US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Chicago Healthcare System in Illinois

Healthcare Facility Inspection	26-00063-07	October 29, 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 Chicago Healthcare System (the facility) from June 1 through 4, 2026. The facility is rated as *high complexity* and in fiscal year 2025, provided direct care to about 63,000 patients.[1] The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[2]

What the OIG Examined

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences. The OIG made no recommendations.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy. The OIG made no recommendations.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The OIG made no recommendations.
- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.[3] The OIG found that community care staff did not meet the requirement for scheduling appointments within seven days, as outlined in VHA's *Consult Timeliness Standard Operating Procedure*.[4] The OIG made a recommendation.
- **Veteran-Centered Safety Net.** The inspection also evaluated facility programs that offer support services to vulnerable veterans who are experiencing or at risk of

[1] VHA classifies facilities based on their complexity level. High complexity facilities have "medium-high-volume, high-risk patients, many complex clinical programs, and medium-large 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 May," VHA Support Service Center, updated May 18, 2026, https://reports.vssc.med.va.gov. (This web page is not publicly accessible.)

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

[3] VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393.

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

homelessness or have recently been incarcerated. The OIG made no recommendations.

What the OIG Recommended

1. The Medical Center Director develops an action plan with community care leaders to meet the requirement for staff to schedule appointments within seven days, as outlined in the Veterans Health Administration's *Consult Timeliness Standard Operating Procedure*.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the recommendation and provided an acceptable action plan (see the response in the report body and appendixes B and C 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 the management structure of VHA. On May 1, 2026, the Under Secretary for Health announced the consolidation of the Veterans Integrated Service Networks (VISNs) from 18 networks to 5. On July 15, 2026, the Acting Under Secretary for Health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise.

Abbreviations

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

Contents

Executive Summary i

Abbreviations iii

Introduction 1

Culture 2

Environment of Care 6

Patient Safety 7

Integrated Veteran Care 9

Recommendation 1 11

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 Chicago Healthcare System (the facility) serves six locations in Illinois and Indiana. It includes a medical center and three community-based outpatient clinics in Chicago, as well as one clinic in Chicago Heights, Illinois, and one in Crown Point, Indiana. In fiscal year (FY) 2025, the facility's medical care budget was approximately $954 million. The facility had 156 inpatient hospital, 26 domiciliary, and 22 community living center beds, and served more than 63,000 veterans.[11]

Figure 1. *Facility photo.*
Source: "VA Chicago Health Care," VA, accessed May 13, 2026, https://www.va.gov/chicago-health-care.

The OIG team inspected the facility from June 1 through 4, 2026. Executive leaders referred to throughout this report include the Director, Chief of Staff, Associate Director for Patient Care Services, Associate Director, and Assistant Director. The executive leaders had worked together since November 16, 2025, when the Director and Assistant Director were assigned to their positions.

CULTURE

The OIG team examined the facility's culture across multiple dimensions, including unique circumstances and system shocks (planned or unplanned events that disrupt an organization's daily operations), and both employees' and veterans' experiences.[12] The OIG administered its own facility-wide questionnaire and reviewed Veterans Signals (VSignals) survey scores (which summarize real-time information from veterans about their experiences after an appointment and assess their level of trust in VA).[13] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[14]

---

[11] A domiciliary is a residential "clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans," VA, accessed June 29, 2026, https://department.va.gov/homeless/dchv. A community living center (CLC) 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.

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

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

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

System Shocks

Executive leaders identified two system shocks that affected the facility's ability to maintain stable operations. These included the VA Police Classification Consistency Review, which paused police hiring for more than one year, and information technology issues that prevented computer logins for clinical employees.

During an interview, the executive leadership team said the VA Police Classification Consistency Review, which began in 2025, created staffing challenges. Leaders described collaborating with the chief of police to maintain coverage by suspending programs such as victim advocacy, reassigning staff, and requiring mandatory overtime. Leaders held both virtual and in-person meetings with the chief of police to discuss challenges and share updates. In addition, leaders described being required to eliminate vacant positions, which reduced authorized police positions approximately 50 percent and created long-term effects on staffing models, operational coverage, and workforce planning.

Leaders reported that an April 2026 national information technology issue affected operations and prevented employees from logging into some computer workstations on wheels. Leaders activated the incident command center (an emergency management system used by VA medical facilities) to establish reporting channels between leaders and employees to ensure continuity of services.[15] They regularly met with representatives from the Office of Information and Technology, biomedical engineering service, nursing service, and clinical teams. Leaders reported that biomedical engineering and information technology employees installed an update to the computer program to resolve the issue. Nursing staff implemented contingency procedures such as using the working computers and conducting rounds to ensure safe medication administration. Leaders distributed notifications to all employees through the emergency alert and accountability system and confirmed that all inpatient units had computers to support patient care. Leaders reported no adverse effect on patient care, and the issue was resolved within three days.

Employee Experiences

Responses to the OIG questionnaire indicated that the top three reasons employees remain at the facility are because of the VA mission, pay and benefits, and overall job satisfaction. Respondents generally felt comfortable reporting patient care or safety concerns and suggesting ways to improve the culture.

[15] VHA Directive 0320.12(1), *National Incident Management System Compliance*, December 8, 2020, amended January 25, 2021.

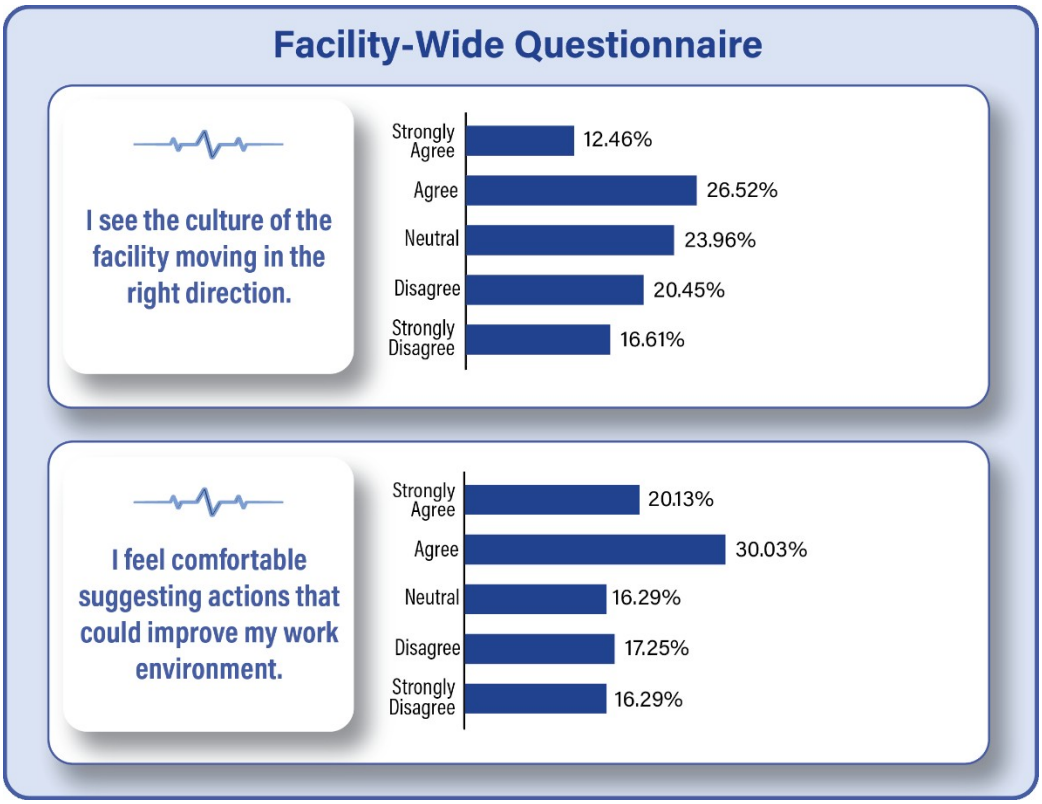

Figure 2. *Employee perceptions of facility culture.*
Source: OIG analysis of selected questionnaire responses.

To ensure open and two-way communication, executive leaders held twice monthly town halls and monthly patient safety forums, participated in weekly environment of care rounds, and distributed weekly emails from the Director to update employees. Employees could submit anonymous questions and comments for leaders to address during the town halls, which were recorded for those who were unable to attend. In addition, leaders conducted routine leadership rounds in work areas to maintain visibility, directly engage with employees, and identify operational concerns and opportunities for improvement. Leaders also explained that they were piloting a phone application to track issues found during rounds, measure how work areas had improved, and follow the issues to resolution.

Facility documents showed that leaders invested in employees' experiences through several initiatives. These included wellness booths located throughout the facility that allow employees to take a break from stressful situations and visits from the employee experience officer who had a wellness cart that contained educational resources, aromatherapy, and stress balls. Leaders also shared that their facility patient safety forum was highlighted at Veterans Integrated Service

Network (VISN) and VHA meetings and featured in poster presentations at various conferences.[16]

Veteran Experiences

The OIG team found the facility's VSignals score for FY 2025 was 94 percent, which was the same as VHA's national average. Patient advocate respondents to an OIG questionnaire reported that veterans' most common responses for FY 2025 included compliments to employees and requests for new providers. The patient advocates reported on the questionnaire and leaders confirmed in an interview that the veterans experience officer was working on a project to address provider-related concerns.

In contrast to the VSignals scores, the Director reported that the facility's inpatient survey scores remained below the VHA average in communication, cleanliness, and quietness at night. These deficits may negatively affect veterans' perceptions of care quality and overall satisfaction, prompting ongoing efforts to improve in these areas. In response, leaders implemented several changes to address veterans' concerns, such as environmental management service staff placing notes in patient rooms stating they have been cleaned. Additionally, the nurse manager checks in on new admissions to help orient the veteran to the unit, answer questions, and ask about their first night in the hospital. Further, when a call light is activated, anyone in the area responds. The Director also meets with veterans and visits with inpatients.

Executive leaders reported engaging veterans through open-door policies and monthly town halls on topics like women's health and outpatient clinics. Leaders stated that veterans frequently express confidence in their providers and nursing staff and positive experiences with care delivery. Leaders discussed how the Veterans Experience Office tracks satisfaction data and updates them regularly. The Director reported meeting monthly with patient advocates, which enabled them to identify and resolve concerns to improve veterans' experiences.

[16] 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/visn. 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 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.

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 and Joint Commission standards. Best practice principles from academic literature were also considered.[18]

General Inspection

The OIG team observed ample parking, including accessible spaces for individuals with mobility issues. The parking garage had adequate lighting, and police services monitored security cameras and patrolled the garage.

At the main entrance, large automatic doors opened into a clean, well-lit lobby with seating along the walls of a long corridor. Employees and volunteers at the information desk provided veterans with directions, assistance, and information, and escorted them to appointments as needed.

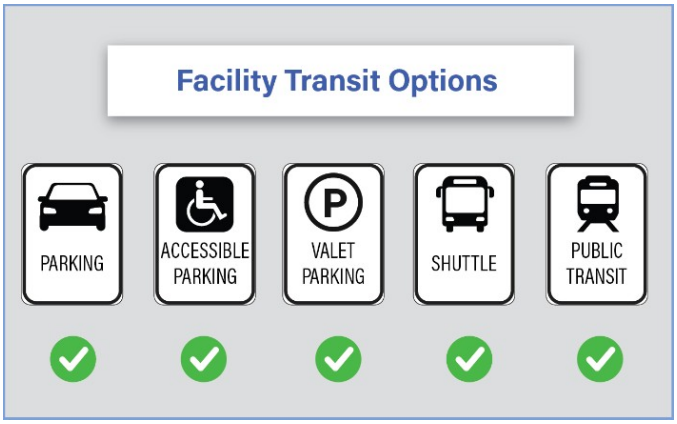

Figure 3. *Transit options for arriving at the facility. Source: Facility map, OIG team observations, and facility documents.*

[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; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2025.

Figure 4. *Accessibility tools available to veterans with impairments.*
Source: Lists of sensory aids provided by audiology and optometry staff, OIG team observations, and information provided by the liaison.

The inspection team noted clinic and office directories posted in hallways, near elevators, and on walls throughout the facility. The facility also offers tools and resources for sensory-impaired veterans, including assistive listening devices and signs with braille and large font.

The team inspected patient care areas and the community living center and found them clean and well lit. Medical equipment had up-to-date inspection stickers, and employees protected patient privacy. Personal protective equipment, such as gloves and masks, was readily available, and contaminated medical waste was stored in a locked area with restricted access.

According to facility documents, previous inspections conducted between February 2024 and February 2026 identified issues regarding exit signs and obstructed exits routes. The OIG team confirmed that staff had either corrected the issues or were in the process of making improvements. Addressing these issues and maintaining a well-organized, safe, and clean environment enhances patient safety and strengthens facility operations. The facility's progress demonstrates sustained attention to safety standards across patient care areas.

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, Noncritical Test Results

The OIG team found that the facility's Medical Center Policy 11-054-2031, *Communicating Test Results to Providers and Patients*, met the requirements listed in VHA Directive 1088(1),

Communicating Test Results to Providers and Patients.[19] The facility policy includes processes for communicating test results to providers and patients, designating a surrogate when the primary provider is unavailable, and conveying results outside clinic hours. Leaders reported that service-level workflows were posted on the facility's intranet site to provide clinicians with easier access to providers after hours and during weekends.

The Chief of Staff stated that providers are responsible for communicating test results to patients in accordance with the facility policy and service-level workflows. Leaders described the steps providers take to notify patients of results, which include phone calls, secure messaging, and ensuring patients' contact information is up to date. Providers also use software that automatically generates test result letters to mail when phone calls are unsuccessful.

VHA Directive 1088(1) requires facilities to monitor test result communications to providers and patients. According to facility documents, staff launched a systems redesign project in July 2023 to improve the communication of test results. The project resulted in refined workflows, implemented action plans, and mechanisms for monitoring progress and sustaining improvements. Quality management staff reported that compliance with timely communication of test results increased from 30 percent in July 2023 to 96 percent in May 2026. To sustain these gains, external peer review program coordinators stated they now conduct random chart audits to monitor compliance in clinical documentation and identify improvement opportunities.[20] Overall, the OIG team found that facility leaders had consistent processes to monitor and address delays in test result communications.

Action Plans and Process Improvements

The OIG team found no open recommendations from a previous OIG comprehensive healthcare inspection report published in April 2024.[21] Quality management employees provided documentation that they had action plans to address oversight recommendations, monitored action items for six months after completion to ensure sustained improvement, and reported findings to the governing councils. In addition, leaders and employees stated they meet daily to discuss patient safety concerns, provide updates, and identify trends.

[19] MCP [medical center policy] 11-054-2031, *Communicating Test Results to Providers and Patients*, May 1, 2026; VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

[20] VHA established the External Peer Review Program communicating test results measure as a way for facility leaders to review compliance and ensure "corrective action is taken when non-compliance is identified." VHA Directive 1088(1).

[21] VA OIG, *Comprehensive Healthcare Inspection of the Jesse Brown VA Medical Center in Chicago, Illinois*, Report No. 23-00103-138, April 17, 2024.

Leaders and employees also discussed the methods used to identify opportunities for improvement—the Joint Patient Safety Reporting system and patient safety forums.[22] During patient safety forums, staff provide instructions on reporting events, review patient safety trends, discuss high-reliability practices, recognize award recipients, provide electronic health record process updates, and present safety stories (real-life narratives that illustrate safety events and lessons learned). Leaders and employees also reported that patient safety concerns are discussed in town halls, committee meetings, huddles, patient safety newsletters, and clinical areas.

As an example of process improvement in July 2025, community care and primary care employees initiated a systems redesign project to improve consult processes, streamline communication of mammogram results between community and facility providers, and address facility providers' limited access to community databases. The chief of community care reported that they are actively identifying new processes as part of the redesign project. Effective safety reporting and timely communication of abnormal test results are critical to preventing missed or delayed diagnoses, maintaining veterans' trust, and ensuring veterans receive safe, coordinated care across both facility and community settings.

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[23] 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

Documents showed that in May 2026, primary care leaders confirmed that the facility had 33 primary care teams, with 12 vacant positions: three providers, two licensed practical nurses, and seven medical support assistants. A primary care team member reported that vacancies among medical support assistants made scheduling follow-up appointments for veterans difficult. Leaders confirmed that the loss of positions and centralization of the medical support assistants

[22] The Joint Patient Safety Reporting (JPSR) system is a database used as a collaborative tool for employees to document patient safety events including medical errors and close calls, and for the patient safety manager to track and trend reported events. VHA National Center for Patient Safety, *JPSR Guidebook*, *Version 9.0*, March 18, 2026.

[23] "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.

in FY 2025 contributed to the challenge; nursing staff helped manage schedules. The Chief of Staff stated they have recently received approval to hire medical support assistants.

Leaders stated the fastest growing patient population was women veterans. To meet this increasing demand, leaders identified primary care providers with a specialized women's health certification to increase access to care for women veterans. While the primary care panels (the number of patients assigned to a provider) at the medical center clinics are below 90 percent, other outpatient clinics have increased capacity. Despite this, primary care staff reported panel sizes were manageable. 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 longer than 20 days.[24] As of July 2026, the facility's wait time for a new patient primary care appointment was approximately 17.6 days.

Leaders reported multiple upcoming changes to primary care space, including moving the primary care clinic located at the medical center to an off-site annex in Chicago and opening a new community-based outpatient clinic. Leaders also plan to move two primary care teams from the Crown Point community-based outpatient clinic to the new clinic to relieve congestion at Crown Point. When the move occurs, the vacated space at Crown Point will allow consideration of adding specialty care services at the clinic.

Community Care Staffing and Access to Care

The chief of community care reported multiple vacancies, which community care employees stated they were covering through overtime. VHA's *Workforce Allocation Tool* FY 2026 quarter two staffing analysis, generated in March 2026, identified an estimated funded surplus of approximately 18 administrative staff and 2 clinical staff; however, community care leaders noted this tool does not take into account factors that are out of administrative staff's control, such as the time it takes to schedule an appointment with a community provider. Leaders stated they were invited to a national workgroup to review the tool and provided feedback about how standard times used in the tool for consult scheduling do not factor in site-specific information. Leaders also reported cross-training nursing staff to help cover the vacancies and accommodate requested leave, indicating possible ongoing strain on staffing resources.

Facility documents showed community care consults increased from 25,667 in FY 2023 to 29,527 in FY 2025. Community care leaders and employees attributed this to the growing volume of specialty care consults due to the loss of facility providers and dentists, construction within a specialty care clinic, and equipment failures. These factors contributed to an increase in workload for staff to ensure veterans have timely access to care.

[24] 38 C.F.R. § 17.4040 (2025).

At the time of the OIG site visit in June 2026, leaders reported that the time from community care consult entry to appointment scheduling increased from 17 days in FY 2025 to approximately 25 days in June 2026, which exceeded the 7 days required by VHA's *Consult Timeliness Standard Operating Procedure*.[25] Leaders explained the delays were caused by processes outside of the VA staff's control, such as difficulties contacting veterans, community providers' clinical review processes, and delays in staff documenting the appointments when veterans self-scheduled them. Community care leaders and staff reported that in early 2026, leaders introduced an initiative to realign staff and focus on resolving veterans' appointment needs in a single phone call, which would help mitigate consult delays. Although leaders have taken steps to address scheduling timeliness, the OIG found that scheduling wait times continued to increase through August 2026.

Recommendation 1

The Medical Center Director develops an action plan with community care leaders to meet the requirement for staff to schedule appointments within seven days, as outlined in the Veterans Health Administration's *Consult Timeliness Standard Operating Procedure*.

__X__ Concur

_____ Nonconcur

Target date for completion: April 30, 2027

Director Comments

The Chief of Community Care will develop an action plan to meet the First Entry Date (FED)-to-first-scheduled-appointment timeliness, with a facility performance goal of an average of 7 days or less (and at least 90 percent of consults scheduled within 7 days), consistent with the Veterans Health Administration's Consult Timeliness Standard Operating Procedure. Progress will be tracked by Community Care and presented to the Quality Leadership Council (QLC) monthly. Quality will monitor the progress to ensure compliance for 6 consecutive months.

[25] 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.[26]

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).[27] 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)."[28]

Performance and Improvement Highlights

- The facility met the targets for exits to permanent housing (HCHV1) and negative exits (HCHV2) for FY 2025 but did not meet them for the first and second quarters of

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

[27] VHA sets targets for HCHV1 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*, November 2024. Contracted residential services programs include both emergency residential services and low-demand safe haven programs. For 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.

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

FY 2026.[29] Program employees attributed the decline to a decreased number of community partner beds which limited available emergency and transitional housing.

- Program staff covered Chicago and northwest Indiana. In Chicago, staff said homelessness is well known and there are services; however, in northwest Indiana, veterans tend to stay in cars, garages, or doubled-up housing because of the limited number of shelter beds. Staff rely heavily on community referrals, hotline alerts, and walk-ins at the community-based outpatient clinic to identify veterans. Program leaders are in the early stages of securing a contracted emergency residential shelter in northwest Indiana to meet veterans' needs.
- HCHV staff also highlighted a housing event in January 2026 where HUD-VASH staff, the Chicago Housing Authority, and 16 landlords prepared units for immediate leasing; six veterans applied during the event and scheduled a time to view the units.
- At the time of the inspection in June 2026, program employees reported two vacancies, and interns were selected for both positions—interns were considered internal applicants after they completed their internship and were eligible to apply. There had been challenges with filling positions over the prior two years because leaders were limited to internal-only job postings, which restricted the pool of qualified candidates.

Housing and Urban Development-Veterans Affairs Supportive Housing

The HUD-VASH program combines HUD rental assistance with VA case management services to support veterans who face significant barriers to stable housing, including "serious mental illness, physical health diagnoses, and substance use disorders."[30] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[31]

VHA measures how well the program meets veterans' needs by using nationally determined targets, including the number of housing vouchers assigned to the facility currently used by

[29] For FY 2025, the HCHV1 target was 55 percent, and the facility was at 65.08 percent. The HCHV2 target was less than 20 percent, and the facility was at 18.75 percent. In FY 2026, as of April, HCHV1 was 50.88 percent and HCHV2 was 31.58 percent.

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

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

veterans or their families (performance measure HMLS3) and the percentage of veterans who are employed (performance measure VASH3).[32]

Performance and Improvement Highlights

- The facility met the voucher use target (HMLS3) but did not meet the employment target (VASH3) for FY 2025 and the first two quarters of FY 2026.[33] Program staff reported that they did not meet the employment target because the program has only one employment specialist and lost several community employer partners. To improve employment outcomes, staff increased the number of job fairs and expanded community employer relationships. The employment specialist is also retraining program staff on documentation practices after discovering they incorrectly recorded some veterans as actively seeking work, which affected the metric.
- Program staff reported managing 1,308 housing vouchers at the time of the inspection. Due to high voucher use and an insufficient supply, they requested an additional 60 vouchers but only received 18 from the housing authority due to limited availability. The limited number of vouchers resulted in the program having to prioritize issuing vouchers to veterans with the highest need. In addition, veterans were unable to transition from HUD-VASH to traditional (city) housing vouchers due to funding constraints, which further restricted the number of available HUD-VASH vouchers for use.
- Staff emphasized several highlights, including the Keys to Progress program (a national program that provides a car to one veteran in every state). Social work staff submitted a write-up for the past three years and have won a car for a veteran each year, which they described as life-changing for the veteran. Staff also described a local company, Humble Designs, that fully redecorates three veterans' homes per month.
- At the time of the inspection, the program had several vacancies. Program staff reported they hired two interns into open positions as they were also limited to hiring internally. They were awaiting approval to hire for the remaining two vacancies.

[32] VHA sets the target for facilities to provide a minimum of 90 percent of their allotted housing vouchers to participants and at least 50 percent of the participants in the facility's program should be employed. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures.*

[33] For FY 2025, the facility's HMLS3 metric was 91.81 percent, and the VASH3 metric was 41.37 percent. For FY 2026, as of April, HMLS3 was 92.85 percent, and VASH3 was 41.05 percent.

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

Performance and Improvement Highlights

- The facility met its FY 2025 enrollment (VJP1) target. Program staff expressed concerns about meeting the target in FY 2026 because of a program position vacancy and high employee turnover at a local jail that reduced staff's ability to identify eligible veterans and facilitate enrollment in the program. In response, staff took a team approach to meet with all veterans at the jail on a given day and complete treatment assessments, which help to determine needs. The program has since filled the vacancy and is on pace to meet the FY 2026 target.
- Staff highlighted a new misdemeanor court that clears veterans' charges after successful completion of treatment and as of June 2026 they served two veterans. Staff also discussed using direct messaging (an encrypted messaging and information sharing platform) for veterans to coordinate medical and mental health care between the jail and the facility.
- Staff reported no vacancies and worked with veterans through 6 treatment courts (supervised programs that provide monitored treatment and other services), 15 jails, and 3 prisons in the states of Illinois and Indiana.

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

[35] VHA sets escalating targets for this measure at the facility level each year, with the goal to enroll all identified veterans by the end of the fiscal year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

Conclusion

To assist leaders in evaluating the quality of care at the VA Chicago Healthcare System, the OIG conducted an inspection across five domains. The OIG made one recommendation related to compliance with VHA's community care scheduling requirements. The OIG's findings and recommendation may help guide improvement at this and other VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

As to the OIG's Healthcare Facility Inspection program of VHA medical facilities across the nation, OIG leaders are aware of the ongoing transformation to VHA's management structure that could affect future areas of oversight. The OIG will monitor VHA's change management and maintain its focus on risks to the effectiveness and efficiency of VA programs, operations, and services that can affect the health and welfare of veterans and their families.

Appendix A: Methodology

The OIG team reviewed selected facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports.[36] 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 June 1 through 4, 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.[37] 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.*[38]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[39] 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.

[36] Accreditation reports covered the time frame of October 1, 2023, through September 30, 2025—the most recent available at the time of the inspection.

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

[38] 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.

[39] 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.[40] 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.

[40] 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 14, 2026

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

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

To: Director, Office of Healthcare Inspections (54HF02)

Chief Integrity and Compliance Officer (10OIC)

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

(Original signed by:)

Daniel S. Zomchek, Ph.D.
Veterans Integrated Service Network 3 Director, Veterans Health Administration

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: October 2, 2026

From: Director, VA Chicago Healthcare System (537)

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

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

1. Thank you for the opportunity to review and provide a response to the findings from the draft report, Healthcare Facility Inspection of the VA Chicago Healthcare System in Illinois.
2. A corrective action plan has been implemented as detailed in the attached report.
3. I appreciate the Office of Inspector General's partnership in our continuous improvement efforts for our Veterans.

(Original signed by:)

Sarah Unterman, MD, FACEP
Acting 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	Joanne Wasko, MSW, LCSW, Director Hanna Lin, MSW, LCSW, Project Leader Bina Patel, PhD, LCSW, Project Leader Bruce Barnes Jennifer Nalley, AuD, CCC-A
Other Contributors	Dianna Amick, MBA, BSN Kevin Arnhold, FACHE Jolene Branch, MS, RN Richard Casterline Kaitlyn Delgadillo, BSPH Jennifer Frisch, MSN, RN LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Sheeba Keneth, DNP, CNL Simon Kim, PhD Amy McCarthy, JD Daphney Morris, MSN, RN Sachin Patel, MBA, MHA Ronald Penny, BS Joan Redding, MA Larry Ross Jr., MS Rebecca Sloan, MHA, RN April Terenzi, BA, BS Tammra Wood, MSSW, LCSW-S 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 3: VA MidAmerica Health Network
Executive Director, Health Service Area 3.2
Director, VA Chicago Healthcare System (537)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
US Senate
  Illinois Tammy Duckworth, Dick Durbin
  Indiana: Jim Banks, Todd Young
US House of Representatives
  Illinois: Sean Casten, Danny Davis, Jonathan Jackson, Robin Kelly, Mike Quigley, Delia Ramirez, Jan Schakowsky, Brad Schneider, Lauren Underwood
  Indiana: Frank Mrvan

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.