US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Wilkes-Barre Healthcare System in Pennsylvania

Healthcare Facility Inspection	26-00056-280	September 28, 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 Wilkes-Barre Healthcare System (the facility) from April 14 through 16, 2026. The facility is rated as *mid-high complexity* and in fiscal year 2025, provided direct care to almost 40,000 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. Mid-high-complexity facilities have "medium-high volume, medium risk patients, some complex clinical programs, and medium sized research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." "Trip Pack - Operational Statistics Table FY 2026 Through April," VHA Support Service Center, last updated April 1, 2026, https://reports.vssc.med.va.gov. (This website 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 Health Service Area Director and facility Director concurred with the report (see appendixes B and C). No further action is required.

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

Abbreviations

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

Contents

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.[4] 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.[5]

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.[6]

Patient Safety: VHA has programs to identify and reduce system vulnerabilities and risks of harm to veterans.[7]

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.[8]

---

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

[5] 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.

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

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

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

The VA Wilkes-Barre Healthcare System (the facility) has a medical center and eight outpatient clinics.[9] The OIG team inspected the facility from April 14 through 16, 2026. Its fiscal year (FY) 2025 operating budget was approximately $324 million, and at the time of the inspection, it had 147 beds (80 community living center, 45 inpatient acute care unit, 12 inpatient mental health unit, and 10 domiciliary).[10]

Figure 1. *Facility photo.*
Source: "Wilkes-Barre VA Medical Center," VA, last updated June 23, 2025, https://www.va.gov/wilkes-barre-health-care.

The executive leaders referred to throughout this report include the Medical Center Director, Chief of Staff, Associate Director of Patient Care Services/Nurse Executive, Associate Director, and Assistant Medical Center Director. The Chief of Staff, assigned in May 2008, had the longest tenure, and the Assistant Medical Center Director, who started in September 2023, was the newest leader. Other 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 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]

---

[9] The medical center is in Wilkes-Barre, Pennsylvania, with clinics in Allentown, Bangor, Bloomsburg, Honesdale, Sayre, Tobyhanna, and Williamsport.

[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/clc. A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans," VA, last updated June 23, 2026, https://department.va.gov/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.

[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.

System Shocks

Although executive leaders did not identify any system shocks during OIG interviews, they described two situations that had the potential to disrupt the organization: a severe snowstorm in January 2026 and widespread staff uncertainty caused by press releases, news coverage, and social media speculation about VHA restructuring.[14] Leaders emphasized that these events did not rise to the level of a system shock because staff had become accustomed to organizational change, and leaders' actions, such as addressing misinformation during all-employee town halls, helped lessen potential impacts. Leaders also noted that there was no effect on patient care.

Employee Experiences

Almost half of OIG questionnaire respondents indicated the culture was improving, and most felt comfortable suggesting actions to improve the work environment (see figure 2).[15] Many respondents to the OIG questionnaire indicated that executive leaders' communication was clear and useful. However, some respondents expressed that stress and burnout made them consider leaving the facility. During interviews, the Medical Center Director said employee stress and burnout increased because of changes within VA, including VHA restructuring (as previously discussed) and new limits on the number of employees the facility was allowed to have.[16]

[14] 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/. 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/visns.

[15] The facility had 1,382 employees at the time of the OIG questionnaire, which had a response rate of approximately 15 percent.

[16] VA put staffing limits in place for FY 2026, and facilities must base their staffing plans on those limits. Assistant Secretary for Human Resources and Administration, "Updated Department of Veterans Affairs Hiring Guidance (VIEWS 13474675)," memorandum to Under Secretaries, Assistant Secretaries, and Other Key Officials, December 1, 2025.

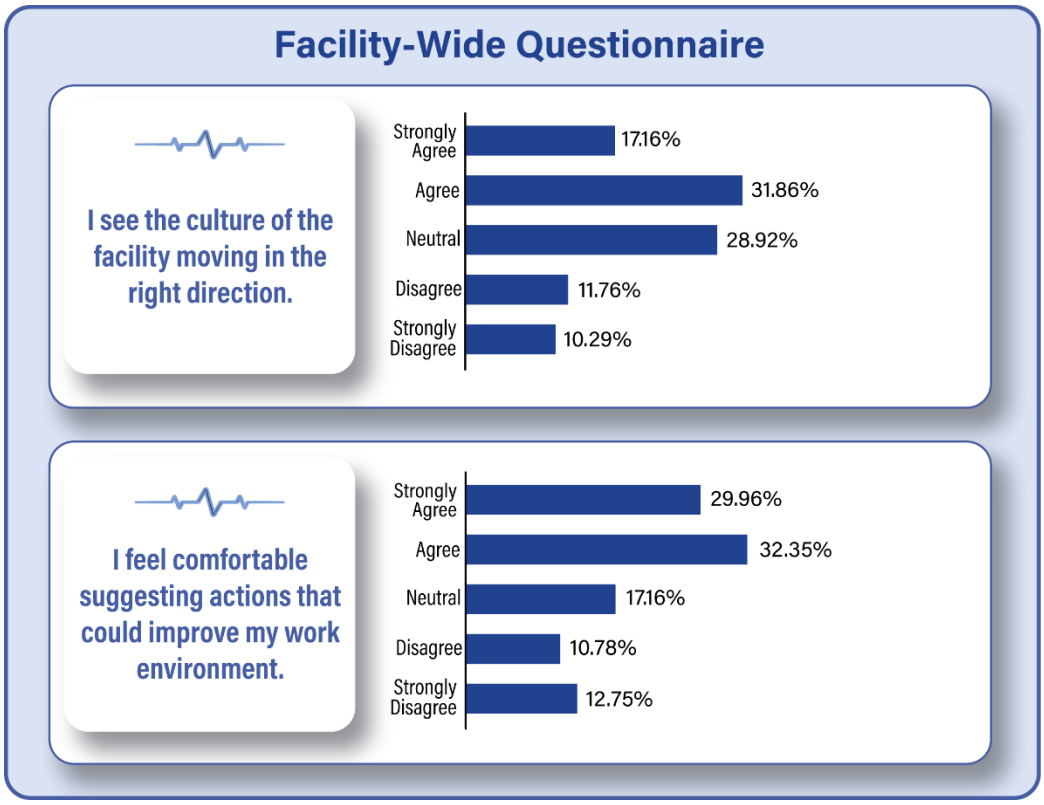

Figure 2. *Employee perceptions of facility culture.*
Source: OIG analysis of selected questionnaire responses.

To support employees, executive leaders offered wellness resources, used technology such as artificial intelligence to reduce administrative work, and held town halls more frequently to provide organizational and staffing updates and answer questions. The chief of the Quality Management Service explained that wellness resources included education, fitness options, flexible scheduling to promote work-life balance, and a dedicated calming break space. The whole health coordinator stated that employees gave positive feedback about the initiatives.

Veteran Experiences

Patient advocates' responses to an OIG questionnaire indicated that facility employees effectively addressed veterans' concerns. The advocates also reported the issue veterans raised most often was getting information about their medications. During an OIG interview, executive leaders explained that concerns with medication included missing or delayed mailed prescriptions; unavailable brand-name medications; and unmet refill requirements, such as when a provider needed updated test results before authorizing a refill. The leaders said employees addressed these issues by educating veterans on refill requirements, using overnight delivery when needed, and offering alternative medications. As shown in figure 3, the facility's VSignals trust scores exceeded VHA averages for the first two quarters of FY 2026, which indicates veterans have confidence in its outpatient services.

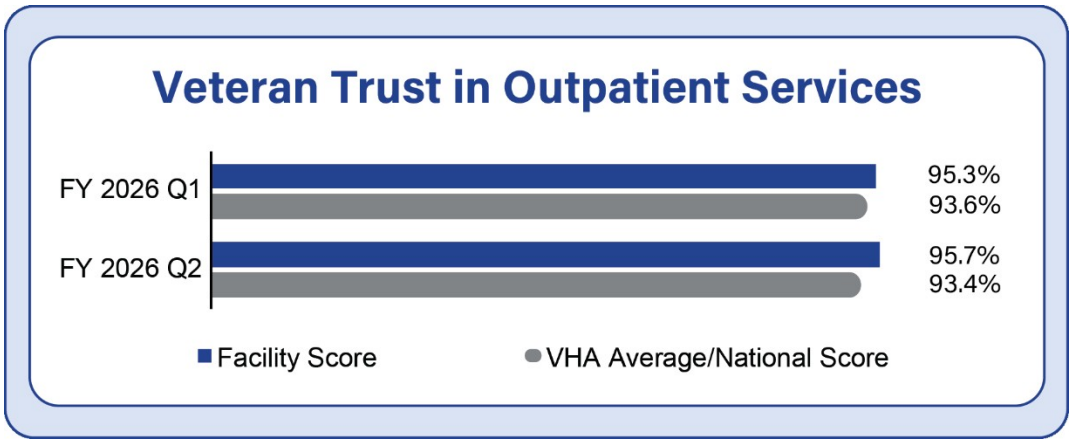

Figure 3. *Veteran trust in outpatient services.*
Source: VSignals data.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[17] 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 standards. Best practice principles from academic literature were also considered.[18]

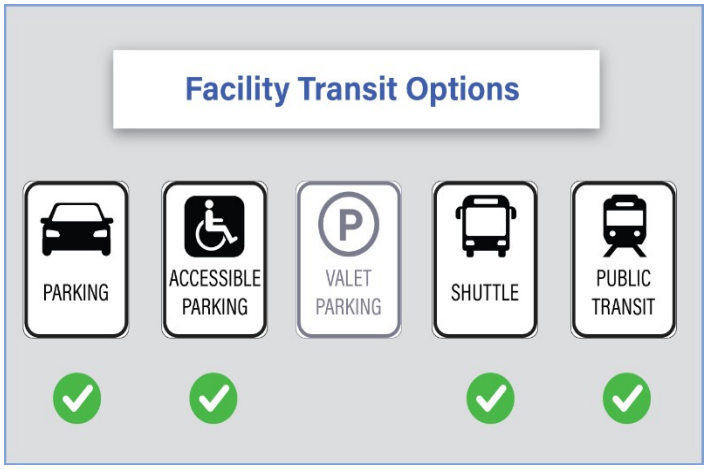

Figure 4. *Transit options for arriving at the facility.*
Source: OIG observations and a written statement from the Center for Development and Civic Engagement assistant and safety and health specialist.

General Inspection

The OIG team found the main entrance welcoming and clean. Volunteers were at an information desk to assist visitors,

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

[18] 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.

and signs, maps, and directories were displayed throughout the facility. The team also observed accessibility tools such as braille on signs, closed captioning on a television, and parking spaces designated for individuals with disabilities.

Figure 5. *Accessibility tools available to veterans with impairments.*
Source: OIG observations and review of a questionnaire response by the chief of quality management.

However, the OIG team noted that a set of elevators opened into a small, enclosed area that led to an exit corridor, but it was blocked by a set of locked double doors. According to the Code of Federal Regulations (title 29, section 1926.34(a)), exits must allow free and unobstructed navigation from all occupied areas of the building.[19] The associate chief of the Facility Management Service reported that immediately following the April 2026 on-site inspection, facility staff disengaged the locks so the door opened to the exit corridor when pushed. As a result, the OIG did not make a recommendation.

Additionally, in multiple supply storage rooms, the OIG team observed basket drawers that lacked a solid base. VHA Directive 1761, *Supply Chain Management Operations* requires bottom shelves in supply storage areas to be solid.[20] The team had concerns that particulate matter may contaminate supplies stored in the basket drawers during floor cleaning. The supply chain management chief reported that staff were replacing empty baskets with prefilled ones instead of refilling the original lined baskets. The OIG did not make a recommendation because the chief reported that staff had received education on the correct practice and resolved the issue.

Further, the OIG team noted that informational posters in clinical areas displayed outdated disposal processes for pharmaceutical waste (leftover, unused, or expired medication) that did not reflect the facility's current practice. The team also found that some clinical staff were not aware of proper waste disposal methods, including which bins to use for different types of waste. In one location, medical equipment blocked pharmaceutical waste bins and prevented staff from accessing them. VHA Directive 1850.06(1), *Waste Management Program* requires facilities to maintain comprehensive waste management processes that include making disposal containers

[19] 29 C.F.R. § 1926.34(a) (2025).
[20] VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

readily available and ensuring staff are trained on their correct use.[21] When staff cannot access the appropriate containers or lack knowledge of correct procedures, the risk of improper disposal increases, which may harm veterans, staff, and the environment.

The environmental protection specialist reported that the facility's waste processes changed approximately three years previously, and outdated posters remained from before the change. During the April 2026 OIG inspection, the specialist provided an action plan to conduct a walk-through of clinical areas to remove outdated information, post updated instructions, educate staff, verify correct bin placement, and perform periodic spot checks of staff practices.

The issues identified by the OIG raised concerns about the effectiveness of the facility's monitoring practices and potential gaps in how staff conduct environmental rounds. The OIG communicated these concerns to executive and service leaders during the site visit. Because leaders promptly addressed all issues and presented credible action plans, the OIG did not make a recommendation.

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 found that the facility's test result communication policy and service-level workflows (which detail how staff obtain test results and share them with patients) for urgent but noncritical results met the requirements of VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[22] The OIG team reviewed facility documents and learned that staff had created a workgroup to improve the facility's test result communication scores (the percentage of outpatient tests with abnormal results communicated to patients within the seven days required by VHA Directive 1088(1)), which in FY 2024 had been below VHA national averages.[23] A systems redesign specialist provided documentation of the workgroup's review of how staff

[21] VHA Directive 1850.06(1), *Waste Management Program*, July 22, 2022, amended June 5, 2024.

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

[23] Communication of Test Results (CTR) 24 is a metric that identifies "the percent of outpatient tests with Abnormal results" requiring action that staff communicate to patients within seven days "from the time the test result is available." VHA does not have a set target for CTR measures but indicates "higher is better" for scoring purposes. "Electronic Technical Manual (eTM) Measure Specification," VHA Office of Quality and Patient Safety Performance Measurement, accessed June 30, 2026, http://pm.rtp.med.va.gov. (This website is not publicly accessible.)

shared test results, updated test notification processes, and revised facility policies. The OIG compared the facility's FY 2024 and FY 2025 data on test result communication and confirmed the FY 2025 scores improved to 83.94 percent, which were above VHA's FY 2025 national average of 81.49 percent.

Action Plans and Process Improvements

The facility had completed all identified actions to address OIG recommendations from the last comprehensive healthcare inspection, conducted in July 2022.[24] In a July 2025 report on community care programs in the Veterans Integrated Service Network (VISN), the OIG issued several recommendations. These recommendations were for the VISN and facility directors to confirm that community care leaders complete a staffing tool reassessment (used to estimate program needs based on workload and staffing) every 90 days and that staff enter patient safety events into a patient safety reporting system.[25] The OIG team reviewed meeting minutes from the Community Care Oversight Committee and noted that staff had begun reporting patient safety events that were entered into the system to the committee, and had started using a staffing tool in response to the recommendations.

The systems redesign coordinator said the facility had 13 active redesign projects in FY 2026. During interviews, staff highlighted a project that improved veterans' experiences by making it easier for them to find their way around the building. Improvements included updating directories, correcting website information, and adding facility maps to appointment letters. The OIG reviewed facility data that showed fewer patients reported to the wrong office or clinic after these interventions.

The OIG team identified two adverse events (unexpected incidents, injuries, or other events that cause or could cause harm) in FY 2026 that required institutional disclosures, but leaders did not document the disclosures as required by VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*.[26] VHA Directive 1004.08 states that an institutional disclosure is needed "when an adverse event has resulted in or is reasonably expected to result in death or serious injury." Further, the directive requires staff to document the discussion in a specific electronic health record note. The formal institutional disclosure process ensures facility leaders and clinicians inform patients or their representatives of the adverse event, applicable treatment options, and their rights and recourse.

[24] VA OIG, *Comprehensive Healthcare Inspection of the Wilkes-Barre VA Medical Center in Pennsylvania*, Report No. 22-00236-212, September 19, 2023.

[25] VA OIG, *Care in the Community Inspection of Medical Facilities in VISN 4: VA Healthcare*, Report No. 24-00825-176, July 30, 2025.

[26] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

Staff explained they conducted an institutional disclosure for one of the events but did not document it. For the other event, staff documented a clinical disclosure (an open, empathetic conversation between providers and patients about an adverse event), believing they fulfilled the institutional disclosure requirement when they did not.

In an OIG interview, the Chief of Staff acknowledged that leaders did not document institutional disclosures as required because medical service leaders were unclear about who was responsible, and each assumed someone else had completed the records. To address this, the Chief of Staff stated the risk manager will implement a formal process that requires the Chief of Staff and the quality management service chief to track and verify that leaders complete and document institutional disclosures.

While the OIG was on site in April 2026, the Chief of Staff provided a process improvement review that included planned actions for each event and shared a draft facility policy on institutional and clinical disclosure documentation. Leaders completed the required institutional disclosure documentation for the adverse events on April 29, 2026, about two weeks after the inspection. Additionally, the OIG reviewed two current events following the inspection and confirmed that leaders had completed the required institutional disclosures. Because facility leaders took prompt action while the team was on site and have since demonstrated compliance with VHA requirements, the OIG did not make a recommendation.

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[27] 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

Facility documents showed the facility had 38 primary care teams. Primary care leaders described a small number of staffing vacancies among primary care providers, registered nurses, and medical support assistants, but stated these gaps did not significantly affect daily operations due to established coverage processes. The OIG found the average panel size (the number of patients assigned to a care team) in FY 2025 was 96 percent of the expected size outlined in

[27] "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.

VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*.[28] Primary care leaders reported they maintained panel sizes through ongoing monitoring and by assigning new patients across providers to balance workloads.

VHA data for the first three quarters of FY 2025 showed primary care appointment wait times of less than 2 days for established patients and less than 14 days for new patients. The Code of Federal Regulations (title 38, section 17.4040) states that patients may be referred to community providers for wait times longer than 20 days, so the facility's reported wait times were within expected parameters.[29] Leaders explained that float staff (employees who can be reassigned as needed) provided cross-coverage by assuming responsibilities during absences. Additionally, the chief of primary care reported that walk-in clinics and registered nurse appointments for medication management help veterans access care more quickly.

Community Care Staffing and Access to Care

Community care leaders reported the staffing tool (mentioned in the patient safety domain) did not capture several key community care functions, limiting their ability to fully assess staffing needs and determine potential workforce gaps. However, they did not identify any current concerns about insufficient staffing during the interview. Leaders also reported a relatively small number of staffing vacancies that did not significantly affect the workload.

Facility documents showed that for FY 2025, dermatology and urology were the most frequently referred specialties based on wait-time eligibility (when VHA could not schedule a veterans' appointment within its required time limits). Staff averaged seven days to schedule appointments, which met the requirement in VHA's *Consult Timeliness Standard Operating Procedure*.[30] Although they met the requirement, the acting chief of community care said that in February 2026, staff implemented a new tracking system to further improve timeliness. The process requires staff to update a shared spreadsheet in real time with referral status and next steps. Because the system had been in place for less than two months before the OIG site visit, specific improvement data were not yet available. However, community care leaders and staff noted the tool was helpful and expect it will enhance timeliness and workflows.

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

[29] 38 C.F.R. § 17.4040 (2025).

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

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.[31]

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).[32] HCHV2 measures the percentage of veterans who are discharged from the 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)."[33]

Performance and Improvement Highlights

- The facility met the discharge to permanent housing (HCHV1) target for FY 2025 and the first two quarters of FY 2026. The program coordinator explained that staff met performance goals by helping veterans in transitional housing apply for VA benefits and developing discharge plans that promote housing stability.

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

[32] 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.

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

- The facility also met the negative exits (HCHV2) target in FY 2025 and the first two quarters of FY 2026. The program coordinator described close staff engagement at a site that served older, lower-income veterans who could not live independently. Program staff coordinated financial assistance for the residents and maintained frequent communication with the site administrator.
- The homeless program supervisor reported that two case managers were responsible for veteran outreach across 19 counties. The program coordinator stated that a third case manager position had been vacant for about one year, and the position was eliminated in March 2026. The coordinator noted that having only two case managers limits the program's ability to conduct outreach effectively across such a large service area, and the supervisor or other staff assist with outreach to cover the gap.
- The OIG toured the program's walk-in clinic for veterans at the medical center, which provided food and clothing, referrals for support services, and same-day mental health evaluations. The program coordinator said a second clinic located at the Allentown site provided similar services.
- The program also operated a food initiative for veterans experiencing homelessness and those who are food-insecure (individuals who cannot reliably obtain adequate food) by collaborating with the facility's nutritional services and distributing monthly food boxes in the community to 120 veterans in need.

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."[34] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[35]

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).[36]

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

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

[36] 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 met the voucher use (HMLS3) target for FY 2025 but did not meet it for the first two quarters of FY 2026. The homeless program supervisor attributed the shortfall to the 30 new vouchers added at the start of the year and two case manager vacancies. Processing the additional vouchers required screening veterans, verifying eligibility, and collecting housing documents; the vacancies slowed this work. The supervisor also reported that the program streamlined its veteran admission process in January 2026 to increase voucher use.
- The program supervisor stated that one HUD-VASH staff vacancy remained unfilled since July 2025. The chief of social work said program leaders selected a candidate for the position in November 2025, but the candidate did not continue with the hiring process. The chief later told the OIG that the position was officially re-announced one week after the April 2026 inspection.
- Additionally, the program supervisor said staff worked with five public housing agencies to help veterans secure permanent housing. The supervisor explained that staff excelled at working with landlords to identify units for veterans, but limited housing stock, deteriorating older buildings, and investor-driven rent increases make the task challenging.
- The facility met the employment (VASH3) target for FY 2025 and the first two quarters of FY 2026.

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]

Performance and Improvement Highlights

- The facility met the enrollment (VJP1) target for FY 2025 but did not meet it in the first and second quarters of FY 2026. Program staff said they began working with a

[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.*

judge in Lackawanna County in March 2026 to establish a regional treatment court, which will expand veteran access to a resource previously unavailable in four counties.[39]

- Facility documents showed that the program's three staff members provided outreach to 19 jails and 12 treatment courts.
- Program staff stated they met with veterans in jails, and that many jails provided tablet computers with the program's contact information, which allowed veterans to request outreach directly.
- Additionally, staff stated that Lehigh County used a mentoring committee (made up of representatives from the judge's office, public defender, jail, pre-trial services, probation, and district attorney's office) as an alternative to a treatment court. Staff explained that a designated jail point of contact provided veterans with the mentoring application, and program staff visited the jail to assess their treatment needs. Staff also noted that veterans on the committee served as mentors and made periodic jail visits to support veterans in the program.

Conclusion

To assist leaders in evaluating the quality of care at the VA Wilkes-Barre 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.

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

Appendix A: Methodology

The OIG team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports.[40] 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 14 through 16, 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.[41] 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.*[42]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[43] 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.

[40] The accreditation reports covered the time frame of August 25, 2023, through February 25, 2026—the most recent available at the time of the inspection.

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

[42] 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.

[43] 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.[44] 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.

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

Appendix B: Health Service Area Director Comments

Department of Veterans Affairs Memorandum

Date: September 10, 2026

From: Director, Health Service Area 1.2

Subj: Healthcare Facility Inspection of the VA Wilkes-Barre Healthcare System in Pennsylvania

To: Director, Office of Healthcare Inspections (54HF03)

Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review the VA OIG DRAFT REPORT - Healthcare Facility Inspection of the VA Wilkes-Barre Healthcare System in Pennsylvania. I concur with the report finding which resulted in no recommendations. We are grateful to the employees and facility leadership that have worked diligently to provide excellent care for our Veterans.
2. We thank the OIG for a thorough review and their ongoing commitment to improve the quality of health care for the Nation's Veterans.

(Original signed by:)

Shawn Defries
Deputy HSA Director
for
Bruce Tucker, LCSW
Director, Health Service Area 1.2

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: September 10, 2026

From: Director, VA Wilkes-Barre Healthcare System (693)

Subj: Healthcare Facility Inspection of the VA Wilkes-Barre Healthcare System in Pennsylvania

To: Director, VA North Atlantic Health Network (10N1)

Director, Health Service Area 1.2

1. I have reviewed the draft report of the Office of Inspector General (OIG) Healthcare Facility Inspection that was conducted at the Wilkes-Barre VA Medical Center in Pennsylvania.
2. I have reviewed the documentation and concur with the response as submitted.
3. I appreciate the insights and guidance provided by OIG as a collaborative partner in assisting our facility to improve our processes as we strive to deliver high-quality care for Veterans.
4. Should you need further information, please contact Wilkes-Barre's Chief of Quality Management Service.

(Original signed by:)

Russell E. Lloyd
Medical Center 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	Marissa Betancourt, LCSW, MSW, Team Leader Erin Allman, MSN, RN Holly Bahrenburg, BS, DC Stephanie Long, LCSW, MSW Lauren Olstad, LCSW, MSW Michelle Wilt, MBA, RN
Other Contributors	Kevin Arnhold, FACHE Jolene Branch, MS, RN Richard Casterline Alicia Castillo-Flores, MBA, MPH Kaitlyn Delgadillo, BSPH Jennifer Frisch, MSN, RN LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Simon Kim, PhD Amy McCarthy, JD Daphney Morris, MSN, RN Sachin Patel, MBA, MHA Ronald Penny, BS Joan Redding, MA Larry Ross Jr., MS April Terenzi, BA, BS 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, VA North Atlantic Health Network (10N1)
Director, Health Service Area 1.2
Director, VA Wilkes-Barre Healthcare System (693)

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: John Fetterman, Dave McCormick
US House of Representatives: Rob Bresnahan Jr., Ryan Mackenzie, Daniel Meuser, Glenn 'GT' Thompson

OIG reports are available at www.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.