



# US DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

---

## VETERANS HEALTH ADMINISTRATION

---

### Healthcare Facility Inspection of the VA Illiana Healthcare System in Danville, Illinois

Healthcare Facility  
Inspection

25-00240-125

June 16, 2026

**BE A**  
**VOICE FOR**  
**VETERANS**

---

**REPORT WRONGDOING**  
**vaoig.gov/hotline | 800.488.8244**

---

## 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.

Visit our website to view more publications.  
**vaoig.gov**



## 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 Illiana Healthcare System (the facility) from May 20 through 22, 2025. The facility is rated as *low complexity* and in fiscal year 2025, provided direct care to about 30,000 unique patients.<sup>1</sup> The inspection team examined aspects of care delivery and patient safety within the facility using five domains.<sup>2</sup>

### 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 facility had services spread across multiple buildings that were identified by number, rather than descriptive signs to help veterans navigate the facility more easily. The OIG made one recommendation.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The OIG made no recommendations.
- **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*.<sup>3</sup> The OIG made no recommendations.
- **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.

---

<sup>1</sup> VHA classifies facilities based on their complexity level. Low-complexity facilities have “low volume, low risk patients, few or no 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.” VA, *Facility Trip Pack (VISN [Veterans Integrated Service Network] 12) Danville VA Medical Center*, last updated February 12, 2026.

<sup>2</sup> See appendix A for a description of the OIG’s inspection methodology.

<sup>3</sup> 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.

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. Facility leaders ensure staff place signs on or near each building to help veterans easily navigate where services are located.

### **VA Comments and OIG Response**

The 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.



DAVID C. KRULAK, MD, MPH, MBA  
Assistant Inspector General  
for Healthcare Inspections

## 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
Environment of Care.....	5
Recommendation 1.....	6
Patient Safety .....	7
Primary Care .....	8
Veteran-Centered Safety Net .....	10
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>4</sup> 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.<sup>5</sup>



**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.<sup>6</sup>



**Patient Safety:** VHA programs identify and reduce system vulnerabilities and risks of harm to veterans.<sup>7</sup>



**Primary Care:** Facilities must comply with directives and guidance governing the VHA multidisciplinary care model.<sup>8</sup>



**Veteran-Centered Safety Net:** VA offers coordinated medical care and social support services to vulnerable individuals, including those experiencing homelessness or recent incarceration.<sup>9</sup>

---

<sup>4</sup> “About VHA,” VA, last updated January 20, 2025, <https://www.va.gov/aboutvha>.

<sup>5</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>6</sup> VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023.

<sup>7</sup> VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

<sup>8</sup> VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 16, 2026.

<sup>9</sup> VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

The OIG team inspected the VA Illiana Healthcare System (the facility) from May 20 through 22, 2025. At the time of the inspection, the facility had 32 hospital, 120 community living center, 35 domiciliary, and 6 compensated work therapy transitional residence beds. It had a fiscal year (FY) 2025 medical care budget of approximately \$538 million.<sup>10</sup>



**Figure 1.** Facility photo.

Source: “Danville VA Medical Center,” VA, accessed June 12, 2025, <https://www.va.gov/illiana-health-care>.

The executive leaders referred to throughout this report include the Executive Director, Chief of Staff, Associate Director for Patient Care Services, and Associate Director. According to the leaders, the Executive Director had been temporarily assigned to another VA medical center, and the Associate Director for Patient Care Services was serving as the Acting Executive Director at the time of the inspection.



## 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.<sup>11</sup> The OIG administered its own facility-wide questionnaire and reviewed VA’s All Employee Survey scores for

<sup>10</sup> A domiciliary is “an active clinical rehabilitation and treatment program” for veterans. “Domiciliary Care for Homeless Veterans Program,” VA, last updated May 1, 2025, <https://www.va.gov/homeless/dchv>. 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/VA\\_CLC](https://www.va.gov/VA_CLC). Compensated work therapy “provides evidence based and evidence informed vocational rehabilitation services” for veterans as well as other supports and partnerships for employment. “Compensated Work Therapy,” VA, last updated October 13, 2021, <https://www.va.gov/health/cwt>. VA, *Facility Trip Pack (VISN [Veterans Integrated Service Network] 12) Danville VA Medical Center*, last updated February 12, 2026.

<sup>11</sup> 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>.

October 1, 2023, through September 30, 2024.<sup>12</sup> The team also interviewed executive and facility leaders and employees and considered data from patient advocates.<sup>13</sup>

## System Shocks

The system shocks that executive leaders identified were the relocation and expansion of services, employees' fear of job loss with possible reductions in force, and the return to in-person work requirement. A 2022 VA market assessment recommended relocating some Illiana healthcare services from Danville to Champaign, Illinois, where more veterans live.<sup>14</sup> The Acting Executive Director requested leased space in Champaign for primary care, specialty care, and clinical procedures. To expand services at the facility in Danville, leaders planned to enlarge the community living center and open an inpatient mental health unit. Leaders also reported moving the Springfield community-based outpatient clinic to a larger, more centrally located building.<sup>15</sup>

The Acting Executive Director emphasized that plans to relocate services, return to in-person work, and possible reductions in force contributed to employees' uncertainty about the future.<sup>16</sup> To reduce the effects of system shocks, executive leaders focused on supportive communication and increased employee recognition. Despite the challenges they face, executive leaders said most employees were happy and eager to work at the facility.

## Employee Experiences

The VA all-employee survey scores showed a small increase in senior leader communications for FY 2024, but senior leaders' information-sharing scores declined.<sup>17</sup> Executive leaders reported ongoing efforts to improve communication and information sharing through

- newsletters;

---

<sup>12</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. The All Employee Survey was not administered in FY 2025.

<sup>13</sup> 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.

<sup>14</sup> "VISN 12 Market Recommendations," VA Recommendations to the Asset and Infrastructure Review Commission, March 2022, [https://www.va.gov/AIRCOMMISSIONREPORT/Volume\\_II](https://www.va.gov/AIRCOMMISSIONREPORT/Volume_II).

<sup>15</sup> "A community-based outpatient clinic (CBOC) is a VA-operated, VA-funded, or VA-reimbursed site of care, which is located separate from a VA medical facility." VHA Directive 1229(1), *Planning and Operating Outpatient Sites of Care*, July 7, 2017, amended October 4, 2019.

<sup>16</sup> Return to In-Person Work, 90 Fed Reg. 8251 (Jan. 20, 2025); "Reductions in Force (RIF)," Office of Personnel Management, accessed January 20, 2026, <https://www.opm.gov/policy-data-oversight/workforce-restructuring>.

<sup>17</sup> *Sr leader goal communication* measures leaders' communication of the organization's goals, and *Sr leader info sharing* measures how satisfied employees are with the information received from leaders. "2024 VA All Employee Survey (AES) Questions by Organizational Health Framework," VHA National Center for Organization Development.

- listening sessions;
- monthly facility leaders' and supervisors' meetings; and
- one-on-one time with employees to answer their questions, address concerns, and encourage them to communicate with their immediate supervisors and service leaders before escalating those concerns.

Psychological safety scores in FY 2024 were unchanged from previous years.<sup>18</sup> The OIG questionnaire showed most respondents felt comfortable reporting concerns and suggesting actions to improve their work environment. Executive leaders asserted that employees questioned things they felt needed to change. For example, the Associate Director said employees noticed an old fire alarm system in the emergency room was still in place after a newer system was installed. Employees asked facility leaders why the old system was still there, and leaders removed it.

## Veteran Experiences

In the OIG questionnaire, patient advocates indicated executive leaders were responsive to veterans' concerns. Executive leaders said they reviewed the patient advocate tracking system information and discussed with advocates how veterans' concerns could be addressed. The top concerns patient advocates received were about community care billing, lack of confidence in providers or other staff, and requests for a new provider.<sup>19</sup> Executive leaders reported that they wanted staff to more quickly review and resolve all concerns. Therefore, they empowered the patient advocates, frontline staff, and service advocates (designated staff members in each department who help address patient issues) to take independent action on concerns within their scope of responsibility.

---

<sup>18</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>19</sup> 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.

## ENVIRONMENT OF CARE

Attention to environmental design improves patients’ and staff’s safety and experience.<sup>20</sup> The OIG team assessed how a facility’s physical features may shape the veteran’s perception of health care they receive. The team also inspected patient care areas and focused on safety, cleanliness, infection prevention, and privacy.

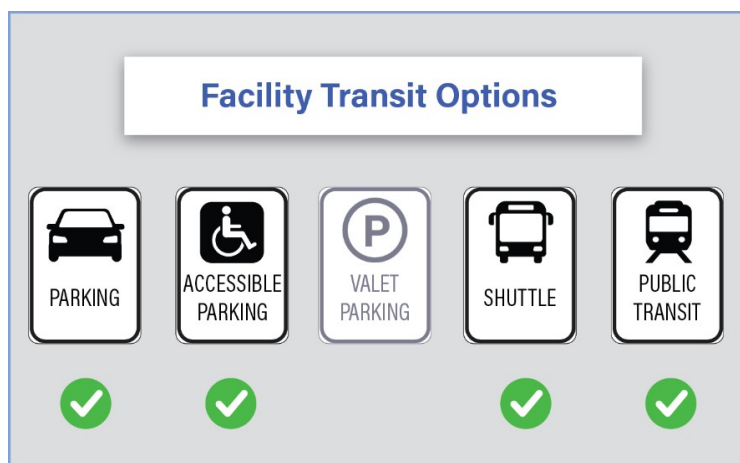
The inspectors examined compliance with key VA and VHA guidelines and standards, as well as with Architectural Barriers Act and Joint Commission standards. Best practice principles from academic literature were also considered.<sup>21</sup>

### General Inspection

The OIG team accessed the facility’s public website to obtain directions and found the information clear and easy to follow. On arrival, the team observed signs that directed vehicles to parking areas, which included accessible spaces for individuals with mobility limitations. The facility did not provide valet service, but staff operated a shuttle between parking areas and facility buildings. According to the accreditation coordinator and observations, a public bus route included a stop at the facility.

The main entrance featured covered passenger loading zones, power-assisted doors, and wheelchairs readily available for public use. The inside was spacious, with sufficient natural and overhead lighting, and appeared well-maintained. Employees at the front desks helped veterans with wayfinding or other informational needs and distributed printed facility maps.

Front desk staff confirmed they were available to help individuals with impairments. The OIG team observed braille signs on elevators throughout the facility. The facility also had wall signs



**Figure 2.** Transit options for arriving at the facility.  
Source: Exterior maps provided by the facility liaison and OIG observations.

<sup>20</sup> “Informing Healing Spaces through Environmental Design: Thirteen Tips,” VA, last updated May 1, 2024, <https://www.va.gov/WholeHealth/Healing-Spaces>.

<sup>21</sup> 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.

and color-coded maps that provided information to help veterans find their way around. However, services are distributed across multiple buildings, which are designated by building numbers. The OIG made one recommendation to improve the signs.

---

---

## Recommendation 1

Facility leaders ensure staff place signs on or near each building to help veterans easily navigate where services are located.

Concur

Nonconcur

Target date for completion: August 30, 2026

### Director Comments

Health Care System response: The Medical Center Director and Associate Director reviewed and did not determine any additional reasons for noncompliance. A multi-disciplinary team, including representatives from Facilities Management, Quality Management, Safety and Patient Experience, has been established to review our current signage in comparison to relevant VA Design and Wayfinding manuals to identify improvement opportunities for exterior signage. The team will prepare a proposal for local leadership with updated signage options, timeline, cost and sign placement.

Compliance will be tracked through the Quality and Patient Safety Committee, which is chaired by the Director, until signage is updated.

---

---

The team also observed unobstructed exit routes, clean sinks and ice machines, and biohazard signs on soiled utility rooms throughout all clinical areas inspected. Inspectors reviewed the most recent Joint Commission report, published on May 29, 2024, and did not identify any repeat environment of care findings.<sup>22</sup>

However, labels on patient beds in the urgent care clinic and community living center, as well as on an exam table in a primary care clinic, indicated that staff had not completed preventive maintenance. The Joint Commission *Standards Manual*, EC [Environment of Care].02.04.03 requires that staff routinely inspect and test medical equipment.<sup>23</sup> When staff perform maintenance in accordance with manufacturers' guidelines, it helps ensure equipment remains safe, reliable, and functional.

---

<sup>22</sup> The Joint Commission, *Final Accreditation Report: VA - Illiana Health Care System*, May 29, 2024.

<sup>23</sup> The Joint Commission, *Standards Manual*, E-dition, EC.02.04.03, July 1, 2025.

During the May 2025 site visit, facility staff addressed the preventive maintenance concerns and updated the schedules for conducting it for approximately 2,400 equipment items going forward. The OIG recognizes the facility's efforts to address the issue and therefore 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.

### Communication of Urgent but Noncritical Test Results

Both the acting chief of imaging and the chief of primary care stated in an interview they had established processes for staff to communicate test results to providers who order tests, ensure providers promptly notify patients of abnormal results, and had standard operating procedures for communicating test results. VHA Directive 1088(1), *Communicating Test Results to Providers and Patients* dictates that staff must communicate test results that require action to patients within seven calendar days from the date results were available.<sup>24</sup> A review of aggregate data showed that staff met this requirement 100 percent of the time in quarter one of FY 2025.

### Action Plans and Process Improvements

The inspection team reviewed the most recently published OIG report (April 2024) for the facility and found no open recommendations.<sup>25</sup> The assistant chief of quality management stated the accreditation specialist tracked action plans related to external reviews; then patient safety and quality management staff monitored for sustained improvements and reported findings to the Quality Patient Safety Committee for oversight.

The patient safety manager described a weekly forum known as the *Leadership Lens*, where leaders share information such as patient safety trends. They also discuss actions, outcomes, and lessons learned from root cause analyses.<sup>26</sup> According to the assistant chief of quality management and patient safety manager, 400 to 600 staff members typically attend, and approximately 420 watched the recording of the most recent forum.

---

<sup>24</sup> VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

<sup>25</sup> VA OIG, [Comprehensive Healthcare Inspection of the VA Illiana Health Care System in Danville, Illinois](#), Report No. 23-00107-135, April 24, 2024.

<sup>26</sup> A root cause analysis is a "comprehensive team-based, systems-level investigation with a formal charter for review of health care adverse events and close calls." VHA Directive 1050.01(1).

The systems redesign coordinator explained that most improvement projects come from executive leaders to address a specific problem, and others are developed from reported patient safety events. The coordinator also mentioned various other ways staff propose process improvement projects, such as through an internal facility website or emailing the coordinator directly.

Executive leaders said employees participated in several process improvement projects. For instance, they replaced patient transfer slings (tools used to move patients with limited mobility) to minimize infection risk in urgent care and reported improperly stored medications to the pharmacy.



The OIG team examined 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*.<sup>27</sup> The team interviewed staff, analyzed primary care team staffing data, and examined new patient appointment wait times.

## Primary Care Teams

The OIG reviewed primary care staffing documents that identified 17 position vacancies: 6 providers, 7 registered nurses, 2 licensed practical nurses, and 2 medical support assistants. The chief of primary care reported challenges hiring primary care physicians due to a limited candidate pipeline in the rural area, even though VA physicians' salaries are competitive with the private sector. The Acting Executive Director said it was difficult to recruit nurses because they asked for at least two years of nursing experience, which limited the applicant pool.

Primary care leaders said they offered education debt reduction for physicians and recruitment and relocation bonuses for physicians and nurses.<sup>28</sup> However, the Chief of Staff acknowledged the facility had limited success with these incentives because of the community's poor economy and high crime rate. In addition, leaders shared that two physicians recently declined job offers due to concerns about the stability of government employment.

The chief of primary care reported successfully recruiting advanced practice registered nurses from hospitals in urban areas such as Champaign, Illinois. However, primary care leaders

<sup>27</sup> VHA Directive 1406(3); VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

<sup>28</sup> The education debt reduction program is financial assistance to eligible candidates to offset student loan costs. VHA Handbook 1021.01, *Education Debt Reduction Program Procedures*, May 31, 2012.

mentioned that, in the past few years, advanced practice registered nurses found the workload difficult and often transitioned to other clinical areas.

The Chief of Staff stated their targets for panel sizes (the number of patients assigned to a care team) were 1,200 patients for physicians and 900 for nonphysician providers, which reflect VHA's baseline capacities per VHA Directive 1406(3). The OIG found that 6 of the 28 teams exceeded the baseline capacity. According to the chief of primary care, one reason the panel sizes were above capacity was that nurse practitioners were covering for physicians. The Chief of Staff added that hiring additional physicians would give them more flexibility to move patients between teams.

The patient centered management module coordinator reported meeting twice per month with the chief of primary care, assistant chief of primary care, nurse managers, group practice managers, assistant officers, and chief of health administrative service to review panel sizes. The chief of primary care stated that they shift patients among primary care teams every three months to balance panel sizes.

The Acting Executive Director explained that a challenge at the Springfield clinic was limited space, which made it difficult to expand patient capacity there. The current clinic is 6,900 square feet but would need to be 75,000 square feet to accommodate more teams and all patients in that area. To address this challenge, they plan to build a larger clinic in Springfield in 2028, which will allow space for leaders to redistribute teams.

The OIG reviewed access data for the first quarter of FY 2025 and determined that despite vacancies and space challenges, new patients had appointment wait times of less than 20 days. The Chief of Staff, chief of health administration service, and chief of primary care explained that periodic Saturday clinics help them reduce wait times.

However, primary care leaders and staff explained that walk-in patients disrupted workflow and efficiency. To assist, the Acting Executive Director assigned a primary care nurse to evaluate patients and a virtual urgent care provider to treat them. To address other inefficiencies, the chief nurse of primary care reported an initiative in which patients arrive for their appointment early, so staff can complete health questionnaires or identify their medical needs. The chief of primary care explained that when staff complete these tasks before appointments, patients could see their providers on time.



## VETERAN-CENTERED SAFETY NET

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.

### 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.<sup>29</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 veterans who received an HCHV program intake assessment.<sup>30</sup> 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 residences for veterans with mental health or substance use conditions).<sup>31</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>32</sup>

<sup>29</sup> VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

<sup>30</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 2025 Homeless Performance Measures*, November 2024.

<sup>31</sup> VHA sets targets for HCHV1 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 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>32</sup> VHA also sets targets for HCHV2 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

## Performance and Improvement Highlights

- The program exceeded the intake assessment (HCHV5) target for the first quarter of FY 2025. Facility program staff attributed it to outreach and good relationships with community partners who helped them identify veterans.
- Program staff conducted outreach at libraries, bus stations, churches, community parks, food pantries, hospitals, and encampments. Staff said they are sometimes able to identify veterans and house them on the same day.
- According to program staff, veterans in the program need financial assistance, mental health or substance abuse treatment, employment, food, and medical care. Program staff referred veterans to VA and community programs to address these needs.

## 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>33</sup> The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.<sup>34</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 veterans or their families (performance measure HMLS3) and the percentage of veterans who are employed (performance measure VASH3).<sup>35</sup>

## Performance and Improvement Highlights

- The program did not meet the voucher use (HMLS3) target for FY 2024. The facility program supervisor said there was a lack of affordable housing in the area. The supervisor reported hiring a housing specialist, who built relationships with landlords interested in renting to veterans. Additionally, the facility has Cannon Place (figure 3), which offers veterans 65 affordable housing units.

---

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

<sup>34</sup> VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

<sup>35</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 2024 Homeless Performance Measures*, October 1, 2023. At the time of the inspection, FY 2024 data were available.

- The program supervisor attributed meeting the employment (VASH3) target in FY 2024 to educating staff on how to properly update veterans’ employment status and auditing the information quarterly to ensure compliance. Staff also referred veterans to the vocational rehabilitation and compensated work therapy programs to support their employment goals.<sup>36</sup>
- The supervisor reported that veterans’ needs included housing, food, and utility assistance; sufficient income; and medical, mental health, and substance abuse treatment. Local community agencies provided various household items such as dishes, furniture, and beds, and paid security deposits or utilities for veterans moving into permanent housing.



**Figure 3.** Cannon Place.  
Source: Photo taken by OIG inspector.

## 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>37</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>38</sup> VHA sets a target for the number of veterans entering the Veterans Justice Program each fiscal year (performance measure VJP1).<sup>39</sup>

## Performance and Improvement Highlights

- The facility program exceeded the enrollment (VJP1) target in FY 2024. Program staff said they conducted outreach and educated stakeholders and community partners, such as attorneys and probation staff, first responders, and jail and prison

---

<sup>36</sup> “VHA’s Voc [vocational] Rehab [rehabilitation] Service includes recovery-oriented clinical vocational rehabilitation services. Through a continuum of vocational, educational, training, employment, and therapeutic work services, the Voc Rehab Service endeavors to support Veterans who are experiencing barriers from mental health, medical, or psychosocial conditions to obtain and maintain community integrated competitive employment.” VHA Directive 1160.13, *VHA Vocational Rehabilitation Service*, August 14, 2025.

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

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

<sup>39</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 2024 Homeless Performance Measures*. At the time of the inspection, FY 2024 data were available.

staff about the program using brochures and posters. In addition, a local veterans treatment court took on more cases, which resulted in a large increase in referrals to the program.<sup>40</sup>

- According to program staff, veterans' needs included housing and financial assistance; transportation; and medical, mental health, and substance abuse treatment. For example, incarcerated veterans who were scheduled for release frequently needed transportation to the facility's inpatient substance abuse residential rehabilitation treatment program.

## Conclusion

To assist leaders in evaluating the quality of care at the Danville facility, the OIG conducted an inspection across five domains. The OIG made one recommendation related to navigational signs. 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.

---

<sup>40</sup> "A veterans treatment court is a treatment court model that brings Veterans together on one docket to be served as a group. A 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.

## Appendix A: Methodology

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>41</sup> 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. Additionally, 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.<sup>42</sup> 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*.<sup>43</sup>

Possible limitations on the information collection methods include questionnaire and interview participants’ self-selection bias and response bias.<sup>44</sup> 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 May 20 through 22, 2025. During site visits, the team refers

---

<sup>41</sup> The All Employee Survey and accreditation reports covered the time frame of October 1, 2021, through September 30, 2024—the most recent available at the time of the inspection.

<sup>42</sup> Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation*, December 2020.

<sup>43</sup> 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.

<sup>44</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>.

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.<sup>45</sup> 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.

---

<sup>45</sup> 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 20, 2026

From: Network Director, Veterans Integrated Service Network (VISN) 12 (10N12)

Subj: Healthcare Facility Inspection of the VA Illiana Healthcare Network in Danville, Illinois

To: Director, Office of Healthcare Inspections (54HF04)  
Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review and provide a response to the draft report, Healthcare Facility Inspection of the VA Illiana Healthcare System in Danville, Illinois.
2. I concur with the findings and recommendations identified by OIG, and the corrective action plans submitted by the facility.
3. I would like to thank the OIG inspection team for their review of the VA Illiana Healthcare System.

*(Original signed by:)*

Daniel S. Zomchek, PhD  
Network Director, VISN 12

## Appendix C: Facility Director Comments

### Department of Veterans Affairs Memorandum

Date: May 12, 2026

From: Director, VA Illiana Healthcare Network (550/00)

Subj: Healthcare Facility Inspection of the VA Illiana Healthcare Network in Danville, Illinois

To: Director, VISN 12: VA Great Lakes Health Care System (10N12)

1. Thank you for the opportunity to review and provide a response to the draft report of the Healthcare Facility Inspection of the VA Illiana Healthcare System in Danville, Illinois. I extend my gratitude to the Office of the Inspector General and the Healthcare Facility Inspection team for their collaboration during the inspection.
2. I have reviewed the draft report and concur with the findings and single recommendation issued. An action plan to address the recommendation has been implemented and is detailed in the response submitted.
3. The VA Illiana Health Care System has been serving the Nation's Veterans since 1898 and remains committed to providing the highest quality of care. I appreciate the Office of Inspector General's partnership in our continuous improvement efforts for our Veterans.

*(Original signed by:)*

Staci M. Williams, Pharm D, RPh  
Executive Director

## OIG Contact and Staff Acknowledgments

---

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

---

<b>Inspection Team</b>	Laura Harrington, DBA, MSN, Project Leader Rondina Marcelo, LCSW, Team Leader Shelia Farrington-Sherrod, MSN, RN Joseph Giries, MHA Nancy Krzanik, MSN, RN Veronica Leon, PhD, RN Kinh-Luan Nguyen, PharmD, MBA Robert Ordonez, MPA Laura Pond, MSW, LCSW Stephanie Stall, MSN, RN Temekia Toney, LCSW, MSW
------------------------	---

---

<b>Other Contributors</b>	Kevin Arnhold, FACHE Jolene Branch, MS, RN Richard Casterline Kaitlyn Delgadillo, BSPH Jennifer Frisch, MSN, RN LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Amy McCarthy, JD Scott McGrath, BS Daphney Morris, MSN, RN Sachin Patel, MBA, MHA Ronald Penny, BS Joan Redding, MA Larry Ross Jr., MS April Terenzi, BA, BS Ashley Wilson Dan Zhang, MSC
---------------------------	--

## Report Distribution

### VA Distribution

Office of the Secretary  
Veterans Health Administration  
Office of Accountability and Whistleblower Protection  
Office of Public and Intergovernmental Affairs  
Office of General Counsel  
Office of Congressional and Legislative Affairs  
Director, VISN 12: VA Great Lakes Health Care System (10N12)  
Director, VA Illiana Healthcare System (550)

### 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  
Illinois: Tammy Duckworth, Dick Durbin  
Indiana: Jim Banks, Todd Young  
US House of Representatives  
Illinois: Mike Bost, Nikki Budzinski, Darin LaHood, Mary Miller, Eric Sorensen  
Indiana: Jim Baird, Mark Messmer

**OIG reports are available at [www.vaogig.gov](http://www.vaogig.gov).**

*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.*