US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Northern Indiana Healthcare System in Marion

Healthcare Facility Inspection	**26-00080-235**	**November 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 Northern Indiana Healthcare System (the facility) from April 28 through 30, 2026, and received additional information from the facility in September 2026. The facility is rated as *medium complexity* and in fiscal year 2025, provided direct care to 46,565 patients.[1] The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[2]

What the OIG Examined

Overall, the OIG inspection did not reveal issues that warranted recommendations for corrective action in any of the five domains.

- **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.
- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.[3]
- **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 have recently been incarcerated.

[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." "Facility Trip Pack (VISN 10) Marion VA Medical Center," last updated February 27, 2026; "VHA Station Listing," VHA Support Service Center, last updated June 1, 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] 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.

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).[4] No further action is required.



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[4] In December 2025, VA announced plans to reorganize the management structure of the Veterans Health Administration. On May 1, 2026, the Under Secretary for Health announced the consolidation of the Veterans Integrated Service Networks (VISNs) from 18 networks to 5. On July 15, 2026, the Acting Under Secretary for Health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise.

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

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Introduction

The Office of Inspector General (OIG), 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 has programs to identify and reduce system vulnerabilities and risks of harm to veterans.[8]



Integrated Veteran Care: Facilities must comply with directives and guidance governing the VHA multidisciplinary care model.



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

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[5] "About Us," VA, last updated June 2, 2026, https://department.va.gov/vha/about-us.

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

The VA Northern Indiana Healthcare System (the facility) consists of the Marion VA Medical Center, the Fort Wayne VA Medical Center, and six community clinics. In fiscal year (FY) 2025, the facility's budget was approximately $705.7 million, and it had 137 operating beds (35 in the hospital at Fort Wayne, and 77 in the community living center and 25 in the domiciliary, both at Marion).[10]



Figure 1. *Facility photo.*
Source: "Marion VA Medical Center," VA, accessed April 29, 2026, https://www.va.gov/northern-indiana-health-care/locations.

The OIG inspected the facility from April 28 through 30, 2026, and received additional information from the facility in September 2026. The executive leaders referred to throughout this report had all started in their roles within the last few years, and include the Medical Center Director (since June 2024), Associate Director (since January 2025), Assistant Director (since November 2024), interim Chief of Staff (since March 2026), and interim Associate Director for Patient Care and Nursing Services (since January 2026). Additional facility leaders referred to in this report may include managers, supervisors, and service chiefs who implement policies and maintain daily operations.

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.[11] 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

[10] A community living center is also referred to as a VA nursing home. "Geriatrics and Extended Care," VA, last updated March 27, 2026, https://www.va.gov/VA_CLC. A domiciliary is a residential "clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans," VA, accessed June 29, 2026, https://department.va.gov/homeless/dchv.

[11] 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.

assess their level of trust in VA).[12] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[13]

System Shocks

Executive leaders identified two system shocks: a fire that destroyed three buildings at the Marion VA Medical Center and the planned implementation of the Federal Electronic Health Record system.[14] According to executive leaders and facility documents, the fire occurred on February 21, 2026, in buildings that were under renovations. Eight fire departments and approximately 100 firefighters responded. The cause of the fire was undetermined due to the extent of the damage. The buildings housed engineering offices and maintenance shops, but no one was inside at the time of the fire. Executive leaders said no injuries occurred and patient care continued uninterrupted. However, the fire damaged a fiber line that supported the fire alarm panel for other buildings and displaced 52 employees.

In response to the fire, executive leaders said they quickly established an incident command center to clearly communicate with employees and veterans, secured alternative workspaces, and began repairs on the fiber line. The Medical Center Director acknowledged the fire's emotional effects on employees and ensured access to wellness services such as the employee assistance program, chaplain services, and occupational health. Leaders said consistent rounding (visits to employees in their work areas), prompt updates, and reassurance helped employees remain focused on veterans' care.

Additionally, although no known construction-related safety issues contributed to the fire, executive leaders required more scheduled reviews of construction documents and increased communication between the Associate Director, police department, safety employees, and engineering employees to improve internal oversight of construction-related safety measures. They also increased the frequency of meetings for projects that required infrastructure work, strengthened relationships with the local fire department, and conducted safety assessments of older buildings. Leaders said improved planning and regular reassessments reduced organizational risk.

According to executive leaders, the other system shock (preparing to implement the Federal Electronic Health Record system, which occurred in August 2026) was a major change that

[12] "Veteran Trust in VA," VA, last updated June 4, 2026, https://www.va.gov/initiatives/veteran-trust-in-va.

[13] 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.

[14] The Federal Electronic Health Record system connects VA medical facilities with the Department of War, US Coast Guard, National Oceanic and Atmospheric Administration, and participating community providers, allowing providers to easily access a veteran's full medical history in one location. "Transforming Health Care for Veterans, Revolutionizing Health Care for All," VA, last updated February 20, 2026, https://digital.va.gov/ehr-modernization.

required strong coordination, clearly designated roles, and sustained communication. To guide employees through the transition, they formed a change leadership team and designated deployment leads, site leads, and superusers—those who can help other people to use the system. Executive leaders and the designated employees joined national and Veterans Integrated Service Network (VISN) calls to coordinate with facilities at different stages of implementation and learn about their challenges and successes.[15]

Further, facility representatives shared that leaders met weekly to prepare for the transition. Employees reported they identified several needs through advanced planning:

- An additional 100 parking spaces for training at the Fort Wayne VA Medical Center, with leaders considering off-site parking and shuttle options
- Hands-on training at VA facilities that have already implemented the new system
- Proactive assessments to ensure clinical staff participation in training would not disrupt patient care
- Additional biomedical engineering support for equipment testing and troubleshooting
- Early retrieval of patient safety reports to allow more time for review during the transition

Executive leaders anticipated that the number of patient appointments would decrease while the length of each visit would increase because clinic employees have to reestablish patients' electronic health records during the first appointment after implementing the new system. To prevent potential delays in care, leaders planned to use the VISN Clinical Resource Hub (which provides access to clinical services when local facilities have gaps in care or services).[16] Executive leaders informed veterans about the electronic health record transition through public events, emails, signs, and advisory boards.

[15] VA administers healthcare services through a nationwide network of regional systems referred to as VISNs. "Veterans Integrated Service Networks," VA, last updated August 14, 2026, https://department.va.gov/visn. In December 2025, VA announced plans to reorganize the management structure of VHA. On May 1, 2026, the Under Secretary for Health announced the consolidation of the VISNs from 18 networks to 5. On July 15, 2026, the Acting Under Secretary for Health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise.

[16] "Clinical Resource Hubs (CRH)," VA, last updated March 20, 2024, https://www.patientcare.va.gov/CRH.

Employee Experiences

Most OIG questionnaire respondents reported that executive leaders' communications were clear, useful, and frequent.[17] Leaders held weekly virtual meetings to improve transparency, answer employees' questions, share updates, and increase their visibility. The Medical Center Director said these meetings served as an immediate way to share information, helped employees adapt to change, and maintained stability during policy shifts or major events.

Most questionnaire respondents also indicated they feel comfortable reporting safety concerns and suggesting actions to improve their work environment (see figure 2). The Medical Center Director stated that leaders emphasized visible actions in response to employees' concerns, and that accountability and follow-through built trust and encouraged more employees to speak up.

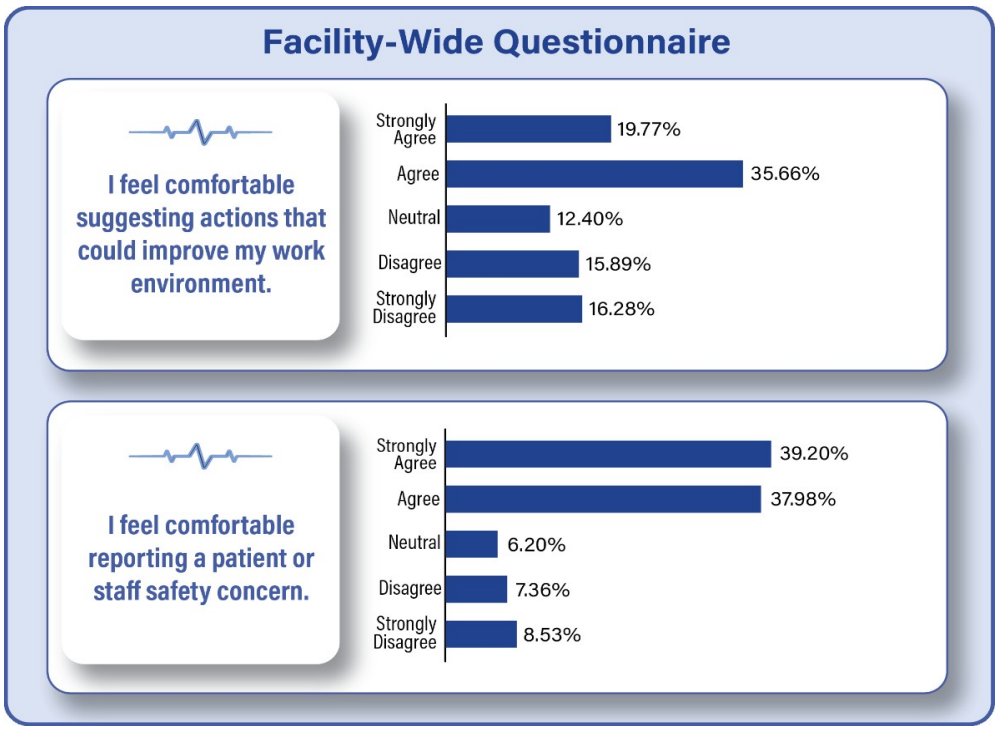


Figure 2. *Employee perceptions of facility culture.*
Source: OIG analysis of selected questionnaire responses.

For example, the interim Associate Director for Patient Care and Nursing Services stated that during one of the Medical Center Director's visits to work areas, a staff member raised a concern about the facility's morgue. The Medical Center Director shared the issue with executive leaders, engaged subject matter experts, and oversaw corrective actions to reorganize the space, ensure proper engineering standards, and improve the environment. The interim Associate Director for Patient Care and Nursing Services reported that the Medical Center Director informed the staff

[17] The facility liaison reported the facility had 1,956 employees at the time of the site visit; 258 of them responded to the OIG questionnaire.

member that the issue had been fully addressed, demonstrating that their feedback directly led to meaningful improvements and reinforcing confidence that raising concerns results in action.

Veteran Experiences

VSignals outpatient scores for trust in the facility exceeded the VHA national average of 94 percent for FY 2025 and met the national average of 95 percent for the first two quarters of FY 2026. However, executive leaders and a patient advocate reported that veterans receiving bills for community care was a top concern.[18] The OIG reviewed data submitted to patient advocates and verified that community care billing concerns were the most frequently reported complaint in 2025, accounting for 659 of the 5,621 complaints. During interviews, the Associate Director explained that missing data or incorrect billing codes submitted by community providers caused the unpaid bills.

To address the concerns, facility leaders set up a specific phone line for veterans to provide their billing information, tracked the causes of errors to identify trends, and met regularly with community providers and the third-party administrator (a company that VA contracts to create a regional network of community care providers).[19] Community care staff also met with veterans to explain authorized community services and ensure veterans understood the status of their claims.



Attention to environmental design improves veterans' and staff's safety and experience.[20] 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.

[18] 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.

[19] VHA, *Patient Safety Events in Community Care: Reporting*, *Investigation*, *and Improvement Guidebook*, February 2022.

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

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.[21]

General Inspection

At both the Fort Wayne and Marion VA Medical Centers, the OIG team observed signs that directed veterans to large parking lots with accessible spaces for those with disabilities. The Fort Wayne VA Medical Center provided valet parking services; the Marion VA Medical Center did not, but the chief engineer told the OIG that volunteers helped veterans to the building entrance when needed.

The Fort Wayne VA Medical Center's main entrance had a covering to shelter veterans from adverse weather conditions. Both main entrances appeared clean and well-lit, with lobbies that provided ample seating. Signs throughout both sites were clear and easy to read, and elevator panels included braille.



Figure 3. *Accessibility tools available to veterans with impairments.*
Source: OIG analysis of questionnaire responses and on-site observations.

The OIG team inspected the emergency department, intensive care unit, medical-surgical unit, and primary care clinics at the Fort Wayne VA Medical Center, and the urgent care clinic, community living center, and primary care clinics at the Marion VA Medical Center. The team found that patient care areas were generally clean, furnishings were in good condition, medical equipment had inspection stickers with dates indicating preventive maintenance was completed on time, and medication and supply rooms were secure and contained no expired items.

However, inspectors identified dust on multiple surfaces—the bottom of a medical supply cart stored in a hallway, windowsills, one set of blinds, and the top and inside of a cabinet in a patient exam room—in the Fort Wayne VA Medical Center's emergency department. Additionally, both

[21] 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: A Supplement to the Architectural Barriers Act Accessibility Standards (ABAAS)*, 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.

medical centers had multiple nonlaminated signs attached to red biohazard trash bins, which could not be disinfected with hospital-grade cleaners and might harbor pathogens.

To address the dust in the emergency department, the chief of environmental management services provided the OIG team with a detailed corrective action plan, which included an updated deep cleaning schedule and checklist. The environment of care coordinator and infection control specialist removed the nonlaminated signs attached to the biohazard trash bins. Therefore, the OIG did not make a recommendation.

In addition, while inspecting an inpatient area, the team observed a clinician who logged off a computer, stepped away from the workstation, and left their government-issued identification card (used to access federally controlled facilities and information systems) in the keyboard. Another staff member immediately located the clinician, returned the identification card, and reviewed privacy and security rules with them. The OIG did not make a recommendation since this was the only security concern, and it was immediately corrected.



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

The OIG team found the facility had policies and processes consistent with VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, which requires staff to notify patients within seven days for abnormal test results that require follow-up, monitor communication timeliness, and develop service-level workflows (which define staff members' roles) to communicate urgent but noncritical test results to patients.[22] However, the team found Joint Patient Safety Reporting system data showing two incidents in 2025 where staff did not communicate test results to patients in a timely manner.[23] According to the acting chief of quality management, staff investigated both incidents and took corrective actions as a result of their findings. Facility data for the timely communication of noncritical abnormal test results that require follow-up improved from an FY 2025 average of 70 percent to an FY 2026 average (through June) of 79 percent.

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

[23] The Joint Patient Safety Reporting system is a database VA employees use to report patient safety events that could cause harm or did cause harm. VHA Directive 1050.01(1).

Action Plans and Process Improvements

The interim Associate Director for Patient Care and Nursing Services stated the executive leadership team reviews all Joint Patient Safety Reporting system submissions from the previous 24 hours to assign the correct department to investigate and discuss follow-up actions. During an interview, quality management and systems redesign staff explained that they use outcome data and committee reports daily to monitor corrective actions and determine when actions required follow-up. The acting chief of quality management also said executive leaders actively engaged in patient safety activities during daily morning meetings with facility leaders and included quality management staff to resolve patient safety issues.

Additionally, the patient safety manager briefed safety events and related process improvements during bimonthly forums, which were attended by several hundred staff. According to facility leaders, the forums and ongoing activities provide an opportunity for staff to share lessons learned to strengthen patient care and create a culture receptive to process improvement.



VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[24] The OIG evaluated facilities' primary care and community care staff vacancies, veterans' access to care, actions staff took to enhance processes, and how leaders supported improvements. The inspection team also examined community care referral processing timelines and program effectiveness in improving access to care.

Primary Care Staffing and Access to Care

The facility provides primary care services through 46 primary care teams across its locations. On April 14, 2026, the OIG received documents from the human resource supervisor that reported 25 primary care team vacancies. On September 15, 2026, primary care leaders sent the OIG an update showing 17 vacancies.

Community care and primary care leaders reported that the Health Administrative Service was restructured during 2026 to improve workforce flexibility, balance workloads, and increase efficiency.[25] The service's chief reported that medical support assistants moved to the busiest work areas instead of staying in one assigned location.

[24] "Community Care," VA, accessed June 29, 2026, https://department.va.gov/vha/community-care.

[25] The Health Administration Service at VA medical facilities enables timely veteran access to care by overseeing appointment scheduling, continuity of care, and coordination between VA and community providers. VHA Directive 1230, *Outpatient Scheduling Management*, June 1, 2022.

However, staff said they experienced additional stress and lower morale due to heavier workloads, and the high volume of tasks slowed their ability to meet patient needs. The chief nurse of primary care said nurses often feel overwhelmed because they cover multiple teams and make follow-up calls for patients with chronic health conditions; recently, nurses also increased outreach and began coordinating care for patients who visit the emergency department more than five times a month. Additionally, preparation for transition to the new Federal Electronic Health Record system increased training requirements, especially for superusers.

Primary care leaders reported 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 represents 100 percent of the baseline capacities stated in VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*.[26] However, provider vacancies can increase panel sizes, which may decrease the availability of patient appointments and delay care. The OIG team determined that 17 out of 46 provider panels exceeded 100 percent capacity; 2 panels operated at 100–105 percent of the recommended capacity, and the others were over 105 percent. To manage panel sizes, the interim Chief of Staff described continuing to fill provider vacancies, monitoring the number of new enrollees, and evaluating when to expand primary care services. In their September 15, 2025, update, primary care leaders reported that panel sizes had risen by 0.46 percent from May through July 2026 due to increased patient enrollment.

Despite larger panel sizes and staffing vacancies, the OIG team found that from October 1, 2025, through June 30, 2026, primary care wait times averaged an estimated 15 days for new patients and less than 4 days for established patients. This is below the 20-day wait time established in the Code of Federal Regulations (title 38, section 17.4040) for allowing primary care referrals to community providers.[27] To maintain these wait times, leaders explained that each primary care provider has two reserved appointments slots on their daily schedule; clinic administrative staff can schedule new patients into these slots up to 48 hours in advance. If new patients do not use them, staff can schedule established patient into the appointments.

Community Care Staffing and Access to Care

According to the Code of Federal Regulations (title 38, section 17.4040), veterans are eligible for community care when their drive time to a VA facility is longer than 30 minutes for primary care and 60 minutes for specialty care. The community care administrative officer reported that drive-time eligibility accounted for the largest volume of referrals in FY 2025 through

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

[27] 38 C.F.R. § 17.4040 (2025).

April 12, 2026, and the highest number of requests were for orthopedics, cardiology, and dermatology.

The chief of community care explained that in 2024, the facility processed 7,500 referrals per month, which increased to roughly 8,000–9,500 per month by the time of the OIG inspection in April 2026. Community care leaders attributed these numbers to the need for additional VA providers specializing in cardiology, gynecology, nephrology, optometry, and orthopedics. The OIG team found that in FY 2025, community care staff took an average of 18.5 days to schedule appointments, which increased to 20.3 days in FY 2026, remaining above the 7-day requirement in VHA's *Consult Timeliness Standard Operating Procedure (SOP)*.[28]

Community care leaders stated they are working to improve scheduling timeliness by assigning certain times of the day for staff to work only on scheduling referrals and using overtime to meet workload demands. The OIG noted that at the time of the inspection, the Workforce Allocation Tool staffing model (used across VA community care programs to determine appropriate staffing levels for administrative and clinical staff) indicated the facility needed to hire for 1 clinical position and 21 administrative positions.[29] The community care supervisors explained that nurses and one supervisor often assisted with administrative duties due to the impact of limited staffing on department operations. On September 15, 2026, the community care administrative officer reported hiring three registered nurses and starting recruitment for five advanced medical support assistants. The community care program analyst said leaders will make further hiring decisions after analyzing workflows in the new electronic health record system.

[28] VHA Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," October 2, 2025.

[29] "IVC CC [Integrated Veteran Care Community Care] Workforce Allocation Tool–Output," VA Northern Indiana Healthcare System–Marion Campus, March 16, 2026.



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.[30]

VHA uses performance measures to determine the success of each medical facility's program. HCHV1 measures 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).[31] HCHV2 measures 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)."[32]

Performance and Improvement Highlights

- The facility exceeded the discharge to permanent housing (HCHV1) target for FY 2025 and the first and second quarters of FY 2026. The HCHV liaisons attributed this success to the contract staff who build good rapport with the veterans and develop housing plans upon their admission to the program. The liaisons also stated that contract staff work with facility staff and community partners to identify

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

[31] VHA sets targets for HCHV1 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*, November 2024. 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 and 6 months. VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

[32] VHA also sets targets for HCHV2 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures.*

community resources for permanent supportive housing and improve relationships with landlords.

- The facility also had fewer negative exits (HCHV2) than the target for FY 2025 and the first two quarters of FY 2026. The HCHV liaisons explained that contract staff deescalated situations before altercations occurred and detected attempts to bring contraband into the building, which helped reduce rule violations and negative exits.
- The outreach coordinator conducted outreach at libraries, jails, shelters, and community events, and stated these efforts were very effective. Another HCHV staff member shared a success story about a veteran with no identification who lived in a tent at a campsite and was not enrolled in VA health care. The staff member helped the veteran obtain identification, access VA health care, and enroll in a transitional housing program before finding permanent housing.
- The program operated two homeless walk-in clinics, where a social worker assisted veterans with services such as housing and mental health and primary care. Clothing, food, hygiene products, and gift and gas cards were also available.
- Staff also discussed challenges such as transportation and getting veterans ineligible for VA health care connected to services. Staff described transporting veterans when needed, and working with facility and community partners 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."[33] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[34]

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).[35]

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

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

[35] 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 2025 Homeless Performance Measures.*

Performance and Improvement Highlights

- The facility did not meet the target for voucher use (HMLS3) of 90 percent for FY 2025 but improved in the first two quarters of FY 2026. The HUD-VASH supervisor reported that despite staffing vacancies, in FY 2025, 82.9 percent of the vouchers were used. The supervisor informed the OIG that this was the highest rate of voucher use in their program's history.
- The facility exceeded the employment (VASH3) target for FY 2025 and the first two quarters of FY 2026. The HUD-VASH supervisor attributed this success to the employment coordinator's relationships with employers willing to hire veterans, as well as the employment team accurately recording employment data. Staff also reported helping veterans who are unable to work apply for pensions and Social Security disability benefits.
- In addition, the supervisor shared that using the *One Team Approach* (a coordinated approach to provide services to every veteran) directly contributed to housing stability, veteran engagement, and community partnerships.[36] Program staff reported having good relationships with community partners and meeting the needs of enrolled veterans through collaboration and teamwork.
- However, program staff explained there are challenges in meeting the needs of aging veterans in the program. They described seeking services such as home health and medication management to help some aging veterans maintain independent living and identifying alternative housing for those who need it.

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.[37] 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).[38]

[36] "The One Team Approach: A New Chapter in Ending Veteran Homelessness," (DAV) Disabled American Veterans of Idaho, September 10, 2024, https://dav-idaho.org/-ending-veteran-homelessness.

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

[38] 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 2025 Homeless Performance Measures.*

Performance and Improvement Highlights

- The facility met the veteran enrollment (VJP1) target for FY 2025 and the first two quarters of FY 2026. Facility program staff cited using the veteran reentry search service (used to locate veterans in the justice system) and entering veterans into the national homeless database as contributing factors to this success.[39]
- Staff described conducting outreach and education at jails, prisons, and community events, while also working closely with local law enforcement and other community partners to identify and enroll veterans. They reported no significant barriers to their enrollment efforts.
- Program staff also host a monthly legal clinic at the Fort Wayne VA Medical Center.[40] The clinic offers virtual and online access as options for veterans who are unable to come in person.
- Staff worked with 12 veterans treatment courts (which require participants to complete treatment and case management services).[41] In FY 2025, 57 veterans graduated from treatment courts, and most can get their charges dismissed.
- Staff shared the story of a veteran who successfully graduated from treatment court, was awarded VA service-connected disability benefits (for a disability or condition that occurred or was aggravated during active military duty), enrolled in graduate studies, gained employment, and became a homeowner.

Conclusion

To assist leaders in evaluating the quality of care at the VA Northern Indiana Healthcare System, 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, 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.

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[39] "Welcome to the Veterans Re-Entry Search Services, Veterans Reentry Search Service (VRSS) – Terms and Conditions of Use," VA, accessed April 11, 2025, https://vrss.va.gov. (This website is not publicly accessible.)

[40] "Many legal service providers offer free legal clinics in VA facilities." "Office of General Counsel, Legal Help for Veterans," VA, July 18, 2023, https://www.va.gov/OGC/LegalServices.

[41] VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024.

Appendix A: Methodology

The OIG team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports.[42] 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 from April 28 through 30, 2026, and received additional information from the facility in September 2026. During site visits, the team refers concerns that are beyond the scope of the inspections to the OIG's hotline management personnel for further review.

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.[43] 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 SI-generated content.[44] The inspection teams do not use SI 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.*[45]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[46] The OIG acknowledges potential bias because the facility liaison selected employees who participated in the interviews; the OIG asked

[42] The accreditation reports covered the time frame of October 1, 2023, through December 30, 2025—the most recent available at the time of the inspection.

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

[44] In accordance with Exec. Order No. 14434, 91 Fed. Reg. 63129 (September 29, 2026), the VA OIG uses the term "super intelligence" and the abbreviation "SI" to refer to what is known as "artificial intelligence" and "AI" (except where consistency with cited criteria may be warranted).

[45] 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.

[46] 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.

for this selection to minimize the impact of the inspection on patient care responsibilities and primary care clinic workflows.

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.[47] 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.

[47] 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: October 29, 2026

From: Director, VA MidAmerica Health Network (10N3)

Subj: Healthcare Facility Inspection of the VA Northern Indiana Healthcare System in Marion

To: Director, Office of Healthcare Inspections (54HF04)

Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review OIG's draft report for the Healthcare Facility Inspection of the VA North Indiana Healthcare System.
2. I concur with the report as written.
3. Please contact the VISN 3 Interim Quality Management for questions or if additional information is needed.

(Original signed by:)

Daniel S. Zomchek, Ph.D.
Veteran Integrated Service Network 3 Director, VHA

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: October 26, 2026

From: Director, VA Northern Indiana Healthcare System (610)

Subj: Healthcare Facility Inspection of the VA Northern Indiana Healthcare System in Marion

To: Director, VA MidAmerica Health Network (10N3)

Thank you for the opportunity to review the draft report from the Office of Inspector General's (OIG) Healthcare Facility Inspection of the VA Northern Indiana Health Care System. Following our review, we concur with the conclusion that no recommendations were identified. We value our partnership with the OIG and remain committed to providing safe, high-quality care to Veterans we are privileged to serve.

(Original signed by:)

Jon Beidelschies, JD, FACHE

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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.