US DEPARTMENT OF VETERANS AFFAIRS
**OFFICE OF INSPECTOR GENERAL**

Office of Healthcare Inspections

## VETERANS HEALTH ADMINISTRATION

# Healthcare Facility Inspection of the VA Marion Healthcare System in Illinois

| Healthcare Facility Inspection | 26-00049-163 | November 6, 2026 |
|---|---|---|




## OUR MISSION

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

## CONNECT WITH US

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

## PRIVACY NOTICE

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

# Executive Summary

The VA Office of Inspector General (OIG) 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 Marion Healthcare System (the facility) from April 21 through 23, 2026. The facility is rated as *medium complexity* and in fiscal year 2025, provided direct care to about 42,300 patients.[1] The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[2]

## What the OIG Examined

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences. The OIG made no recommendations.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy. The OIG made no recommendations.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. Inspectors found the facility did not have an updated policy for communicating test results, and leaders had not developed service-level workflows that designate roles of providers and staff in communicating test results to patients, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[3] The OIG made two recommendations.
- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.[4] The OIG made no recommendations.

---

[1] VHA classifies facilities based on their complexity level. Medium-complexity facilities have "medium volume, low risk patients, few complex clinical programs, and small or no research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." "Trip Pack - Operational Statistics Table FY2026 Through April," VHA Support Service Center, accessed April 29, 2026, https://reports.vssc.med.va.gov/OperationalStatisticsTable. (This web page is not publicly accessible.)

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

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

[4] 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.

- **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. The OIG made no recommendations.

## What the OIG Recommended

1. The Director updates the facility policy for communicating test results in accordance with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.
2. The Chief of Staff and Associate Director for Patient Care Services develop service-level written workflows in accordance with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

## VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the findings and recommendations and provided acceptable action plans (see the responses in the report body and appendixes B and C for the full text of the directors' comments).[5] 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

[5] In December 2025, VA announced plans to reorganize VHA's management structure. 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

| | |
|---|---|
| ADPCS | Associate Director for Patient Care Services |
| 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 ..... 6

Patient Safety ..... 7

Recommendation 1 ..... 8

Recommendation 2 ..... 9

Integrated Veteran Care ..... 10

Veteran-Centered Safety Net ..... 12

Conclusion ..... 16

Appendix A: Methodology ..... 17

Appendix B: VISN Director Comments ..... 19

Appendix C: Facility Director Comments ..... 20

OIG Contact and Staff Acknowledgments ..... 21

Report Distribution ..... 22

# 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.[6] 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.[7]



**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.[8]



**Patient Safety:** VHA has programs to identify and reduce system vulnerabilities and risks of harm to veterans.[9]



**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.[10]

---

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

[7] 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.

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

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

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

The VA Marion Healthcare System (the facility) was established in 1942. In fiscal year (FY) 2025, the facility served more than 42,300 veterans across southern Illinois, southwestern Indiana, and northwestern Kentucky, and had an annual budget of over $363 million.[11] The facility provides a range of services, including primary care, specialty care, mental health services, and a community living center.[12]



***Figure 1.*** *Facility photo.*
*Source: "VA Marion Health Care," VA, accessed April 29, 2026, https://www.va.gov/marion-health-care.*

The OIG inspected the facility from April 21 through 23, 2026. The executive leaders referred to throughout this report include the interim Director and interim Associate Director (who both served since March 2026), interim Assistant Director (who began in April 2026), Chief of Staff, and the Associate Director for Patient Care Services (ADPCS). The accreditation coordinator stated that the ADPCS had held a permanent position since July 2022, and the Chief of Staff since October 2022.

## 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.[13] The OIG administered its own facility-wide questionnaire and reviewed Veterans Signals (VSignals) survey scores (which summarize real-time information from veterans about their experiences after an appointment and assess their level of trust in VA).[14] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[15]

---

[11] "FY25 Medical Center Allocation System [MCAS] Table of Contents," VA, accessed April 29, 2026, https://vaww.arc.med.va.gov/reports/MCAS_25/FY25_MCAS. (This web page is not publicly accessible.) "Trip Pack - Operational Statistics Table FY2026 Through April," VHA Support Service Center, accessed April 29, 2026, https://reports.vssc.med.va.gov/OperationalStatisticsTable. (This web page is not publicly accessible.)

[12] 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.

[13] 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.

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

[15] Patient advocates are employees who receive feedback from veterans and help resolve their concerns. "Patient Advocate," VA, last updated May 9, 2022, https://www.va.gov/patientadvocate. For more information on the OIG's data collection methods, see appendix A.

## System Shocks

Executive leaders identified the deferred resignation program, Voluntary Early Retirement Authority, hiring freeze (in effect from January 20, 2025, to October 15, 2025), return to in-person work, and termination of probationary employees as system shocks that created fear among employees and caused applicants to hesitate when considering facility job offers.[16] According to executive leaders, the issues remained problematic at the time of the inspection in April 2026.

Executive leaders stated that about 30 employees left through the deferred resignation program and Voluntary Early Retirement Authority in 2025. They highlighted the important work these employees performed and their inability to fill vacant positions due to the hiring freeze, which increased the workload of remaining employees and reduced morale and efficiency. Executive leaders reported that when the hiring freeze began, they had to withdraw job offers, and some applicants had already relocated to the area or given notice to their employers.

As a result of the return to in-person work, executive leaders reported that some radiologists and medical support assistants, who previously worked remotely, left employment at the facility. The Director stated that certain healthcare roles routinely telework in the industry, which has affected both current staffing levels and ongoing hiring efforts.

Executive leaders explained that because of an April 2025 executive order, probationary employees received termination notices from the VA chief human capital officer, which stated underperformance as the justification.[17] Facility leaders, who considered these employees strong performers, had not received notification before the notices were issued. They reported that several employees had completed their one-year probationary period but were still notified that

[16] The deferred resignation program provided employees with an option to depart federal government positions while retaining pay and benefits and exemption from the return to in-person work requirements until September 30, 2025. "Original Email to Employees, Deferred Resignation Email to Federal Employees," Office of Personnel Management, accessed October 7, 2025, https://www.opm.gov/fork/original-email-to-employees. The Voluntary Early Retirement Authority allows employees at federal "agencies that are undergoing substantial restructuring" to retire with lower (earlier) age and service requirements. "Voluntary Early Retirement Authority," Office of Personnel Management, accessed May 5, 2026, https://www.opm.gov/voluntary-early-retirement-authority. Hiring Freeze, 90 Fed. Reg. 8247 (Jan. 28, 2025). Shortly after the hiring freeze memorandum was issued, the Acting Secretary provided guidance and identified a list of exempted "positions critical to delivering care to Veterans in" VHA. Acting Secretary, "Hiring Freeze Guidance," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, January 21, 2025. As of December 1, 2025, VA adopted new policies for filling vacancies and creating new positions in compliance with the executive order for Ensuring Continued Accountability for Federal Hiring. Executive Order 14356, 90 Fed. Reg. 48387 (Oct. 20, 2025); Assistant Secretary for Human Resources and Administration (006), "Updated Department of Veterans Affairs Hiring Guidance (VIEWS 13474675)," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, December 1, 2025; Implementing the President's "Department of Government Efficiency" Cost Efficiency Initiative, 90 Fed. Reg. 11095 (March 3, 2025); Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025); Strengthening Probationary Periods in the Federal Service, 90 Fed. Reg. 17729 (April 29, 2025).

[17] Strengthening Probationary Periods in the Federal Service, 90 Fed. Reg. 17729.

their employment was terminated. Some probationary employees eventually returned, but others found new jobs because the return process took four to six weeks. The Chief of Staff said hiring was already difficult because candidates were reluctant to move to the economically depressed area, which offered few activities for children and families, and hiring became even more challenging after the federal initiatives began in early 2025.

Additionally, executive leaders reported that the executive orders and memorandums contributed to a sense of instability at the facility. In response, executive leaders increased communication through town halls, an anonymous suggestion box, designated times for supervisors to meet with employees, and rounding (when leaders set aside time to talk to employees in their work settings). The ADPCS said executive leaders provided emotional support by acknowledging employee concerns through group discussions and one-on-one meetings. The ADPCS added that although the support did not eliminate fear, employees expressed their appreciation for these efforts. Additionally, the interim Director stated that, at the time of the visit in April 2026, facility leaders were identifying critical positions to fill and prioritizing hiring, noting that they had just reached the point where the hiring freeze had been lifted.

## Employee Experiences

As shown in figure 2, about 47 percent of respondents to the OIG's questionnaire believed the facility's culture was improving, and 60 percent felt comfortable recommending changes in their work areas.

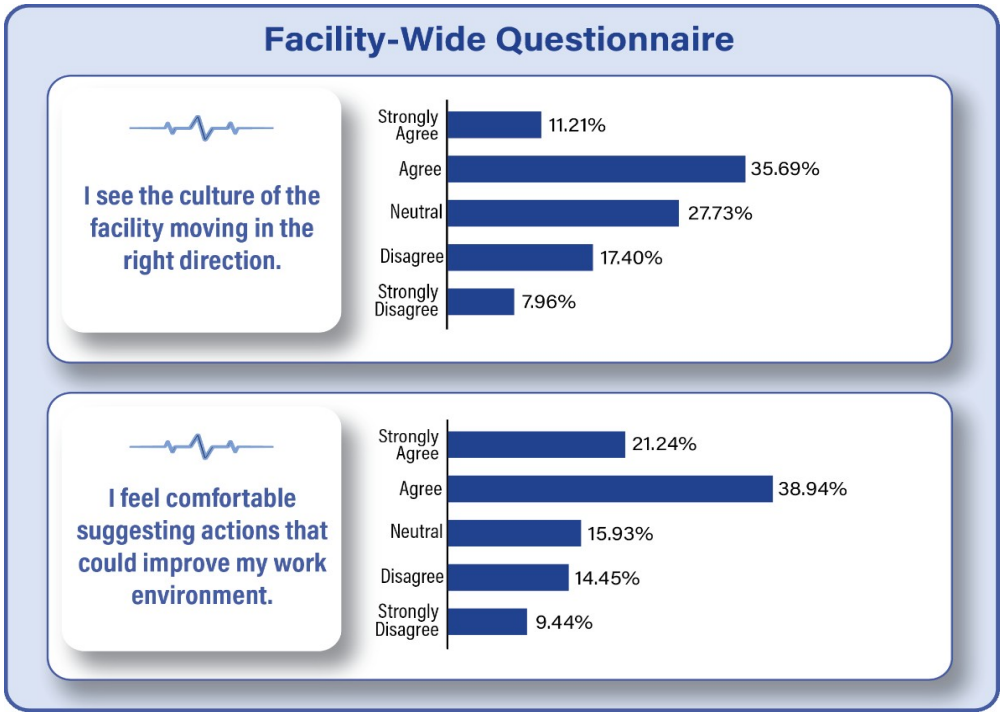



***Figure 2.*** *Employee perceptions of facility culture.*
*Source: OIG analysis of selected questionnaire responses.*

To assess employee satisfaction, executive leaders monitored the number of patient safety events reported. In the year prior to the inspection in April 2026, the leaders said they had a 21 percent increase in safety events reported, which they considered a sign of employee engagement. The Joint Commission recognizes that a psychologically safe culture enables employees to speak up about safety failures without fear of retaliation, reinforcing the importance of these reporting trends.[18]

Executive leaders also monitored participation in process improvement initiatives. They described several frontline employee workgroups, including one focused on reducing cases of sepsis (a life-threatening condition that causes organ dysfunction).[19] This workgroup updated the facility's sepsis treatment protocol, improved workflows, researched products that help prevent contamination, and revised the physicians' ordering process (the steps to enter and manage clinical orders). Executive leaders reported that these efforts resulted in a 6 percent decrease in the number of sepsis cases as of April 2026. Additionally, because of leadership rounds, the interim Director believed that employees were happy to work at the facility and felt comfortable voicing concerns to executive leaders.

## Veteran Experiences

Executive leaders reported strong collaboration with the veteran experience officer, veterans service organizations (groups dedicated to supporting veterans), and patient advocates, which enabled prompt responses to veterans' concerns. For example, the ADPCS and a patient advocate described a response to concerns about telephone hold times. A multidisciplinary workgroup analyzed the telephone system and identified a problem with how staff transfer phone calls within the healthcare system. To address the issue, patient advocates reeducated employees on the appropriate transfer process, and the facility recorded a 40 percent decrease in weekly phone calls that remained on hold more than 15 minutes following a transfer.

Additionally, the veteran experience officer created a workgroup to improve performance by addressing low provider ratings in 2025 patient surveys. The work group created a pre-visit checklist that veterans completed while waiting for their appointment to begin. The checklist asked about the reason for the visit, concerns about stress, current medications, and what in life brings joy. This provided a list of all topics the veteran wished to cover during the appointment and facilitated communication with the provider. Primary care teams piloted the checklist in the lowest performing clinics, which resulted in higher provider ratings at the end of the year. The veteran experience officer planned to expand use of the checklist across all primary care clinics.

[18] "High Reliability," The Joint Commission, accessed May 26, 2026, https://www.jointcommission.org/high-reliability.

[19] Mervyn Singer et al., "The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3)," *JAMA* 315, no. 8 (February 23, 2016): 801–10, https://doi.org/10.1001/jama.2016.0287.

# ENVIRONMENT OF CARE

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.

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

On arrival at the facility, the OIG team followed clear signs to well-lit parking areas with accessible spaces, tactile walking-surface warnings (textured ground indicators used to alert visually impaired individuals to hazards or changes in walking paths), and a security camera. A public bus stop was within walking distance of the main entrance, and volunteers provided shuttle services for veterans with mobility needs and helped them navigate the site.

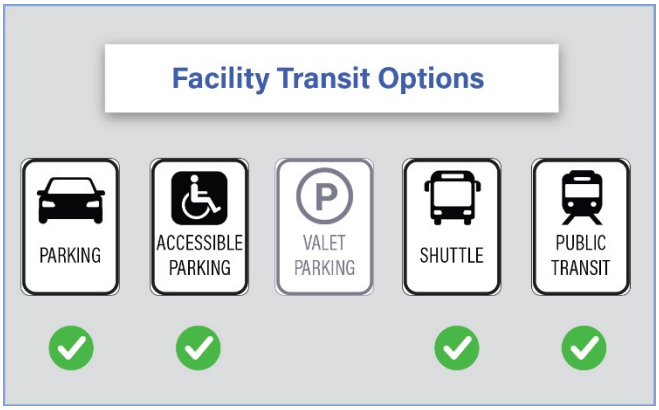



***Figure 3.*** *Transit options for arriving at the facility. Source: OIG questionnaire responses and team observations.*

The main entrance included a covered passenger drop-off area, power-assisted doors, natural lighting, seating, and a sufficient supply of wheelchairs. Televisions in public and patient care areas had closed captioning.

The OIG team learned that translation services were available through a regional contract; information desk staff and volunteers had access to these services through the facility's home page. Based on staff questionnaire responses, the team determined the facility supported hearing-impaired veterans by providing hearing aids and assistive listening devices as recommended by audiology staff. For visually impaired veterans, the facility's Visual Impairment Service Team

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

[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*, 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.

provided low-vision evaluations, case management, and adaptive skills training for daily living activities, safe navigation techniques, and computer assistive technology.

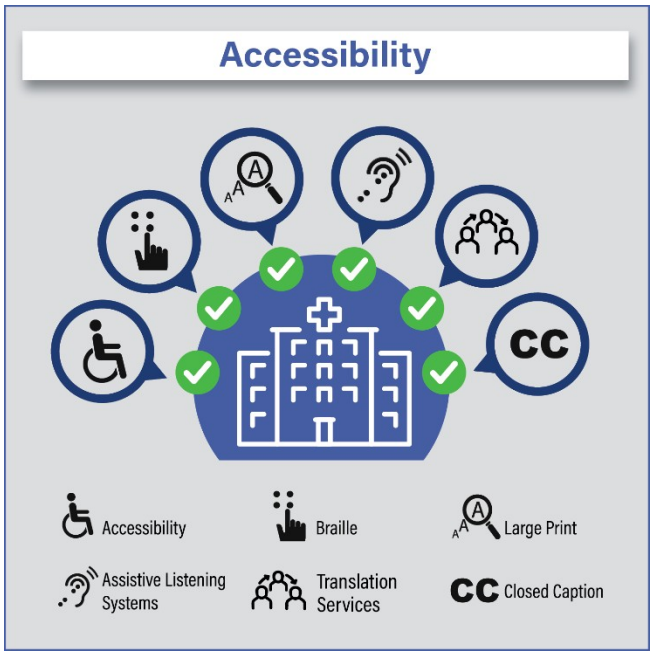



***Figure 4.*** *Accessibility tools available to veterans with impairments.*
*Source: OIG questionnaire responses and team observations.*

Throughout the facility, signs were clear and easy to read, color-coded maps helped with navigation, and elevator panels included braille. Inspectors found clean patient care areas with no privacy issues in the emergency department, primary care clinic, intensive care unit, and medical-surgical unit. Medical equipment had inspection stickers indicating preventive maintenance was up to date; furnishings were clean and in good condition; and medication and supply rooms were secure and contained no expired items.

The community living center appeared homelike; however, the OIG team observed floor cleaning supplies left unattended in a hallway. The team also found an intravenous pump stored in a clean supply room that lacked a label or protective covering indicating whether it was clean or dirty. Staff corrected these issues during the visit and provided additional education to all community living center personnel on proper storage of cleaning supplies and equipment.

# 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

The OIG team found there was an established process for communicating test results to providers and patients. However, the facility policy had not been updated, and leaders did not develop service-level workflows that describe staff's roles in communicating test results to patients, as

required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[22] The OIG identified the following missed opportunities for the facility to revise its policy and develop service-level workflows:

- On July 11, 2023, VHA published Directive 1088, which required the facility to develop a local policy and service-level workflows within 6 to 12 months.[23]
- On September 20, 2024, VHA amended the directive, clarifying expectations for service-level workflows.[24]
- In March 2026, the OIG requested facility policies and service-level workflows related to test result communications.
- Additionally, the OIG published reports that cited other facilities' identified problems with VHA requirements for test result communication.[25]

Outdated policies and lack of service-level workflows can result in delayed or missed communication of abnormal test results and follow-up actions, which could compromise safety and the quality of care provided to veterans. During interviews, the Chief of Staff and ADPCS acknowledged workflows were missing and stated they would update their policy.

## Recommendation 1

The Director updates the facility policy for communicating test results in accordance with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

_X_ Concur

____ Nonconcur

Target date for completion: February 28, 2027

### Director Comments

MCP 11-629, *Communication and Management of Test Results*, will remain in place without revisions in alignment with VHA's June 26, 2026, directive to pause all new policy

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

[23] VHA Directive 1088, *Communicating Test Results to Providers and Patients*, July 11, 2023.

[24] VHA Directive 1088(1).

[25] Two examples of OIG reports with findings and recommendations on test result communications are VA OIG, *Healthcare Facility Inspection of the VA Dublin Healthcare System in Georgia*, Report No. 24-00592-60, March 6, 2025, and VA OIG, *Healthcare Facility Inspection of the VA Hampton Healthcare System in Virginia*, Report No. 24-00603-86, March 26, 2025.

development. In the interim, the facility Chief of Staff and Associate Director for Patient Care Services are developing a Standard Operating Procedure (SOP) that incorporates requirements from VHA Directive 1088(1). The SOP will include detailed, service-level workflows that clarify responsibilities for providers and staff and ensure consistent, compliant communication and management of test results across the organization.

### Recommendation 2

The Chief of Staff and Associate Director for Patient Care Services develop service-level written workflows in accordance with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

_X_ Concur

____ Nonconcur

Target date for completion: February 28, 2027

### Director Comments

The Chief of Staff, Associate Director for Patient Care Services, and Quality Management have completed a comprehensive review of VHA Directive 1088(1). Based on this review, the facility will develop and implement a SOP including service-level workflows. These workflows will outline provider and staff responsibilities across clinical areas. Finalized SOP and workflows will be distributed to appropriate staff.

## Action Plans and Process Improvements

The inspection team reviewed the most recently published facility OIG report (July 2020) and noted that leaders had completed all improvement actions in response to the recommendations.[26] During an interview, the patient safety manager discussed monitoring how staff sustain improvements, in part by periodically remeasuring outcomes and reporting them to the Quality, Safety, Value and High Reliability Executive Board. The patient safety manager also provided an example of how the facility sustained a decrease in the number of falls in a clinical unit, an effort the Veterans Integrated Service Network (VISN) 15 interim Director and patient safety

[26] VA OIG, *Comprehensive Healthcare Inspection of the Marion VA Medical Center in Illinois*, Report No. 20-00206-180, July 15, 2020.

officer recognized with an award.[27] Continuous quality management helps prevent harm and improve the quality of care delivered to veterans.

Quality management staff shared various ways they identified improvement opportunities: they reviewed reported patient safety events, peer reviewed cases to find systems issues, and looked at issues communicated by frontline staff to the systems redesign coordinator. The systems redesign coordinator discussed an improvement project that helped inpatient nurses understand and feel more confident interpreting electrocardiograms to correctly identify arrhythmias that required intervention. The systems redesign coordinator shared the improvement project in two professional conferences, and a peer-reviewed journal selected it for publication. Sharing knowledge related to improved patient outcomes enhances clinical practice, helps clinicians stay updated, and maximizes the value of data used for evidence-based policy decisions.




VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[28] 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

At the time of the April 2026 inspection, there were five vacant primary care positions: two physicians, one nurse practitioner, one physician assistant, and one advanced medical support assistant. When the OIG team asked about filling these positions, primary care leaders said it was difficult to attract physicians because of the facility's rural location, and private employers offered more competitive pay. The leaders explained they adjusted physician salaries, offered VA Education Debt Reduction Program benefits, and used physician recruiters, but these efforts

[27] VA administers healthcare services through a nationwide network of regional systems referred to as Veterans Integrated Service Networks (VISNs). "Veterans Integrated Service Networks," VA, last updated July 24, 2026, https://department.va.gov/visns. 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.

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

had limited success.[29] As a result, the chief of primary care reported hiring nurse practitioners and physician assistants instead of physicians for provider vacancies.

According to the chief of primary care, the facility also had float staff who included two physicians, four nurse practitioners, five registered nurses, three licensed practical nurses, and a medical support assistant. These staff did not have a permanent assignment on any primary care teams; instead, they assisted clinics with high workloads, supported quality improvement activities, and coordinated patient care.

The patient centered management module coordinator, who is responsible for calculating, adjusting, and monitoring provider panel sizes (the number of patients assigned to a care team), reported meeting weekly with the chief of primary care, the administrative officer, and a program support assistant to assess the panels.[30] The chief of primary care explained that their targets were 1,200 patients for physicians and 900 for nonphysician providers, which matched the expected panel sizes according to VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*.

The Code of Federal Regulations (title 38, section 17.4040) states that patients may be referred to community providers if the primary care wait time is more than 20 days.[31] However, despite the challenges of physician recruitment, the chief of primary care reported appointment wait times of less than 20 days for both new and established primary care patients for FY 2025 through the first two quarters of FY 2026.

## Community Care Staffing and Access to Care

At the time of the April 2026 inspection, the chief of community care reported 15 vacancies: 8 advanced medical support assistants, 4 medical support assistants, and 3 registered nurses. According to the chief, hiring and retaining advanced medical support assistants was difficult because the positions had previously been virtual, and the return to in-person work order in January 2025 made it hard to compete with virtual jobs in the community or those with more flexible schedules.[32] The medical support assistant supervisor added that some applicants declined offers because of long commutes. In response to these challenges, community care leaders said they adjusted salaries to retain current medical support assistants.

The OIG team found that the facility's community care referrals increased by roughly 9,000 from FY 2024 to FY 2025; according to the chief of community care, this was due to the loss of specialty care providers at the facility and limited space to provide patient care. The team also

[29] VHA Handbook 1021.01, *Education Debt Reduction Program Procedures*, May 31, 2012.

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

[31] 38 C.F.R. § 17.4040 (2025).

[32] Return to In-Person Work, 90 Fed. Reg. 8251.

found that in FY 2025, the facility's community care staff took an average of 15 days to schedule appointments, although this time frame decreased to 13 days for the first quarter of FY 2026 and 11 days for the second quarter. However, VHA Directive 1232, *Consult Management* and VHA's *Consult Timeliness Standard Operating Procedure* require community care staff to schedule patients' appointments within 7 days.[33]

The chief of community care attributed the wait times to the limited availability of community providers, especially in rheumatology, endocrinology, dermatology, and neurology and reported working with the third-party administrator (a company that VHA contracts with to create a regional network of community care providers) to add more.[34] The chief explained that community care leaders improved work efficiency by redistributing workloads among teams, cross-training registered nurses and advanced medical support assistants to different specialty care referrals, and implementing software that gives staff access to schedule patients directly into community providers' appointment slots. However, the chief highlighted that these actions could not fully overcome challenges created by the staffing vacancies, limited availability of community care appointments, high referral volumes, and the time required to gather test results and other clinical records requested by community providers.




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.[35]

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

[33] VHA Directive 1232, *Consult Management*, November 22, 2024; VHA, Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," June 12, 2025.

[34] VHA, *Patient Safety and Quality Events in Community Care: Reporting*, *Investigation*, *and Improvement Guidebook*, November 2024.

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

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).[36] 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)."[37] VHA excluded the facility from HCHV1 and HCHV2 performance measures because it did not offer contracted emergency residential services or low-demand safe haven programs, according to the program coordinator.

## Performance and Improvement Highlights

- Facility program staff told the OIG they referred veterans who required supportive services to programs outside the service area or placed them in hotels that provided lodging but no other services. The program manager said the facility received approval to contract for residential services, and several agencies were interested in applying.
- Program staff also said that outreach effectively helps them identify both veterans and community partners, but they did not reach all areas and therefore missed opportunities to support some veterans.
    - To bolster HCHV outreach in Kentucky, the program manager explained that the HUD-VASH coordinator conducted outreach and visited veterans in the HCHV program when making HUD-VASH visits.
    - In some parts of Illinois north of the facility—another area that lacks HCHV outreach—facility staff work with a community organization that provides outreach and housing services for veterans.

Staff also reported that veterans experiencing homelessness often needed primary and mental health care, substance abuse treatment, shelter, and transportation. Staff identified transportation as a major barrier because of the rural environment and limited public transportation options and said veterans seeking employment faced added challenges when public transportation did not

[36] 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.

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

support work schedules. In response, staff said they assisted veterans with transportation to employment or career centers, but this reduced the time they had for other job duties.

The outreach program manager told the OIG that the large, rural service area often required staff to drive up to four hours or more to meet veterans in the community. The program manager said staff tracked drive times to assess travel feasibility and identify areas, such as northwest Kentucky, that needed additional homeless program staff and services, but prior resource requests had not been granted.

## 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."[38] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[39]

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).[40]

### Performance and Improvement Highlights

- The facility program did not meet the voucher use (HMLS3) target for FY 2025 or the first two quarters of FY 2026. The program manager cited limited housing in rural areas, high rental prices, and limited resources to help veterans obtain required documents. At the time of the OIG site visit in April 2026, 33 veterans were waiting for a voucher (15 in Kentucky, 15 in Indiana, and 3 in Illinois).
- The facility surpassed the employment (VASH3) target for FY 2025 and through February 2026. The program coordinator attributed this success to staff education that improved the accuracy of employment status documentation.

The program coordinator reported that the program had two case managers in Evansville and a case manager and program coordinator in Marion. The program manager told the OIG that the program limited housing locations to improve case management coverage across the large, rural

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

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

[40] 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.*

area. A case manager explained that increasing needs in Kentucky further complicated the program's ability to respond to urgent situations because of the distance between Evansville and Kentucky.

The case manager also reported an increased need for two case managers to meet with veterans in their homes or community due to staff safety concerns caused by some veterans exhibiting disruptive behaviors. The program manager said that staff report safety incidents in VA's disruptive behavior reporting system.[41] The program manager provided an example of a veteran who received outreach from facility staff about appropriate conduct expectations, which improved their behavior.

To increase awareness of homeless programs and discuss care coordination challenges, the program coordinator told the OIG that they established office hours for facility staff and community providers. The coordinator stated these hours gave social workers, nurse managers, and providers a place to discuss difficult cases and review veterans' medical and mental health concerns. As a result, the program manager reported an increase in appropriate referrals and stronger collaboration.

## 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.[42] 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).[43]

### Performance and Improvement Highlights

- The facility met the enrollment (VJP1) target for FY 2025 and the first two quarters of FY 2026.
- Veterans justice outreach coordinators described ongoing outreach and education efforts with law enforcement to increase referrals.

Despite this success, the different law enforcement protocols across the service area created challenges in identifying veterans for the program. For example, one of the coordinators said

[41] VHA Directive 1160.08(1), *VHA Workplace Violence Prevention Program*, August 23, 2021, amended February 22, 2025.

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

[43] 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.*

many veterans in Illinois were released from jail before staff received an alert about the arrest. Another coordinator explained it was harder to contact and engage veterans in treatment after their release.

According to the coordinators, the service area lacked an assigned staff person to provide health care for reentry veterans services (developed in response to federal law that requires VHA to assess needs and services for veterans soon to be released from federal and state prisons).[44] The coordinator at Marion volunteered for additional reentry duties about a year and a half before the OIG visit in April 2026 and received informal support and training from a coordinator at the VA St. Louis Healthcare System. The coordinator described providing reentry services in several prisons in southern Illinois when veterans justice outreach responsibilities allowed.

# Conclusion

To assist leaders in evaluating the quality of care at the VA Marion Healthcare System, the OIG conducted an inspection across five domains. The OIG made two recommendations related to the facility's test communication policy and service-level workflows. The OIG's findings and recommendations 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.

[44] 38 U.S.C. § 2022.

# 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.[45] 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 physically inspected various areas of the medical facility from April 21 through 23, 2026, and interviewed facility leaders and employees to discuss processes, validate findings, and explore reasons for identified problems. 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.[46] 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*.[47]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[48] 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.

[45] The accreditation reports covered the time frame of October 1, 2023, through March 27, 2026—the most recent available at the time of the inspection.

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

[47] 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.

[48] 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.

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.[49] 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.

[49] 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 16, 2026

From: Director, VISN 4 (10N4); Director, Health Service Area 4.2

Subj: Healthcare Facility Inspection of the VA Marion Healthcare System in Illinois

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

Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review the Healthcare Facility Inspection of the VA Marion Healthcare System in Illinois. I reviewed the documentation and concur with the submitted response.
2. Should you need further information, contact the VISN 4, Health Service Area 4.2 Regional Quality Officer.

*(Original signed by:)*

Chelsea N. Childress
HSA 4.2 Deputy Director
for
Sunaina Kumar-Giebel, MHA
VISN 4: Health Service Area 4.2 Director

Angela Athmann
VISN 4 Deputy Network Director
for
Fernando O. Rivera, FACHE
Network Director, VISN 4, VHA

# Appendix C: Facility Director Comments

## Department of Veterans Affairs Memorandum

Date: October 5, 2026

From: Executive Director, VA Marion Healthcare System (657A5/00)

Subj: VA Officer of Inspector General (OIG) Draft Report, Healthcare Facility Inspection of the VA Marion Healthcare System in Illinois

To: Director, VISN 4 (10N4); Director, Health Service Area 4.2 (10N4.2)

1. We appreciate the opportunity to review and comment on the Office of Inspector General's Healthcare Facility Inspection report for the VA Marion Healthcare System. I have thoroughly reviewed the associated documentation and concur with the response as submitted.
2. For assistance, contact the Marion VA Healthcare System Chief of Quality, Safety, Value, and High Reliability.

Sincerely,

*(Original signed by:)*

Fred Roché, MHA
Marion VA Health Care System Director

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
| **Contact** | For more information about this report, please contact the Office of Inspector General at (202) 461-4720. |
| **Inspection Team** | Joseph Giries, MHA, Director<br>Robert Ordonez, MPA, Project Leader<br>Veronica Leon, PhD, MSN, Team Leader<br>Kinh-Luan Nguyen, PharmD, MBA<br>Laura Pond, MSW, LCSW<br>Stephanie Stall, MSN, RN |
| **Other Contributors** | Kevin Arnhold, FACHE<br>Leakie Bell-Wilson, EdD, MSN, RN<br>Jolene Branch, MS, RN<br>Richard Casterline<br>Kaitlyn Delgadillo, BSPH<br>Jennifer Frisch, MSN, RN<br>LaFonda Henry, MSN, RN<br>Cynthia Hickel, MSN, CRNA<br>Simon Kim, PhD<br>Amy McCarthy, JD<br>Daphney Morris, MSN, RN<br>Sachin Patel, MBA, MHA<br>Ronald Penny, BS<br>Joan Redding, MA<br>Larry Ross Jr., MS<br>April Terenzi, BA, BS<br>Tammra Wood, MSSW, LCSW-S<br>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 4: VA Heart of America Health Network
Director, Health Service Area 4.2
Director, VA Marion Healthcare System (657A5)

## 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
  Kentucky: Mitch McConnell, Rand Paul
US House of Representatives
  Illinois: Mike Bost, Mary Miller
  Indiana: Mark Messmer
  Kentucky: James Comer, Brett Guthrie

**OIG reports are available at vaoig.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.*