



# US DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

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## VETERANS HEALTH ADMINISTRATION

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# Healthcare Facility Inspection of the VA Fayetteville Coastal Healthcare System in North Carolina

Healthcare Facility  
Inspection

25-00195-65

March 20, 2026

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## Executive Summary

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) established the Healthcare Facility Inspection program to review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle. The OIG inspected the VA Fayetteville Coastal Healthcare System (the facility) from February 11 through 13, 2025. In fiscal year 2024, the facility provided care to more than 90,000 patients. The inspection team examined aspects of care delivery and patient safety within the facility using five domains.<sup>1</sup>

### What the OIG Examined

Overall, the OIG inspection did not reveal concerns or deficiencies that warranted recommendations for corrective action.

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement.
- **Primary Care.** The OIG determined whether primary care teams were staffed per VHA Directive 1406(2), *Patient Centered Management Module (PCMM) for Primary Care*, and Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*.<sup>2</sup>
- **Veteran-Centered Safety Net.** The inspection also evaluated facility programs that offer support services to vulnerable veterans who are experiencing or at risk of homelessness, or recently incarcerated.

The OIG is aware of the transformation in VHA's management structure. The OIG will monitor implementation and direct its oversight efforts on the effectiveness and efficiency of VA programs and services that improve the health and welfare of veterans and their families.

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<sup>1</sup> See appendix A for a description of the OIG's inspection methodology.

<sup>2</sup> VHA Directive 1406(2), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 10, 2025; VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

## What the OIG Recommended

The OIG made no recommendations.

## VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the report (see appendixes B and C). No further action is required.



JULIE KROVIAK, MD

Principal Deputy Assistant Inspector General,  
in the role of Acting Assistant Inspector General,  
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## Abbreviations

FY	fiscal year
HCHV	Health Care for Homeless Veterans
HUD-VASH	Housing and Urban Development–Veterans Affairs Supportive Housing
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

## Contents

Executive Summary .....	i
Abbreviations .....	iii
Introduction.....	1
CULTURE .....	2
System Shocks .....	3
Employee Experiences .....	3
Veteran Experiences.....	3
ENVIRONMENT OF CARE .....	4
General Inspection .....	5
Toxic Exposure Screening Navigators.....	6
PATIENT SAFETY .....	6
Communication of Urgent, Noncritical Test Results.....	6
Action Plans and Process Improvements .....	8
PRIMARY CARE.....	8
Primary Care Teams.....	8
VETERAN-CENTERED SAFETY NET.....	9
Health Care for Homeless Veterans .....	9
Housing and Urban Development–Veterans Affairs Supportive Housing .....	11

Veterans Justice Program .....12

Conclusion .....13

Appendix A: Methodology .....14

Appendix B: VISN Director Comments .....16

Appendix C: Facility Director Comments .....17

OIG Contact and Staff Acknowledgments .....18

Report Distribution .....19



## Introduction

The Office of Inspector General's (OIG's) Office of Healthcare Inspections focuses on overseeing the Veterans Health Administration (VHA), which offers care to more than nine million enrolled veterans through its 1,380 healthcare facilities.<sup>1</sup> VHA's vast care delivery structure requires sustained and thorough OIG scrutiny to ensure the nation's veterans receive high-quality care.

The OIG established the Healthcare Facility Inspection program to routinely evaluate VHA medical facilities on an approximately three-year cycle. Healthcare Facility Inspection reports provide insight into the experience of staff working in VHA facilities and veterans receiving care. They inform veterans, the public, and Congress about the conditions for care delivery and patient safety and highlight specific corrective actions leaders and staff can take. Each inspection focuses on five content domains:



**Culture:** Culture is the system of shared values that shape an organization's behavioral norms; a positive culture is associated with better patient outcomes.<sup>2</sup>



**Environment of Care:** To ensure medical facilities are safe and clean, VHA established a comprehensive environment of care program.<sup>3</sup>



**Patient Safety:** VHA implemented patient safety programs to identify system vulnerabilities and reduce patient harm.<sup>4</sup>



**Primary Care:** To promote positive health outcomes, VHA uses a multidisciplinary team-based approach for its primary care model.<sup>5</sup>



**Veteran-Centered Safety Net:** VA serves as a coordinated national safety net for veterans, administering programs that offer medical care and social support services to vulnerable individuals, including those experiencing homelessness.<sup>6</sup>

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<sup>1</sup> "About VHA," Department of Veterans Affairs, last updated January 20, 2025, <https://www.va.gov/aboutvha>.

<sup>2</sup> Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," *BMJ Open* 7, no. 11 (2017): 1–11, <https://doi.org/10.1136/bmjopen-2017-017708>.

<sup>3</sup> VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023.

<sup>4</sup> VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

<sup>5</sup> VHA Directive 1406(2), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 10, 2025.

<sup>6</sup> VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

The VA Fayetteville Coastal Healthcare System (the facility) consists of the Fayetteville VA Medical Center, Fayetteville Health Care Center, and community-based outpatient clinics in outlying counties.<sup>7</sup> The facility also has a rehabilitation center in Fayetteville and an inpatient acute dialysis center at the Womack Army Medical Center, which are joint partnerships with the Department of Defense.<sup>8</sup> In fiscal year (FY) 2024, the facility provided care to more than 90,000 patients with a medical care budget of over \$900 million, and had 59 hospital and 41 community living center beds.<sup>9</sup>



**Figure 1.** Fayetteville VA Medical Center. Source: “VA Fayetteville Coastal Health Care,” Department of Veterans Affairs, accessed October 15, 2025, <https://www.va.gov/fayetteville-coastal-health-care/locations/>.

The OIG inspected the facility from February 11 through 13, 2025. The executive leaders referred to throughout this report include the Executive Director (Director), Chief of Staff, Associate Director of Operations, Associate Director of Patient Care Services/Chief Nurse Executive, Associate Director for Access and Clinical Business Operations, and Assistant Director. The executive leaders had been working together since May 2024.



## CULTURE

The OIG examined the facility’s culture across multiple dimensions, including unique circumstances and system shocks (planned or unplanned events that disrupt an organization’s daily operations), and both employees’ and veterans’ experiences. The OIG administered its own facility-wide questionnaire and reviewed VA’s All Employee Survey results for October 1, 2020, through September 30, 2023. The team also interviewed executive and facility leaders and employees and considered data from patient advocates.<sup>10</sup>

<sup>7</sup> A health care center is a multi-specialty outpatient clinic that provides mental health care, primary care, and surgical services. VHA Directive 1229(1), *Planning and Operating Outpatient Sites of Care*, July 7, 2017, amended October 4, 2019.

<sup>8</sup> A September 5, 2025, executive order designated the Department of War as a secondary title for the Department of Defense. Restoring the United States Department of War, 90 Fed. Reg. 43893 (Sep. 10, 2025).

<sup>9</sup> A community living center is also referred to as a VA nursing home. “Geriatrics and Extended Care,” Department of Veterans Affairs, last updated June 3, 2025, <https://www.va.gov/geriatrics/CLC>.

<sup>10</sup> The All Employee Survey is an annual, voluntary survey of VA workforce experiences. “AES Survey History, Understanding Workplace Experiences in VA,” VHA National Center for Organization Development. Patient advocates are employees who receive feedback from veterans and help resolve their concerns. “Patient Advocate,” Department of Veterans Affairs, last updated May 9, 2022, <https://www.va.gov/patientadvocate>. For more information on the OIG’s data collection methods, see appendix A.

## System Shocks

Executive leaders mentioned challenges related to the facility's aging infrastructure, including two events that occurred on a single day in November 2024. First, an old water pipe burst and caused a flood, requiring a temporary relocation of sterile processing operations.<sup>11</sup> Second, a contractor accidentally started a fire while repairing the roof, which required staff to move patients to other areas of the hospital. Although operations returned to normal a few days later, leaders said they identified opportunities to update emergency management plans and better educate staff on how to respond during such events. Leaders also shared that facility engineers began to include mechanical upgrades, like plumbing, into future construction projects.

## Employee Experiences

OIG questionnaire respondents generally reported feeling comfortable raising safety concerns, which aligned with improvements in psychological safety scores from the FY 2024 VA All Employee Survey.<sup>12</sup> Leaders also observed an increase in patient safety event reporting—an indicator they view as greater staff engagement in safety practices.

Executive leaders detailed multiple ways they communicate with employees, such as through a daily email, a monthly town hall, and an online question portal that allows leaders to respond directly to employees' questions. The Director described focusing on employee engagement since arriving at the facility. Executive leaders said they founded an employee association, which organizes outside activities such as attending hockey games as a group. Leaders also hired an organizational psychologist to lead the Whole Health program team, which emphasizes employees' well-being and provides them with related resources.<sup>13</sup> Additionally, leaders identified workgroups with low VA All Employee Survey scores and participation rates and developed and implemented action plans to improve their scores.

## Veteran Experiences

In response to an OIG questionnaire, a patient advocate identified telephone communication as one of veterans' most common complaints. Executive leaders acknowledged challenges with call transfers, particularly the lack of warm handoffs. They explained that facility staff often

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<sup>11</sup> Sterile processing is "the cleaning, disinfection, testing, repair, repackaging and sterilization of contaminated reusable medical equipment (RME) in order to make them available for use in patients." Department of Veterans Affairs, PG-18-12: *Sterile Processing Service and Logistics Service Design Guide*, revised September 1, 2022.

<sup>12</sup> "Psychological safety is an organizational factor that is defined as a shared belief that it is safe to take interpersonal risks in the organization." Jiahui Li et al., "Psychological Safety and Affective Commitment Among Chinese Hospital Staff: The Mediating Roles of Job Satisfaction and Job Burnout," *Psychology Research and Behavior Management* 15 (June 2022): 1573–1585, <https://doi.org/10.2147/PRBM.S365311>.

<sup>13</sup> Employee Whole Health is VA's approach to support employees to prioritize their health and well-being. "Whole Health," Department of Veterans Affairs, last updated February 10, 2026, <https://www.va.gov/wholehealth>.

transferred calls without confirming someone answered at the receiving end. To address this, leaders reinforced expectations for staff to remain on the line until the call was answered.

Leaders also reported that they have upgraded the facility's outdated phone systems to a single standardized platform across all sites. This upgrade will enable advanced capabilities such as detailed call metrics, including incoming call volume, call duration monitoring, and call handling performance. These enhancements will allow supervisors to monitor service quality, improve accountability, and reduce complaints related to phone access.

To keep veterans informed of system-wide improvements, executive leaders conduct regular town halls and meet with congressional offices and veterans service organizations to share information, such as encouraging veterans to call the facility's main number to ensure proper call routing, rather than relying on individual staff extensions that may no longer be valid.<sup>14</sup>

Leaders said they review feedback from the patient advocate tracking system and veteran trust scores.<sup>15</sup> Based on feedback, they believe their efforts to improve telephone communication have been effective and they have received fewer complaints.



## ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.<sup>16</sup> The OIG team assessed how a facility's physical features may shape the veteran's perception of the health care they receive. The team also inspected patient care areas and focused on safety, cleanliness, infection prevention, and privacy.

The inspectors examined compliance with key VA and VHA guidelines and standards, as well as with Architectural Barriers Act and Joint Commission standards. Best practice principles from academic literature were also considered.<sup>17</sup>

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<sup>14</sup> "Veterans Service Organizations (VSOs) are organizations that aid and serve veterans, servicemembers, dependents, and survivors." Congressional Research Service, *Veterans Service Organizations (VSOs): Frequently Asked Questions*, updated February 6, 2024.

<sup>15</sup> The patient advocate system "tracks patient complaints, compliments, and other key program data" in one central location. Office of Patient Advocacy, *Veteran Centered Complaint Resolution Guidebook*, updated January 2023, <https://dvagov.sharepoint.com/VCCRGuide>. "VA measures customer experience and trust through the ease, effectiveness, and emotion" staff demonstrate in care delivery, benefits and services. "Veteran Trust in VA," Department of Veterans Affairs, last update January 20, 2026, <https://www.va.gov/veteran-trust-in-va>.

<sup>16</sup> "Informing Healing Spaces through Environmental Design: Thirteen Tips," Department of Veterans Affairs, last updated May 1, 2024, <https://www.va.gov/WholeHealth/Healing-Spaces>.

<sup>17</sup> Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*, December 2012; Department of Veterans Affairs, *VA Signage PG-18-10, Design Manual*, May 16, 2023, revised February 19, 2025; Department of Veterans Affairs, *VA Barrier Free Design Standard*, January 1, 2017, revised May 1, 2025; VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook*, 2025; Access Board, *Architectural Barriers Act (ABA) Standards*, 2015; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2025.

## General Inspection

The OIG inspected the Fayetteville VA Medical Center and Fayetteville Health Care Center and located the sites with directions from the facility’s website. Both locations provided valet services and a bus stop near the main entrance.

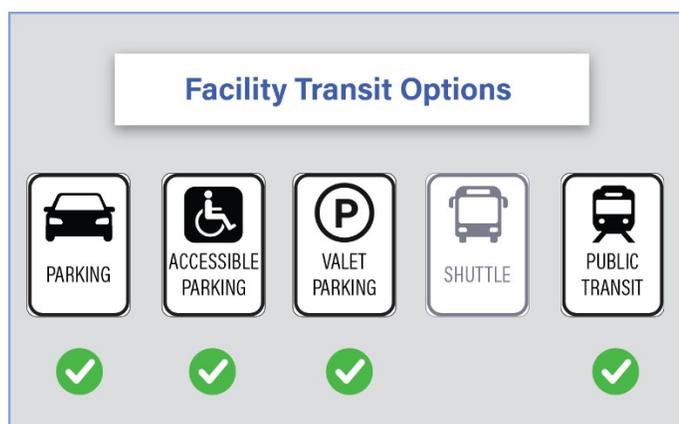
Both main entrances featured covered passenger loading zones, available wheelchairs, and power-assisted doors. The inspection team easily located the information desk at the Fayetteville Health Care Center; however, the desk at the Fayetteville VA Medical Center was behind plexiglass in a corridor and difficult to find.

The facilities management service chief reported that there was a project planned to relocate the desk, but it was delayed after the contractor lost key staff, prompting the Network Contracting Office to suspend the contract. The earliest expected completion date is June 2026.<sup>18</sup>

The OIG observed volunteers and staff helping veterans with navigation at both locations. There were directional signs that made it easy to find clinical areas, maps with large print near the entrances, and elevators with audio cues and braille. The OIG also noted braille on room plaques throughout both locations.

At the Fayetteville VA Medical Center, the OIG noted dirty surfaces and damaged infrastructure in the Emergency Department, medical surgical unit, community living center, and throughout common areas. There were dusty patient equipment and dirty floors in the Emergency Department. In the medical surgical unit, there was dirt on the cover of a clean linen cart and red adhesive tape stuck to the floor of the clean linen room, which could prevent staff from adequately cleaning the floor. Joint Commission standard IC.06.01.01 requires staff to maintain a clean and sanitary environment to reduce the risk of infection.<sup>19</sup>

The OIG also observed damaged walls and broken handrails throughout the first and basement floors of the Fayetteville VA Medical Center’s main building. The chief said the maintenance staff will repair what they can until the facility gets a contractor to address the deficiencies. In December 2025, the Associate Director of Operations reported implementing processes to ensure



**Figure 2.** Transit options for arriving at the facility.  
 Source: OIG observations, a campus map, and an email from the senior security specialist.

<sup>18</sup> Each Network Contracting Office provides procurement support at the local, regional, and national levels to advance the delivery of high-quality care and services to Veterans. “VHA Procurement & Logistics Office (P&LO),” Department of Veterans Affairs, last updated April 25, 2023, <https://www.va.gov/plo/about/saos>.

<sup>19</sup> The Joint Commission, *Standards Manual*, E-dition, IC.06.01.01, March 20, 2025.

staff properly clean and maintain the facility, and supervisors validate completed work. Therefore, the OIG did not make a recommendation.

The OIG also found that several exam rooms lacked privacy curtains in the Fayetteville Health Care Center. VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, requires facilities to provide privacy curtains in exam rooms and ensure tables are shielded from view when the door is opened.<sup>20</sup> The Fayetteville Health Care Center administrator noted there were plans to install the privacy curtains; therefore, the OIG did not make a recommendation.

## Toxic Exposure Screening Navigators

VA recommends that each facility identify two toxic exposure screening navigators.<sup>21</sup> The OIG confirmed the facility has one designated toxic exposure navigator who also serves as a compensation and pension provider.

The OIG reviewed facility data and found providers did not complete over 400 secondary toxic exposure screenings (screenings that require follow-up because veterans reported exposures during the initial screen) within 30 days of the initial screen.<sup>22</sup> The navigator described efforts to educate providers on how to complete secondary screens. In December 2025, the primary care chief reported that most veterans received screenings during regularly scheduled appointments, and the navigator received dedicated time in November and December 2025 to reduce the screening backlog. The navigator also monitors the number of secondary screens weekly.



## PATIENT SAFETY

The OIG inspectors examined the facility's patient safety processes. They focused on communication procedures for urgent but noncritical test results, the sustainability of changes made by leaders in response to previous oversight recommendations and other facility investigations, and improvement projects.

## Communication of Urgent, Noncritical Test Results

The facility had test result communication policies and service-level workflows (which describe staff members' roles in the process), as required by VHA Directive 1088(1), *Communicating*

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<sup>20</sup> VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

<sup>21</sup> Assistant Under Secretary for Health for Operations (15), "Toxic Exposure Screening Installation and Identification of Facility Navigators," memorandum to Veterans Integrated Service Network Directors (VISN) (10N1-23), October 31, 2022; VA, *Toxic Exposure Screening Navigator: Roles, Responsibilities, and Resources*, updated April 2023.

<sup>22</sup> Department of Veterans Affairs, *Toxic Exposure Screening Process*, updated January 2025.

*Test Results to Providers and Patients.*<sup>23</sup> However, quality management staff noted that external peer review data revealed providers did not consistently communicate abnormal test results to patients in a timely manner.<sup>24</sup> Therefore, a quality management nurse began reviewing random laboratory and radiology notifications daily; shared data with the Chief of Staff, who provided it to service chiefs to follow up with the provider, and reported it to the Quality Patient Safety Committee. The OIG reviewed external peer review data from quarter four of FY 2024 to quarter one of FY 2025 and found the communication of abnormal test results had improved.

Clinical and quality management leaders attributed challenges in timely test result communications to VHA's National Teleradiology Program and the Care in the Community service.<sup>25</sup> The chief of radiology explained that teleradiology providers do not consistently meet facility policy time frames, such as communicating critical and actionable results within 30 and 60 minutes, respectively.<sup>26</sup> The chief said the program complied with the policy about 70 percent of the time. The chief worked with Veterans Integrated Service Network (VISN) leaders to address the delays, and quality management staff said there have been no adverse events from untimely radiology test result notifications.<sup>27</sup>

The OIG reviewed facility safety event data and identified seven events related to community care test results. In response, patient safety staff reported they performed a root cause analysis, established a workgroup, and implemented improvement actions.<sup>28</sup> In February 2025, staff still were monitoring implemented actions; therefore, the OIG did not make a recommendation.

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<sup>23</sup> VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

<sup>24</sup> Providers must communicate urgent non-critical test results to patients that require action within seven days of the results being available. VHA Directive 1088(1). The External Peer Review Program conducts "external review[s] of medical records...to assess the quality of both inpatient and outpatient care." "External Peer Review Program Guide," Department of Veterans Affairs, Analytics and Performance Integration, Performance Measurement, accessed December 1, 2025, <https://vawww.qps.med.va.gov/download=77130>. (This website is not publicly accessible.)

<sup>25</sup> The VHA National Teleradiology Program "provides 24/7 diagnostic radiology services" to VA medical facilities. VHA Directive 1084, *VHA National Teleradiology Program*, April 9, 2020. VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393 (2018) § 101.

<sup>26</sup> Fayetteville NC VA Coastal Health Care System, *Reporting of Critical Tests and Critical Results*, MCP [medical center policy] 11-89, September 2024.

<sup>27</sup> Veterans Integrated Service Networks are "regional systems of care working together to better meet local health care needs and provides greater access to care." "Veterans Integrated Service Network (VISN)," Department of Veterans Affairs, last updated August 11, 2025, <https://www.va.gov/HEALTH/visns>.

<sup>28</sup> A root cause analysis is a comprehensive and focused review that is used for "adverse events and close calls" requiring analysis. VHA Directive 1050.01(1).

## Action Plans and Process Improvements

The facility had no recommendations from oversight agencies within the previous three years related to test result communications. Quality management staff said they monitor oversight findings, inform leaders of safety events and trends, and present progress reports to the Quality and Patient Safety Council. The OIG reviewed council meeting minutes from November 2023 to November 2024 and confirmed staff updated members on improvement actions from survey findings and discussed patient safety events.

The Associate Director of Patient Care Services/Chief Nurse Executive explained that staff, managers, and executive leaders discuss this information during daily huddles. Quality management staff said they facilitate small groups to promote communication and develop process improvement plans. They recently worked with staff from the operating room and Environmental Management Service to update cleaning procedures. The systems redesign specialist described teaching staff process improvement skills, such as how to identify problems, create solutions, and track action plans.



### PRIMARY CARE

The OIG determined whether primary care teams were staffed per VHA Directive 1406(2), *Patient Centered Management Module (PCMM) for Primary Care*, and Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*.<sup>29</sup> The OIG interviewed staff, analyzed primary care team staffing data, and examined new patient appointment wait times.

## Primary Care Teams

The facility reported vacancies for 14 providers, 7 registered nurses, 19 licensed practical nurses, and 16 medical support assistants. Additionally, a social worker described covering six primary care teams, which could delay care coordination. VHA Handbook 1101.10(2) suggests a staffing ratio of one social worker for every two primary care teams.<sup>30</sup> The social work supervisor reported they were actively recruiting to fill two social worker vacancies. However, one candidate withdrew, citing uncertainty about federal employment. The supervisor described meeting with social workers daily to discuss their workload, patient safety concerns, and ways to improve efficiency.

Executive leaders explained that provider recruitment and retention have been an ongoing struggle since December 2023, when several providers left the facility due to retirement or

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<sup>29</sup> VHA Directive 1406(2); VHA Handbook 1101.10(2).

<sup>30</sup> VHA Handbook 1101.10(2).

relocation. Executive and primary care leaders said they work with VISN human resources staff to hire providers as quickly as possible and update the VISN Director every two weeks.

The primary care chief also shared that provider vacancies limit new patient appointments, which resulted in longer wait times. The OIG reviewed access data from October 2023 through September 2024 and determined appointment wait times for new patients ranged from 67 to 83 days, which is longer than the target of 20 days, as stated in VHA Directive 1231(4), *Outpatient Clinic Practice Management*.<sup>31</sup>

The chief said primary care uses unassigned providers to see new patients with urgent needs or refers them to community providers. The Chief of Staff also said VISN 2 clinical video telehealth providers and those from the VISN 6 Clinical Resource Hub cover vacancies when needed.<sup>32</sup>

Executive and primary care leaders said they support projects to improve clinic efficiency and access to care. For example, primary care leaders and staff initiated a project in January 2025 to extend clinic operations by two hours per day, which increased the daily number of appointments. Leaders said they piloted the project at the community-based outpatient clinic in Wilmington and plan to implement it throughout the facility and measure success based on veteran and staff surveys.



## VETERAN-CENTERED SAFETY NET

The OIG reviewed the Health Care for Homeless Veterans (HCHV), Housing and Urban Development–Veterans Affairs Supportive Housing (HUD-VASH), and Veterans Justice Programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans’ needs. The inspection team analyzed enrollment and performance data and interviewed program staff.

### Health Care for Homeless Veterans

According to VHA, the HCHV program aims to reduce homelessness by improving access to health care, based on the premise that addressing health needs enables veterans to pursue broader

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<sup>31</sup> VHA Directive 1231(4), *Outpatient Clinic Practice Management*, October 18, 2019, amended February 7, 2024.

<sup>32</sup> Clinical video telehealth (CVT) is “the use of real-time interactive video conferencing...to assess, treat and provide care to a patient remotely. Typically, CVT links the patient(s) at a clinic to the provider(s) at another location.” Department of Veterans Affairs, Patient Care Services, *VHA Telehealth Services, Clinic Based Telehealth Operations Manual*, revised July 2014. “Clinical Resource Hubs (CRH) are VISN-owned and governed programs that provide support to increase access to VHA clinical services for Veterans when local facilities have gaps in care or service capabilities.” “Patient Care Services, Clinical Resource Hubs (CRH),” Department of Veterans Affairs, last updated March 20, 2024, <https://www.patientcare.va.gov/CRH>.

life goals. Program staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.<sup>33</sup>

During this inspection, VHA used three performance measures to determine the success of each medical facility's program. The first, HCHV5, measured the percentage of homeless veterans who received an HCHV program intake assessment.<sup>34</sup> However, this fiscal year (FY 2026), VHA no longer uses this intake percentage as a performance measure. The second measure used during the inspection, HCHV1, measured the percentage of veterans placed into permanent housing from contracted emergency residential services (stable living arrangements for veterans while they seek permanent housing) as well as those from low-demand safe haven programs (transitional residences for veterans with mental health or substance use conditions).<sup>35</sup> Finally, HCHV2 measured the percentage of veterans who are discharged from the program's contracted emergency residential services or low-demand safe haven beds due to a "violation of program rules...failure to comply with program requirements...or [who] left the program without consulting staff (referred to as negative exits)."<sup>36</sup>

## Performance and Improvement Highlights

- For FY 2023, the VHA Homeless Programs Office exempted the facility's HCHV program from the intake percentage (HCHV5) measure due to the small number of homeless veterans in the area. In FY 2024, the program exceeded the target. The program coordinator indicated the program received about six additional positions that year, which allowed staff to expand outreach efforts. Program staff conduct outreach in places such as churches, homeless shelters, and other areas where homeless individuals are known to live. Furthermore, program staff said they

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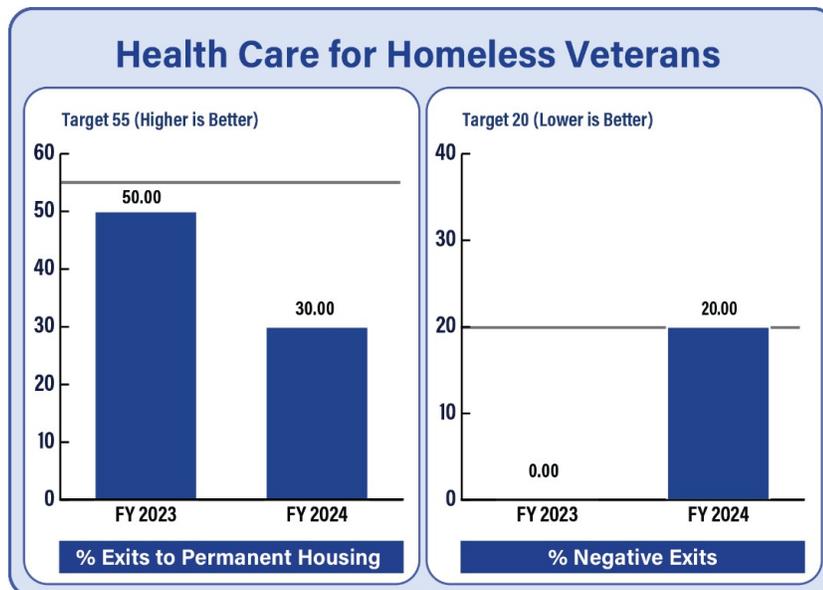
<sup>33</sup> VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

<sup>34</sup> VHA's goal is for facility program staff to perform intake assessments for all identified veterans by the end of each fiscal year. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*, October 1, 2022; VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*, October 1, 2023.

<sup>35</sup> VHA sets targets for HCHV1 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*. Contract residential services programs include both contracted emergency residential services and low-demand safe haven programs. For contracted emergency residential services, veterans can usually stay from 30 to 90 days. For low-demand safe havens a veteran can typically stay between 4 to 6 months. VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

<sup>36</sup> VHA sets targets for HCHV2 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*.

operate a walk-in clinic, which provides clinical services, resources, and referrals to assist homeless veterans with food, clothing, and housing.



**Figure 3.** HCHV program performance measures.  
 Source: VHA Homeless Performance Measures data.

- The program did not meet the HCHV1 target in FYs 2023 and 2024 but met the HCHV2 target in both fiscal years. The homeless program manager attributed meeting the HCHV2 target to staff collaborating with contracted residential personnel to reduce veterans’ premature program exits.

## Housing and Urban Development–Veterans Affairs Supportive Housing

The HUD-VASH program combines HUD rental assistance with VA case management services to support veterans who face significant barriers to stable housing, including “serious mental illness, physical health diagnoses, and substance use disorders.”<sup>37</sup> The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.<sup>38</sup>

VHA measures how well the program meets veterans’ needs by using nationally determined targets, including the number of housing vouchers assigned to the facility currently used by

<sup>37</sup> VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

<sup>38</sup> VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

veterans or their families (performance measure HMLS3) and the percentage of veterans who are employed (performance measure VASH3).<sup>39</sup>

## Performance and Improvement Highlights

- The program met the HMLS3 target in FY 2024 and nearly met it in FY 2023.<sup>40</sup> The program coordinator attributed missing the FY 2023 target to the position being vacant for two to three months prior to the coordinator's appointment in March 2022, which delayed issuing vouchers. To improve performance, the program implemented a new entry team consisting of a case manager and a housing specialist, who were able to quickly house veterans and help meet the target in FY 2024. As of December 2024, of the 503 vouchers allocated to the facility, 468 veterans were housed, 5 had been referred to a public housing agency to receive their voucher, and 24 were still searching for housing.
- The program did not meet the VASH3 target for FY 2023 but met it in FY 2024.<sup>41</sup> The coordinator attributed missing the FY 2023 target to a vacant employment specialist position. This role is responsible for updating veterans' employment status in the national database. A new specialist, who started in September 2023, significantly improved data entry and helped the program meet the FY 2024 target.

## Veterans Justice Program

The Veterans Justice Program serves veterans throughout all stages of the criminal justice process—from contact with law enforcement to court appearances and their reentry into life in the community after incarceration.<sup>42</sup> Recognizing incarceration as a strong predictor of homelessness on release, the program focuses on connecting veterans to VA health care, services, and benefits.<sup>43</sup> VHA sets a target for the number of veterans entering Veterans Justice Program each fiscal year (performance measure VJP1).<sup>44</sup>

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<sup>39</sup> VHA sets the target for facilities to provide a minimum of 90 percent of their allotted housing vouchers to participants and at least 50 percent of the participants in the facility's program should be employed. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*.

<sup>40</sup> Facility program results were 89.81 and 94.26 percent for FYs 2023 and 2024, respectively.

<sup>41</sup> Facility program results were 32.60 and 54.55 percent for FYs 2023 and 2024, respectively.

<sup>42</sup> VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

<sup>43</sup> VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

<sup>44</sup> VHA sets escalating targets for this measure at the facility level each year, with the goal to enroll all identified veterans by the end of the fiscal year. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*.

## Performance and Improvement Highlights

- The program did not meet the target in FYs 2023 or 2024.<sup>45</sup> The homeless program manager said there were instances when program staff worked with veterans who were transferred from another jurisdiction to jails or detention centers within their service area. These efforts were not reflected in the metric because the veterans were enrolled at different VA facility.<sup>46</sup> The program coordinator also noted some jails did not ask individuals whether they had served in the military, which prevented identification of veterans and referral to the program. Staff reported they continue to work proactively with law enforcement agencies to identify veterans at the time of arrest to connect them with VA services as early as possible.
- The veterans justice program coordinator explained that outreach specialists work with community partners to help veterans clear their criminal records, making them eligible for housing. Staff also collaborate with community partners willing to hire justice-involved veterans to support their efforts to obtain employment.

## Conclusion

To assist leaders in evaluating the quality of care at the Fayetteville facility, the OIG conducted an inspection across five domains. The OIG did not make recommendations following this inspection. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

As to the OIG's Healthcare Facility Inspection program of VHA medical facilities across the nation, program leaders are aware of the ongoing transformation to VHA's management structure that could affect future areas of oversight. The OIG will monitor VHA's change management and maintain its focus on risks to the effectiveness and efficiency of VA programs, operations, and services that can affect the health and welfare of veterans and their families.

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<sup>45</sup> For VJP1, facility program results were 56 and 80 percent for FYs 2023 and 2024, respectively.

<sup>46</sup> VHA Homeless Programs, *Technical Manual: FY 2023 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*.

## Appendix A: Methodology

### Inspection Processes

The OIG inspection team reviewed facility policies and standard operating procedures, administrative and performance measure data, VA All Employee Survey results, and relevant prior OIG and accreditation survey reports.<sup>1</sup> The OIG distributed voluntary questionnaires to all employees through the facility’s employee mail groups to gain insight and perspective related to the organizational culture. The OIG interviewed facility leaders and employees to discuss processes, validate findings, and explore reasons for identified problems. Finally, the OIG physically inspected selected areas of the medical facility.

The OIG’s analyses relied on inspectors identifying significant information from questionnaires, surveys, interviews, documents, and observational data, based on professional judgment, as supported by Council of Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation*.<sup>2</sup>

Potential limitations on the information collection methods include questionnaire and interview participants’ self-selection bias and response bias.<sup>3</sup> The OIG acknowledges potential bias because the facility liaison selected staff who participated in the interviews; the OIG requested this selection to minimize the impact of the OIG inspection on patient care responsibilities and primary care clinic workflows.

Healthcare Facility Inspection directors selected inspection sites and OIG leaders approved them. The team inspected the facility from February 11 through 13, 2025. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG’s hotline management team for further review.

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 issues.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.<sup>4</sup> The OIG reviews available evidence within a specified

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<sup>1</sup> The All Employee Survey and accreditation reports covered the time frame of October 1, 2020, through September 30, 2023.

<sup>2</sup> Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation*, December 2020.

<sup>3</sup> Self-selection bias is when individuals with certain characteristics choose to participate in a group, and response bias occurs when participants “give inaccurate answers for a variety of reasons.” Dirk M. Elston, “Participation Bias, Self-Selection Bias, and Response Bias,” *Journal of American Academy of Dermatology* (2021): 1-2, <https://doi.org/10.1016/j.jaad.2021.06.025>.

<sup>4</sup> Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

## Appendix B: VISN Director Comments

### Department of Veterans Affairs Memorandum

Date: January 23, 2026

From: Interim VA Mid-Atlantic Health Care Network Director, VISN 6 (10N6)

Subj: Healthcare Facility Inspection of the VA Fayetteville Coastal Healthcare System in North Carolina

To: Director, Office of Healthcare Inspections (54HF05)  
Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review and respond to the draft report Healthcare Facility Inspection of the VA Fayetteville Coastal Healthcare System in North Carolina.
2. I concur with the report, which included no recommendations.
3. Please contact the VISN 6 Quality Management Officer for questions or if additional information is needed.

*(Original signed by:)*

Mary Parker

Interim Chief Medical Officer

for

Kevin P. Amick, MBA, MHRM

Interim VA Mid-Atlantic Health Care Network Director, VISN 6

## Appendix C: Facility Director Comments

### Department of Veterans Affairs Memorandum

Date: January 22, 2026

From: Executive Director, VA Fayetteville Coastal Healthcare System (565)

Subj: Healthcare Facility Inspection of the VA Fayetteville Coastal Healthcare System in North Carolina

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

1. Thank you for the opportunity to review and respond to the draft report *Healthcare Facility Inspection of the VA Fayetteville Coastal Healthcare System in North Carolina*.
2. While the OIG made no recommendations for improvement, VA Fayetteville Coastal Healthcare System in North Carolina remains committed to continuously improving the quality and safety of Veteran care.
3. If you have any additional questions or need further information, please contact the Chief, Quality & Patient Safety.

*(Original signed by:)*

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

## OIG Contact and Staff Acknowledgments

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<b>Contact</b>	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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