US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Wilmington Healthcare System in Delaware

Healthcare Facility Inspection	25-00257-149	June 22, 2026

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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.

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Executive Summary

The 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 Wilmington Healthcare System (the facility) from June 3 through 5, 2025. The facility is rated as *medium-complexity* and in fiscal year 2025 provided direct care to 50,616 unique patients.[1] The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[2]

What the OIG Examined

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences. The OIG made no recommendations.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy. The OIG made no recommendations.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The facility did not have workflows that describe staff members' roles in the medical test result communication process for each service, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[3] The OIG made one recommendation.
- **Primary Care.** The OIG assessed whether primary care teams were staffed according to VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care* and Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*.[4] The OIG made no recommendations.

[1] VHA classifies facilities based on their complexity level. Medium-complexity facilities have "medium volume, low risk patients, few complex clinical programs, and small or no research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." "Trip Pack - Operational Statistics Table FY2026 Through February," VHA Support Service Center, accessed April 7, 2026, https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer. (This web page is not publicly accessible.)

[2] See appendix A for a description of the OIG's inspection methodology.

[3] VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

[4] VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 16, 2026; VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

- **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 made no recommendations.

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

What the OIG Recommended

1. The Chief of Staff ensures facility leaders develop workflows for all services to identify team members' roles in the process for communicating test results.

VA Comments and OIG Response

The Interim Veterans Integrated Service Network Director and facility Director concurred with the recommendation and provided an acceptable action plan (see the response in the report body and appendixes B and C). The OIG will follow up on the planned actions until they are completed.

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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

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.[5] VHA's vast care delivery structure requires sustained and thorough OIG oversight 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 domains and assesses facilities' adherence to VA standards and other governing authorities:

Culture: VA supports a system of shared values that shape an organization's behavioral norms. Effective responses to system shocks as well as favorable employee and veteran experiences are elements of positive organizational culture.[6]

Environment of Care: Medical facilities must maintain safety, cleanliness, and accessibility. VHA established a comprehensive program that addresses physical spaces, equipment and systems, privacy, and other concerns.[7]

Patient Safety: VHA programs identify and reduce system vulnerabilities and risks of harm to veterans.[8]

Primary Care: Facilities must comply with directives and guidance governing the VHA multidisciplinary care model.[9]

Veteran-Centered Safety Net: VA offers coordinated medical care and social support services to vulnerable individuals, including those experiencing homelessness or recent incarceration.[10]

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[5] "About VHA," VA, last updated January 20, 2025, https://www.va.gov/aboutvha.

[6] 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.

[7] VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023.

[8] VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

[9] VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 16, 2026.

[10] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

The VA Wilmington Healthcare System (the facility) began providing patient care on August 26, 1946. In fiscal year (FY) 2025, it had five community-based outpatient clinics, 104 operating beds (60 hospital and 44 community living center), and a medical care budget of approximately $540 million.[11]

Figure 1. *Facility photo.*
Source: "Wilmington VA Medical Center," VA, accessed February 3, 2026, https://www.va.gov/wilmington-health-care/locations.

The OIG team inspected the facility from June 3 through 5, 2025. The executive leaders referred to throughout this report include the Executive Medical Center Director (Director), Chief of Staff, Associate Director for Patient Care Services (Nurse Executive), Interim Associate Director of Operations, and Director of Quality Management. The Interim Associate Director of Operations was the newest member and had been in the role since March 2025, and three of the remaining four executive leaders had been in their roles for less than three years.

CULTURE

The OIG team 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.[12] The OIG administered its own facility-wide questionnaire and reviewed Veterans Signals (VSignals) survey scores (which summarize real-time information from veterans about their experiences after an appointment and assess their level of trust in VA).[13] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[14]

[11] A community living center is also referred to as a VA nursing home. "Geriatrics and Extended Care," VA, last updated June 3, 2025, https://www.va.gov/CLC."Trip Pack - Operational Statistics Table FY2026 Through February," VHA Support Service Center, accessed April 7, 2026, https://reports.vssc.med.va.gov//ReportViewer. (This web page is not publicly accessible.)

[12] Valerie M. Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies," *BMJ Quality and Safety* 28 (2019): 74–84, https://doi.org/10.1136/bmjqs-2017-007573.

[13] "Veteran Trust in VA," VA, last updated January 20, 2026, https://www.va.gov/initiatives/veteran-trust-in-va.

[14] Patient advocates are employees who receive feedback from veterans and help resolve their concerns. "Patient Advocate," VA, 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

In an interview, executive and facility leaders said an update to the telephone system significantly disrupted operations. Between September and October 2024, executive leaders replaced over 1,400 telephones in the facility. The upgrade changed telephone extensions and introduced modern communication capabilities, including enabling employees to answer veterans' calls from their computers. To prepare for the transition, leaders informed employees of the upcoming changes via email and trained them how to use the new devices. Additionally, facility leaders said they communicated the upcoming changes to veterans through emails, text messages, and social media posts.

From reports in the patient advocate system, the OIG team identified that veterans complained that their calls to the new telephone extensions went unanswered or directly to voicemail and disrupted communication among clinical services within the facility. Patient advocates reviewed complaints and called veterans to address them. Further, quality management employees reviewed events related to the telephone upgrade and found examples of close calls (incidents that could have adversely affected patients), though no veterans were harmed. The team reviewed patient safety reports from October 2024 through May 2025 and noted that no employees have reported telephone issues since October 2024.

Employee Experiences

Responses to the OIG questionnaire showed about two-thirds of employees agreed (or were neutral) that the facility is moving in the right direction. In addition, more than half of employees surveyed agreed they feel comfortable suggesting improvements to the work environment (about 54 percent, with close to 17 percent stating they were neutral).

Executive and facility leaders attributed positive scores to leaders earning employees' trust and increased employee engagement. For example, the facility's Battle Buddy Program is a peer-led mentoring initiative in which new and experienced employees provide personal and professional support for one another. Additionally, leaders described several methods they use to communicate with employees such as weekly newsletters, town halls, and monthly visits to work areas. Newsletters announced events and recognized employees, while town halls provided updates on training opportunities. OIG questionnaire respondents described these communication methods as clear, frequent, and useful.

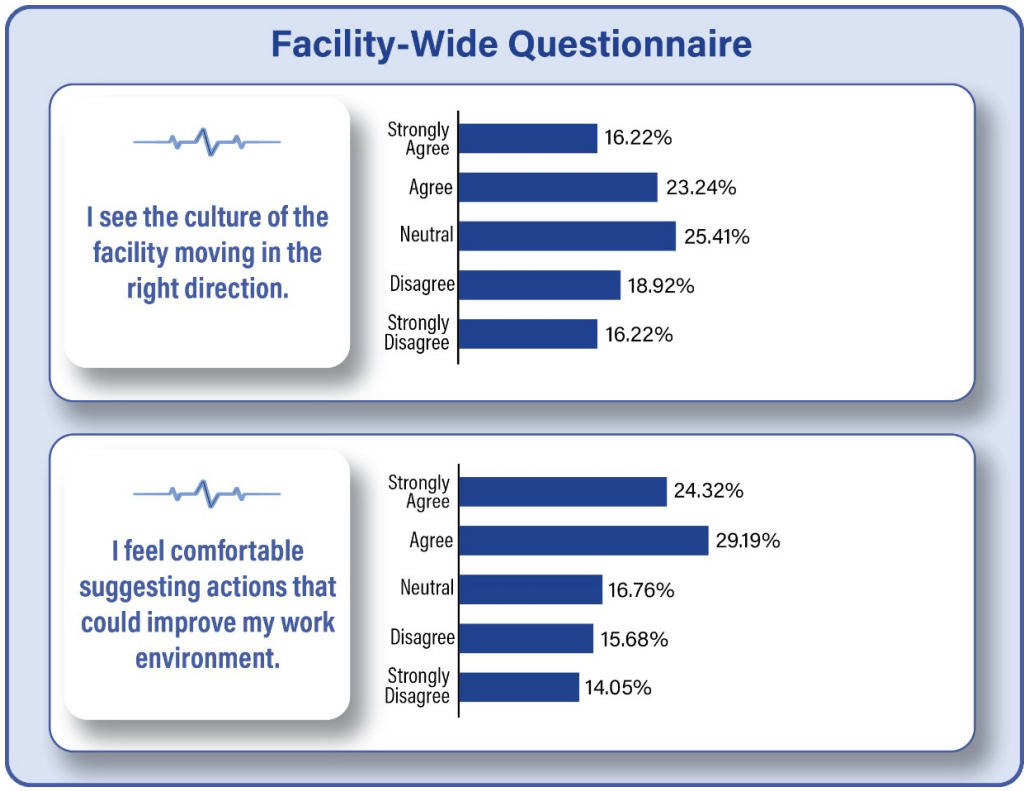

Figure 2. *Employee perceptions of facility culture.*
Source: OIG analysis of selected questionnaire responses.

Veteran Experiences

Patient advocates reported that veterans' most common complaints were requests to change medical providers and concerns with care in the community.[15] Executive and facility leaders said primary care leaders modified the process for patients to change providers during FY 2024, which decreased the complaints.

When asked about concerns related to care in the community, executive leaders said the return to in-person work requirement enacted in January 2025 affected employee retention in the community care department and led to increased wait times for care.[16] For example, a dentist resigned who had worked remotely to review requests for community dental care to determine if requirements were met. After the resignation, the Chief of Staff reported that the facility's community care department sent dental staff more veteran requests for dental care than they were able to review in a timely manner. To address this, executive leaders attempted to recruit another dentist and kept the Veterans Integrated Service Network (VISN) Chief Medical Officer aware

[15] 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, § 101, 132 Stat. 1393.

[16] Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025).

of the issue.[17] The Chief of Staff added in an interview in June 2025 that it would take time to find a solution.

Executive and facility leaders also mentioned several events and initiatives intended to improve veterans' experiences. The facility had a 75th anniversary celebration in May 2025, which featured a veteran choir performance. Leaders also implemented a service-line advocate work group to serve as the main contact for veterans and track their needs until resolved.

Leaders cited VSignals scores as an indicator of success. From October 2024 to March 2025, 95 to 96 percent of veterans reported they trusted the facility to meet their healthcare needs, which is just higher than the VHA average of 94 percent. Leaders also shared examples of veterans choosing the facility over nearby community hospitals because they trusted VA care more.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[18] 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.[19]

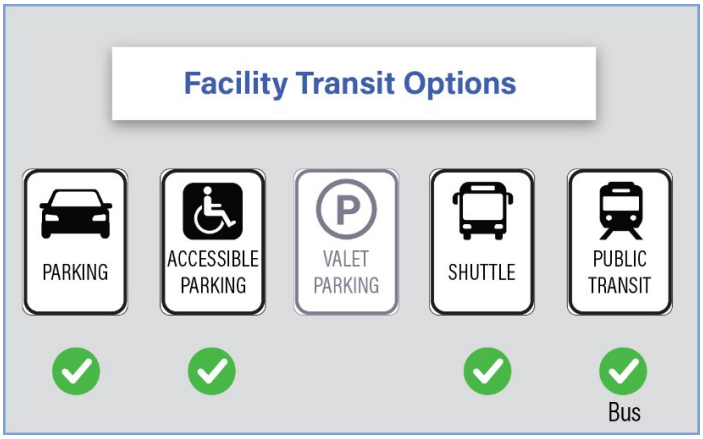

Figure 3. *Transit options for arriving at the facility.*
Source: OIG observations and analysis of facility parking and transit documents.

[17] VA administers healthcare services through a nationwide network of regional systems referred to as Veterans Integrated Service Networks. "Veterans Integrated Service Networks," VA, last updated July 28, 2025, https://www.va.gov/visns.

[18] "Informing Healing Spaces through Environmental Design: Thirteen Tips," VA, last updated May 1, 2024, https://www.va.gov/WholeHealth/Healing-Spaces.

[19] VA, *Integrated Wayfinding & Recommended Technologies*, December 2012; VA, *VA Signage PG-18-10, Design Manual*, May 16, 2023, revised February 19, 2025; VA, *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 team observed clearly posted signs to direct veterans to designated parking areas and building entrances. The parking garage had accessible spaces, sufficient lighting, and emergency call buttons. While valet parking was not available, a shuttle service and nearby bus stop provided access to the facility's main entrance.

Figure 4. *Accessibility tools available to veterans with impairments.*
Source: OIG analysis of questionnaire responses, and observations.

Directional signs were located throughout the building to help with navigation. The main entrance lobby was clean and had adequate seating. An information desk was staffed by volunteers who helped veterans locate their destinations. There were also multiple measures to assist veterans with impairments, such as available wheelchairs, large-font signs, and braille and location announcements on elevators.

However, the facility had wall damage, stained ceiling tiles, and dirty floors in several areas. VHA Directive 1850, *Environmental Programs Service* requires healthcare facilities to maintain a clean environment to avoid infection sources and transmission.[20] When the medical facility is not cleaned regularly, bacteria or viruses can accumulate and increase the risk of infection for veterans and employees who use those spaces. The environmental management chief said the floors are made of material that stains and is difficult to clean completely. Leaders added that staff had previously identified damaged walls and stained ceiling tiles during environment of care inspections, and leaders reminded them to enter work orders to fix the issues. Leaders submitted updated information in January 2026 that showed staff had entered the work orders, and therefore, the OIG did not make a recommendation.

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 improvement projects.

[20] VHA Directive 1850, *Environmental Programs Service*, January 30, 2023.

Communication of Urgent but Noncritical Test Results

Facility leaders had established processes to inform providers of urgent, noncritical test results; to follow up on the results with patients; to assign a substitute when the provider was unavailable; and to transmit results outside of regular clinic hours. Additionally, leaders said staff review electronic health records to determine whether providers and patients received results that require action within seven days. The OIG reviewed data for FY 2024 and found that staff communicated 92 percent of abnormal test results that require action to the patient within seven days, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[21]

However, the OIG found that leaders had not developed service-level workflows that outline the roles of team members in the process for communicating test results, as mandated by VHA Directive 1088(1). Facility leaders said they were unaware of the requirement until VISN leaders informed them about it in July 2024. The OIG reviewed updated information in January 2026 and noted leaders had still not developed workflows for all services.

Recommendation 1

The Chief of Staff ensures facility leaders develop workflows for all services to identify team members' roles in the process for communicating test results.

__X__ Concur

_____ Nonconcur

Target date for completion: August 31, 2026

Director Comments

Leadership at the Wilmington VA Medical Center reviewed current Medical Center Policy and Standard Operating Procedures and will amend policy and procedure to identify workflow processes for reporting services (i.e. lab, radiology, respiratory, cardiology and results received through community care) and ordering practitioners.

Additionally, facility leaders did not evaluate the numbers and types of electronic health record notifications providers receive at the time of the inspection, as required by VHA Directive 1088(1). This evaluation helps ensure that notifications such as test results are effective, do not overwhelm providers with unnecessary information, and do not obscure results that require prompt follow-up. Leaders reported they were unaware of this requirement and had not conducted such evaluations. The OIG reviewed updated information in January 2026 and

[21] VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

found facility leaders had begun evaluating electronic health record notifications. Therefore, the OIG did not make a recommendation.

Action Plans and Process Improvements

The inspection team reviewed the most recently published OIG comprehensive healthcare inspection report (January 2024) for the facility and found leaders had implemented all correction actions in response to the recommendations.[22] Facility leaders credited quality management staff's dashboard for tracking action plans. Quality management staff also review compliance with action plans and submit quarterly reports to the Quality Patient Safety Board.

The OIG assessed whether primary care teams were staffed in compliance with VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care* and Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*.[23] The OIG interviewed staff, analyzed primary care team staffing data, and examined new patient appointment wait times.

Primary Care Teams

Primary care leaders said the facility's 37 primary care teams had several vacancies at the time of the inspection in June 2025: two primary care providers, two registered nurses, two licensed practical nurses, and seven medical support assistants. The provider vacancies were in the Georgetown and Dover clinics. Facility leaders explained that positions at the Georgetown clinic are difficult to fill because of its rural location. Leaders stated they continue recruitment efforts.

VHA Directive 1406(3) recommends a maximum panel size (the number of patients assigned to a primary care team) of 1,200. Facility leaders said that when panel sizes are kept at 80 to 85 percent of VHA's recommended size, teams can balance workload and work efficiently. The OIG team found that primary care teams averaged 92 percent of VHA's recommended size in the first quarter of FY 2025, compared to 87 percent in the same quarter of the prior fiscal year. Leaders added that they were concerned with burnout due to growing panel sizes, so they used the VISN's clinical resource hub (a network of clinicians) to provide coverage when needed.[24] The Code of Federal Regulations (title 38, section 17.4040) states that patients may be referred

[22] VA OIG, *Comprehensive Healthcare Inspection of the Wilmington VA Medical Center in Delaware*, Report No. 23-00093-51, January 9, 2024.

[23] VHA Directive 1406(3); VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended April 16, 2026.

[24] "Clinical Resource Hubs (CRH)," VA, accessed March 26, 2025, https://www.patientcare.va.gov/CRH.

to community providers if the primary care wait time is greater than 20 days.[25] The team ascertained that new primary care patients waited an average of 13 days for appointments, and established patients waited an average of 5 days.

Additionally, primary care staff mentioned that facility leaders support them by holding frequent forums to share information, encourage discussion, and exchange feedback. Leaders said that one result of the discussions was a plan to optimize clinic workflow by hiring an additional provider to see walk-in patients and reduce primary care team interruptions.

The OIG reviewed 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 facility program staff. At the time of the OIG inspection in June 2025, FY 2024 was the most current fiscal year data available for these performance measures.

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 life goals. Program staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.[26]

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 veterans who received an HCHV program intake assessment.[27] However, this fiscal year (FY 2026), VHA no longer uses 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

[25] 38 C.F.R. § 17.4040 (2025/2024). The 2024 publication was in effect at the time of inspection.

[26] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[27] 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 2024 Homeless Performance Measures,* October 1, 2023.

residences for veterans with mental health or substance use conditions).[28] 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)."[29]

Performance and Improvement Highlights

- The facility's program missed the FY 2024 intake assessment (HCHV5) target when a community partner lost funding, which caused staff to refer veterans to neighboring counties for short-term housing. This shift reduced the number of veterans in the service area to enroll in the program.
- The program met both the discharge to permanent housing (HCHV1) and negative exit (HCHV2) targets in FY 2024. Staff said HUD-VASH personnel helped veterans secure permanent housing, which helped them meet the HCHV1 target. To reduce negative exits, staff explained the program expectations to veterans and when notified about unwanted behaviors, met with the veteran and residential services staff to resolve issues.

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."[30] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[31]

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

[28] VHA sets targets for HCHV1 at the national level each year. 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.

[29] VHA also sets targets for HCHV2 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*.

[30] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[31] 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).[32]

Performance and Improvement Highlights

- The facility program did not meet the voucher use (HMLS3) target in FY 2024, which program staff attributed to a lack of affordable housing and limited support from housing agencies. To address these barriers, staff conducted outreach, held virtual events to recruit landlords, and created an educational video that featured a veteran and landlord explaining program benefits. They also pursued nontraditional housing options, such as a hotel, shared housing arrangements, and medical foster homes (private residences with caregivers who provide full-time care and supervision).[33]
- Staff explained they found a state rental assistance program for veterans and National Guard service members who do not qualify for the VA homeless program. They also work with other VA programs to subsidize rent and encourage veterans to apply for low-income and senior-subsidized housing.
- The program supervisor said there were several staff vacancies. As a result, nurses acted as social workers to manage cases, which left them limited time to assist with medical needs. Staff also reduced veterans' social events, which contributes to social isolation and depression. The OIG reviewed updated information in January 2026 and noted leaders were hiring for three vacant positions and therefore did not make a recommendation.
- The program met the employment (VASH3) target for enrolled veterans for FY 2024. Staff attributed this success to the employment specialist who worked with community partners, attended job fairs, met regularly with employers, attended court hearings to identify veterans seeking employment, and arranged for employment skills training.

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

[32] 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 2024 Homeless Performance Measures*.

[33] "Medical Foster Homes, Geriatrics and Extended Care," VA, last updated May 29, 2025, https://www.va.gov/MedicalFosterHomes.

the community after incarceration.[34] Recognizing incarceration as a strong predictor of homelessness on release, the program focuses on connecting veterans to VA health care, services, and benefits. VHA sets a target for the number of veterans entering the Veterans Justice Program each fiscal year (performance measure VJP1).[35]

Performance and Improvement Highlights

- Staff reported they conduct outreach at jails, prisons, veteran treatment courts, and diversion programs, yet the facility program missed the enrollment (VJP1) target for FY 2024.[36] Staff identified opportunities to expand outreach to probation officers, Department of Justice staff, and prosecution and defense teams.
- OIG questionnaire respondents described the program's Veterans Response Team, which trains law enforcement officers who are veterans to respond when other veterans are in crisis. The training covers de-escalation and referrals to VA justice and behavioral health programs, or other needed services, as an alternative to arrest. Four other VA medical centers adopted the program based on the facility's model. In addition, law enforcement officers reportedly referred six-and-a-half times as many veterans to VA treatment since the program's inception.
- The facility is one of four VA facilities that offers an integrated treatment intervention called Maintaining Independence and Sobriety through Systems Integration, Outreach and Networking, Criminal Justice Version (MISSION-CJ). This approach addresses mental health problems, substance use, and criminal justice involvement simultaneously.

[34] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[35] 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 2024 Homeless Performance Measures*.

[36] A veteran treatment court is "a long-term, judicially supervised, often multi-phased program through which criminal offenders are provided with treatment and other services that are monitored by a team which usually includes a judge, prosecutor, defense counsel, law enforcement officer, probation officer, court coordinator, treatment provider and case manager." VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024.

Conclusion

To assist leaders in evaluating the quality of care at the Wilmington facility, the OIG conducted an inspection across five domains. The OIG made one recommendation related to the process for communicating medical test results. The single recommendation does not reflect the overall quality of all services delivered within the facility. However, the OIG's findings and recommendation may help guide improvement at this and other VHA healthcare facilities. 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, OIG 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.

Appendix A: Methodology

The OIG inspection team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports.[37] The OIG administered voluntary questionnaires to all employees through the facility's email distribution lists 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 various areas of the medical facility.

The inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's standards.[38] During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, questionnaire responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and took full responsibility for the content of the publication. All references are for original source material, not AI-generated content. The inspection teams do not use AI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget (OMB) Memorandum M-25-21, *Accelerating Federal Use of AI through Innovation, Governance, and Public Trust.*[39]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[40] The OIG acknowledges potential bias because the facility liaison selected employees who participated in the interviews; the OIG asked for this selection to minimize the impact of the 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 June 3 through 5, 2025. During site visits, the team refers

[37] The accreditation reports covered the time frame of October 1, 2021, through September 30, 2024—the most recent available at the time of the inspection.

[38] Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation,* December 2020.

[39] Director for the Office of Management and Budget, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust," memorandum to Heads of Executive Departments and Agencies, April 3, 2025.

[40] 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.

concerns that are beyond the scope of the inspections to the OIG's hotline management personnel 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.

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.[41] The OIG reviews available evidence within a specified 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.

[41] Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: May 29, 2026

From: Director, VISN 4: VA Healthcare (10N4)

Subj: Healthcare Facility Inspection of VA Wilmington Healthcare System in Delaware

To: Director, Office of Healthcare Inspections (54HF01)

Chief Integrity and Compliance Officer (10OIC)

I have reviewed the VA OIG Draft Report: Healthcare Facility Inspection of the VA Wilmington Healthcare System in Delaware. I am in concurrence with the findings, recommendations, and facility responses provided.

(Original signed by:)

Jennifer Harkins, MS, FACHE
Interim Network Director, VISN 4

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: May 15, 2026

From: Director, VA Wilmington Healthcare System (460)

Subj: Healthcare Facility Inspection of the VA Wilmington Healthcare System in Delaware

To: Director, VISN 4: VA Healthcare (10N4)

1. I have reviewed the findings from the VA Wilmington Healthcare Facility Inspection Program reviewed by the Office of the Inspector General (OIG) conducted June 3 to 5, 2025, and concur with the recommendations.
2. I am submitting the facility plan to correct these findings and will monitor for compliance.
3. I appreciate the OIG's review and look forward to our partnership for continued compliance and improvements.

(Original signed by:)

Thandiwe Nelson-Brooks, MPH, FACHE

OIG Contact and Staff Acknowledgments

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Pursuant to Pub. L. No. 117-263 § 5274, codified at 5 U.S.C. § 405(g)(6), nongovernmental organizations, and business entities identified in this report have the opportunity to submit a written response for the purpose of clarifying or providing additional context to any specific reference to the organization or entity. Comments received consistent with the statute will be posted on the summary page for this report on the VA OIG website.