.

2. Should you need further information, please contact the Veterans Integrated Service Network Quality Management Officer1.

(*Original signed by:*)

Donald McDonald, MD
Interim Chief Medical Officer
For
Bruce Tucker, LCSW-R

[OIG comment: The OIG received the above memorandum from VHA on December 4, 2025.]

VISN Director Response

Recommendation 1

The New York/New Jersey VA Healthcare Network Director evaluates the circumstances that led to Network and Syracuse VA Medical Center leaders not following clinical restructuring requirements according to VHA Directive 1043.

_X _Concur

____Nonconcur

Target date for completion: June 2026

Director Comments

All Senior Executive Service (SES) Staff involved at the time of the review have retired from the Veterans Health Administration (VHA). The Interim Network Director will charge a fact-finding to determine the decision process and identify where noncompliance with VHA Directive 1043, Restructuring of VHA Clinical Programs occurred at Syracuse Department of Veterans Affairs (VA) Medical Center. The results of the fact-finding and any recommendations will be presented at the Veterans Integrated Service Network (VISN) Quality Safety and Value (QSV) Council, which is chaired by the Network Director. The QSV Council will track action plans monthly for identified gaps until mitigation strategies are implemented if applicable. Sustainment of action will be monitored quarterly for two consecutive quarters.

Recommendation 7

The New York/New Jersey VA Healthcare Network Director evaluates fiscal year 2026 procedural complexity designation infrastructure reviews for all Veterans Integrated Service New York/New Jersey VA Health Care Network facilities and takes action to ensure reviews are accurate and deficiencies are addressed as required.

_X _Concur

____Nonconcur

Target date for completion: June 2026

Director Comments

All fiscal year 2026 procedural complexity designation infrastructure reviews for all New York/New Jersey VA Health Care Network facilities will be reviewed for compliance with VHA Directive 1220(1). These reviews will be conducted by the VISN Surgical [Integrated Clinical Community] ICC Lead, VISN Specialty ICC Leads, and VISN Chief Medical Officer for

accuracy and reported to the VISN Healthcare Delivery Council. Any deficiencies that are identified will be reported to the VISN QSV Committee which is chaired by the Network Director. Corrective actions will be tracked until identified deficiencies are resolved.

Appendix D: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: November 10, 2025

From: Interim Director, Department of Veterans Affairs (VA) Syracuse VA Medical Center in New York (528A7)

Subj: VA Office of Inspector General (OIG) Report, Review of Leaders' Actions Affecting Clinical Services at the Syracuse VA Medical Center in New York

To: Interim Director, New York/New Jersey VA Health Care Network (10N02)

1. We appreciate the opportunity to review and comment on the OIG draft report. The Syracuse VA Medical Center 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.

(*Original signed by*:)

Michael DelDuca, MBA-HCM

[OIG comment: The OIG received the above memorandum from VHA on December 4, 2025.]

Facility Director Response

Recommendation 2

The Syracuse VA Medical Center Director evaluates the implementation of high reliability organization principles when communicating changes to clinical operations that include stakeholders, service and section leaders, and staff input.

_X _Concur

____Nonconcur

Target date for completion: June 2026

Director Comments

Using the high reliability organization (HRO) concept of Leadership Commitment, the Syracuse VA Medical Center Director will enhance communication strategies to ensure information is shared widely. Leadership rounding will be expanded to support the development of strong relationships and trust among Syracuse VA leaders, staff members, and Veterans. It will be utilized to promote open communication, provide real-time feedback, and strengthen leadership commitment. Leadership will also communicate key information regarding clinical operations and organizational changes at the weekly all employee town hall, which is open to all employees and recorded for those who cannot attend. Employees will be able to submit concerns regarding changes to clinical operations, via the "employee suggestion box" located on the Syracuse Intranet site, which will be reviewed by the Executive Leadership Council (ELC). ELC is the governance body responsible for overseeing leadership decisions and is chaired by the Medical Center Director. Additionally, changes in clinical operations will be reported monthly to the ELC through the Integrated Clinical Community (ICC) Leadership team. Compliance will be monitored monthly through ELC.

Recommendation 3

The Syracuse VA Medical Center Director evaluates facility contract processes and takes action to ensure leaders maintain adequate oversight of contracting milestones.

_X _Concur

____Nonconcur

Target date for completion: June 2026

Director Comments

The Syracuse VA Medical Center Director will charge a review of current contracting process to identify any gaps. Actions will be developed for any deficiencies. Contract services and activities

will be reported to the ELC, which is chaired by the Medical Center Director, on a quarterly basis to include renewal timelines and escalation of issues or concerns. Compliance will be monitored monthly for three months and then quarterly for two quarters until identified gaps in contracting processes are considered resolved by ELC.

Recommendation 4

The Syracuse VA Medical Center Director evaluates the communication of established contingency plans and ensures alignment with high reliability organization principles.

_X _Concur

____Nonconcur

Target date for completion: June 2026

Director Comments

In alignment with the HRO principle of Clear Communication, tiered huddling will be employed as an effective communication tool. Tier One and Tier Two huddles will be conducted across all departments within the medical center. This structured approach will assist in facilitating sequential flow of information from frontline staff to executive leadership, ensuring timely and appropriate action. Furthermore, the Syracuse VA Medical Center Director will leverage established communication channels including weekly employee town halls and the facility intranet site, to ensure the consistent dissemination of critical information including contingency plans. The contingency plans will be monitored monthly by the ELC and communicated by the ICC Leadership teams. Compliance will be monitored monthly through ELC.

Recommendation 5

The Syracuse VA Medical Center Director ensures the monitoring and evaluation of patient transfers according to Veterans Health Administration Directive 1094(1) and takes action as warranted.

_X _Concur

____Nonconcur

Target date for completion: June 2026

Director Comments

The Medical Center Director has established an Inter-Facility Transfer Standard Operating Procedure that delineates the process for patient transfers both into and out of the Medical Center in accordance with VHA Directive 1094(1), Inter-Facility Transfer Policy. Transfer audits being conducted by Quality Management have been updated to include timeliness of transfers. Transfer

audits will be presented monthly to the Quality and Patient Safety Committee co-chaired by the Medical Center Director. Compliance will be monitored until 90% is reached for 6 consecutive months.

Recommendation 6

The Syracuse VA Medical Center Director ensures annual procedural complexity designation infrastructure reviews are completed accurately and ensures administrative actions are performed as required.

_X _Concur

____Nonconcur

Target date for completion: June 2026

Director Comments

The Medical Center Director ensures that infrastructure reviews, directed by the VISN Director, are completed in compliance with VHA Directive 1220(1), Facility Procedure Complexity Designation Requirements to Perform Invasive Procedures in Any Clinical Setting. These annual reviews will be conducted by the Surgical ICC Lead, the Medicine/Specialty ICC Lead, and Rehab and Extended Care ICC Lead for accuracy and reported to the Medical Executive Committee (MEC). The MEC is chaired by the Chief of Staff. Any deficiencies that are identified will be reported to the VISN 2 Surgical Workgroup and the facility ELC which is chaired by the facility Medical Center Director. The ELC will monitor the completion and accuracy of the annual complexity designation infrastructure reviews and ensure that all necessary administrative actions are completed.

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	Ariel Drobnes, LCSW, MBE, Director David Allton, MD Tabitha Eden, MSN, RN Jonathan Ginsberg, JD Michelle Kamel, MBA, RN Zaire Smith, LCSW Erica Taylor, MSW, LCSW
Other Contributors	Christopher D. Hoffman, LCSW, MBA Carol Lukasewicz, BSN, RN Larry Ross Jr., MS Natalie Sadow, MBA Alyssa Witten

Report Distribution

VA Distribution

Office of the Secretary
Office of Accountability and Whistleblower Protection
Office of Congressional and Legislative Affairs
Office of General Counsel
Office of Public and Intergovernmental Affairs
Veterans Health Administration
Director, New York/New Jersey VA Health Care Network (10N02)
Director, Syracuse VA Medical Center (528A7/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
US Senate: Kirsten Gillibrand, Chuck Schumer
US House of Representatives: John Mannion, Josh Riley, Elise Stefanik, Claudia Tenney

OIG reports are available at www.vaoig.gov.