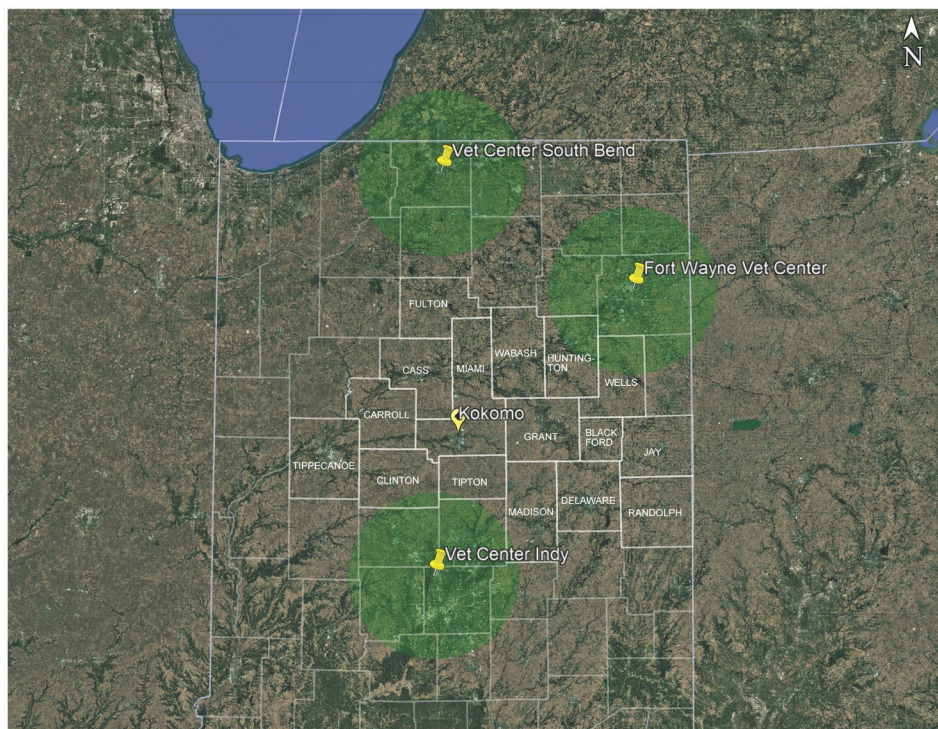




DAV Chapter 28
Kokomo, Indiana

North Central Indiana Regional Vet Center Feasibility Assessment Including Adjacent Regional Service Areas

*Evaluation of Veteran Service Accessibility,
Behavioral Health Access Conditions, and
Readjustment Counseling Service Considerations*



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Prepared by DAV Chapter 28 as an independent
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Prepared for informational and planning purposes.

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DISCLAIMER

This assessment was independently prepared by DAV Chapter 28, Department of Indiana, as a community-led evaluation of regional veteran service-access conditions within North Central Indiana and adjacent surrounding counties.

The contents of this report are intended solely for informational, planning, and stakeholder-engagement purposes. This assessment does not represent an official determination, recommendation, endorsement, or policy position of the U.S. Department of Veterans Affairs (VA), Readjustment Counseling Service (RCS), the Indiana Department of Veterans Affairs (IDVA), or any other governmental agency unless explicitly stated.

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Reasonable efforts were made to ensure analytical accuracy, methodological consistency, and source reliability at the time of publication. However, certain datasets, stakeholder inputs, service conditions, and organizational structures may evolve following publication.

TABLE OF CONTENTS

DISCLAIMER	2
LIST OF FIGURES	8
LIST OF TABLES	9
ACRONYMS & ABBREVIATIONS.....	10
EXECUTIVE SUMMARY	11
1 — METHODOLOGY	17
1.1 – Assessment Purpose.....	17
1.2 – Geographic Scope of Evaluation	17
1.3 – Assessment Framework	18
1.4 – Drive-Time Tier Classification Framework.....	20
1.4.1 Geographic Routing and Mapping Methodology	20
1.5 – Data Collection Methodology.....	21
1.6 – Stakeholder Engagement Process	22
1.6.1 Stakeholder Identification and Documentation	24
1.7 – Analytical Limitations and Constraints	24
2 — GEOGRAPHIC SERVICE GAP ANALYSIS	26
2.1 – Purpose of Geographic Analysis.....	26
2.2 – Geographic Scope of Analysis.....	26
2.3 – Analytical Framework for Geographic Access.....	27
2.4 – Data Sources and Methodology for Geographic Analysis.....	27
2.5 – Observed Geographic Access Conditions.....	29
2.6 – Analytical Considerations and Limitations.....	32
2.7 – Summary of Geographic Findings	33
3 — POPULATION AND DEMAND ANALYSIS	35
3.1 – Purpose of Population and Demand Analysis.....	35
3.2 – Data Sources and Methodology for Population and Demand Analysis.....	35
3.3 – Regional Veteran Population Overview	36
3.4 – Veteran Demographic Composition	38
3.5 – Indicators of Service Demand.....	40

3.6 – Summary of Population and Demand Findings	41
4 — BEHAVIORAL HEALTH AND RISK INDICATORS.....	43
4.1 – Behavioral Health System Capacity	43
4.1.1 System-Level Context.....	43
4.1.2 State-Level Behavioral Health Indicators (Indiana)	44
4.1.3 Interpretation — System Capacity vs. Demand.....	44
4.2 – Access Barriers and Service Friction.....	46
4.2.1 Geographic Access Constraints	46
4.2.2 Service Availability and Wait Times.....	47
4.2.3 Provider Availability and System Gaps	47
4.2.4 Compounding Access Factors.....	47
4.2.5 Observed Access Conditions	48
4.3 – Veteran Behavioral Health Risk Profile	48
4.3.1 Overview of Behavioral Health Risk Indicators	48
4.3.2 Clinical Severity and Co-Occurring Conditions	49
4.3.3 Demographic-Associated Risk Factors.....	50
4.3.4 System Interaction and Risk Exposure	50
4.3.5 Observed Behavioral Health Risk Conditions	51
4.4 – Compounding Risk and Socioeconomic Factors	51
4.4.1 Overview of Socioeconomic Context	51
4.4.2 Income and Poverty-Related Indicators.....	52
4.4.3 Employment and Economic Stability	52
4.4.4 Housing Stability and Environmental Conditions	52
4.4.5 Integrated Socioeconomic Context.....	52
4.5 – Summary of Behavioral Health and Risk Findings	53
5 — STAKEHOLDER VALIDATION.....	54
5.1 – Overview of Stakeholder Engagement	54
5.2 – Validation of Geographic Access Conditions.....	55
5.3 – Validation of Service Availability and Capacity Constraints	55
5.4 – Validation of Provider Availability and Service Appropriateness	56
5.5 – Validation of Behavioral Health Risk Conditions	56

5.6 – Validation of Socioeconomic and Environmental Factors	57
6 — INTEGRATED ANALYSIS AND COMPARATIVE POSITIONING.....	59
6.1 – Purpose and Role of Integrated Analysis.....	59
6.2 – Convergence of Geographic, Population, and Behavioral Health Findings	60
6.3 – Convergence of Stakeholder Validation and System Conditions	61
6.4 – Overall Integrated Assessment of Access and Need Conditions	62
6.5 – Analytical Summary	63
7 — SERVICE MODEL CONSIDERATIONS	64
7.1 – Purpose of Service Model Considerations.....	64
7.2 – Overview of Potential Service Models	65
7.3 – Community-Based Vet Center Model	66
7.4 – Expanded Mobile / Outreach Model.....	67
7.5 – Partnership-Based / Hybrid Model	68
7.6 – Comparative Considerations Across Models.....	69
7.7 – Summary of Service Model Considerations	70
8 — EVALUATION AND STRATEGIC CONSIDERATIONS	72
8.1 – Purpose of Evaluation and Strategic Considerations	72
8.2 – Evaluation Criteria Framework.....	73
8.3 – Evaluation of Community-Based Vet Center Model.....	74
8.4 – Evaluation of Expanded Mobile / Outreach Model	75
8.5 – Evaluation of Partnership-Based / Hybrid Model.....	76
8.6 – Comparative Evaluation Across Models	77
8.7 – Strategic Considerations and Pathway Forward	78
9 — CONCLUSIONS AND RECOMMENDATIONS	80
9.1 – Purpose of Recommendations.....	80
9.2 – Recommended Service Delivery Approach.....	81
9.3 – Supporting Considerations for Recommended Approach	81
9.4 – Implementation Considerations / Pathway	82
Appendix A — Methodology and Assessment Design	84
A.1 – Assessment Design Overview.....	84
A.2 – Geographic Methodology	84

A.3 – Data Collection Methodology	85
A.4 – Stakeholder Methodology	86
A.5 – Analytical Integration Method	86
A.6 – Limitations and Constraints	87
Appendix B — Stakeholder Engagement Documentation	88
B.1 – Stakeholder Classification Definitions	88
B.2 – Stakeholder Engagement Scope Summary	88
B.3 – Notes on Attribution	91
B.4 – Stakeholder Engagement Limitations	91
B.5 – Analytical Role of Stakeholder Engagement	92
Appendix C — Geographic and Mapping Products	93
C.1 – Purpose and Scope	93
C.2 – Mapping Methodology and Interpretation Notes	93
C.3 – Figure Inventory	94
C.4 – General Figure Notes	94
Appendix D — Quantitative Data Tables	100
D.1 – Regional Veteran Population Summary	100
D.2 – Veteran Age and Sex Distribution	102
D.3 – Veteran Era-of-Service Distribution	102
D.4 – Veteran Household Composition	103
D.5 – Quantitative Data Limitations	104
Appendix E — Behavioral Health & Access Indicators	105
E.1 – Behavioral Health Analytical Framework	105
E.2 – Behavioral Health Professional Shortage Area Context	105
E.3 – Suicide and Behavioral Health Context Indicators	106
E.4 – Digital Divide and Access-Condition Indicators	107
E.5 – Provider Capacity and Service-System Context	108
E.6 – Socioeconomic and Environmental Context	109
E.7 – Behavioral Health and Access Indicator Limitations	113
Appendix F — Source Documentation & Reference Framework	114
F.1 – Federal Veteran-Service and Readjustment References	114

F.2 – Purdue University Military Family Research Institute (MFRI) References.....	115
F.3 – Behavioral Health and Access-Condition References	115
F.4 – Geographic and Mapping References.....	115
F.5 – Community and Service-System References.....	116
F.6 – Stakeholder and Consultation Support	116
F.7 – Source and Reference Limitations.....	116
Appendix G — Supplemental Stakeholder & Qualitative Documentation	118
G.1 – Roundtable Engagement Context.....	118
G.2 – Generalized Qualitative Themes	118
G.3 – Service-System and Referral Observations.....	119
G.4 – Community and Veteran-Support Context	119
G.5 – Qualitative Methodology Controls.....	120
G.6 – Qualitative and Stakeholder Limitations.....	120
Appendix H — Comparative Vet Center Infrastructure Context	121
H.1 – Purpose and Context	121
H.2 – Comparative Vet Center Infrastructure Overview	122
H.2.1 Comparative Infrastructure Metrics	122
H.2.2 Supplemental VA Infrastructure Context	124
H.3 – Comparative Contextual Observations	125
H.4 – Analytical Limitations and Interpretive Considerations	126
H.5 – Appendix H Summary	127

LIST OF FIGURES

Figure 1.1	Vet Center Feasibility Assessment Framework	19
Figure 2.1	Veteran Population Distribution by Drive Time Access Tier	30
Figure 2.2	County Level Drive Time Access Classification	32
Figure 3.1	Veteran Population Distribution by County	38
Figure 3.2	Veteran Population by Era of Service	39
Figure 4.1	Regional Behavioral Health Access Environment Framework	45
Figure C.1	Baseline Vet Center Locations	97
Figure C.2	30-Minute Vet Center Drive Time Coverage	98
Figure C.3	60-Minute Vet Center Drive Time Coverage	99
Figure C.4	Rural-Urban Distribution and Access Context	100
Figure C.5	Digital Divide Index by County	101

LIST OF TABLES

Table 1.1	Summary of Data Collection Sources and Methodologies.....	22
Table 1.2	Vet Center Feasibility Roundtable Stakeholder Composition.....	23
Table 2.1	Observed Regional Drive-Time Access Classification Framework.....	28-29
Table 2.2	County-Level Veteran Population and Access Classification.....	31
Table 3.1	Regional Veteran Population Distribution by County.....	36
Table 3.2	Veteran Population Distribution by Access Tier.....	37
Table 3.3	Veteran Population by Sex.....	39
Table 3.4	Summary of Service Demand Indicators and Data Sources.....	40
Table 3.5	Behavioral Health and Service-Related Indicators.....	41
Table 4.1	Travel Time and Distance to Services.....	46
Table 4.2	Summary of Behavioral Health Risk Indicators.....	50
Table 4.3	Observed Behavioral Health Conditions at Point of System Entry.....	51
Table B.1	Stakeholder Engagement Summary.....	92
Table B.2	Stakeholder Participation & Classification Summary.....	92-93
Table B.3	Engagement Terminology Definitions.....	94
Table D.1	County-Level Veteran Population and Access Classification.....	103
Table D.2	Veteran Population by Age Group and Sex	104
Table D.3	Veteran Population by Era of Service	105
Table D.4	Veteran Household With and Without Children.....	105
Table E.1	Behavioral Health Indicators by Age Group.....	108
Table E.2	Behavioral Health Wait Times and Availability Constraints.....	109
Table E.3	Behavioral Health Provider Capacity and Availability Constraints.....	110
Table E.4	Clinical Indicators from Veterans Treatment Court Participants.....	111
Table E.5	Socioeconomic Indicators Summary.....	112
Table E.6	Veteran and Non-Veteran Population Below Poverty Line	113
Table E.7	Veteran and Non-Veteran Unemployment Rates.....	113
Table E.8	Housing Stability and Support Indicators	114
Table H.1	Comparative Vet Center Infrastructure Distribution by State.....	125
Table H.2	Supplemental VA infrastructure Context.....	126

ACRONYMS & ABBREVIATIONS

Acronym	Definition
BH	Behavioral Health
CFR	Code of Federal Regulations
CIT	Crisis Intervention Team
CoC	Continuum of Care
CVSO	County Veteran Service Officer
DAV	Disabled American Veterans
DDI	Digital Divide Index
DMHA	Division of Mental Health and Addiction
DOL	Department of Labor
GAO	U.S. Government Accountability Office
GIS	Geographic Information System
HHS	United States Department of Health and Human Services
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IDVA	Indiana Department of Veterans Affairs
MFRI	Military Family Research Institute
MST	Military Sexual Trauma
MVC	Mobile Vet Center
NCVAS	National Center for Veterans Analysis and Statistics
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
PTSD	Post-Traumatic Stress Disorder
RCS	Readjustment Counseling Service
SAMHSA	Substance Abuse and Mental Health Services Administration
SNAP	Supplemental Nutrition Assistance Program
SOP	Standard Operating Procedure
SSVF	Supportive Services for Veteran Families
SUD	Substance Use Disorder
TBI	Traumatic Brain Injury
U.S.C.	United States Code
VA	United States Department of Veterans Affairs
VBA	Veterans Benefits Administration
VFW	Veterans of Foreign Wars
VHA	Veterans Health Administration

EXECUTIVE SUMMARY

Purpose of Assessment

This assessment evaluates the potential need, feasibility, and strategic justification for expanded Vet Center services within the North Central Indiana service area. The analysis was initiated in response to preliminary indicators suggesting potential barriers to access for veterans seeking readjustment counseling and behavioral health services, including travel burden, service availability constraints, and stakeholder-identified concerns regarding unmet need.

The objective of this assessment is to provide a structured, evidence-based evaluation of regional service-access conditions to inform consideration of Vet Center service delivery options within the Department of Veterans Affairs Readjustment Counseling Service (RCS) framework.

Through integration of geographic analysis, population and demographic review, behavioral health indicators, stakeholder engagement, and comparative regional evaluation, the assessment identified recurring patterns of access limitation and service burden across multiple analytical domains affecting veterans within the evaluated region.

Geographic Scope

The assessment focuses on a multi-county region in North Central Indiana centered around Kokomo, encompassing a functional service area of 17 counties with a combined veteran population of approximately 45,987.

Geographic analysis indicates that:

- 0% of the veteran population resides within a ≤ 30 -minute access threshold to an existing Vet Center
- Approximately 40% reside within a 31–60 minute range
- Approximately 60% reside beyond 60 minutes

Collectively, these findings indicate that large portions of the evaluated veteran population lack practical localized access to existing Vet Center services under the assessment's functional drive-time framework. The geographic distribution of access conditions suggests that current Vet Center placement provides limited regional proximity for substantial portions of the assessed service area.

The tiered access framework utilized throughout this assessment was developed as an analytical tool intended to categorize relative travel burden and practical service accessibility conditions within the evaluated region. These thresholds were informed by practical transportation considerations, commonly utilized healthcare-access evaluation concepts, and comparative drive-time analysis rather than formal Department of Veterans Affairs access standards.

Population and Demand Context

The regional veteran population is geographically dispersed across both urban and rural communities, with significant variation in population density by county.

Key population characteristics include:

- Representation across multiple service eras, with a large proportion of Vietnam-era and post-9/11 veterans
- A predominantly older veteran population, alongside younger cohorts with elevated behavioral health risk indicators
- Household composition reflecting both independent and family-based support needs

Population distribution patterns indicate that service-access conditions affect a broad and dispersed veteran population rather than a single concentrated area. The evaluated conditions therefore represent a regional accessibility concern affecting multiple demographic groups, service eras, and community types across the broader assessment area.

Behavioral Health and Risk Environment

Behavioral health analysis identified measurable indicators of need within the regional veteran population, including:

- PTSD and co-occurring conditions
- Elevated suicide risk consistent with state and national veteran trends
- Evidence of delayed engagement with care, often occurring after escalation of conditions
- System-level indicators of sustained behavioral health demand
- Additional contextual factors include:
 - Behavioral Health Professional Shortage Area (HPSA) designations
 - Wait times of approximately 2–3 months for mental health services
 - Provider availability constraints, including limited military-specific cultural competency

These findings indicate a behavioral health environment characterized by sustained demand, access constraints, and clinical complexity. When evaluated in combination with the geographic-access findings, these indicators suggest that portions of the region may experience compounded barriers involving both physical access to Vet Center services and broader behavioral health service-system limitations.

Stakeholder Validation

Stakeholder engagement included participation from behavioral health providers, county veteran service officers, law enforcement, community organizations, and justice-system stakeholders.

Key validated observations include:

- Consistent reports of extended travel requirements for accessing services
- Service delays, scheduling challenges, and provider shortages affecting access
- Limited availability of providers with military-specific expertise
- High prevalence of co-occurring behavioral health conditions
- Socioeconomic factors (income, employment, housing) influencing service engagement

Stakeholder observations consistently reinforced the quantitative and geographic findings identified throughout the assessment, particularly regarding travel burden, delayed service engagement, provider-capacity limitations, and the limited availability of military-culturally competent behavioral health services within portions of the region.

Integrated Analysis

Synthesis of geographic, population, behavioral health, socioeconomic, and stakeholder data demonstrates multi-domain convergence of conditions affecting veterans within the region.

Key integrated findings include:

- Persistent travel burden associated with accessing existing Vet Center services
- Geographic dispersion of the veteran population across a broad regional area
- Behavioral health demand indicators occurring alongside provider-capacity limitations
- Stakeholder-validated reports of delayed engagement, referral burden, and service-access difficulty
- Evidence suggesting that barriers to access may disproportionately affect vulnerable or underserved veteran populations

The assessment did not identify a single isolated factor driving feasibility considerations. Rather, the findings demonstrate convergence across multiple independent analytical domains.

Geographic analysis identified substantial travel burden and limited localized Vet Center accessibility across the evaluated region. Population analysis confirmed that these access conditions affect a large and geographically dispersed veteran population spanning multiple service eras and demographic groups. Behavioral health indicators identified sustained demand conditions, provider shortages, and access limitations within the broader regional care environment. Stakeholder engagement further validated recurring operational concerns regarding service accessibility, delayed engagement, referral burden, and military-specific behavioral health support capacity.

When evaluated collectively, these findings support the conclusion that portions of North Central Indiana demonstrate conditions consistent with potential unmet or under-accessed Vet Center service demand warranting further consideration within the Readjustment Counseling Service planning framework.

Service Model Evaluation

Three primary service delivery approaches were evaluated:

- Community-Based Vet Center (Fixed Location)
- Expanded Mobile / Outreach Model
- Partnership-Based / Hybrid Model

Comparative evaluation indicates:

- The community-based model demonstrates the strongest alignment with continuity of care, provider specialization, structured service delivery, and localized veteran accessibility
- The mobile/outreach model demonstrates the strongest alignment with geographic reach and extension of access into underserved areas
- The hybrid model supports broader system integration opportunities but presents increased variability in coordination, consistency, and long-term operational continuity

No single model independently resolves all identified regional access conditions. However, comparative evaluation suggests that certain approaches may provide stronger alignment with the multi-domain findings identified throughout the assessment.

Conclusion

The assessment identifies a regional service environment characterized by:

- Lack of localized Vet Center access within functionally reasonable travel thresholds
- A geographically distributed veteran population with measurable behavioral health and readjustment-related needs
- System-level constraints affecting service availability, provider accessibility, and continuity of care
- Consistent multi-source validation of access barriers and service-access challenges across multiple stakeholder sectors

When evaluated collectively, these conditions establish a structured analytical basis supporting continued consideration of expanded Vet Center service accessibility within North Central Indiana and adjacent regional service areas.

Strategic Service Model Consideration

Based on the integrated analysis and comparative evaluation, the assessment identified a community-based Vet Center model as demonstrating the strongest overall alignment with the regional conditions evaluated throughout the assessment process.

Primary Consideration

Consideration of a community-based Vet Center presence within the North Central Indiana service area due to its relative alignment with:

- Continuity and consistency of care
- Localized service accessibility
- Military-culturally competent behavioral health support
- Structured readjustment counseling delivery
- Long-term regional service stability

Supporting Consideration

Incorporation of supplemental outreach and/or mobile-service elements to extend accessibility into geographically dispersed and underserved portions of the evaluated region.

Rationale for Recommendation

Potential service-access enhancement approaches identified throughout this assessment:

- Addresses the absence of localized, functionally accessible services
- Supports continuity and consistency of care for veterans with complex behavioral health needs
- Provides access to providers with military-specific expertise
- Extends reach into rural and underserved areas through outreach mechanisms
- Aligns with both quantitative findings and stakeholder-validated conditions

Implementation Considerations

Key considerations for any future evaluation or planning efforts may include:

- Geographic site selection and service-area definition
- Resource allocation and staffing requirements
- Integration of outreach components to support broader regional coverage
- Coordination with existing federal, state, and community-based service providers
- Continued stakeholder engagement to support future planning and evaluation efforts

Final Statement

This assessment provides a comprehensive, data-informed evaluation of Vet Center service accessibility within North Central Indiana. The findings establish a structured foundation for continued planning, evaluation, and informed decision-making regarding potential future Vet Center service-access considerations within the region.

The conclusions and considerations presented throughout this assessment are grounded in multi-domain analysis integrating geographic access conditions, population characteristics, behavioral health indicators, stakeholder engagement, and comparative regional evaluation. Collectively, these findings support continued strategic consideration regarding Vet Center service accessibility within North Central Indiana and adjacent regional service areas.

1 — METHODOLOGY

This section outlines the methodology and assessment design used in the development of this feasibility assessment. It establishes the analytical foundation supporting all subsequent findings by defining the purpose, geographic scope, evaluation framework, data collection methods, stakeholder engagement approach, and acknowledged limitations associated with this review.

The methodology is structured to support a balanced, multi-factor evaluation of Vet Center service accessibility within North Central Indiana through integration of quantitative analysis and qualitative stakeholder validation. This approach is intended to provide a comprehensive and evidence-informed assessment of regional service conditions while maintaining analytical objectivity and transparency.

The following subsections describe how each methodological component was applied and how data and stakeholder input were systematically incorporated into the evaluation process.

1.1 – Assessment Purpose

The purpose of this assessment is to evaluate the potential need, feasibility, and strategic justification for expanded Vet Center services within North Central Indiana through the development of a structured, community-informed analysis of regional veteran behavioral health and readjustment access.

This assessment was initiated in response to preliminary indicators suggesting that portions of North Central Indiana may experience barriers to accessing existing Vet Center services, including geographic travel burden, limited proximity to current service locations, and stakeholder-identified concerns regarding unmet veteran behavioral health and readjustment needs. The assessment seeks to determine whether sufficient evidence exists to support consideration of expanded Vet Center presence or service accessibility within the evaluated region.

To accomplish this objective, the assessment applies a structured multi-factor analytical framework described in Section 1.3.

The ultimate objective of this assessment is to produce a structured community feasibility analysis capable of informing future discussion, planning, and potential consideration by the U.S. Department of Veterans Affairs regarding Vet Center service accessibility within North Central Indiana.

1.2 – Geographic Scope of Evaluation

The geographic scope of this assessment focuses on North Central Indiana, with primary emphasis placed on the regional area centered around Kokomo, Indiana, and the surrounding communities identified as experiencing potential access limitations to existing Vet Center services.

The assessment area was selected based upon preliminary review of current Vet Center placement, regional veteran population distribution, stakeholder feedback, and observable travel-distance considerations associated with accessing existing Vet Center locations.¹

The assessment evaluates North Central Indiana as a functional service area rather than limiting analysis to fixed municipal or county boundaries. This approach reflects practical travel patterns, service utilization behaviors, and the multi-county structure of veteran support networks across the region.

The assessment includes consideration of travel-time and access-related factors, including review of existing Vet Center coverage areas, drive-time accessibility, and relative proximity between the evaluated region and currently established Vet Center service locations.

While Kokomo serves as the central reference point for the assessment due to its regional positioning and concentration of support infrastructure, the analysis is intended to evaluate broader regional accessibility conditions impacting veterans throughout the surrounding North Central Indiana area.

1.3 – Assessment Framework

This assessment utilizes a multi-factor community feasibility evaluation framework designed to examine regional Vet Center accessibility and potential service need through analysis of both quantitative and qualitative indicators. The framework was developed to provide a balanced, evidence-informed methodology for evaluating service accessibility conditions and determining whether sufficient indicators exist to support consideration of expanded Vet Center presence within the assessed region.

The assessment framework is structured across five primary analytical domains:

- Geographic Accessibility and Travel Burden
- Veteran Population and Demographic Distribution
- Behavioral Health and Service Demand Indicators
- Provider Capacity and Service Infrastructure
- Stakeholder and Community Validation

Rather than relying on a single metric, the framework integrates multiple analytical domains to provide a comprehensive evaluation of feasibility and comparative service-access conditions.

This structure combines objective statistical analysis with stakeholder-informed qualitative validation to capture both measurable service-access conditions and operational realities observed by community partners, providers, and veteran-serving organizations.

¹ U.S. Department of Veterans Affairs, Readjustment Counseling Service (RCS), Vet Center Locations and Directory, accessed during assessment development period.

Findings are evaluated holistically based on the cumulative weight and convergence of evidence across all domains. No single factor is treated as independently determinative.

To operationalize this framework, a structured data collection methodology was implemented as outlined in Section 1.4.

VET CENTER FEASIBILITY ASSESSMENT FRAMEWORK

Integrated Multi-Domain Methodology



Figure 1.1 - Vet Center Feasibility Assessment Framework

1.4 – Drive-Time Tier Classification Framework

For purposes of geographic analysis, this assessment utilized a tiered drive-time accessibility framework intended to evaluate relative travel burden and practical service accessibility conditions associated with existing Vet Center locations within the evaluated region.

The framework categorized estimated access conditions into three analytical tiers:

- Tier I – Functional Access (≤ 30 minutes)
- Tier II – Moderate Travel Burden (31–60 minutes)
- Tier III – Elevated Travel Burden (> 60 minutes)

These classifications were developed specifically for analytical purposes within this assessment and do not represent formal Department of Veterans Affairs or Readjustment Counseling Service access standards.

The tier thresholds were informed by practical transportation considerations, commonly utilized healthcare-access evaluation concepts², rural service-access realities, and comparative regional drive-time analysis. The framework was intended to provide a structured method for evaluating relative accessibility conditions across a geographically dispersed regional veteran population rather than to establish rigid operational or regulatory thresholds.

Within the context of behavioral health and readjustment counseling services, travel burden may influence continuity of care, appointment consistency, referral engagement, and practical service utilization, particularly within rural or underserved areas. Accordingly, the tiered framework was utilized as an analytical tool to support comparative regional assessment of accessibility conditions affecting the evaluated veteran population.

1.4.1 Geographic Routing and Mapping Methodology

Estimated drive-time accessibility and regional routing observations utilized throughout this assessment were developed through generalized roadway-network review and drive-time approximation methods using Google Earth Pro and publicly available transportation-routing information.³

The mapping products and estimated accessibility zones contained within this assessment are intended to function as analytical approximations supporting regional accessibility evaluation and are not intended to represent engineering-grade GIS modeling, real-time traffic analysis, or exact route-specific determinations for every potential travel scenario.

² General healthcare-access and travel-burden concepts referenced throughout this assessment are informed by commonly utilized healthcare accessibility evaluation methodologies and rural service-access considerations.

³ Google Earth Pro, Google LLC, utilized for generalized roadway-network review, regional accessibility approximation analysis, and travel-time modeling support during assessment development.

The geographic-access methodology described above was integrated with broader quantitative, demographic, behavioral health, and stakeholder data collection efforts to support the assessment's multi-factor analytical framework. The following section outlines the data collection methods utilized throughout the assessment process.

1.5 – Data Collection Methodology

Data utilized within this assessment was collected through a structured multi-source methodology designed to capture both quantitative and qualitative information relevant to evaluating Vet Center feasibility and service accessibility within North Central Indiana. The collection process incorporated publicly available statistical and demographic information, stakeholder-provided qualitative feedback, professional service-provider observations, and region-specific supplemental data submissions.

Quantitative data collection included review of veteran population estimates, demographic distribution information⁴, geographic accessibility modeling, behavioral health and service-demand indicators⁵, and related metrics derived from federal, state, academic, and institutional sources, supplemented by stakeholder-provided inputs. Publicly accessible governmental, academic, and organizational reporting tools were utilized to support data reliability and consistency.

Supplemental behavioral health, provider-capacity, and community-demand analysis incorporated review of publicly available veteran suicide-prevention reporting⁶, Behavioral Health Professional Shortage Area (HPSA) datasets⁷, and aggregated Indiana 211 regional service-request reporting and related utilization indicators⁸.

Qualitative data collection was conducted through structured stakeholder engagement efforts, including direct outreach, formal roundtable discussion, supplemental stakeholder questionnaires, and professional provider input requests. These collection efforts were designed to obtain practical field-level observations regarding veteran service utilization, perceived service gaps, provider capacity, behavioral health demand, referral challenges, and operational barriers affecting veterans within the assessed region.

⁴ Purdue University Military Family Research Institute (MFRI), *Measuring Communities: The State of Military and Veteran Families in the United States*, county-level demographic and veteran population datasets utilized throughout assessment analysis.

⁵ U.S. Department of Veterans Affairs, veteran population, utilization, and behavioral health reference datasets utilized during assessment development, including publicly available reporting and statistical resources.

⁶ U.S. Department of Veterans Affairs, *2025 National Veteran Suicide Prevention Annual Report*, statewide behavioral health and veteran suicide context data utilized for supporting analysis.

⁷ U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Behavioral Health Professional Shortage Area (HPSA) datasets utilized for provider-capacity and behavioral-health access evaluation.

⁸ Indiana 211 regional service-request datasets and aggregated utilization reporting provided during the assessment period and utilized as supplemental community-demand indicators.

Supplemental qualitative and observational data were also gathered through direct engagement with veteran service organizations, county veteran service officers, behavioral health providers, community partners, and related veteran-support stakeholders to ensure inclusion of practical operational perspectives from entities actively serving veterans throughout the evaluation area.

All collected information was reviewed, organized, and categorized according to the analytical framework established in Section 1.3 to support systematic evaluation across each domain.

Stakeholder-specific engagement methods are further detailed in Section 1.5.

Table 1.1 – Summary of Data Collection Sources and Methodologies

Data Type	Source	Methodology	Purpose
Quantitative	Purdue University MFRI	Data extraction and analysis	Population and demographic evaluation
Quantitative	U.S. Department of Veterans Affairs	Public data review	Behavioral health and utilization context
Quantitative	U.S. Department of Health and Human Services	Public data review	Provider shortage indicators
Quantitative	Indiana 211	Aggregated data analysis	Community demand signals
Qualitative	Stakeholder Roundtable	Structured discussion	Identify service gaps
Qualitative	Provider Input Sheets	Supplemental collection	Operational insight
Qualitative	Direct Outreach	Follow-up communication	Validate stakeholder input

1.6 – Stakeholder Engagement Process

The stakeholder engagement process for this assessment was designed to systematically capture multi-sector input regarding veteran service accessibility, behavioral health demand, and observed service gaps within North Central Indiana.

Engagement efforts were structured to ensure representation from key stakeholder groups directly involved in veteran support systems, including government entities, behavioral health providers, veteran service organizations, law enforcement, and community-based service providers.

A total of 58 stakeholders were identified through this process, reflecting a diverse cross-section of organizations and service domains. Participation included representation from government leadership, behavioral health providers, law enforcement agencies, veteran service organizations, healthcare systems, and community-based support networks.

This diversity of representation supports a multi-domain assessment approach and reduces reliance on any single-source perspective.

Formal engagement was conducted through a structured community roundtable session, supplemented by follow-up data collection efforts. Of those identified, 27 confirmed participation, with 15 attending the roundtable session. Additional stakeholders contributed through post-event follow-up and data-sharing commitments, ensuring continued input beyond the initial engagement event.

Table 1.2 summarizes the overall stakeholder engagement structure supporting this assessment, while expanded stakeholder classifications, participation documentation, and engagement details are provided in Appendix B.

Table 1.2 – Vet Center Feasibility Roundtable Stakeholder Composition

Engagement Category	Count
Total Stakeholders Identified	58
Anchor Stakeholders	24
Confirmed Participation	27
Roundtable Attendance	15
Stakeholder Sectors Represented	11

The composition of stakeholder participation demonstrates deliberate inclusion across multiple service domains relevant to veteran readjustment and behavioral health support.

Representation from government, behavioral health, law enforcement, and veteran-focused organizations provides a balanced cross-sector perspective, supporting the reliability of qualitative findings derived from stakeholder input.

It is important to note that stakeholder categories are not mutually exclusive, as several participating entities operate across multiple service domains (e.g., law enforcement agencies engaged in crisis response, or community organizations providing behavioral health support). As such, the classification framework reflects functional representation rather than discrete population segmentation.

The stakeholder engagement process serves as a critical qualitative validation component within the broader assessment framework, complementing quantitative analysis by incorporating direct field-level observations, operational insights, and community-identified service access challenges. Stakeholder input was evaluated as a qualitative supplement to, not a replacement for quantitative analysis.

1.6.1 Stakeholder Identification and Documentation

For purposes of methodological clarity and documentation transparency, stakeholders engaged in this assessment have been formally identified, categorized, and documented based on their organizational affiliation, functional role, and level of involvement in veteran-related service systems.

A complete listing of participating stakeholders, including organizational representation, functional roles, classification categories, and engagement type, is provided in **Appendix B – Stakeholder Engagement Documentation**. This appendix serves as the authoritative reference for stakeholder participation and supports traceability of qualitative inputs incorporated throughout the assessment.

Within the analytical framework of this report, stakeholder input is incorporated using a structured classification model to ensure consistent evaluation and appropriate weighting of qualitative data. Specific references to stakeholder groups throughout the report reflect aggregated input by stakeholder classification and functional role rather than individual attribution, except where explicitly noted and verifiable.

1.7 – Analytical Limitations and Constraints

While this assessment was developed utilizing a structured and multi-source methodology designed to provide a comprehensive review of regional Vet Center feasibility considerations, certain limitations and constraints should be acknowledged in evaluating the findings contained herein.

First, the assessment is based upon currently available public-source data, stakeholder-provided information, and supplemental qualitative observations available at the time of analysis.

As with any community-based assessment effort, data availability, reporting timelines, and source limitations may affect completeness or timeliness of certain referenced information.

Second, while stakeholder and provider input serves as an important qualitative validation component, such input reflects professional observations, experiential insight, and perceived operational conditions rather than independently verified quantitative measurement. Accordingly, stakeholder feedback is utilized within this assessment to supplement and contextualize broader data analysis rather than function as sole evidentiary basis for findings.

Third, this assessment constitutes an independent community-level feasibility evaluation intended to identify potential indicators of service-access need and strategic consideration. It does not constitute a formal Department of Veterans Affairs feasibility determination, operational review, or official federal site-selection analysis, and should not be interpreted as independently authorizing or guaranteeing future Vet Center establishment or service expansion.

Finally, this assessment is intended to evaluate broad regional trends and service-access conditions within the assessed geographic area; therefore, findings should be interpreted as reflective of general regional patterns and not necessarily as determinative of conditions affecting every individual veteran, provider, or locality within the broader evaluation area.

Despite these limitations, the methodology provides a balanced and evidence-informed assessment based on the best available information at the time of review.

The methodology established in this section provides the analytical foundation for the evaluation that follows. Subsequent sections apply this framework to examine geographic accessibility, population distribution, behavioral health indicators, and stakeholder-validated service conditions across the North Central Indiana region.

The following section applies this methodology to evaluate geographic service accessibility, which serves as the foundational analytical domain for assessing regional Vet Center access conditions.

2 — GEOGRAPHIC SERVICE GAP ANALYSIS

Geographic access to existing Vet Center services represents a core analytical component of this assessment due to its direct influence on service utilization, continuity of care, and overall accessibility of readjustment counseling services for veterans within the evaluated region.

Existing Vet Center locations serving Indiana are concentrated in South Bend, Fort Wayne, and the Indianapolis metropolitan area.⁹ While these locations provide established service coverage within their respective areas, their distribution results in uneven accessibility across North Central Indiana, particularly for communities located outside primary metropolitan corridors.

This section evaluates geographic accessibility using a drive-time-based analytical framework intended to approximate functional access under typical regional travel conditions. This approach emphasizes travel burden rather than straight-line distance and provides the geographic foundation for the population, behavioral health, and stakeholder analyses that follow.

Drive-time accessibility classifications referenced throughout this section reflect assessment-developed analytical categories intended to evaluate relative travel burden and practical service-access conditions rather than formal VA access standards.

2.1 – Purpose of Geographic Analysis

This section evaluates geographic accessibility to existing Vet Center services within the North Central Indiana assessment area to determine whether current service placement provides functionally reasonable access for veterans residing throughout the region.

The analysis examines proximity, travel-time burden, and general coverage patterns associated with existing Vet Center locations. Its purpose is to identify observable geographic access constraints and establish the regional access context within which subsequent assessment factors are evaluated.

Geographic analysis is not treated as a standalone or independent determinative measure of feasibility. Rather, it serves as one component within the broader evaluation framework, informing later analysis of veteran population distribution, behavioral health indicators, service demand, and stakeholder-validated access barriers.

2.2 – Geographic Scope of Analysis

The geographic scope of this analysis focuses on the North Central Indiana region, with primary emphasis on the service area centered around Kokomo, Indiana, and surrounding communities identified for evaluation within this assessment.

⁹ U.S. Department of Veterans Affairs, Readjustment Counseling Service (RCS), Vet Center Locations and Directory, accessed during assessment development period.

For purposes of this review, the geographic area is considered as a functional service region rather than being limited strictly to municipal or county boundaries.

This approach reflects practical travel patterns, regional service utilization behaviors, and the multi-county nature of veteran support networks operating within the area.

While Kokomo serves as the central analytical reference point due to its geographic positioning and role within the regional service network, the analysis evaluates accessibility conditions across the surrounding multi-county area as a whole.

Expanded geographic mapping products illustrating the North Central Indiana assessment region and existing Vet Center service locations are provided in Appendix C.

2.3 – Analytical Framework for Geographic Access

Geographic accessibility within this assessment is evaluated using a structured drive-time framework designed to approximate practical access to existing Vet Center service locations across the North Central Indiana service area.

This approach reflects roadway-based travel considerations rather than straight-line distance, providing a more realistic representation of how geographic positioning may influence veterans' ability to access services within the region.

For purposes of this assessment, geographic access conditions are categorized using a three-tier classification structure:

- **≤30 Minutes:** Represents a travel range generally associated with functional access to routine outpatient services, including behavioral health and readjustment counseling.
- **31–60 Minutes:** Represents a travel range in which access conditions may vary depending on individual circumstances, including frequency of required services, transportation availability, and other situational factors.
- **>60 Minutes:** Represents a travel range in which access conditions may present increased logistical considerations, particularly in the context of recurring service utilization or for individuals with additional access constraints.

These classifications are applied consistently across the geographic analysis to support standardized comparison of access conditions throughout the assessed region.

2.4 – Data Sources and Methodology for Geographic Analysis

Geographic analysis within this assessment is based on a structured review of spatial data, regional mapping inputs, and travel-time modeling designed to evaluate access conditions associated with existing Vet Center service locations across the North Central Indiana service area.

Data utilized in this analysis includes geographic location information for existing Vet Center facilities, regional population distribution references, and mapping-based travel-time estimations reflecting typical transportation conditions within the assessed region.

Where applicable, publicly available geographic and mapping tools were used to support consistent and replicable evaluation of travel-time accessibility.¹⁰

Travel-time estimates were developed using standard roadway-based routing assumptions in order to approximate real-world travel conditions. These estimates are intended to provide a general representation of access conditions and do not account for all potential variables, including traffic fluctuations, weather conditions, individual transportation availability, or route-specific variations that may affect travel time on a case-by-case basis.

Geographic data and travel-time classifications were applied uniformly across the assessed region to support comparative evaluation of access conditions among different communities and counties within the service area. This standardized application allows for consistent identification of relative access ranges based on the analytical framework established in Section 2.3.

Table 2.1 – Observed Regional Drive-Time Access Classification Framework

Component	Data Source	Methodology	Purpose
Veteran Population by County	Purdue University Military Family Research Institute (MFRI)	County-level demographic extraction and regional aggregation across the 17-county North Central Indiana Assessment Region	Establish baseline veteran population distribution within the assessment region
Geographic Coordinates (Anchor Point)	Kokomo, Indiana (city-center coordinates)	Centralized geographic reference point utilized for regional travel-time and access modeling	Define regional analytical anchor for service-access evaluation
Existing Vet Center Locations	U.S. Department of Veterans Affairs Readjustment Counseling Service (RCS)	Identification and mapping of existing Vet Centers, satellite locations, and relevant service-access points	Establish current regional Vet Center service network and proximity relationships
Drive-Time Modeling	GIS-based mapping and routing analysis tools (including Google Earth Pro and regional routing analysis)	Generalized travel-time approximation modeling utilizing roadway connectivity, regional transportation patterns, and estimated routing conditions	Evaluate practical geographic accessibility to existing Vet Center services

¹⁰ Google Earth Pro and publicly available roadway-routing information were utilized to support generalized regional drive-time approximation and geographic accessibility review.

Component	Data Source	Methodology	Purpose
Travel-Time Classification	Assessment analytical framework	County-level categorization utilizing ≤30-minute, 31–60-minute, and >60-minute estimated access thresholds	Define functional access tiers and identify potential regional service-access gaps
Regional Boundary Definition	North Central Indiana Assessment Region (17 counties)	Functional regional service-area methodology emphasizing veteran access patterns and regional connectivity rather than strict administrative boundaries	Reflect realistic veteran utilization geography and regional service relationships

The table above summarizes the primary data inputs, mapping tools, and classification assumptions used in the development of the geographic access model.

Geographic analysis is conducted using available data sources and reasonable modeling assumptions intended to support broad regional evaluation rather than precise point-specific measurement. Findings derived from this analysis are therefore intended to reflect general access patterns and conditions across the region.

These geographic findings are evaluated in conjunction with other assessment domains, including demographic analysis, behavioral health indicators, and stakeholder input, to support a comprehensive evaluation of service accessibility.

2.5 – Observed Geographic Access Conditions

Geographic access conditions within the North Central Indiana service area were evaluated through application of the drive-time framework described in Section 2.3 and the data sources outlined in Section 2.4.

This analysis examines the distribution of veteran populations relative to existing Vet Center service locations, with emphasis on the proportion of veterans residing within each defined access tier.

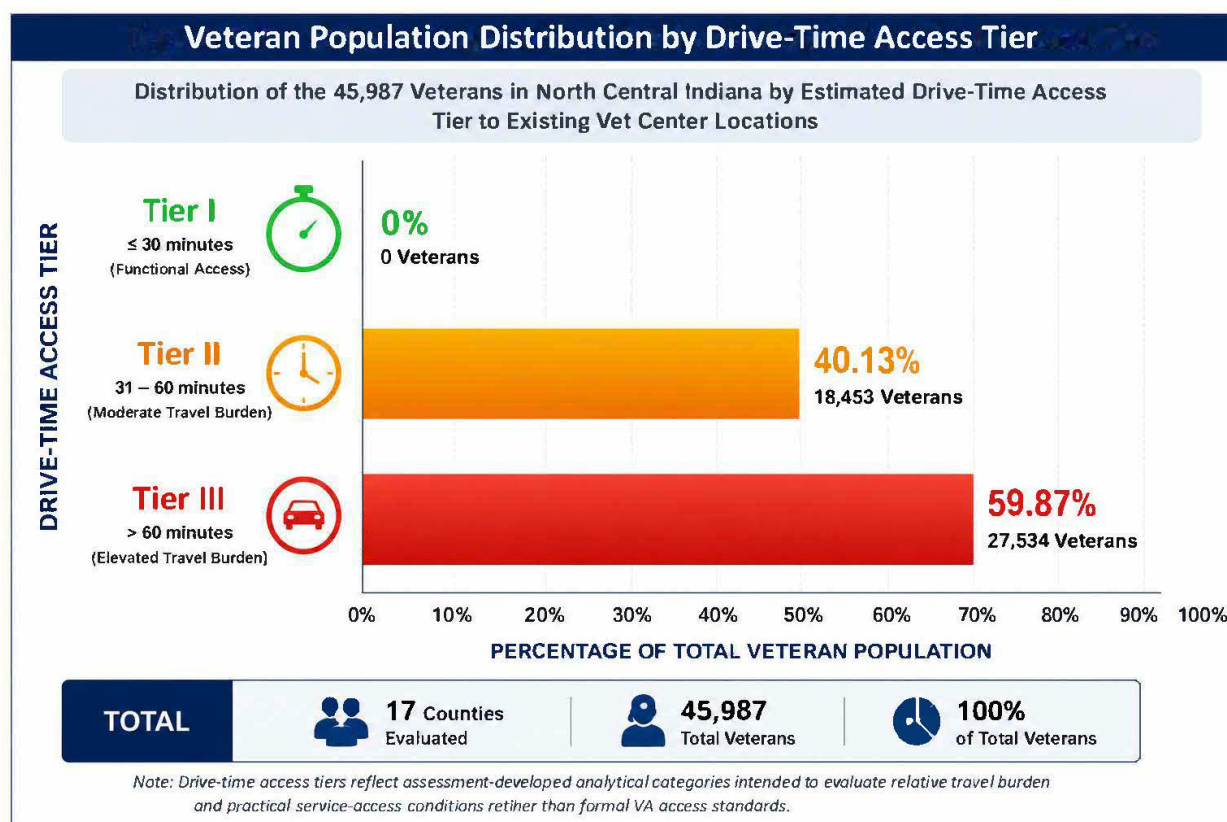


Figure 2.1 – Veteran Population Distribution by Drive-Time Access Tier

Note: Drive-time tiers are based on the geographic access framework defined in Section 2.3. Tier I represents functional access within approximately 30 minutes; Tier II represents moderate access within approximately 31–60 minutes; and Tier III represents extended access beyond 60 minutes. No counties within the assessed region meet the ≤30-minute threshold.

Figure 2.1 indicates that no portion of the assessed veteran population falls within the ≤30-minute functional access range. Approximately 40.13% of the veteran population falls within the 31–60-minute range, while 59.87% resides in areas classified within the >60-minute access range.¹¹

As depicted, 30-minute access coverage from existing Vet Center locations does not extend into the Kokomo-centered service area or much of the surrounding North Central Indiana region.

A substantial portion of the regional veteran population lacks immediate, functionally convenient access to Vet Center services.

¹¹ Purdue University Military Family Research Institute (MFRI), county-level veteran population data utilized for regional aggregation and drive-time access-tier distribution analysis.

This distribution suggests the presence of a geographic service-access gap at the ≤ 30 -minute level. This condition is further examined through expanded travel-time analysis, county-level population distribution, and stakeholder-informed validation of access barriers.

Supplemental geographic mapping products illustrating generalized 30-minute drive-time access approximations associated with existing Vet Center locations are provided in Appendix C.

Expanding the travel-time threshold to approximately 60 minutes increases theoretical service coverage; however, it also reflects a level of access that may involve increased travel burden depending on individual circumstances, transportation availability, and frequency of care needs.

Accordingly, while the 60-minute model reduces the proportion of the region considered entirely outside service reach, it does not resolve the access gap identified at the ≤ 30 -minute level. Instead, it demonstrates that a significant portion of the regional veteran population remains dependent on extended travel conditions to access Vet Center services.

Table 2.2 – County-Level Veteran Population and Access Classification

Access Tier	Counties	Veteran Population	% of Regional Total
Tier II (31–60 min)	8	18,453	40.13%
Tier III (>60 min)	9	27,534	59.87%

Table 3.2 summarizes regional veteran population distribution across the defined access classifications, while expanded county-level access classifications and veteran population tables are provided in Appendix D.

County-level analysis indicates that access conditions are not uniform across the region. Some counties are more closely associated with moderate travel-time ranges, while others are primarily classified within extended travel-time ranges. These differences reflect variation in proximity to existing Vet Center locations, roadway connectivity, population distribution, and regional travel patterns.

To further illustrate how geographic access conditions are distributed across the region, Figure 2.2 provides a county-level visualization of access classifications based on the defined drive-time tiers.

This spatial representation reinforces the distribution patterns identified in Figure 2.1 and Table 2.3 by highlighting the concentration of Tier II and Tier III access conditions across the North Central Indiana service area.

As a result, Figure 2.2 serves as a spatial synthesis of geographic analysis, supporting the conclusion that a substantial portion of the regional veteran population is positioned outside the ≤ 30 -minute threshold for functionally convenient access to Vet Center services.

These observed geographic conditions establish the access context for the population and demand analysis presented in Section 3.

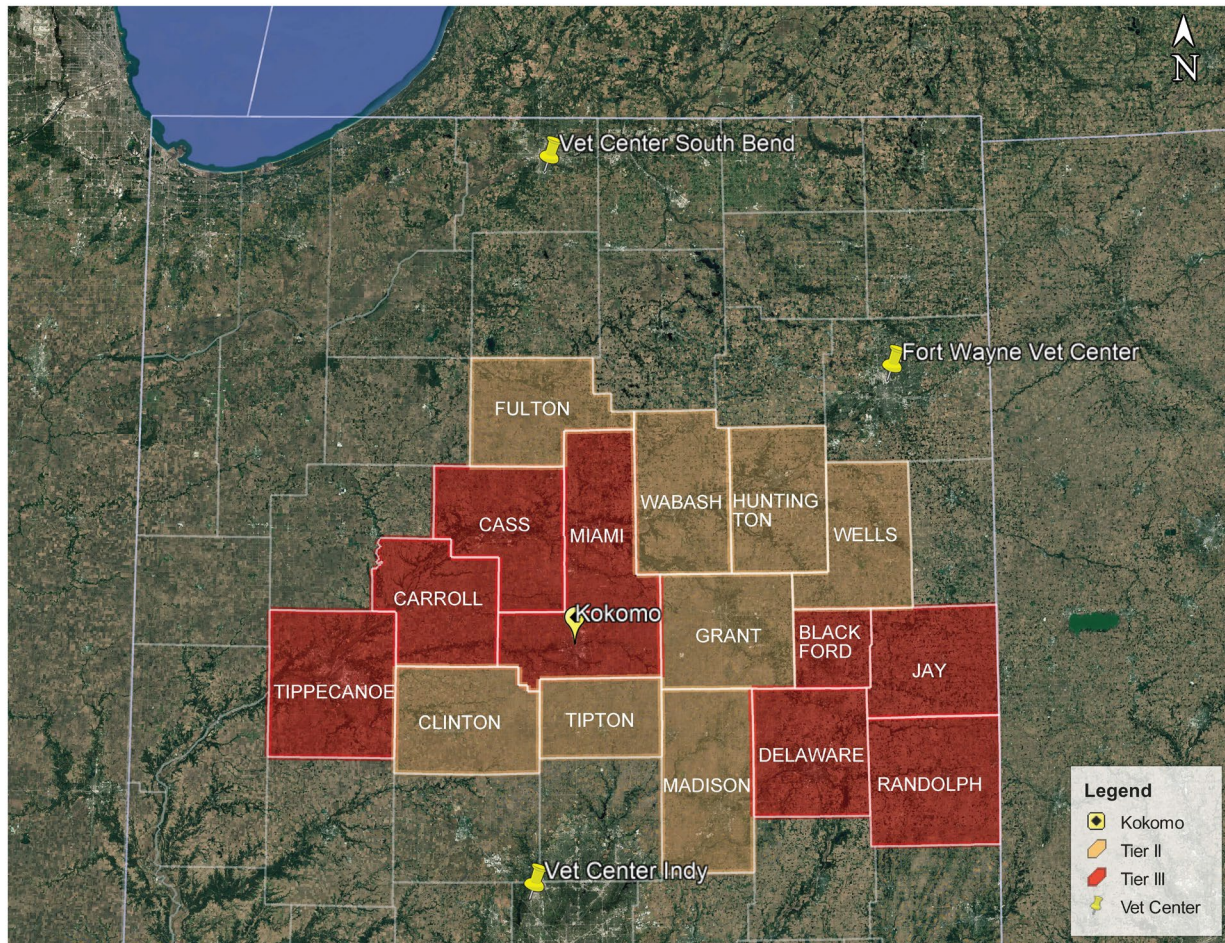


Figure 2.2 – County-Level Drive-Time Access Classification

2.6 – Analytical Considerations and Limitations

The geographic analysis presented in this section is based on modeled travel-time estimations and regional spatial data intended to support evaluation of general access conditions across the North Central Indiana service area. As with all modeling-based analyses, the results are subject to certain considerations and limitations.

Travel-time estimates are derived from standard roadway-based routing assumptions and are intended to approximate typical travel conditions.

These estimates do not account for all potential variables that may influence actual travel time, including traffic congestion, weather conditions, road construction, individual route selection, transportation availability, or mobility limitations.

Geographic accessibility also does not account for all factors that may influence service utilization.

Variables such as socioeconomic conditions, scheduling flexibility, service preferences, and individual willingness to engage care may affect whether and how veterans access available services. These factors are considered separately within other components of the assessment.

The analysis reflects current known locations of existing Vet Center services at the time of evaluation. Changes in service locations, operating schedules, mobile service availability, or satellite operations could affect access conditions in ways not captured within this analysis.

The access tiers used in this section are analytical classifications intended to describe relative travel conditions. They do not establish definitive thresholds of acceptable or inadequate access and should not be interpreted as independently determinative of service adequacy.

Consistent with the overall assessment methodology, geographic findings are evaluated in conjunction with additional domains, including population distribution, behavioral health indicators, and stakeholder input.

2.7 – Summary of Geographic Findings

The geographic analysis conducted in this section provides an overview of access conditions associated with existing Vet Center service locations across the North Central Indiana service area, based on the drive-time framework and methodology outlined in Sections 2.3 and 2.4.

Evaluation of travel-time–based access conditions indicates that no counties within the assessed region fall within the ≤ 30 -minute functional access threshold. Approximately 40.13% of the regional veteran population is classified within the 31–60-minute access range, while 59.87% is classified within the >60 -minute access range, indicating that a majority of veterans within the assessment region reside in areas associated with elevated travel burden to existing Vet Center services.

County-level analysis further demonstrates that access conditions are not uniform across the service area. Moderate and extended travel-time classifications vary by county, reflecting differences in geographic positioning, roadway connectivity, population distribution, and proximity to existing Vet Center service locations.

These findings establish that geographic access to existing Vet Center services within the North Central Indiana region is limited, with the full assessed veteran population located outside the threshold generally associated with functionally convenient access to routine outpatient and community-based services.

Consistent with the overall assessment methodology, these findings are not independently determinative.

They are intended to be evaluated in conjunction with population characteristics, behavioral health indicators, provider capacity, and stakeholder input in subsequent sections of this report.

The following section builds on this geographic access analysis by examining veteran population distribution and demand characteristics within the assessed region.

3 — POPULATION AND DEMAND ANALYSIS

Section 3 evaluates the veteran population within the North Central Indiana service area to establish a population-based foundation for assessing potential demand for Vet Center services. This analysis examines population size, demographic composition, and indicators associated with service demand to support understanding of how geographic access conditions may influence service utilization and engagement.¹²

The purpose of this section is to provide a structured population-level context that informs subsequent evaluation of behavioral health conditions, access constraints, and stakeholder-identified service needs. While population characteristics alone do not determine service feasibility, they represent a critical component of the multi-domain assessment framework established in Section 1.

3.1 – Purpose of Population and Demand Analysis

This section evaluates veteran population characteristics and service-demand indicators within the North Central Indiana assessment area in order to establish the scale, distribution, and general composition of the population potentially affected by Vet Center service accessibility conditions.

The analysis examines demographic and utilization-related data to provide context regarding the size, distribution, and composition of the veteran population within the assessed region. This includes consideration of population distribution, demographic characteristics, and indicators relevant to understanding potential service demand.

Population and demand analysis is not treated as a standalone or independently determinative measure of feasibility. Rather, it serves as one component within the broader evaluation framework, informing subsequent analysis of service accessibility conditions in relation to the regional veteran population.

3.2 – Data Sources and Methodology for Population and Demand Analysis

Population and demand analysis within this assessment is based on a structured review of demographic data, veteran population estimates, and service utilization indicators relevant to the North Central Indiana service area.

Primary data sources include publicly available demographic and veteran population datasets, with particular reliance on data provided by the Military Family Research Institute (Purdue University). These datasets provide county-level and regional-level information related to veteran population size, demographic composition, and selected indicators associated with veteran characteristics.

¹² Purdue University Military Family Research Institute (MFRI), county-level veteran demographic datasets utilized throughout regional population and distribution analysis.

Additional contextual inputs include aggregated service-demand indicators derived from Indiana 211. These data provide a general reference point for community-level demand patterns and are used as a proxy for broader service utilization trends where veteran-specific data is not available.

Population estimates and demographic indicators were compiled and evaluated at both county and regional levels to support comparative analysis across the North Central Indiana service area.

Data is interpreted as a general representation of conditions within the assessed region and may reflect reporting lags or aggregated timeframes depending on source availability. Findings derived from this analysis are evaluated in conjunction with geographic access conditions, behavioral health indicators, and stakeholder input to support a comprehensive multi-factor assessment.

3.3 – Regional Veteran Population Overview

Table 3.1 – Regional Veteran Population Distribution by County

Metric	Value
Total Veteran Population	45,987
Number of Counties	17
Highest Population County	Madison County (8,238)
Second Highest Population County	Tippecanoe County (6,538)
Third Highest Population County	Howard County (5,164)
Fourth Highest Population County	Delaware County (5,052)
Lowest Population County	Blackford County (738)
Counties Classified Tier III (>60 min)	9
Tier III Veteran Population	27,534
% of Veterans in Tier III	59.87%

Source: Purdue University Military Family Research Institute (MFRI), county-level veteran population datasets aggregated for regional assessment analysis.

The regional veteran population totals approximately 45,987 individuals across 17 counties, with population distribution varying significantly by county. Madison County represents the largest concentration, followed by Tippecanoe and Howard Counties, while several rural counties maintain comparatively smaller veteran populations.

This distribution reflects a regional population structure characterized by a small number of higher-density counties and a broader set of lower-density rural areas.

Population scale and distribution provide context for understanding the regional impact of service accessibility conditions identified in Section 2.

Table 3.2 – Veteran Population Distribution by Access Tier

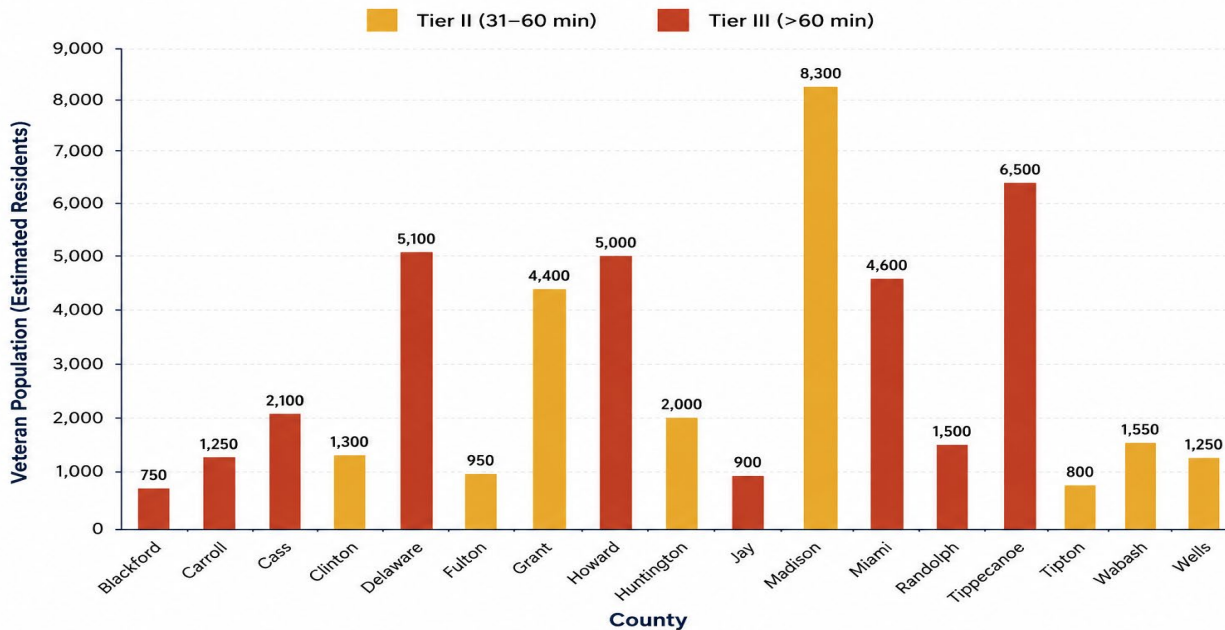
Drive-Time Tier	Veteran Population	% of Total
≤30 minutes (Tier I)	0	0.0%
31–60 minutes (Tier II)	18,453	40.1%
>60 minutes (Tier III)	27,534	59.9%
TOTAL	45,987	100%

Source: Assessment-derived calculations utilizing Purdue University MFRI veteran population data and assessment-developed drive-time accessibility classifications.

Table 3.2 presents estimated veteran population distribution across defined drive-time access tiers within the North Central Indiana service area.

These estimates indicate that no portion of the regional veteran population falls within the ≤30-minute access range, while approximately 40.1% resides within the 31–60 minute range and 59.9% within the >60-minute range.

This distribution aligns population exposure directly with the geographic access conditions identified in Section 2 and demonstrates that the full assessed veteran population is subject to moderate or extended travel-time conditions when accessing existing Vet Center services.



Source: Purdue University Military Family Research Institute (MFRI), Veteran Demographic Data (2024).

Figure 3.1 – Veteran Population Distribution by County

3.4 – Veteran Demographic Composition

Veteran demographic characteristics within the North Central Indiana service area were evaluated to provide context regarding the composition of the population identified in Section 3.3. This analysis examines selected indicators including age distribution, sex distribution, era of service, and household characteristics.

These indicators are used to describe regional population structure and support comparative analysis relevant to service accessibility considerations.

Expanded demographic distribution tables, including age, sex, era-of-service, and household composition data, are provided in Appendix D and support broader contextual interpretation of regional veteran population characteristics.

Review of age distribution indicates a concentration within older age cohorts, with representation across all age groups. Sex distribution reflects a predominantly male population, with female veterans representing a smaller but meaningful proportion of the overall population.

Table 3.3 – Veteran Population by Sex

Sex	Estimated Veteran Population	Percentage of Regional Veteran Population
Male	42,126	91.6%
Female	3,861	8.4%
Total	45,987	100.0%

Source: Purdue University Military Family Research Institute (MFRI), Veteran Demographic Data (2024).

Note: Percentages are based on the finalized 17-county regional assessment baseline.

Expanded era-of-service demographic distributions are provided in Appendix D and support contextual interpretation of generational composition within the regional veteran population.

This distribution reflects a mix of generational cohorts within the regional veteran population and provides context for understanding variation in population characteristics.

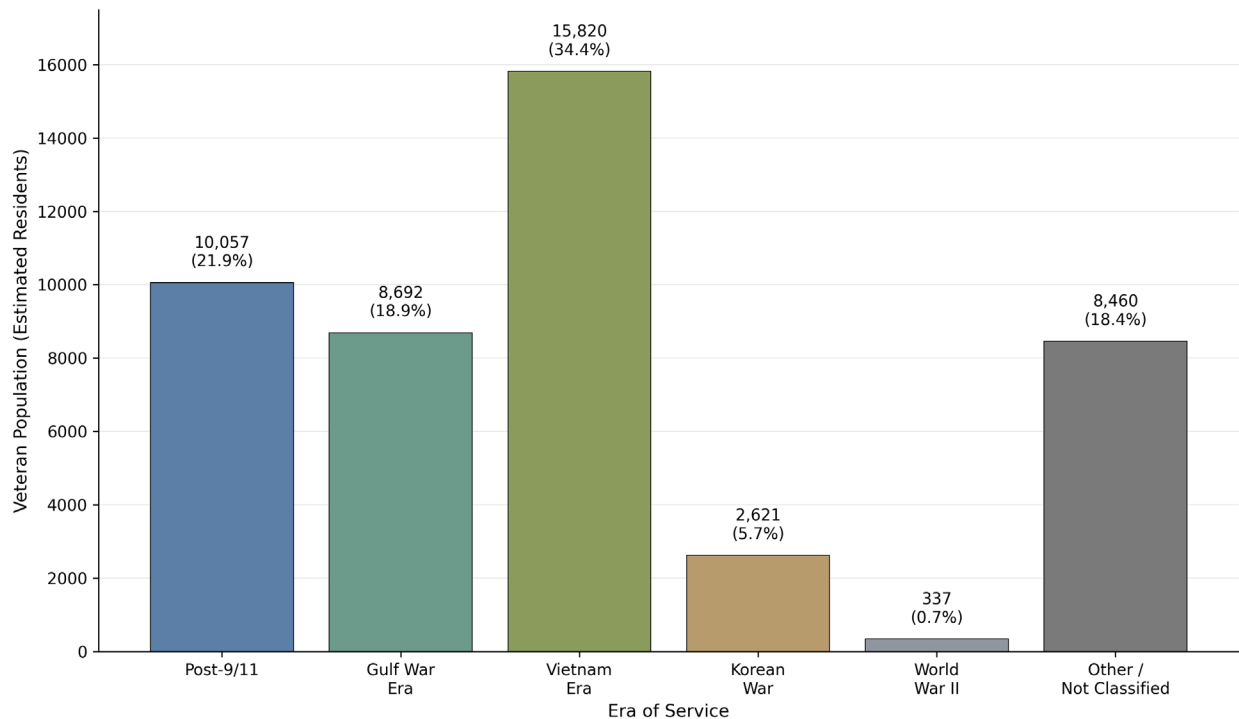


Figure 3.2 – Veteran Population by Era of Service

Source: Purdue University Military Family Research Institute (MFRI), Veteran Demographic Data (2024).

Note: Percentages reflect proportional distribution within the finalized 17-county regional veteran population baseline. Era classifications are based on MFRI county-level veteran demographic reporting categories.

Expanded veteran household composition data is provided in Appendix D and supports contextual understanding of veteran family composition across the assessed region.

Household distribution indicates that the majority of veteran households do not include children, with a smaller proportion representing households with dependents.

3.5 – Indicators of Service Demand

Indicators of potential service demand within the North Central Indiana service area were evaluated using available data sources to provide contextual understanding of conditions associated with utilization of behavioral health and related support services.

This analysis incorporates selected indicators derived from demographic data, behavioral health measures, and community-level demand signals to support interpretation of potential service demand patterns within the region.

Table 3.4 – Summary of Service Demand Indicators and Data Sources

Indicator Category	Indicator	Data Source
Demographic	Veteran Age Distribution	Purdue University Military Family Research Institute (MFRI)
Demographic	Veteran Era of Service Distribution	Purdue University Military Family Research Institute (MFRI)
Demographic	Veteran Household Composition	Purdue University Military Family Research Institute (MFRI)
Behavioral Health	Behavioral Health Professional Shortage Areas (HPSAs)	U.S. Department of Health and Human Services (HHS)
Behavioral Health	Veteran Suicide Rate Indicators	U.S. Department of Veterans Affairs (VA)
Community Demand	Veteran-Related Service Request Data	Indiana 211

The table above summarizes the primary indicators considered in this analysis, including demographic characteristics, behavioral health–related measures, and aggregated service-demand signals.

These indicators are evaluated as contextual measures and provide supporting insight into population-level conditions relevant to service utilization.

Table 3.5 – Behavioral Health and Service-Related Indicators

Indicator	Description	Interpretation Context
Behavioral Health Professional Shortage Areas	Geographic areas identified as lacking adequate behavioral health provider capacity	Used to evaluate potential behavioral health service-access limitations within the assessed region
Suicide Rates	State-level suicide rate data for veteran and non-veteran populations	Provides contextual insight regarding the broader behavioral health risk environment
Demographic Distribution	Veteran population characteristics including age, sex, and era-of-service composition	Used to evaluate regional veteran population structure and potential service-access considerations
Household Composition	Distribution of veteran households with and without dependent children	Provides contextual insight regarding family composition and potential support-system considerations
Service Request Data	Aggregated Indiana 211 service-request and referral activity data	Utilized as a proxy indicator for broader community-level service demand and support-access trends

Behavioral health–related indicators and community-level demand signals provide additional context regarding conditions within the region that may influence service utilization patterns.

These indicators reflect variation across geographic areas and population groups and are interpreted as general measures of regional conditions rather than direct indicators of individual service use.

3.6 – Summary of Population and Demand Findings

The population and demand analysis conducted in this section provides an overview of veteran population size, distribution, demographic composition, and selected indicators associated with service demand within the North Central Indiana service area.

Evaluation of population distribution indicates that the regional veteran population is dispersed across multiple counties, with variation in population concentration reflecting both urbanized and rural characteristics.

Demographic analysis demonstrates representation across multiple age groups, service eras, and household structures, providing context for understanding variation in population composition across the region.

Indicators associated with service demand provide additional context regarding conditions that may influence regional service utilization patterns.

Consistent with the overall assessment methodology, indicators presented in this section are not independently determinative of service demand or feasibility. Rather, they are evaluated as part of a broader multi-factor framework and are considered in conjunction with geographic access conditions, population characteristics, and stakeholder input in subsequent sections of this assessment.

Collectively, this analysis establishes a population and demand context that supports continued evaluation of service accessibility conditions within the North Central Indiana region.

4 — BEHAVIORAL HEALTH AND RISK INDICATORS

Section 4 provides a multi-factor analysis of behavioral health conditions and associated risk factors affecting the veteran population within the North Central Indiana service area. The analysis examines system-level service capacity, access conditions, clinical risk indicators, and socioeconomic factors that may influence both the prevalence of behavioral health conditions and the ability of veterans to engage with available services.

This section is structured across five analytical domains. Section 4.1 examines system-level behavioral health capacity and high-level demand indicators. Section 4.2 evaluates access barriers and service friction. Section 4.3 analyzes clinical and behavioral health risk indicators. Section 4.4 provides contextual analysis of socioeconomic factors. Section 4.5 synthesizes these elements to describe the overall behavioral health and risk environment within the region.

Consistent with the overall assessment methodology, findings presented in this section are descriptive and analytical in nature and are not independently determinative. These indicators are evaluated in conjunction with geographic access conditions, population characteristics, and stakeholder input.

The analysis begins with system-level behavioral health capacity to establish the broader context within which regional access and demand conditions are evaluated.

4.1 – Behavioral Health System Capacity

Section 4.1 examines behavioral health system capacity at the national and state levels to establish the broader context within which regional access and demand conditions are evaluated. This includes review of system infrastructure, service distribution, and high-level demand indicators relevant to veteran behavioral health.

4.1.1 System-Level Context

The behavioral health system serving veterans in Indiana operates within a broader national framework characterized by high demand and constrained access capacity. The Department of Veterans Affairs (VA), through the Veterans Health Administration (VHA), provides services to over 6.33 million unique patients annually.¹³

Within this system, mental health conditions—particularly those associated with readjustment—represent a significant portion of care demand. Nationally, hundreds of thousands of veterans are

¹³ U.S. Department of Veterans Affairs, Veterans Health Administration (VHA) utilization and patient-volume reporting referenced during assessment development.

compensated for PTSD alone,¹⁴ indicating sustained long-term behavioral health service requirements.

At the infrastructure level, the VA operates approximately 300 Vet Centers nationwide,¹⁵ designed specifically to provide community-based readjustment counseling services outside of traditional clinical environments, thereby serving as localized access points for veterans experiencing reintegration challenges.

However, the distribution and expansion of these facilities are not purely demand-driven. According to the Government Accountability Office, the Readjustment Counseling Service (RCS) lacks fully developed strategic asset planning tied to mission demand, does not consistently validate or document modeling assumptions for future site placement, and has gaps in prioritizing new locations based on need.¹⁶ This indicates that the current Vet Center footprint may not fully reflect current or region-specific behavioral health demand.

4.1.2 State-Level Behavioral Health Indicators (Indiana)

At the state level, behavioral health demand among veterans is measurable through suicide data, which serves as a high-severity indicator of unmet or insufficient behavioral health support.

According to the VA's 2023 Veteran Suicide Data Sheet, 149 veteran suicide deaths occurred in Indiana in 2023. The veteran suicide rate is 39.9 per 100,000.¹⁷ While Indiana aligns with national veteran suicide rates, the rate remains significantly higher than that of the general population.

This distinction highlights that, while Indiana aligns with national veteran trends, veterans experience substantially higher suicide risk than non-veterans, reinforcing the need for targeted behavioral health infrastructure.

Age-stratified observations indicate that the 18–34 age group demonstrates the highest relative suicide rate at 67.6 per 100,000, with sustained elevated rates across the 35–74 age groups indicating broad, cross-generational demand for behavioral health services.¹⁸

4.1.3 Interpretation — System Capacity vs. Demand

When considered collectively, these indicators reflect a measurable relationship between system capacity and behavioral health demand.

¹⁴ U.S. Department of Veterans Affairs behavioral health and disability-compensation reporting utilized for contextual evaluation of veteran behavioral health demand.

¹⁵ U.S. Department of Veterans Affairs, Readjustment Counseling Service (RCS), national Vet Center program information and facility inventory accessed during assessment development.

¹⁶ U.S. Government Accountability Office (GAO), *VA Readjustment Counseling Service: Actions Needed to Improve Data and Strategic Planning for Vet Centers*, GAO-25-106781.

¹⁷ U.S. Department of Veterans Affairs, *2023 Veteran Suicide Data Sheet: Indiana*, utilized for statewide veteran behavioral health context analysis.

¹⁸ U.S. Department of Veterans Affairs suicide-prevention reporting and age-stratified veteran suicide-rate analysis utilized for contextual behavioral health evaluation.

System capacity indicators, including the number and distribution of Vet Centers and limitations in strategic placement modeling, suggest that existing infrastructure may not be fully aligned with current demand patterns.

Demand indicators, including elevated suicide rates relative to the general population and sustained risk across multiple age cohorts, reflect ongoing behavioral health needs within the veteran population.

Taken together, these observations indicate that behavioral health demand is sustained while service distribution may not be fully aligned with observed patterns of need, particularly within community-based counseling infrastructure.

Figure 4.1 provides a conceptual synthesis of the behavioral health access environment evaluated throughout this assessment. The figure is intended to illustrate the relationship between regional access constraints, provider-capacity limitations, behavioral health risk indicators, and broader socioeconomic conditions that collectively influence veteran behavioral health service engagement within the assessed region.

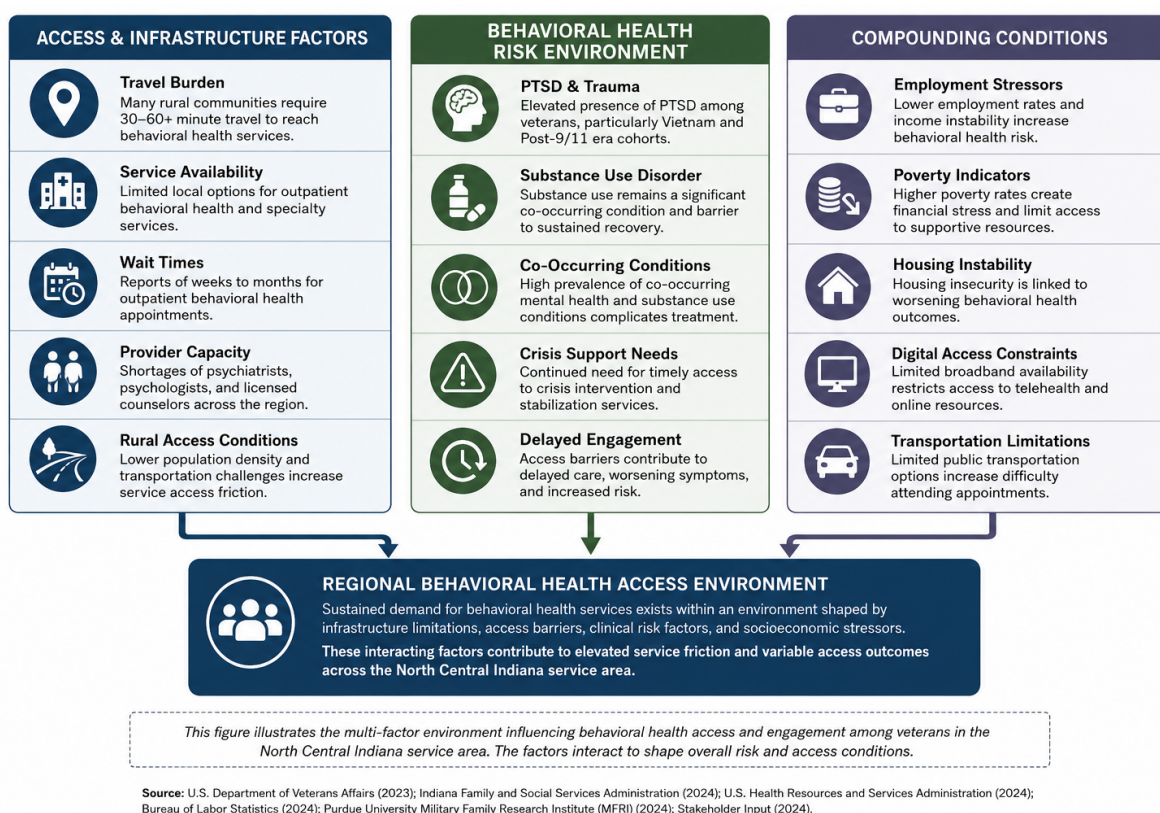


Figure 4.1 – Regional Behavioral Health Access Environment Framework

As illustrated in Figure 4.1, behavioral health access conditions within the assessed region are not attributable to a single isolated factor. Rather, observed service-access conditions reflect the combined interaction of geographic travel burden, provider-capacity limitations, behavioral

health demand indicators, and broader socioeconomic conditions that may affect continuity of care, service utilization, and timely engagement with behavioral health resources. Consistent with the assessment methodology, these conditions were evaluated collectively as part of a multi-factor regional feasibility framework rather than as independently determinative variables.

4.2 – Access Barriers and Service Friction

Section 4.2 evaluates access barriers and service friction affecting the ability of veterans within the North Central Indiana service area to engage with behavioral health services.

This includes analysis of geographic constraints, service availability, provider capacity, and additional factors influencing access conditions.

4.2.1 Geographic Access Constraints

Access to behavioral health services for veterans within the North Central Indiana service area is influenced by the geographic distribution of existing service infrastructure and associated travel requirements.

Available data from Veterans Treatment Court participants indicates that approximately 80 percent of participants travel more than 30 minutes to access services, while approximately 20 percent travel more than 45 minutes. Average travel distances are reported to range between 30 and 45 miles. These travel patterns reflect the geographic distribution of available providers relative to veteran populations within the region.

The following table summarizes key indicators related to geographic access conditions, providing structured representation of observed travel patterns and service accessibility within the assessed region.

Table 4.1 – Travel Time and Distance to Services

Metric	Observed Value	Source	Analytical Relevance
Reported Travel Time to Services	30–60 minutes for most veterans	County Veteran Service Officer Data	Indicates moderate to high geographic access burden
Extended Travel Time	>45 minutes for a subset of veterans	County Veteran Service Officer Data	Reflects elevated access barriers in rural areas
Average Travel Distance	30–45 miles	County Veteran Service Officer Data	Reinforces spatial mismatch between population and services
Referral Destinations	Marion VA and Hoosier VA	County Veteran Service Officer Data	Indicates reliance on distant service hubs
Local Service Availability	No Vet Center within ~60 miles	County Veteran Service Officer Data	Demonstrates absence of localized readjustment counseling
Transportation Barriers	Mobility and transport limitations reported	County Veteran Service Officer Data	Compounds geographic access constraints

Metric	Observed Value	Source	Analytical Relevance
Impact on Utilization	Veterans decline referrals due to travel	County Veteran Service Officer Data	Shows access barriers affecting engagement behavior
Alignment with Access Model	Tier II / Tier III classification	Comparative Analysis	Confirms modeled access burden

Table 4.1 summarizes observed travel times, distances, and service access patterns within the assessed region. These indicators provide a structured representation of travel burden experienced by veterans accessing behavioral health services.

Geographic access constraints are further influenced by the spatial distribution of service providers, which are not uniformly located across the region. As a result, veterans residing in certain areas may experience increased travel requirements relative to others.

4.2.2 Service Availability and Wait Times

In addition to geographic considerations, access to behavioral health services is influenced by service availability and system capacity constraints.

Stakeholder input from county-level veteran service providers indicates that reported wait times for mental health services range between two to three months. Appointments may be subject to cancellation or rescheduling with limited notice, and these delays may result in veterans declining or discontinuing pursuit of services.

Expanded behavioral health service wait-time and availability indicators supporting this analysis are provided in Appendix E.

4.2.3 Provider Availability and System Gaps

Access to behavioral health services is also affected by the availability of providers with appropriate specialization and capacity to serve veteran populations. Stakeholder input indicates that there is a limited number of providers with military-specific cultural competency, that loss or reduction of available providers may impact system capacity, and that certain services may not be consistently available across all areas of the region.

Expanded provider-capacity and behavioral health service-availability indicators supporting this analysis are provided in Appendix E.

4.2.4 Compounding Access Factors

Access barriers are further influenced by additional factors that may affect the ability of veterans to engage with available services.

These factors include rural geographic characteristics present in portions of the service area, digital access limitations as indicated by Digital Divide Index data, transportation constraints

affecting travel to service locations, and variability in localized provider availability and infrastructure capacity.

Supplemental geographic and infrastructure-context mapping products provided in Appendix C support interpretation of these regional conditions and provide additional contextual insight regarding rurality, transportation conditions, and technology-access considerations across the assessed region.

Together, these factors provide contextual insight into broader environmental conditions that may influence behavioral health access and continuity of care. While digital access does not appear to represent the primary differentiating constraint across the region, rurality, travel burden, service availability, and provider-capacity limitations remain relevant factors influencing observed access conditions.

4.2.5 Observed Access Conditions

Taken together, geographic travel requirements, service availability constraints, provider limitations, and additional access-related factors describe the operational conditions under which veterans attempt to engage with behavioral health services within the assessed region.

Observed access conditions indicate that service engagement may be influenced by a combination of travel burden, provider availability, scheduling delays, infrastructure limitations, and variability in localized service capacity. These conditions do not affect all portions of the service area uniformly and may contribute to differing patterns of service utilization and continuity of care across the region.

Consistent with the overall assessment methodology, these observations are descriptive and are evaluated in conjunction with behavioral health indicators, demographic characteristics, and stakeholder input presented in subsequent sections.

Analysis of behavioral health risk indicators provides additional context regarding the nature and severity of conditions associated with these observed access patterns.

4.3 – Veteran Behavioral Health Risk Profile

Section 4.3 examines behavioral health risk indicators observed within the veteran population, including clinical conditions, demographic-associated risk factors, and system interaction patterns. This analysis provides insight into the nature and severity of behavioral health conditions within the assessed region.

4.3.1 Overview of Behavioral Health Risk Indicators

This section examines behavioral health risk within the veteran population of the North Central Indiana service area using clinical indicators, demographic characteristics, and contextual data to describe the presence and distribution of behavioral health conditions.

Primary indicators considered in this analysis include the prevalence of post-traumatic stress disorder (PTSD), substance use disorder (SUD), co-occurring conditions, and other behavioral health diagnoses observed within available datasets.

Table 4.2 – Summary of Behavioral Health Risk Indicators

Metric	Observed Value	Source
PTSD Prevalence	Frequently observed among veterans seeking services	Stakeholder Roundtable Input + County Veteran Service Officer Data
Substance Use Disorder (SUD)	Commonly observed in conjunction with behavioral health conditions	Stakeholder Roundtable Input
Co-Occurring Conditions	Multiple behavioral health conditions frequently present simultaneously	Stakeholder Roundtable Input
Crisis Support Needs	Crisis-related requests commonly reported	County Veteran Service Officer Data
Severity of Conditions	High-acuity conditions frequently observed at time of engagement	Assessment Analysis
Alignment with Demand Indicators	Consistent with increasing behavioral health demand across service area	Comparative Analysis

Table 4.2 summarizes key behavioral health indicators derived from available data sources, including observed prevalence of conditions and patterns of clinical presentation within the veteran population.

4.3.2 Clinical Severity and Co-Occurring Conditions

Data derived from Veterans Treatment Court participants provides a measured view of behavioral health conditions among a subset of veterans engaged in structured intervention programs.

Observed clinical indicators include high prevalence of PTSD (approximately 90 percent), substance use disorder (approximately 95 percent), and co-occurring PTSD and SUD (approximately 95 percent). Depression and anxiety are widely present across participants, while traumatic brain injury (TBI) is observed in approximately 50 percent of cases. Military sexual trauma (MST)-related conditions are reported in approximately 20 percent of participants.

Expanded Veterans Treatment Court clinical-indicator data supporting this analysis is provided in Appendix E.

4.3.3 Demographic-Associated Risk Factors

Behavioral health risk is also influenced by demographic characteristics, including age and era of service. The veteran population within the region includes representation from multiple service eras, with variation in behavioral health indicators observed across age groups.

Available data indicates that older veteran cohorts, including those from earlier service eras, may experience behavioral health conditions with delayed onset or progression over time, while younger veteran cohorts demonstrate elevated risk in certain indicators, including suicide rates.

Expanded behavioral health demographic-context indicators supporting this analysis are provided in Appendix E.

4.3.4 System Interaction and Risk Exposure

Behavioral health risk is further contextualized by the interaction between veterans and various service systems, including healthcare providers, community-based services, and justice-related programs.

Data from Veterans Treatment Court and stakeholder input indicate that veterans frequently engage with services after conditions have progressed to higher levels of severity, and that delays in access to services may influence the timing and context in which veterans seek assistance.

Table 4.3 – Observed Behavioral Health Conditions at Point of System Entry

Metric	Observed Value	Source
Timing of Entry	Veterans frequently enter system after escalation of conditions	Stakeholder Roundtable Input
Entry Pathways	Common pathways include crisis response, court involvement, and family intervention	Stakeholder Roundtable Input
Severity at Entry	Moderate to high severity commonly observed at first engagement	Stakeholder Roundtable Input
Crisis Response Delays	Crisis line callbacks reported at 24–48+ hours	Stakeholder Roundtable Input
Engagement Pattern	Veterans often disengage following delays or disrupted care	Stakeholder Roundtable Input

Metric	Observed Value	Source
System Interaction Outcome	Entry into care often occurs at elevated levels of need rather than early intervention	Assessment Analysis

The table above summarizes observed behavioral health conditions at the point of system interaction, reflecting the types of conditions present when veterans engage with structured support systems.

These observations provide additional context regarding how behavioral health conditions present within service environments and how veterans interact with available support systems.

4.3.5 Observed Behavioral Health Risk Conditions

Taken together, clinical indicators, demographic characteristics, and system interaction data describe the behavioral health risk environment within the veteran population of the North Central Indiana service area.

These indicators reflect the presence of multiple behavioral health conditions across different population segments, with variation observed based on demographic factors and system interaction pathways.

Consistent with the overall assessment methodology, these findings are descriptive and are evaluated in conjunction with system capacity, access conditions, and stakeholder input.

4.4 – Compounding Risk and Socioeconomic Factors

Section 4.4 provides contextual analysis of socioeconomic factors that may influence behavioral health risk and service engagement. These indicators are evaluated to understand environmental conditions that may interact with behavioral health needs within the veteran population.

4.4.1 Overview of Socioeconomic Context

Behavioral health conditions among veterans are influenced by socioeconomic factors that affect both the prevalence of conditions and the ability of individuals to access and engage with services. Within the North Central Indiana service area, selected socioeconomic indicators were evaluated to provide contextual understanding of conditions that may interact with behavioral health risk. Expanded socioeconomic and access-condition indicators supporting this analysis are provided in Appendix E.

These indicators include measures related to income, employment, housing stability, and broader community conditions.

While these factors are not direct measures of behavioral health conditions, they provide critical context for understanding the environment in which such conditions occur and how access to services may be influenced.

4.4.2 Income and Poverty-Related Indicators

Income and poverty-related measures provide insight into financial conditions that may influence access to services, stability, and overall engagement with care systems.

Available data indicates variation in income levels across counties within the service area. Expanded poverty and income-related indicators supporting this analysis are provided in Appendix E.

4.4.3 Employment and Economic Stability

Employment status and economic stability represent factors that may influence both behavioral health conditions and service engagement. Available data indicates that unemployment rates vary across the region and may differ between veteran and non-veteran populations. Employment conditions contribute to financial stability and access to resources, while economic stressors may be present in certain areas of the service region. Expanded employment and economic-stability indicators supporting this analysis are provided in Appendix E.

4.4.4 Housing Stability and Environmental Conditions

Housing stability represents a critical factor influencing both behavioral health conditions and the ability of veterans to maintain consistent engagement with services.

Available indicators suggest that housing instability is present within portions of the population and may affect continuity of care. Variability in housing conditions across geographic areas further contributes to differences in service engagement. Expanded housing-stability and environmental-condition indicators supporting this analysis are provided in Appendix E.

Housing instability may affect the ability of individuals to maintain consistent engagement with services and may interact with other socioeconomic factors to influence overall access conditions.

4.4.5 Integrated Socioeconomic Context

Taken together, income, employment, and housing-related indicators describe the broader socioeconomic environment within which behavioral health conditions occur.

These factors may influence both the presence of behavioral health conditions and engagement with services, with variation observed across geographic areas and population groups.

Consistent with the overall assessment methodology, these indicators are descriptive and are evaluated in conjunction with behavioral health conditions, system capacity, access factors, and stakeholder input.

4.5 – Summary of Behavioral Health and Risk Findings

Section 4.5 synthesizes findings from preceding subsections to describe the combined behavioral health and risk environment within the assessed region.

System-level indicators reflect sustained behavioral health demand within a framework of established but constrained service infrastructure.

Access conditions demonstrate that travel requirements, service availability constraints, and provider capacity limitations influence the ability of veterans to engage with behavioral health services.

Clinical indicators describe the presence of multiple behavioral health conditions within segments of the veteran population, including cases of elevated severity and co-occurring conditions.

Demographic characteristics provide context for variation in risk across population groups, while socioeconomic indicators describe environmental factors influencing service engagement.

Taken together, these elements describe a behavioral health environment characterized by sustained demand, variable access conditions, and multiple interacting factors influencing both need and engagement.

Consistent with the overall assessment methodology, these findings are descriptive and are evaluated in conjunction with geographic analysis and population characteristics.

The following section builds upon this analysis through stakeholder validation, incorporating perspectives from service providers and veteran-serving organizations.

5 — STAKEHOLDER VALIDATION

Section 5 presents findings derived from stakeholder engagement conducted as part of the North Central Indiana Vet Center Feasibility Assessment.¹⁹ This section provides qualitative validation of conditions identified in previous sections through perspectives from behavioral health providers, county veteran service officers, community-based organizations, and justice-system stakeholders.

Stakeholder engagement was conducted through structured roundtable discussion and follow-on data collection, with input organized into thematic categories to identify recurring observations across participating sectors.

Findings presented in this section are descriptive and serve as a validation layer within the broader multi-factor assessment framework. Stakeholder input is evaluated in conjunction with geographic analysis, population data, behavioral health indicators, and socioeconomic context.

Subsections that follow present stakeholder observations aligned to key analytical domains, including geographic access (Section 5.2), service availability and capacity (Section 5.3), provider availability and service appropriateness (Section 5.4), behavioral health risk conditions (Section 5.5), and socioeconomic and environmental factors (Section 5.6).

5.1 – Overview of Stakeholder Engagement

Stakeholder engagement was conducted to supplement quantitative analysis and provide contextual validation of observed conditions within the North Central Indiana service area.

Engagement included participation from multiple sectors, including behavioral health providers, county-level veteran service officers, community-based organizations, and justice-related programs. Activities consisted of a structured community roundtable and follow-on data collection through standardized input sheets.²⁰

Input was reviewed and organized into thematic categories to identify recurring observations and patterns across participating organizations and sectors. These themes were evaluated in relation to quantitative indicators presented in previous sections.

To maintain analytical consistency and reduce attribution bias, stakeholder input is presented using aggregated institutional and role-based attribution (e.g., “behavioral health providers,” “county veteran service officers,” and “community stakeholders”), except where attribution is clearly verifiable and analytically necessary.

¹⁹ Stakeholder engagement findings summarized throughout this section are derived from structured roundtable discussion, supplemental provider input sheets, stakeholder outreach communications, and qualitative assessment activities conducted during the North Central Indiana Vet Center Feasibility Assessment process.

²⁰ Appendix B contains stakeholder participation summaries, engagement classifications, outreach documentation, and supplemental qualitative engagement materials utilized during assessment development.

Consistent with the overall assessment methodology, stakeholder input is utilized as a validation layer and is evaluated in conjunction with geographic analysis, population data, behavioral health indicators, and socioeconomic context.

5.2 – Validation of Geographic Access Conditions

Behavioral health providers and county veteran service officers indicated that veterans frequently travel extended distances to access behavioral health services, with travel times exceeding 30 minutes in many cases and longer durations reported for veterans residing in more rural portions of the service area. Transportation requirements—including distance, time, and availability of reliable transportation—were identified as factors that may influence both initiation and continuity of care.

Access conditions were described as variable across counties, reflecting differences in proximity to available behavioral health providers. These variations were reported as more pronounced in areas with limited local service availability, where veterans may be required to travel to neighboring counties to access care.

Extended travel requirements were further associated with impacts on continuity of engagement, including missed appointments, reduced frequency of participation, and discontinuation of services. Similar access conditions were observed within justice-related programs, where participants also experience travel requirements to meet program and treatment obligations.

These observations align with geographic access conditions identified in Sections 2 and 4.2, providing multi-source validation of travel burden and variability in access to behavioral health services across the region.

5.3 – Validation of Service Availability and Capacity Constraints

Behavioral health providers and county veteran service officers indicated that access to services is influenced by limitations in provider availability and overall system capacity. Reported wait times for behavioral health services range from several weeks to multiple months, with variation based on provider type and service location. Scheduling processes were described as subject to delays, rescheduling, and cancellation with limited notice, contributing to uncertainty in service access and affecting continuity of care.

Access to services was further described as variable across the region, influenced by staffing levels, provider availability, and organizational capacity. In some cases, changes in provider availability—including loss or reassignment of personnel—were identified as affecting access within specific geographic areas.

Extended wait times and scheduling challenges were associated with impacts on engagement, including instances where veterans declined services or discontinued care. Similar conditions were reported within justice-related programs, where coordination across multiple systems may be required to maintain continuity of care.

These observations align with service conditions described in Section 4.2, including wait times and provider capacity limitations, providing validation of system-level constraints affecting behavioral health access.

5.4 – Validation of Provider Availability and Service Appropriateness

Behavioral health providers and county veteran service officers indicated that provider availability varies across the region, with some areas experiencing limited access to behavioral health professionals. These limitations were described as affecting both the timeliness and consistency of service delivery.

In addition to general availability, challenges were identified related to the presence of providers with experience in addressing military-related behavioral health conditions. Veterans may encounter difficulty locating providers with familiarity in military service, trauma exposure, and reintegration-related challenges.

Service availability was further described as variable in terms of the types of behavioral health care offered. In some cases, veterans may access general behavioral health services that do not specifically address military-related conditions, while more specialized services are less consistently available.

Differences in provider experience and service focus were identified as influencing the perceived appropriateness of care. These factors may affect engagement, including willingness to initiate or continue services when providers are perceived as lacking understanding of military-specific experiences. Justice-system stakeholders similarly reported that coordination of care often requires identifying providers with appropriate experience to address complex behavioral health conditions, particularly in cases involving co-occurring disorders and service-related trauma.

These observations align with provider availability and behavioral health complexity indicators described in Sections 4.2 and 4.3, providing validation of the relationship between provider availability and service appropriateness.

5.5 – Validation of Behavioral Health Risk Conditions

Behavioral health providers, county veteran service officers, and justice-system stakeholders indicated that veterans frequently present with multiple behavioral health conditions, including post-traumatic stress disorder (PTSD), substance use disorder (SUD), and other co-occurring mental health conditions.

Conditions were described as being identified at varying stages, including cases in which symptoms had progressed prior to engagement with services. In some instances, veterans were observed entering structured programs or seeking assistance following increased severity of symptoms or functional impact.

Co-occurring conditions were commonly reported, particularly in cases involving substance use and trauma-related conditions.

These observations reflect the complexity of behavioral health needs within portions of the veteran population and suggest the potential need for coordinated approaches to care.

Justice-system stakeholders similarly reported that veterans participating in structured intervention programs frequently present with multiple behavioral health conditions. These conditions may influence engagement with services, including the ability to initiate or maintain participation in treatment.

These observations align with clinical indicators and behavioral health risk patterns described in Section 4.3, providing validation of the presence and complexity of behavioral health conditions within the region.

5.6 – Validation of Socioeconomic and Environmental Factors

Stakeholder input reflected observations related to socioeconomic and environmental factors affecting the veteran population within the North Central Indiana service area.

Community stakeholders, behavioral health providers, and county veteran service officers indicated that financial conditions influence how veterans access and engage with behavioral health services. Observations included the impact of income limitations, cost considerations, and competing financial priorities on service utilization.

Employment conditions were also identified as contributing to variability in service engagement. Differences in employment status, job stability, and work schedules were described as factors affecting the ability of veterans to seek and maintain participation in services.

Housing stability was similarly identified as influencing continuity of care. Community-based organizations and service providers reported that housing-related challenges may affect the ability of veterans to maintain consistent engagement with services and access available resources.

Environmental and infrastructure-related factors, including transportation availability and access to community resources, were also described as influencing service engagement and access to care. These conditions vary across counties and population groups, reflecting differences in local environments and available support systems.

These observations correspond with socioeconomic indicators described in Section 4.4, providing contextual validation of environmental conditions influencing behavioral health and service access within the region.

Consistent with the overall assessment methodology, these observations are presented as validation of previously identified socioeconomic and environmental conditions and are not independently determinative of service demand or feasibility. Stakeholder input is evaluated in conjunction with quantitative indicators and system-level analysis.

The following section builds upon this validated analysis through comparative and benchmark evaluation, positioning observed regional conditions within broader service-access and prioritization frameworks relevant to Vet Center service delivery.

6 — INTEGRATED ANALYSIS AND COMPARATIVE POSITIONING

Section 6 synthesizes findings from preceding sections of the North Central Indiana Vet Center Feasibility Assessment to evaluate the extent to which observed conditions reflect consistent and analytically significant patterns across multiple domains. This section integrates geographic access conditions, population characteristics, behavioral health indicators, socioeconomic factors, and stakeholder validation to assess the overall service environment affecting veterans within the region.

This section evaluates convergence and consistency across previously established findings to determine whether observed patterns are isolated or mutually reinforcing. By examining alignment across independent domains of analysis, the section strengthens the overall analytical basis of the assessment.

In addition to integrated synthesis, this section positions regional findings within a broader comparative and benchmarking context relevant to Vet Center service delivery. This includes consideration of service-access thresholds, regional variation, and prioritization factors commonly applied in the evaluation of community-based behavioral health services.²¹

Expanded comparative benchmarking and supplemental regional contextual analysis supporting this section are provided in Appendix H.

The analysis presented in this section establishes the foundation for subsequent conclusions and recommendations through structured, evidence-based interpretation of multi-domain findings.

6.1 – Purpose and Role of Integrated Analysis

Integrated analysis within this assessment evaluates the extent to which findings from geographic, population, behavioral health, socioeconomic, and stakeholder domains collectively describe service conditions affecting veterans within the North Central Indiana service area.

Sections 2 through 5 presented evidence across these domains, including geographic access conditions, population characteristics, behavioral health indicators, socioeconomic factors, and stakeholder validation. Each domain provides a distinct perspective on the service environment.

This section synthesizes those findings to assess whether consistent patterns emerge across domains. The analysis emphasizes convergence, consistency, and the strength of alignment between independent sources of evidence.

Integrated analysis is necessary because no single indicator is sufficient to characterize the service environment. Geographic access, population distribution, behavioral health conditions,

²¹ Comparative analysis incorporated publicly available Vet Center infrastructure information, regional accessibility observations, behavioral health indicators, and assessment-derived comparative service-access evaluation measures.

provider capacity, and stakeholder observations each describe different aspects of the broader system.

Considered together, these elements provide a more complete basis for evaluating whether conditions are isolated, mixed, or mutually reinforcing.

Accordingly, the integrated analysis focuses on relationships between domains rather than repetition of domain-specific findings. Where multiple domains reflect similar conditions, those patterns are treated as analytically significant. Where domains diverge, that distinction is also considered in evaluating the overall strength of observed conditions.

6.2 – Convergence of Geographic, Population, and Behavioral Health Findings

Evaluation of findings across the geographic, population, and behavioral health domains indicates recurring patterns observed across multiple areas of analysis within the North Central Indiana service area.

Geographic analysis presented in Section 2 identified variation in access to existing behavioral health service infrastructure, including areas where travel time and distance to services exceed baseline thresholds. These findings reflect differences in proximity to service locations across counties and contribute to variability in physical access to care.

Population analysis in Section 3 demonstrates that the region contains a veteran population distributed across multiple counties, including both population centers and rural areas. This pattern indicates that access conditions identified in the geographic analysis affect a population that is geographically dispersed rather than concentrated in a single location.

Behavioral health analysis in Section 4 identified measurable behavioral health conditions within the veteran population, including indicators of clinical complexity, co-occurring conditions, and sustained behavioral health risk across demographic cohorts. These indicators demonstrate the presence of behavioral health needs independent of geographic location.

Taken together, these domains describe a relationship in which a geographically dispersed veteran population with identified behavioral health risk is interacting with a service environment characterized by variable geographic access. This relationship indicates that access conditions are experienced across a population in which behavioral health indicators are consistently present.

Behavioral health indicators were observed across multiple demographic groups, while geographic access varies by location. This combination reflects a pattern in which behavioral health needs are broadly distributed, while access to services is influenced by geographic factors.

The interaction between population distribution and geographic access suggests that portions of the veteran population may encounter differing levels of access to services based on location, while behavioral health needs remain present across the broader population.

The alignment of geographic access conditions, population distribution, and behavioral health indicators is therefore considered analytically significant in understanding the service environment within the region.

6.3 – Convergence of Stakeholder Validation and System Conditions

Evaluation of stakeholder input in relation to previously identified system conditions indicates consistent alignment between qualitative observations and quantitative findings across multiple domains within the North Central Indiana service area.

Stakeholder validation presented in Section 5 reflects recurring observations related to geographic access, service availability, provider capacity, behavioral health conditions, and socioeconomic factors. These observations were reported across multiple stakeholder groups, including behavioral health providers, county veteran service officers, community-based organizations, and justice-system representatives.

Geographic access conditions identified in Section 4.2, including extended travel times and variability in proximity to services, were consistently reflected in stakeholder input, with stakeholders reporting that travel requirements may influence service engagement and continuity of care.

Service availability and capacity conditions, including wait times, scheduling variability, and provider limitations, were similarly reinforced through stakeholder input, indicating that system constraints may affect the timeliness and consistency of service delivery.

Provider availability and service appropriateness considerations, including variability in access to providers with experience addressing military-related behavioral health conditions, were also reflected in stakeholder observations, aligning with system characteristics described in Sections 4.2 and 4.3.

Behavioral health risk conditions identified through quantitative indicators were reinforced by stakeholder input, including observations related to co-occurring conditions and variability in the timing and context of service engagement.

Socioeconomic and environmental factors identified in Section 4.4 were likewise reflected in stakeholder input, including the influence of financial conditions, employment, housing stability, and environmental factors on service engagement and access to care.

Taken together, stakeholder input demonstrates consistent alignment with system conditions identified through quantitative analysis. The presence of recurring observations across independent stakeholder groups and analytical domains indicates that identified conditions are not isolated to a single data source or perspective.

This convergence between stakeholder validation and system-level findings is considered analytically significant within the integrated analysis framework, reflecting consistency across both quantitative indicators and qualitative observations.

6.4 – Overall Integrated Assessment of Access and Need Conditions

Evaluation of findings across geographic, population, behavioral health, socioeconomic, and stakeholder domains indicates the presence of consistent and recurring patterns affecting access to behavioral health services within the North Central Indiana service area.

Geographic analysis identified variation in access to behavioral health services based on location, including areas where travel time and distance to services exceed baseline thresholds. Population analysis further demonstrated that the veteran population is distributed across multiple counties, including both population centers and rural areas, indicating that access conditions affect a geographically dispersed population.

Behavioral health analysis identified measurable behavioral health conditions within the veteran population, including indicators of clinical complexity and co-occurring conditions across multiple demographic groups. These findings demonstrate sustained behavioral health needs within the population independent of geographic location.

Socioeconomic analysis identified factors that may influence service engagement, including income variability, employment conditions, housing stability, and environmental characteristics. These factors provide additional context regarding how veterans access and engage with behavioral health services.

Stakeholder validation demonstrated consistent alignment with these findings across multiple sectors, including behavioral health providers, county veteran service officers, community-based organizations, and justice-system representatives. Observations reinforced the presence of geographic access constraints, service availability limitations, provider variability, and behavioral health complexity within the region.

Taken together, these domains describe a service environment in which a geographically dispersed veteran population with identified behavioral health needs interacts with a system characterized by variability in access, capacity, and service availability. This interaction reflects patterns that influence how veterans access and engage with behavioral health services across the region.

The convergence of findings across independent data sources and stakeholder groups indicates that these patterns are not isolated or limited to a single domain. Rather, they are consistently reflected across geographic, population, behavioral health, and stakeholder analyses, demonstrating multi-domain alignment within the service environment.

Consistent with broader comparative observations regarding variability in Vet Center infrastructure distribution and regional service-access conditions, these findings further support the importance of evaluating localized service environments independently rather than assuming uniform accessibility across geographic areas.²²

Within the integrated analysis framework, this alignment is considered analytically significant in assessing overall access and need conditions affecting the veteran population in the region.

Consistent with the methodology of this assessment, these findings do not independently determine service demand or feasibility. However, the presence of consistent patterns across multiple domains provides a structured basis for further evaluation of service needs and system characteristics in subsequent sections of this assessment.

6.5 – Analytical Summary

The integrated analysis conducted in this section evaluated findings across geographic, population, behavioral health, socioeconomic, and stakeholder domains to assess overall service conditions affecting veterans within the North Central Indiana service area.

Findings across these domains demonstrate consistent patterns related to geographic access, population distribution, behavioral health indicators, and contextual factors influencing service engagement. Geographic variability in access to services is observed within a population that is distributed across multiple counties, while behavioral health indicators reflect the presence of sustained and complex needs across demographic groups.

Stakeholder validation further reinforces these patterns, with consistent observations across multiple sectors related to access constraints, service availability, provider capacity, behavioral health complexity, and environmental influences on service engagement.

Taken together, these findings demonstrate convergence across independent data sources and analytical domains. This convergence indicates that observed patterns are not isolated, but are consistently reflected across both quantitative indicators and stakeholder validation.

This analytical synthesis establishes a structured and evidence-based foundation for evaluating service needs, system characteristics, and service delivery considerations.

The following section builds upon this integrated analysis to evaluate potential service models, assess feasibility considerations, and develop evidence-informed recommendations regarding Vet Center service delivery within the North Central Indiana service area.

²² U.S. Government Accountability Office (GAO), *VA Readjustment Counseling Service: Actions Needed to Improve Data and Strategic Planning for Vet Centers*, GAO-25-106781.

7 — SERVICE MODEL CONSIDERATIONS

Section 7 evaluates potential service delivery approaches that may be responsive to the conditions identified through the North Central Indiana Vet Center Feasibility Assessment. This section builds upon the integrated analysis presented in Section 6 by translating observed patterns into structured consideration of how services may be delivered within the regional context.

Service models are examined in relation to geographic, population, behavioral health, socioeconomic, and stakeholder conditions identified in preceding sections. These models are evaluated to determine how different service delivery approaches may align with the characteristics of the service environment affecting veterans within the region.

Service models are presented as conceptual frameworks and are not intended to represent recommendations or final determinations. Each model is described in terms of general structure, operational characteristics, and its potential relationship to identified conditions. Comparative evaluation and prioritization of models are addressed in subsequent sections of this assessment.

7.1 – Purpose of Service Model Considerations

This section identifies and describes potential service delivery models that may be considered in relation to the conditions identified in preceding sections of this assessment.

The integrated analysis presented in Section 6 established the presence of consistent conditions across geographic, population, behavioral health, socioeconomic, and stakeholder domains. These conditions collectively describe the service environment affecting veterans within the North Central Indiana service area.

This section establishes a structured framework for evaluating potential approaches to service delivery that may be responsive to these conditions. Service model considerations are based on the relationship between identified conditions and potential service delivery approaches, including geographic access, population distribution, behavioral health indicators, provider availability, and stakeholder-identified system characteristics.

Each model is described in terms of general structure, operational characteristics, and its potential relationship to conditions identified in earlier sections. These descriptions provide a basis for evaluating how different service approaches may interact with the existing service environment.

Models are evaluated descriptively and comparatively. No single model is presented as inherently preferable within this section. Comparative evaluation and potential prioritization are addressed in subsequent sections of this assessment.

This section serves as a transition from integrated analysis to structured consideration of potential service delivery approaches, maintaining alignment with the analytical framework developed throughout the assessment.

7.2 – Overview of Potential Service Models

Based on the integrated analysis presented in preceding sections, multiple service delivery approaches may be considered in relation to conditions identified within the North Central Indiana service area.

These approaches represent different structural methods for delivering behavioral health services to veteran populations and vary in terms of physical infrastructure, operational scope, geographic reach, and coordination with existing service systems.

For the purposes of this assessment, potential service delivery approaches are grouped into three general categories:

- Community-based service models
- Mobile or outreach-based service models
- Partnership-based or hybrid service models

Each category reflects a distinct approach to service delivery, with differing characteristics related to access, capacity, and operational flexibility.

Community-based models are characterized by fixed physical locations that provide in-person services within a defined geographic area. These approaches emphasize localized access and may support consistent service delivery within specific communities or regions.

Mobile or outreach-based approaches are designed to extend services across broader geographic areas without reliance on a single fixed location. These models may provide flexibility in reaching dispersed populations but may vary in frequency, continuity, and scope of services delivered.

Partnership-based or hybrid approaches involve coordination between multiple organizations or service providers to deliver services across an existing network.

These models may leverage existing infrastructure and resources, with service delivery distributed across multiple locations or systems.

Each category may interact differently with conditions identified in the assessment, including geographic access constraints, population distribution, behavioral health indicators, and provider availability.

These approaches are not mutually exclusive and may be implemented in combination or adapted based on regional conditions and operational considerations.

Consistent with the methodology of this assessment, these models are presented at a conceptual level to establish a framework for evaluating potential service delivery approaches. Detailed analysis of each model and its relationship to identified conditions is provided in subsequent subsections.

7.3 – Community-Based Vet Center Model

The community-based Vet Center model represents a fixed-location service delivery approach designed to provide readjustment counseling and related behavioral health services within a defined geographic area.²³

Vet Centers, operated through the Department of Veterans Affairs Readjustment Counseling Service (RCS), are structured to deliver services outside of traditional medical facility environments. These services typically include individual and group counseling, family services, outreach, and support for veterans experiencing readjustment challenges.

As a fixed-location approach, this model emphasizes localized access, with a defined service area that supports consistent service delivery within a specific geographic region. This structure is intended to reduce travel requirements and support continuity of care through proximity and regular availability of services.

When considered in relation to the geographic findings presented in Section 2 and access conditions identified in Section 4.2, a fixed-location approach corresponds to service delivery structures that address variability in travel time and proximity to services. Areas within the service region where travel time exceeds baseline thresholds provide a relevant context for evaluating localized service delivery.

Population findings presented in Section 3 indicate that the veteran population is distributed across multiple counties, including both population centers and rural areas. A centralized service location interacts with this distribution by providing a consistent point of access, with proximity influencing how access is experienced across the region.

Behavioral health indicators presented in Section 4.3 identify the presence of measurable conditions, including co-occurring conditions and sustained behavioral health risk across demographic groups. A fixed-location setting provides a structured environment for delivering consistent services that may support ongoing engagement for veterans requiring regular care.

Stakeholder validation presented in Section 5 reflects observations related to travel burden, service availability, provider variability, and the importance of accessible services within the community. These observations align with service approaches that emphasize consistent, localized access to care.

²³ U.S. Department of Veterans Affairs, Readjustment Counseling Service (RCS), Vet Center program mission and operational service-delivery framework information accessed during assessment development.

Stakeholder input also identified provider familiarity with military-related conditions as a factor influencing engagement. The Vet Center model, as a specialized service approach, is designed to incorporate understanding of military experience and readjustment-related conditions within its service framework.

The community-based Vet Center model represents one of several potential service delivery approaches evaluated in this section. It is not presented as a preferred or recommended option at this stage, but as a conceptual framework for understanding how a fixed-location, community-based approach may interact with the service environment described in preceding sections.

7.4 – Expanded Mobile / Outreach Model

The expanded mobile or outreach-based service model represents a flexible approach to service delivery in which behavioral health services are provided across multiple locations without reliance on a single fixed facility.²⁴

This approach typically involves mobile service units, rotating service locations, or scheduled outreach activities to deliver services within different communities across a defined service area. Services may include counseling, outreach, and coordination with local providers, with frequency and scope varying based on operational design.

As a distributed approach, mobile and outreach services are structured to extend geographic reach by bringing services closer to dispersed populations. This allows for service delivery in multiple locations, including areas where fixed-site services are not currently available.

When considered in relation to the geographic findings presented in Section 2 and access conditions identified in Section 4.2, a mobile or outreach-based approach corresponds to service delivery structures that reduce travel requirements by providing services across multiple locations.

This is particularly relevant in geographically dispersed areas where travel times to existing services exceed baseline thresholds.

Population findings presented in Section 3 indicate that the veteran population is distributed across multiple counties, including both population centers and rural areas.

A distributed service approach interacts with this pattern by providing access across a wider geographic area, potentially improving access for veterans located farther from centralized services.

Behavioral health indicators presented in Section 4.3 identify the presence of ongoing behavioral health needs within the veteran population.

²⁴ U.S. Department of Veterans Affairs, Readjustment Counseling Service (RCS), Mobile Vet Center and outreach-service operational information accessed during assessment development.

Mobile or outreach-based service delivery may support initial engagement and periodic service access, particularly in areas where fixed-site services are limited.

Stakeholder validation presented in Section 5 reflects observations related to travel burden, transportation limitations, and variability in access to services across the region. These observations align with approaches that extend services into multiple communities and reduce reliance on travel to a single location.

At the same time, stakeholder input emphasizes the importance of continuity and consistency of care, particularly for veterans with complex or co-occurring behavioral health conditions. Mobile and outreach-based approaches may vary in frequency and consistency of services at any given location, depending on operational structure.

The expanded mobile or outreach model represents one of several potential service delivery approaches evaluated in this section.

It is not presented as a preferred or recommended option, but as a conceptual framework for understanding how a flexible, distributed service approach may interact with the service environment described in preceding sections.

7.5 – Partnership-Based / Hybrid Model

The partnership-based or hybrid service model represents an approach to service delivery in which behavioral health services are provided through coordination among multiple organizations, providers, and service systems within an existing network.

This approach typically involves collaboration among federal, state, local, and community-based entities to deliver services across multiple locations. Services may be provided through a combination of existing facilities, contracted providers, and coordinated referral systems, with service delivery distributed across participating organizations.

As a coordinated approach, this model is structured to leverage existing infrastructure and resources within the service area.

This may include integration with community-based behavioral health providers, county-level veteran service offices, healthcare systems, and justice-related programs.

When considered in relation to the geographic findings presented in Section 2 and access conditions identified in Section 4.2, a partnership-based approach corresponds to service delivery structures that utilize multiple service points across the region. This alignment may support access by distributing services across existing locations rather than relying on a single centralized facility.

Population findings presented in Section 3 indicate that the veteran population is distributed across multiple counties with varying local resources.

A coordinated service approach interacts with this distribution by aligning service delivery with existing community infrastructure, with access influenced by the availability and capacity of participating organizations.

Behavioral health indicators presented in Section 4.3 identify the presence of complex and co-occurring conditions within portions of the veteran population. A coordinated approach may support referral pathways and multi-provider engagement for veterans requiring different types of services across systems.

Stakeholder validation presented in Section 5 reflects the presence of multiple organizations currently engaged in serving the veteran population, including behavioral health providers, veteran service officers, community-based organizations, and justice-system stakeholders.

These observations align with service approaches that involve coordination across existing systems and providers.

At the same time, stakeholder input reflects variability in provider availability, service capacity, and coordination across the region. A partnership-based approach may depend on consistent communication, alignment, and operational coordination among participating entities, which may vary based on organizational capacity and system structure.

The partnership-based or hybrid model represents one of several potential service delivery approaches evaluated in this section. It is not presented as a preferred or recommended option, but as a conceptual framework for understanding how a coordinated, multi-provider service approach may interact with the service environment described in preceding sections.

7.6 – Comparative Considerations Across Models

The service delivery approaches described in preceding subsections represent distinct methods for providing behavioral health services to veteran populations within the North Central Indiana service area.

Comparative consideration of these approaches provides a structured framework for evaluating how each may interact with conditions identified in this assessment.

Each model reflects a different structural approach to service delivery. The community-based Vet Center model emphasizes a fixed, centralized service location. The expanded mobile or outreach model extends services across multiple locations. The partnership-based or hybrid model coordinates service delivery across existing providers and systems.

When evaluated in relation to geographic findings presented in Section 2, the models differ in how they address variability in travel time and proximity to services. Fixed-location approaches centralize services within a defined area, mobile approaches reduce travel by distributing services across multiple locations, and partnership-based approaches utilize existing service points throughout the region.

In relation to population distribution described in Section 3, each approach interacts differently with a geographically dispersed veteran population. Fixed-location approaches provide centralized access, mobile approaches extend reach across dispersed populations, and partnership-based approaches align service delivery with existing community infrastructure.

Behavioral health indicators presented in Section 4.3 reflect the presence of complex and co-occurring conditions that may require varying levels of service intensity and continuity. Fixed-location approaches may support consistent, ongoing engagement. In contrast, mobile approaches may provide more flexible but less consistent access depending on scheduling and service frequency. Partnership-based approaches may support coordinated care across providers, though continuity may vary based on system integration and coordination.

Stakeholder validation presented in Section 5 reflects observations related to access constraints, service availability, provider capacity, and the importance of continuity and appropriateness of care. These observations align with different aspects of each approach, including localized access, distributed reach, and coordinated service delivery.

Taken together, the models present distinct considerations related to access, continuity, coordination, and operational structure. These differences reflect how services are delivered rather than differences in the underlying conditions identified in the assessment.

Consistent with the methodology of this assessment, these comparative considerations are presented descriptively and are not intended to establish preference or prioritization among models. This section provides a structured basis for evaluating how each approach interacts with the service environment identified through the analysis.

7.7 – Summary of Service Model Considerations

The service delivery approaches presented in this section represent structured methods for addressing behavioral health service conditions within the North Central Indiana service area.

Each approach reflects a distinct structural strategy. The community-based Vet Center model emphasizes centralized, fixed-location service delivery. The expanded mobile or outreach model extends services across multiple locations to address geographic dispersion. The partnership-based or hybrid model leverages coordination among existing providers and service systems to deliver services across a network of organizations.

These approaches correspond to different aspects of the service environment identified in this assessment, including geographic access variability, population distribution, behavioral health indicators, provider availability, and stakeholder-identified system characteristics. They differ in how they address access, continuity of care, geographic reach, and coordination across service providers.

When considered collectively, these approaches illustrate a range of potential service delivery strategies that may interact with the conditions identified through the analysis.

These approaches are not mutually exclusive and may be implemented individually or in combination depending on operational design and regional considerations.

Consistent with the methodology of this assessment, these approaches are described and compared without establishing preference or prioritization. This section provides a structured basis for evaluating how different service delivery strategies may align with the service environment identified through the integrated analysis.

This section concludes the identification and comparative consideration of potential service delivery approaches. The structured comparison of these approaches establishes a consistent analytical basis for evaluating differences in access, continuity, geographic reach, and coordination across service models.

The following section builds upon this framework to evaluate these service delivery approaches in relation to operational feasibility, strategic alignment, and implementation considerations, supporting the development of evidence-based conclusions and recommendations.

8 — EVALUATION AND STRATEGIC CONSIDERATIONS

Section 8 evaluates the potential service delivery approaches identified in Section 7 in relation to the conditions established through the integrated analysis presented in Sections 2 through 6. This section represents the transition from structured model identification and comparison to analytical evaluation of how those models align with the service environment affecting veterans within the North Central Indiana service area.

Evaluation is conducted using a structured, criteria-based framework derived from the analytical domains developed throughout the assessment. These domains include geographic access, population distribution, behavioral health indicators, socioeconomic factors, and stakeholder-identified system characteristics.

Service delivery approaches are evaluated comparatively based on their alignment with these conditions, with emphasis on multi-domain interaction rather than reliance on any single factor.

This section establishes the analytical foundation for subsequent consideration of strategic direction, feasibility, and service delivery recommendations.

8.1 – Purpose of Evaluation and Strategic Considerations

This section evaluates the potential service delivery approaches identified in Section 7 in relation to the conditions established through the integrated analysis presented in Sections 2 through 6.

The preceding sections of this assessment identified consistent patterns across geographic access, population distribution, behavioral health indicators, socioeconomic factors, and stakeholder validation. Section 7 defined multiple service delivery approaches that may be considered in response to these conditions.

Evaluation is conducted using a structured, criteria-based framework derived from the analytical domains developed throughout the assessment. These criteria include geographic access, population coverage, continuity of care, service capacity, provider appropriateness, and system coordination.

The evaluation assesses how each service delivery approach aligns with the range of conditions identified in the assessment, including access variability, population dispersion, behavioral health complexity, and stakeholder-identified system characteristics.

This section represents the transition from model identification and comparison to structured evaluation within the context of the assessed service environment. Findings presented in this section establish the analytical basis for subsequent consideration of strategic direction and service delivery recommendations.

8.2 – Evaluation Criteria Framework

Evaluation of potential service delivery approaches is conducted using a structured framework derived from the analytical domains established in preceding sections of this assessment.

The evaluation criteria are based on conditions identified through geographic analysis (Section 2), population characteristics (Section 3), behavioral health and system conditions (Section 4), and stakeholder validation (Section 5), as synthesized through the integrated analysis presented in Section 6. This framework ensures that evaluation remains aligned with the evidence developed throughout the assessment.

For the purposes of this evaluation, the following criteria are applied:

- Geographic Access and Coverage
- Population Alignment and Reach
- Continuity and Consistency of Care
- Service Capacity and Availability
- Provider Appropriateness and Specialization
- System Coordination and Integration

Each criterion represents a distinct dimension of the service environment and corresponds to conditions identified through the assessment process.

Geographic access and coverage evaluates how an approach addresses variability in travel distance, proximity to services, and geographic dispersion across the service area, consistent with findings related to travel time thresholds and spatial distribution.

Population alignment and reach evaluates how an approach corresponds to the distribution and characteristics of the veteran population, including variation across counties and demographic groups identified in Section 3.

Continuity and consistency of care evaluates the ability to support ongoing engagement with behavioral health services, particularly for veterans with complex or co-occurring conditions, as reflected in behavioral health indicators and stakeholder observations.

Service capacity and availability evaluates the ability to provide timely and consistent access to services, including considerations related to wait times, scheduling, and provider availability, consistent with system conditions identified in Section 4.

Provider appropriateness and specialization evaluates access to providers with experience in military-related behavioral health conditions and readjustment challenges, based on behavioral health considerations and stakeholder input.

System coordination and integration evaluates the extent to which an approach supports coordination across providers, organizations, and service systems, including referral pathways, multi-provider engagement, and alignment with existing infrastructure.

These criteria are applied consistently across all service delivery approaches to provide a structured and comparable basis for evaluation. Each approach is assessed based on its alignment with these criteria in relation to the conditions identified in the assessment.

8.3 – Evaluation of Community-Based Vet Center Model

The community-based Vet Center model is evaluated using the criteria established in Section 8.2, based on its alignment with the conditions identified throughout this assessment.

Geographic Access and Coverage:

A fixed-location Vet Center provides localized access within a defined geographic area. This structure reduces travel distance for populations located near the selected site. Access, however, varies across the service area depending on population distribution, particularly for veterans residing in more distant or rural locations.

Population Alignment and Reach:

The veteran population is distributed across multiple counties, including both population centers and rural areas. A centralized service location aligns more directly with population centers, while access for dispersed populations depends on proximity to the facility.

Continuity and Consistency of Care:

A fixed-location structure supports consistent and ongoing service delivery. This approach aligns with conditions that require regular engagement, particularly for veterans with complex or co-occurring behavioral health needs.

Service Capacity and Availability:

A community-based Vet Center provides dedicated service capacity within a defined operational framework. Service availability is structured and consistent, though the ability to meet demand is dependent on staffing levels and facility capacity.

Provider Appropriateness and Specialization:

The Vet Center model incorporates provider familiarity with military experience and readjustment-related conditions. This aligns with stakeholder observations emphasizing the importance of specialized behavioral health services for veterans.

System Coordination and Integration:

A community-based Vet Center operates within the broader VA Readjustment Counseling Service system and includes defined coordination pathways. Integration with external providers and community systems may vary depending on local relationships and operational practices.

When evaluated across all criteria, the community-based Vet Center model demonstrates strong alignment with conditions related to continuity of care, provider specialization, and structured service delivery. Alignment with geographic access and population distribution is dependent on facility location and may vary across the service area.

This evaluation is presented descriptively and comparatively to support structured analysis across service delivery approaches.

8.4 – Evaluation of Expanded Mobile / Outreach Model

The expanded mobile or outreach-based service model is evaluated using the criteria established in Section 8.2, based on its alignment with the conditions identified throughout this assessment.

Geographic Access and Coverage:

A mobile or outreach-based approach distributes services across multiple locations, extending access to geographically dispersed populations. This structure reduces reliance on a centralized facility and may address variability in travel distance and proximity to services across the service area.

Population Alignment and Reach:

The veteran population is distributed across multiple counties, including rural and less densely populated areas. A distributed service approach aligns with this pattern by extending service reach across multiple communities, potentially improving accessibility for veterans located farther from centralized service points.

Continuity and Consistency of Care:

Continuity within a mobile or outreach-based approach is influenced by operational design, including scheduling frequency and service availability at each location. This structure may support initial engagement and periodic services, while consistency of ongoing care may vary depending on deployment patterns and service frequency.

Service Capacity and Availability:

Service capacity is dependent on resource allocation, staffing, and operational reach across multiple locations. While this approach provides flexibility in service delivery, availability at any given site may vary based on scheduling and deployment frequency.

Provider Appropriateness and Specialization:

Provider appropriateness is influenced by staffing structure and training of personnel delivering services. This approach may incorporate providers with familiarity in military-related behavioral health conditions; however, consistency of specialization may vary depending on deployment and staffing configurations.

System Coordination and Integration:

A mobile or outreach-based approach often requires coordination with local organizations and service providers to support service delivery across multiple locations. Integration with existing systems may vary depending on operational structure and the strength of local partnerships.

When evaluated across all criteria, the expanded mobile or outreach model demonstrates strong alignment with conditions related to geographic access and population reach, while presenting variability in continuity, capacity, and coordination based on operational design.

This evaluation is presented descriptively and comparatively to support structured analysis across service delivery approaches.

8.5 – Evaluation of Partnership-Based / Hybrid Model

The partnership-based or hybrid service model is evaluated using the criteria established in Section 8.2, based on its alignment with the conditions identified throughout this assessment.

Geographic Access and Coverage:

A partnership-based approach distributes services across multiple existing locations through coordination among participating organizations. This structure may improve geographic access by utilizing existing service points, with effectiveness influenced by the availability and distribution of participating providers.

Population Alignment and Reach:

The veteran population is distributed across multiple counties with varying local resources. A coordinated approach aligns with this distribution by leveraging existing community infrastructure, potentially expanding service reach based on the coverage of participating organizations.

Continuity and Consistency of Care:

Continuity of care is dependent on the coordination and integration of participating providers. This approach may support multi-provider engagement; however, consistency of care may vary based on the effectiveness of referral pathways, communication, and coordination among organizations.

Service Capacity and Availability:

Service capacity reflects the combined resources of participating organizations. This approach utilizes existing system capacity, while availability may vary across locations depending on provider resources, staffing, and operational constraints.

Provider Appropriateness and Specialization:

Provider appropriateness depends on the characteristics of participating providers. This approach may include varying levels of familiarity with military-related behavioral health conditions, resulting in differences in specialization across the network.

System Coordination and Integration:

Coordination is a central component of this model, requiring alignment across multiple organizations, referral systems, and service pathways. The effectiveness of this approach is influenced by the consistency and strength of coordination mechanisms across participating entities.

When evaluated across all criteria, the partnership-based or hybrid model demonstrates alignment with conditions related to geographic distribution and utilization of existing system resources, while presenting variability in continuity, provider consistency, and coordination depending on network structure and operational integration.

This evaluation is presented descriptively and comparatively to support structured analysis across service delivery approaches.

8.6 – Comparative Evaluation Across Models

The service delivery approaches evaluated in Sections 8.3 through 8.5 demonstrate differing patterns of alignment across the evaluation criteria established in Section 8.2. Comparative evaluation of these approaches provides a structured basis for assessing how each interacts with the conditions identified in this assessment.

Geographic Access and Coverage:

The expanded mobile or outreach model and the partnership-based model extend services across multiple locations, improving access for geographically dispersed populations. In contrast, the community-based Vet Center model centralizes service delivery, with coverage dependent on proximity to the selected facility location.

Population Alignment and Reach:

Mobile and partnership-based approaches align more directly with a geographically dispersed population by extending services across multiple communities. The fixed-location approach provides centralized access and aligns more closely with population centers, while accessibility varies across the broader service area.

Continuity and Consistency of Care:

The community-based Vet Center model supports consistent, ongoing service delivery within a fixed setting.

In contrast, mobile and partnership-based approaches may provide variable continuity depending on scheduling, service frequency, and coordination across locations and providers.

Service Capacity and Availability:

The community-based model provides dedicated service capacity within a defined operational structure. Mobile and partnership-based approaches distribute capacity across multiple locations, with availability influenced by resource allocation, scheduling, and coordination among participating entities.

Provider Appropriateness and Specialization:

The community-based Vet Center model emphasizes provider familiarity with military-related behavioral health conditions. Mobile and partnership-based approaches may include providers with varying levels of specialization, depending on staffing structures and participating organizations.

System Coordination and Integration:

The partnership-based model emphasizes coordination across multiple providers and service systems. The mobile model also requires coordination across locations, while the community-based model operates within a more centralized structure with defined coordination pathways.

When considered collectively, the models demonstrate distinct patterns of alignment across evaluation criteria. The community-based model aligns more strongly with continuity of care, provider specialization, and structured service delivery. The mobile model aligns more strongly with geographic access and population reach. The partnership-based model aligns with system integration and utilization of existing infrastructure.

These differences reflect variation in service delivery structure rather than differences in the underlying conditions identified in the assessment.

Comparative evaluation is presented descriptively to support structured analysis of alignment across service delivery approaches.

8.7 – Strategic Considerations and Pathway Forward

The evaluation of service delivery approaches presented in this section provides a structured basis for considering potential pathways for addressing behavioral health service conditions within the North Central Indiana service area.

The integrated analysis conducted throughout this assessment identified consistent patterns across geographic access, population distribution, behavioral health indicators, socioeconomic factors, and stakeholder validation. Evaluation of service delivery approaches demonstrates that each model aligns more directly with specific dimensions of these conditions, reflecting differences in how services may be delivered within the region.

Strategic consideration of these approaches involves evaluating how service delivery structures may be applied individually or in combination to address identified regional conditions.

The presence of geographically dispersed populations alongside the need for continuity of care indicates that service delivery strategies must balance localized access with broader geographic reach.

Considerations related to provider appropriateness, system capacity, and coordination across organizations further influence how service delivery approaches may be structured. These factors reflect the interaction between service delivery design and the characteristics of the existing service environment.

Comparative evaluation indicates that no single approach uniformly aligns with all evaluation criteria. Rather, each model demonstrates stronger alignment with specific aspects of the service environment. This pattern suggests that strategic approaches may involve selecting or integrating elements that collectively address multiple dimensions of identified conditions.

Stakeholder validation reinforces the importance of access, continuity of care, provider specialization, and coordination in shaping service delivery considerations. These observations provide additional context for evaluating how service delivery approaches may function within the regional environment.

These considerations are presented to support structured decision-making based on alignment with identified service conditions.

This section transitions from comparative evaluation to strategic consideration and establishes the analytical foundation for subsequent development of evidence-based conclusions and recommendations.

The following section builds upon this evaluation and strategic framework to present structured conclusions and actionable recommendations regarding Vet Center service delivery within the North Central Indiana service area, informed by feasibility, operational considerations, and alignment with identified service conditions.

9 — CONCLUSIONS AND RECOMMENDATIONS

Section 9 presents the conclusions and recommendations of the North Central Indiana Vet Center Feasibility Assessment. This section builds upon the integrated analysis, service model framework, and comparative evaluation conducted in Sections 2 through 8.

Findings across these sections identified consistent patterns related to geographic access, population distribution, behavioral health conditions, socioeconomic factors, and stakeholder-validated system characteristics. Evaluation of service delivery approaches demonstrated that each model aligns with different aspects of the identified service environment, with no single approach uniformly addressing all conditions.

This section synthesizes these findings into structured conclusions and presents evidence-based recommendations regarding Vet Center service delivery strategies within the North Central Indiana service area.

Recommendations are developed based on multi-domain alignment and are intended to support informed decision-making regarding service delivery structure, operational considerations, and strategic direction.

9.1 – Purpose of Recommendations

This section presents structured, evidence-based recommendations derived from the findings and analysis contained within this assessment.

The integrated analysis and comparative evaluation conducted in preceding sections established consistent patterns across geographic access, population distribution, behavioral health conditions, socioeconomic factors, and stakeholder validation. Service delivery approaches were evaluated based on their alignment with these conditions.

Recommendations are informed by the degree of alignment between service delivery models and the identified service environment, emphasizing convergence across multiple analytical domains rather than reliance on any single indicator.

Recommendations are framed in relation to key evaluation factors, including geographic access, population coverage, continuity of care, service capacity, provider appropriateness, and system coordination.

This section translates analytical findings into structured decision-support guidance, providing a basis for evaluating service delivery strategies in relation to feasibility, operational considerations, and strategic alignment.

9.2 – Recommended Service Delivery Approach

Based on the integrated analysis and comparative evaluation presented in this assessment, a community-based Vet Center service model, supported by complementary outreach elements, demonstrates comparatively strong alignment with the service environment within the North Central Indiana service area.

Geographic analysis identified variability in access to behavioral health services across the region, including areas where travel time exceeds baseline thresholds. Population findings further indicate that the veteran population is distributed across multiple counties, including both population centers and rural areas. Together, these patterns reflect the presence of both localized access needs and broader geographic coverage considerations.

Evaluation of service delivery approaches indicates that a fixed-location, community-based model aligns most strongly with requirements related to continuity and consistency of care, provider specialization, and structured service delivery. These factors are particularly relevant in relation to behavioral health indicators reflecting co-occurring conditions and sustained service needs within the veteran population.

At the same time, geographic dispersion and access variability support the inclusion of supplemental outreach or mobile service components. These elements provide additional alignment with conditions related to travel burden and population reach, extending access without altering the core structure of a community-based model.

Stakeholder validation reinforces the importance of localized access, continuity of care, and provider familiarity with military-related behavioral health conditions. These observations are consistent with the characteristics of the Vet Center model as a specialized, community-based service approach.

When considered collectively, the convergence of geographic, population, behavioral health, and stakeholder findings supports a service delivery strategy that combines localized, consistent service availability with the ability to extend reach into areas with greater access constraints.

This recommendation reflects the strongest overall alignment between service delivery structure and the conditions identified across the assessment.

9.3 – Supporting Considerations for Recommended Approach

The recommended service delivery approach identified in Section 9.2 is supported by multiple reinforcing factors derived from the analytical findings and evaluation framework presented in this assessment.

Geographic patterns indicate variability in travel distance and proximity to services across the region, supporting the importance of localized access points. At the same time, population dispersion across counties highlights the need for supplemental outreach elements to extend service reach into more distant or rural areas.

Population distribution across both population centers and less densely populated areas further supports a combined service structure. A centralized service location provides a consistent point of access, while outreach elements extend engagement across a broader geographic area.

Behavioral health indicators reflect the presence of sustained and, in some cases, complex service needs. These conditions reinforce the importance of continuity and consistency of care associated with structured, fixed-location service delivery, while also highlighting the importance of accessible entry points for initial engagement.

Stakeholder validation emphasizes the need to balance access and continuity of care, as well as the importance of culturally appropriate services delivered by providers familiar with military-related conditions. These observations align with a community-based service model supported by outreach capabilities.

System-level considerations related to capacity and coordination further support this approach. The ability to deliver consistent services while extending reach across multiple areas depends on resource allocation, staffing, and coordination across service components. A combined model reflects these factors by integrating structured service delivery with flexible outreach strategies.

When considered collectively, these factors reinforce the alignment between the recommended service delivery approach and the service environment identified throughout the assessment. These considerations provide additional context supporting the recommendation presented in Section 9.2.

9.4 – Implementation Considerations / Pathway

The recommended service delivery approach identified in this assessment is intended to inform consideration within existing planning, evaluation, and implementation processes conducted by relevant agencies and stakeholders.

Implementation of any service delivery model involves factors such as policy requirements, resource allocation, operational capacity, and alignment with organizational priorities. While these factors are external to the scope of this assessment, they represent key considerations in determining how service delivery approaches may be evaluated and advanced.

Based on the findings of this assessment, initial implementation considerations include further evaluation of geographic service areas, population coverage, and potential service locations in relation to identified access patterns. Additional analysis may include assessment of projected service demand, resource requirements, and operational feasibility within existing service systems.

Integration of outreach or mobile service components represents an additional consideration in supporting access across geographically dispersed areas. These components may be structured to complement a fixed-location service model by extending service reach into areas with greater access constraints.

Stakeholder engagement remains an important component of any implementation process. The stakeholder validation conducted as part of this assessment reflects the presence of existing community partners and service providers that may support coordination, outreach, and service delivery planning.

Coordination with federal, state, and local entities represents an additional consideration in aligning service delivery approaches with existing programs, service networks, and operational frameworks.

These considerations provide structured context for evaluating potential next steps in planning, coordination, and implementation.

This section concludes the assessment by establishing a structured transition from evidence-based analysis and recommendations to potential future planning and decision-making. The findings presented in this report provide a comprehensive, data-informed foundation for evaluating Vet Center service delivery options within the North Central Indiana service area and support informed consideration of strategies to address identified service needs.

Appendix A — Methodology and Assessment Design

A.1 – Assessment Design Overview

This appendix provides a detailed technical expansion of the methodology summarized in Section 1 of this assessment. The assessment utilizes a structured multi-factor feasibility framework designed to evaluate regional access to Vet Center services through integration of quantitative and qualitative indicators. This framework incorporates geographic accessibility analysis, veteran population and demographic evaluation, behavioral health demand indicators, stakeholder input, and comparative service considerations.

The methodology is intentionally designed to avoid reliance on any single metric. Instead, findings are derived through convergence of multiple independent data sources, ensuring that conclusions reflect cumulative evidence rather than isolated indicators. This approach aligns with accepted feasibility assessment practices and supports objective, non-causal evaluation of service-access conditions.¹

This assessment is intended to function as a structured community feasibility evaluation rather than a formal Department of Veterans Affairs site-selection determination or operational authorization process. The methodology is designed to evaluate converging indicators associated with regional service accessibility, behavioral health context, stakeholder-observed access conditions, and population distribution in order to identify whether sufficient evidence exists to support further consideration of Vet Center service expansion or enhanced accessibility within the assessed region.

A.2 – Geographic Methodology

Geographic analysis within this assessment is based on a functional service-area model centered on North Central Indiana, with Kokomo serving as the analytical anchor due to its central location and concentration of supporting infrastructure.

Drive-time analysis was utilized as the primary geographic measurement method rather than straight-line distance. This approach more accurately reflects real-world access conditions, transportation routes, and observable service utilization behavior. Travel-time thresholds were defined as follows: ≤30 minutes (functional access), 31–60 minutes (moderate access burden), and >60 minutes (elevated access burden/service-gap conditions).

These classifications were applied consistently across the assessment to identify geographic disparities in service accessibility and to support comparative evaluation of regional coverage

¹ Multi-factor feasibility assessment frameworks commonly incorporate converging quantitative, qualitative, geographic, and stakeholder-informed analytical domains to support structured evaluation of complex service-access environments.

conditions. County-level classifications were assigned based upon the predominant observed travel-time condition affecting the majority of each county's veteran population. Limited localized overlap into shorter travel ranges was not treated as independently sufficient to alter primary county classification.

Geographic analysis incorporated generalized routing and travel-time approximation methodologies utilizing publicly available mapping systems,² roadway connectivity review, and regional routing analysis. Mapping products and travel-time visualizations contained within this assessment are intended to reflect broad regional access patterns rather than precise route-validated measurements for every individual location or travel scenario.

Geographic findings were evaluated in conjunction with demographic analysis, stakeholder-observed access conditions, and related behavioral health indicators in order to support integrated assessment of regional Vet Center accessibility.

A.3 – Data Collection Methodology

Data collection for this assessment was conducted using a multi-source approach integrating quantitative data, qualitative stakeholder input, and supplemental observational information.

Quantitative data sources included publicly available federal, state, institutional, and research-based datasets relevant to veteran population distribution, demographic characteristics, behavioral health conditions, and service-access indicators. Primary data sources utilized throughout the assessment included the Purdue University Military Family Research Institute (MFRI),³ U.S. Department of Veterans Affairs and Readjustment Counseling Service (RCS) reference materials, Indiana 211 service-request data, publicly available Health Professional Shortage Area (HPSA) information,⁴ and supplementary geographic and census-based reference data where applicable.

These data sources were selected to support consistent regional comparison and multi-domain evaluation of geographic accessibility, population distribution, behavioral health context, and observable service-demand conditions.

Qualitative data collection included structured stakeholder engagement through roundtable discussion, targeted data collection instruments, and follow-up outreach.

These efforts were designed to capture operational insights related to service demand, access barriers, referral patterns, and provider capacity.

² Geographic routing review incorporated generalized roadway-network analysis utilizing Google Earth Pro and publicly available transportation-routing information.

³ Purdue University Military Family Research Institute (MFRI), county-level veteran demographic and community-indicator datasets utilized throughout the regional assessment process.

⁴ U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA), Behavioral Health Professional Shortage Area reference datasets.

All collected data was reviewed and categorized according to the assessment framework to support consistent analytical application across all domains.

A.4 – Stakeholder Methodology

Stakeholder engagement was conducted using a structured approach designed to capture both operational and system-level perspectives on veteran service accessibility. Stakeholders were selected based on their involvement in veteran service delivery, behavioral health support, or related systems affecting veteran populations.

To ensure analytical consistency, stakeholders were classified into three categories: Anchor, Support, and Observer. Anchor stakeholders include direct service providers and entities with operational visibility into veteran care. Support stakeholders include organizations interacting with veterans through related systems such as housing, law enforcement, and community services. Observer stakeholders provide contextual insight but are not relied upon as primary evidence.

This classification framework allows for structured weighting of qualitative input, ensuring that findings are grounded in operational evidence while supported by broader system validation.

Stakeholder engagement findings were evaluated in conjunction with quantitative and geographic evidence to support balanced qualitative integration within the broader assessment framework.

A.5 – Analytical Integration Method

The assessment integrates multiple data domains through a structured synthesis process. Geographic accessibility data, population metrics, behavioral health indicators, and stakeholder input were evaluated both independently and collectively.

Findings were not derived from any single data source. Instead, analytical conclusions are based on patterns of alignment across multiple domains. For example, geographic access limitations were evaluated alongside stakeholder-reported travel burdens and service utilization patterns to confirm consistency across data types.

This integrated approach strengthens analytical reliability by ensuring that conclusions reflect corroborated evidence rather than isolated observations.

The assessment methodology intentionally emphasizes convergence across independent analytical domains rather than reliance upon isolated findings. Geographic access conditions, demographic distributions, behavioral health indicators, stakeholder observations, and service-system context were evaluated collectively to determine whether recurring patterns emerged across multiple categories of evidence.

This integrated analytical approach is intended to strengthen methodological reliability by reducing dependence on any single dataset, individual stakeholder perspective, or isolated regional condition. Findings presented throughout the assessment therefore reflect cumulative interpretation of corroborating indicators observed across the broader assessment framework.

A.6 – Limitations and Constraints

This assessment is subject to several limitations inherent in community-based feasibility analysis. Quantitative data availability varies by source and may not fully capture real-time service conditions. Certain provider-level data, including capacity and utilization, is limited or not publicly available.

Qualitative data is dependent upon stakeholder participation and may reflect localized or role-specific perspectives. While efforts were made to ensure diverse representation, not all potential stakeholders within the region were engaged.

Additionally, this assessment does not establish causation. Findings are intended to identify patterns, trends, and potential service-access challenges based on available evidence. All conclusions should be interpreted within the context of these limitations.

In addition, geographic mapping products and drive-time classifications contained within this assessment represent generalized analytical approximations intended to support regional comparison and access modeling. These visualizations should not be interpreted as precise route-specific calculations applicable to all individual travel circumstances.

Similarly, county-level classifications reflect predominant regional access patterns rather than universal conditions affecting every individual location within a county boundary. Localized variations in travel conditions, transportation access, and proximity to existing service locations may result in differing experiences among individual veterans residing within the same county.

Despite these limitations, the structured multi-factor methodology utilized throughout this assessment is intended to provide a balanced, reasonable, and evidence-informed evaluation of regional Vet Center accessibility conditions based upon the best available information at the time of analysis.

Appendix B — Stakeholder Engagement Documentation

This appendix provides a structured record of stakeholder participation supporting the North Central Indiana Vet Center Feasibility Assessment. Stakeholders are documented to ensure transparency, traceability, and methodological rigor in the incorporation of qualitative input.

Stakeholders are categorized based on their functional role and proximity to veteran service delivery systems, consistent with the classification framework defined in Section 1.5.

B.1 – Stakeholder Classification Definitions

Anchor Stakeholders (Primary Operational Sources): Organizations and professionals directly engaged in veteran service delivery, behavioral health care, case management, or clinical support functions. These stakeholders provide primary qualitative evidence due to direct interaction with veteran populations and service systems.

Support Stakeholders (System-Level Contributors): Organizations that interact with veterans through related systems such as crisis response, housing, workforce development, public safety, or community services. These stakeholders provide corroborating system-level insight and validation of observed service conditions.

Observer Stakeholders (Contextual Contributors): Organizations or individuals providing general community perspective, advocacy input, or indirect observations. These stakeholders contribute contextual understanding but are not relied upon as primary analytical sources.

B.2 – Stakeholder Engagement Scope Summary

Stakeholder engagement supporting this assessment included participation and consultation across multiple sectors involved in veteran service delivery, behavioral health support, crisis intervention, housing stability, justice-system interaction, veteran advocacy, and community support systems within the North Central Indiana assessment region.

Engagement activities included structured roundtable participation, follow-up outreach, data-submission requests, supplemental consultation, observational input, and indirect service-system reference analysis. Stakeholder representation included county veteran service organizations, behavioral health providers, veteran treatment court personnel, housing-support entities, law enforcement and crisis-intervention stakeholders, veteran advocacy organizations, state-level consultation participants, and community-support organizations.

Stakeholder engagement was conducted for the purpose of obtaining operational insight regarding observed veteran access conditions, referral patterns, behavioral health concerns, transportation considerations, service-system coordination, and perceived regional barriers affecting Vet Center accessibility.

Table B.1 - Stakeholder Engagement Summary

Engagement Metric	Count
Total Stakeholders Identified	58
Anchor Stakeholders	24
Confirmed Participation	27
Roundtable Attendance	15
Stakeholder Sectors Represented	11

Table B.2 - Stakeholder Participation & Classification Summary

Organization / Entity	Representative Name	Functional Role	Classification	Engagement Type	Notes
Howard County Veterans Service Office	Dale Truax James Clark	County Veteran Service Officer	Anchor Stakeholder	Data Submission/ Roundtable	High service volume; behavioral health demand insight
Howard County Veterans Treatment Court	Blake Dahl/Christine Oyler	Program Coordinator	Anchor Stakeholder	Data Submission / Roundtable	High PTSD/SUD prevalence; travel burden data
Community Howard Behavioral Health	Chad Myers	Behavioral Health Provider	Anchor Stakeholder	Roundtable	Capacity constraints and provider-access conditions discussed
VA Medical Centers (Marion / Indianapolis / Fort Wayne)	Regional Referral Systems	Referral Providers	Anchor Stakeholder	Reference Data	Primary referral destinations
Readjustment Counseling Service (RCS)	Josh Martin	Vet Center Service System	Support Stakeholder	Consultation / Reference	Existing Vet Center access and regional service context

Organization / Entity	Representative Name	Functional Role	Classification	Engagement Type	Notes
Indiana Department of Veterans Affairs (IDVA)	Jake Adams Bryan Schmidt Josh Tolen	State-Level Veteran Services	Support Stakeholder	Consultation	Facilitated stakeholder visibility and regional coordination
Indiana 211	Reference Dataset	Community Service Coordination	Support Stakeholder	Reference Data	Community-level service-demand context
Local Law Enforcement (CIT / Crisis Response)	Sgt Markley-HCSO/ David Huff DCSO	Law Enforcement	Support Stakeholder	Roundtable and Data Submission	Crisis response interface with veterans
Kokomo Housing Authority	Megan Henry	Housing Services	Support Stakeholder	Data Submission	Housing stability and homelessness considerations
Family Service Association	Angie Siske	Executive Director	Support Stakeholder	Data Submission	Behavioral health and community support insight
Indiana National Guard	Sylvia Maixner	Prevention Analyst	Support Stakeholder	Consultation	Guard/Reserve behavioral health insight
Veteran Service Organizations (DAV, VFW, etc.)	Jason Anderson/ DAV Penny Johnson/ DAV	Advocacy / Veteran Support	Support Stakeholder	Roundtable and Data Capture	Veteran engagement and referral observations
Community-Based Organizations	Eli Ireland-Work1/ David Huffman- NAMI Debbie Norris- United Way Tim Pore LVER	Community Support	Observer Stakeholder	Roundtable and Data Submission	General community-level observations
Elected Officials	Tyler Moore-Mayor/ Roger Spencer- Comm. Cass Co.	Community Support	Observer Stakeholder	Roundtable	Government system insight

Organization / Entity	Representative Name	Functional Role	Classification	Engagement Type	Notes
Community Service Providers	Ken Gardner-Counselor Levi Evans- 4C Health	Service Provider	Anchor Stakeholder	Roundtable	Capacity constraints and provider-access conditions discussed

The following definitions describe engagement terminology utilized throughout stakeholder participation documentation within this assessment.

Table B.3 - Engagement Terminology Definitions

Engagement Type	Definition
Roundtable Participation	Direct participation in structured stakeholder discussion session
Data Submission	Completion of structured data collection instrument
Follow-Up Input	Additional qualitative or clarifying information provided post-engagement
Reference Data	Indirect inclusion through documented service utilization, referral patterns, or supporting service-system information
Consultation	Supplemental consultation or coordination visibility supporting broader assessment understanding

B.3 – Notes on Attribution

Consistent with the assessment’s methodological approach, stakeholder input is generally presented in aggregated form throughout the report (e.g., “behavioral health providers indicated,” “county veteran service officers reported”) to maintain analytical clarity and avoid over-attribution unless specific statements are directly verifiable and strategically necessary.

B.4 – Stakeholder Engagement Limitations

Stakeholder participation varied based on organizational availability, operational schedules, and willingness to participate during the assessment period. While efforts were made to obtain broad regional representation, participation levels differed among sectors and organizations.

The absence of participation by any individual organization should not be interpreted as agreement or disagreement with assessment findings.

Stakeholder input was incorporated as one component within the broader analytical framework and was evaluated in conjunction with quantitative and geographic evidence throughout the assessment process.

B.5 – Analytical Role of Stakeholder Engagement

Stakeholder engagement contributed operational context regarding travel burden, referral behaviors, provider-capacity observations, crisis-system interaction, and broader service-access conditions affecting veterans within the assessed region.

Qualitative findings were not treated as independently determinative but were evaluated in conjunction with quantitative and geographic evidence to identify recurring patterns across multiple analytical domains.

Appendix C — Geographic and Mapping Products

C.1 – Purpose and Scope

This appendix provides the full geographic and mapping products supporting the North Central Indiana Regional Vet Center Feasibility Assessment. The mapping products contained within this appendix provide supplemental geographic visualization and contextual support for the findings presented throughout the main report.

The mapping products are intended to visually support the assessment findings by showing the relationship between the 17-county assessment region, existing Vet Center service locations, estimated drive-time access zones, county-level access classifications, rural-urban context, and county-level digital divide conditions.

These products are supporting analytical figures. They are not intended to function as engineering-grade GIS outputs, formal VA site-selection maps, or precise route-specific determinations for every individual residence or travel scenario.

Consistent with the report's analytical structure, supporting geographic figures are consolidated within this appendix while primary synthesis mapping remains within the main report narrative.

C.2 – Mapping Methodology and Interpretation Notes

The mapping products use generalized regional access modeling and county-level classification logic consistent with the methodology described in Section 2 and Appendix A. Drive-time zones are presented as conceptual access proxies based on typical roadway connectivity and regional travel patterns. County-level access classifications are based on the predominant observed travel-time condition affecting the majority of each county's veteran population, with localized overlap into shorter travel ranges not independently altering the primary designation.

County boundaries and county labels are included to improve interpretability and to support comparison across the 17-county assessment region. Where labels are visually constrained by county size or map scale, line breaks or abbreviated placement may be used for readability.

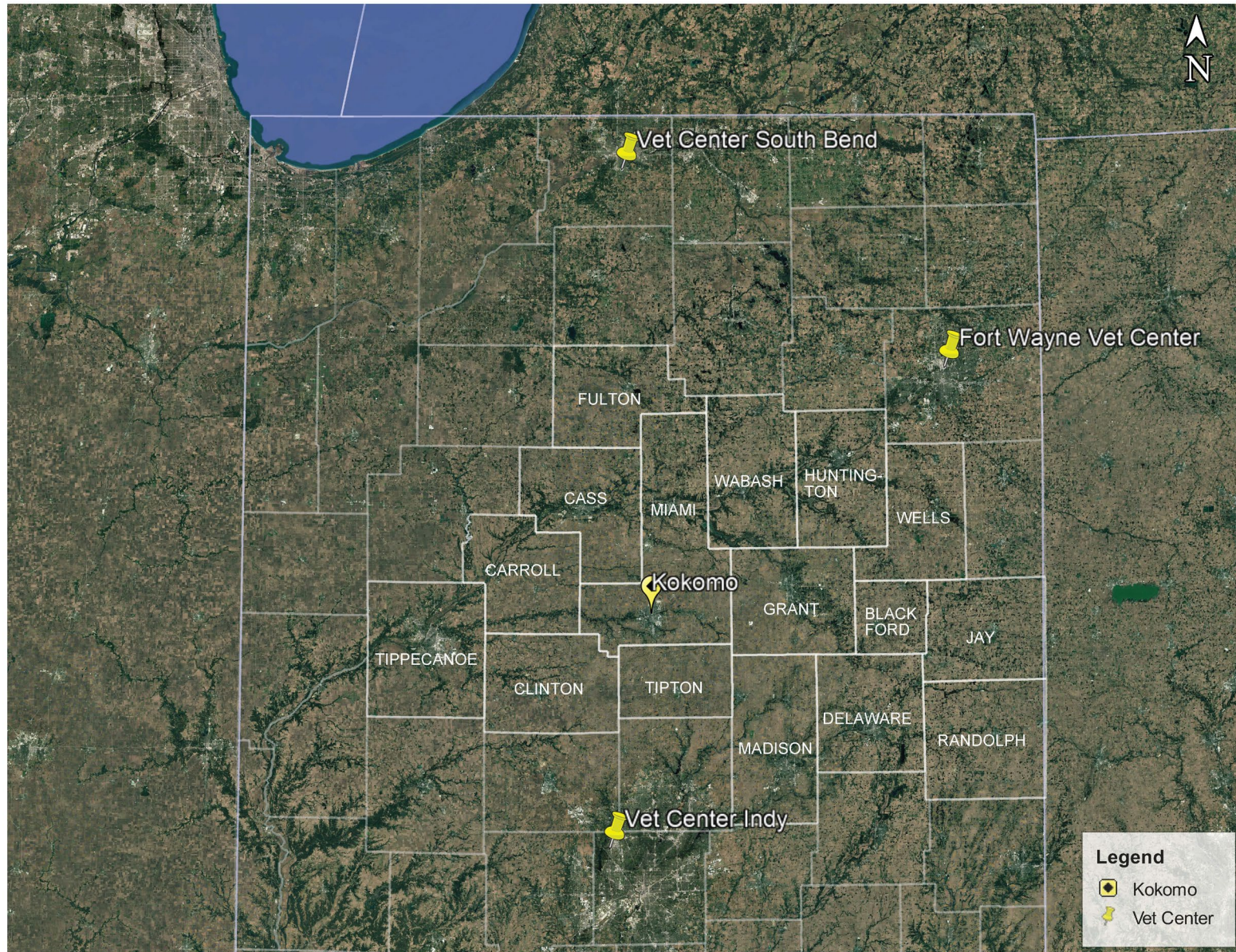
C.3 – Figure Inventory

Figure	Title	Analytical Purpose
Figure C.1	Baseline Vet Center Locations	Shows the North Central Indiana assessment region in relation to existing Vet Center locations serving Indiana.
Figure C.2	30-Minute Vet Center Drive-Time Coverage	Shows approximate 30-minute access zones associated with existing Vet Center locations.
Figure C.3	60-Minute Vet Center Drive-Time Coverage	Shows approximate 60-minute access zones associated with existing Vet Center locations.
Figure C.4	Rural-Urban Distribution and Access Context	Shows rural, micropolitan-adjacent, and metro/urban context across the assessment region.
Figure C.5	Digital Divide Index by County	Shows relative county-level digital access conditions used as contextual support for access analysis.

C.4 – General Figure Notes

Unless otherwise noted, displayed coverage zones represent generalized drive-time approximations and do not reflect full county-level routing validation. County-level classifications represent predominant access conditions and should not be interpreted as definitive travel-time determinations for every individual location within a county. The main report narrative remains the controlling interpretation of these figures.

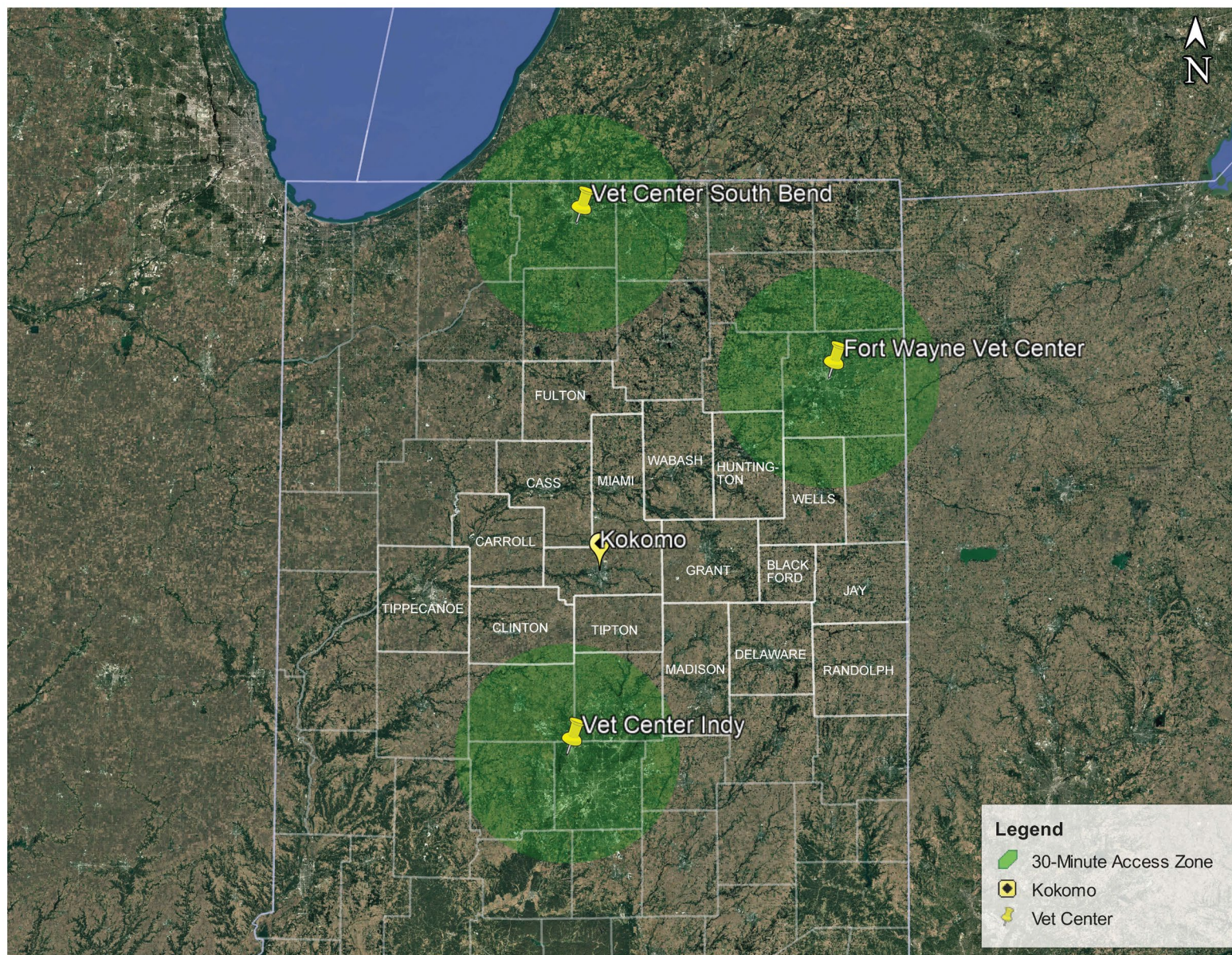
Figure C.1 – Baseline Vet Center Locations



Source: U.S. Department of Veterans Affairs Readjustment Counseling Service (RCS); assessment-developed regional mapping analysis.

Note: This figure provides baseline geographic context for existing Vet Center locations relative to the North Central Indiana assessment region.

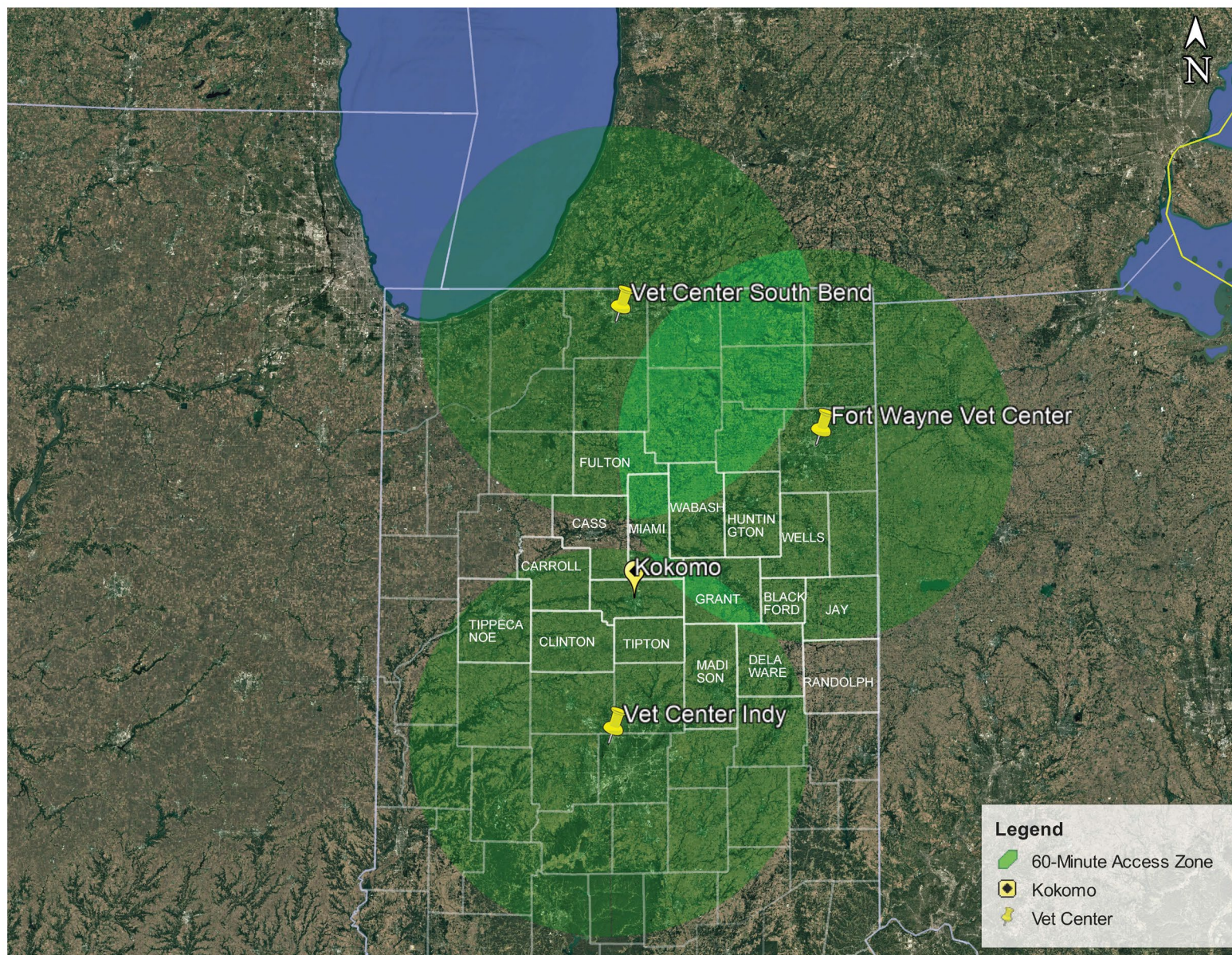
Figure C.2 – 30-Minute Vet Center Drive Time Coverage



Source: U.S. Department of Veterans Affairs Readjustment Counseling Service (RCS); Google Earth Pro regional routing analysis; assessment-developed drive-time accessibility modeling.

Note: Shaded areas represent approximate 30-minute drive-time access zones based on typical regional travel conditions. These zones are conceptual access proxies and are not exact route-based travel-time calculations.

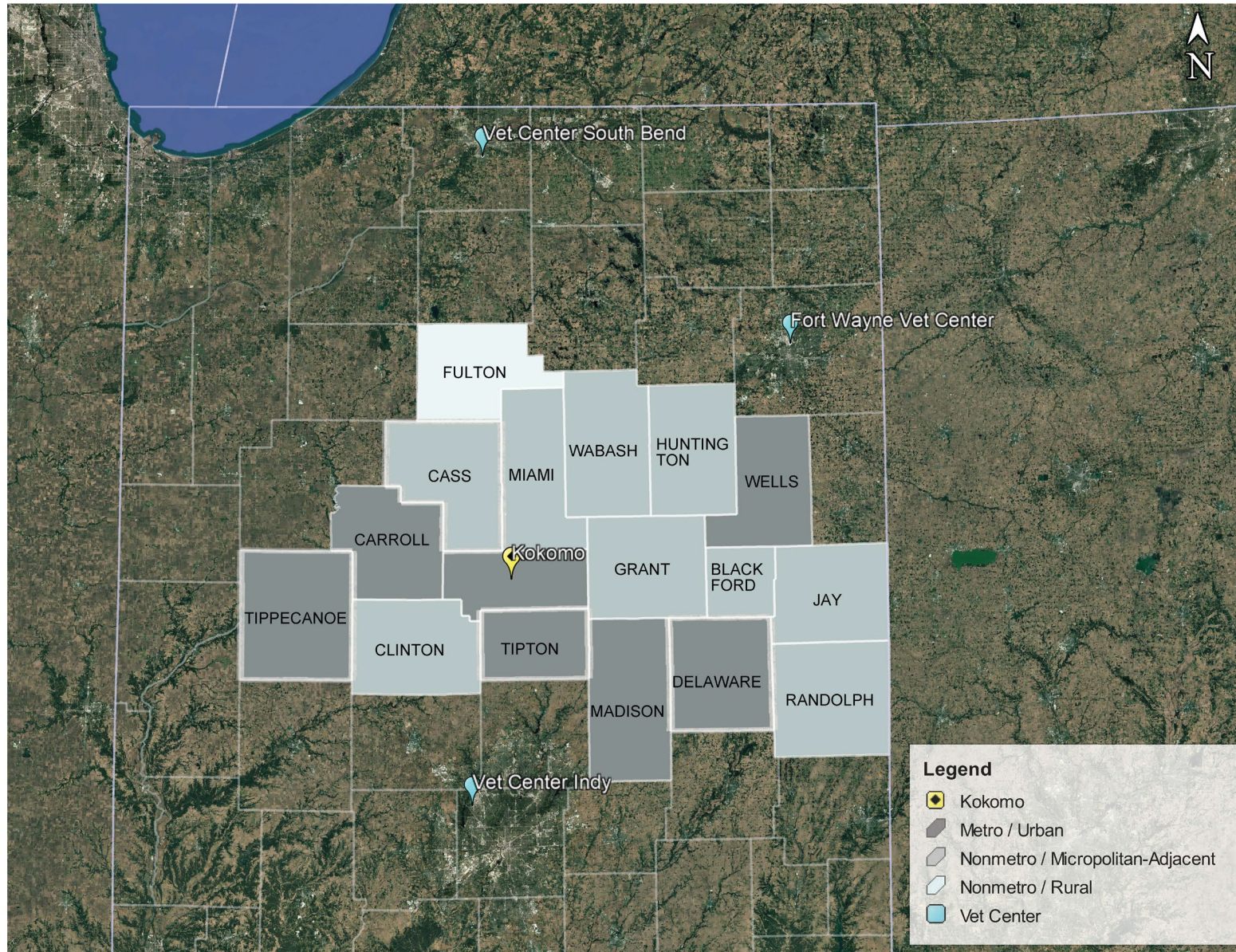
Figure C.3 – 60-Minute Vet Center Drive Time Coverage



Source: U.S. Department of Veterans Affairs Readjustment Counseling Service (RCS); Google Earth Pro regional routing analysis; assessment-developed drive-time accessibility modeling.

Note: Displayed coverage zones represent generalized drive-time approximations and do not reflect full county-level routing validation.

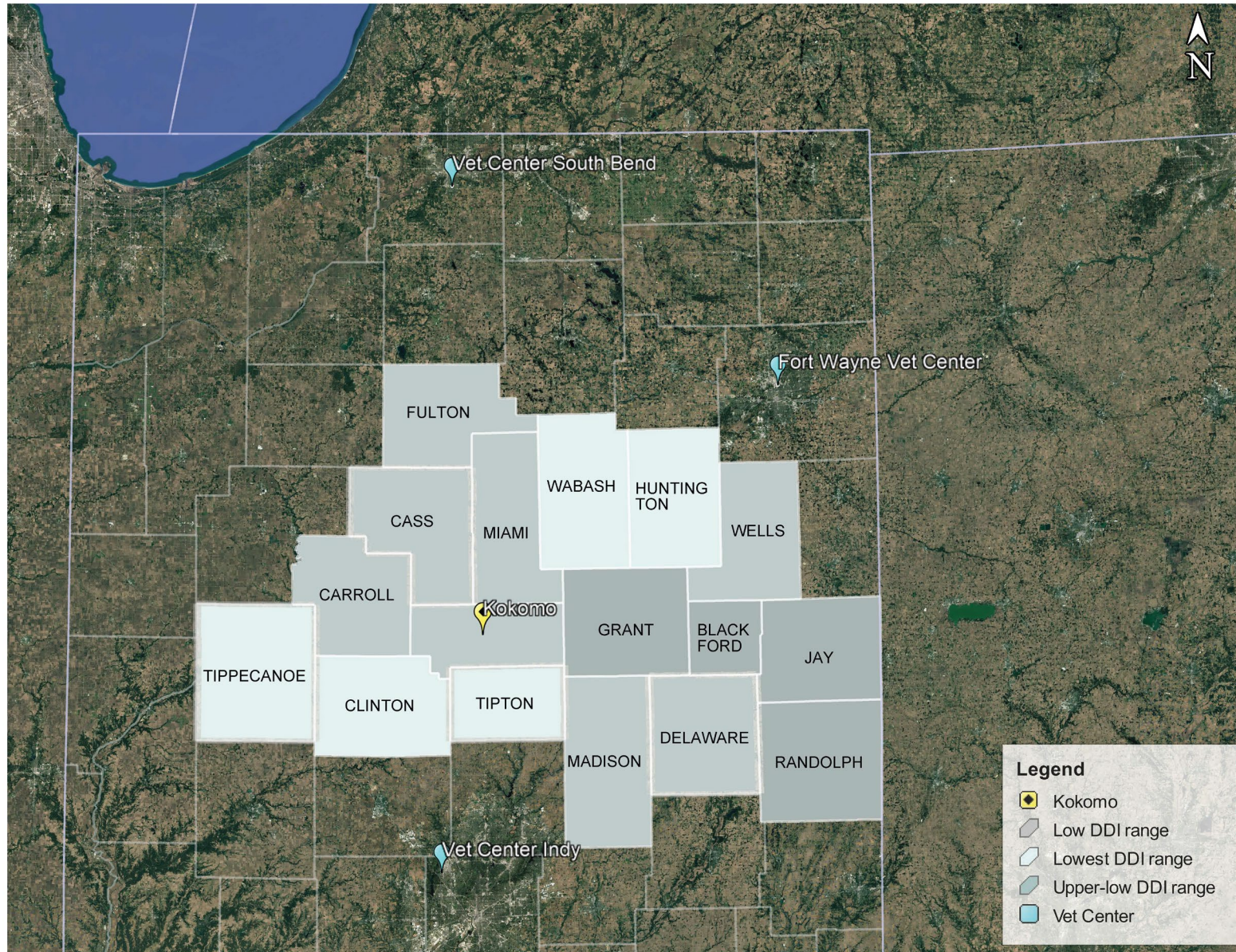
Figure C.4 – Rural - Urban Distribution and Access Context



Source: Purdue University Military Family Research Institute (MFRI); assessment-developed regional geographic contextual analysis.

Note: This figure provides contextual support for interpreting geographic access conditions alongside rural, micropolitan-adjacent, and metro/urban county characteristics.

Figure C.5 – Digital Divide Index by County



Source: Purdue University Military Family Research Institute (MFRI), county-level Digital Divide Index datasets utilized for regional access-context evaluation.

Note: Digital Divide Index categories are used as contextual indicators of digital access conditions and should be interpreted as supporting access context rather than standalone feasibility determinants.

Appendix D — Quantitative Data Tables

This appendix provides supplemental quantitative data supporting the North Central Indiana Regional Vet Center Feasibility Assessment. The tables contained within this appendix are intended to provide expanded demographic, geographic, and population-reference context supporting the analytical findings summarized throughout the main body of the assessment.

Quantitative tables included within this appendix are presented primarily for evidentiary transparency and methodological support. These data tables are not independently determinative and should be interpreted in conjunction with the geographic, behavioral health, stakeholder, and integrated analytical findings discussed throughout the assessment.

Unless otherwise noted, veteran demographic and population estimates contained within this appendix were derived from publicly available data sources, including the Purdue University Military Family Research Institute (MFRI), supplemental census-based references, and related publicly available veteran-population datasets utilized throughout the assessment process.

D.1 – Regional Veteran Population Summary

The North Central Indiana assessment region evaluated within this report includes a 17-county functional service area centered around Kokomo, Indiana. The regional population structure reflects a diverse veteran population distributed across metropolitan, micropolitan, and rural communities exhibiting varying access conditions relative to existing Vet Center service locations.

The following table summarizes estimated veteran population distribution utilized throughout the assessment framework.

Table D.1 - County-Level Veteran Population and Access Classification

County	Veteran Population	% of Regional Total	Primary Access Tier
Howard	5,164	11.23%	Tier III
Cass	2,108	4.58%	Tier III
Miami	2,270	4.94%	Tier III
Clinton	1,338	2.91%	Tier II
Delaware	5,052	10.99%	Tier III
Tipton	808	1.76%	Tier II
Fulton	943	2.05%	Tier II
Grant	4,367	9.50%	Tier II
Wabash	1,539	3.35%	Tier II
Carroll	1,259	2.74%	Tier III
Huntington	1,991	4.33%	Tier II
Blackford	738	1.60%	Tier III
Wells	1,229	2.67%	Tier II
Jay	907	1.97%	Tier III
Randolph	1,498	3.26%	Tier III
Madison	8,238	17.91%	Tier II
Tippecanoe	6,538	14.22%	Tier III
TOTAL	45,987	100%	—

Source: Purdue University Military Family Research Institute (MFRI); assessment-developed regional drive-time accessibility classification analysis utilizing generalized routing and travel-time review methodologies.

Note: County-level access classifications were determined using validated drive-time routing to the nearest existing Vet Center locations and reflect observed travel conditions rather than straight-line distance.

Classifications represent the predominant travel-time condition affecting the majority of each county’s population, with localized overlap into shorter travel ranges not altering the primary designation. No counties within the assessed region meet the ≤30-minute (Tier I) access threshold.

These county-level classifications provide supplemental quantitative support for the geographic-access findings summarized within Sections 2 and 3 of the assessment.

D.2 – Veteran Age and Sex Distribution

Regional veteran demographic composition reflects a predominately older veteran population with substantial Vietnam-era representation. The following table summarizes estimated age and sex distribution across the assessed region.

Table D.2 - Veteran Population by Age Group and Sex

Age Group	Male	Female	Total
18–34	3,233	487	3,720
35–54	7,836	1,437	9,273
55–64	7,264	1,077	8,341
65–74	10,755	552	11,307
75+	11,443	162	11,605
TOTAL	40,531	3,715	44,246

Source: Purdue University Military Family Research Institute (MFRI), county-level veteran age and sex demographic datasets aggregated for regional analysis.

Methodological Note: Demographic subgroup totals presented within this appendix reflect the specific underlying MFRI demographic extraction datasets utilized during the demographic analysis phase of the assessment. Due to subsequent refinement of the regional study area, updated veteran population estimates, and later-stage regional total standardization applied elsewhere within the assessment, aggregate demographic subtotals may not reconcile precisely with the final regional veteran population total presented in the primary report narrative. These differences do not materially affect the analytical conclusions of the assessment.

D.3 – Veteran Era-of-Service Distribution

Era-of-service composition was evaluated to support contextual interpretation of the regional veteran population structure and associated behavioral health and readjustment considerations.

The following table summarizes estimated veteran population distribution by era of service across the assessed region.

Table D.3 - Veteran Population by Era of Service

Era of Service	Estimated Veteran Population	% of Regional Total
Gulf War (Post-9/11)	9,679	21.9%
Gulf War (1990–2001)	8,363	18.9%
Vietnam Era	15,216	34.4%
Korean War Era	2,503	5.7%
World War II Era	324	0.7%
Other / Unclassified	8,161	18.4%
TOTAL	44,246	100%

Source: Purdue University Military Family Research Institute (MFRI), county-level veteran era-of-service demographic datasets utilized for regional aggregation and comparative demographic analysis.

D.4 – Veteran Household Composition

Household composition indicators were reviewed to provide additional contextual understanding regarding family structure and potential downstream impacts associated with veteran service accessibility and support-system engagement. The following table summarizes estimated veteran household composition across the assessed region.

Table D.4 - Veteran Household With and Without Children

Household Type	Estimated Households	% of Total
Veteran Households Without Children	35,412	81.2%
Veteran Households With Children	8,203	18.8%
TOTAL	43,615	100%

Source: Purdue University Military Family Research Institute (MFRI), county-level veteran household composition datasets utilized for regional contextual analysis.

D.5 – Quantitative Data Limitations

Quantitative estimates contained within this appendix are subject to the limitations associated with publicly available demographic and institutional datasets.

Variations in reporting periods, extraction methodologies, aggregation procedures, and source-update cycles may result in minor discrepancies across datasets.

Differences between certain demographic totals and regional veteran population estimates reflect variations in source datasets, reporting structures, available demographic categories, and reporting methodologies across publicly available data systems utilized throughout this assessment.

Population values presented throughout this appendix are intended to support broad regional analysis and comparative assessment rather than precise operational forecasting.

These quantitative indicators are evaluated collectively with geographic analysis, behavioral health indicators, and stakeholder observations as part of the broader multi-factor assessment methodology utilized throughout the report.

Appendix E — Behavioral Health & Access Indicators

This appendix provides supplemental behavioral health, access-condition, and service-environment indicators supporting the North Central Indiana Regional Vet Center Feasibility Assessment. The indicators summarized within this appendix are intended to provide contextual evidence regarding regional behavioral health conditions, provider-access considerations, and broader service-system factors relevant to veteran populations residing within the assessed region.

Behavioral health and access indicators presented within this appendix are evaluated as contextual analytical support rather than independently determinative measures of feasibility. These indicators are intended to be interpreted collectively with geographic accessibility analysis, demographic conditions, stakeholder observations, and integrated assessment findings presented throughout the report.

E.1 – Behavioral Health Analytical Framework

Behavioral health conditions and service-access indicators were incorporated into the assessment framework in order to evaluate broader environmental and systemic factors potentially affecting veteran populations within the North Central Indiana assessment region.

Indicators reviewed throughout the assessment included behavioral health professional shortage conditions, regional access limitations, generalized behavioral health demand context, digital-access conditions, and supplemental stakeholder observations related to provider availability, transportation burden, and continuity-of-care considerations.

These indicators were evaluated using a multi-factor analytical approach intended to identify recurring patterns across multiple independent domains rather than reliance upon any single behavioral health metric or utilization indicator.

E.2 – Behavioral Health Professional Shortage Area Context

Behavioral Health Professional Shortage Area (HPSA) information was reviewed as part of the assessment process to evaluate regional behavioral health provider-access conditions affecting communities within the assessed service area. Review of publicly available HPSA information¹ indicated the presence of behavioral health provider-access limitations affecting multiple portions of the North Central Indiana assessment region.

These shortage-area indicators were evaluated as contextual evidence regarding broader behavioral health service capacity and regional provider availability.

HPSA indicators were not interpreted as veteran-specific measurements.

¹ U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA), Behavioral Health Professional Shortage Area (HPSA) reference datasets utilized during assessment development.

Rather, they were evaluated as generalized regional indicators reflecting broader community-level behavioral health access conditions potentially influencing service accessibility for veteran populations residing within the assessed region.

E.3 – Suicide and Behavioral Health Context Indicators

Behavioral health context within the assessment region was additionally evaluated using publicly available suicide-context and behavioral health reference information where applicable. These indicators were utilized to provide broader contextual understanding regarding behavioral health conditions affecting veteran and non-veteran populations at the state and regional level.

These indicators were not utilized to establish direct causation between geographic access conditions and behavioral health outcomes. Instead, they were evaluated as supporting contextual indicators contributing to the broader understanding of behavioral health environment and potential service-demand considerations within the assessment region.

Table E.1 - Behavioral Health Indicators by Age Group

Metric	Observed Value	Source
Younger Veterans (18–34)	Elevated suicide risk relative to other age groups	U.S. Department of Veterans Affairs Data
Mid-Life Veterans (35–54)	Sustained behavioral health demand and service utilization	Comparative Analysis
Older Veterans (Vietnam Era)	Delayed engagement and underutilization of services reported	Stakeholder Roundtable Input
Telehealth Acceptance	Older and lower-income veterans less likely to use telehealth	Stakeholder Roundtable Input
Cross-Generational Demand	Behavioral health needs present across all age groups	Assessment Analysis
Alignment with Population Distribution	Consistent with multi-era veteran population structure	Comparative Analysis

Source: U.S. Department of Veterans Affairs behavioral health reporting; stakeholder roundtable input; assessment-derived comparative analysis.

State-level data indicates that younger veteran populations exhibit higher relative suicide rates compared to other age groups, while sustained rates across older cohorts indicate continued behavioral health risk across the population.

These observations provide demographic context for understanding variation in behavioral health risk across different segments of the veteran population.

E.4 – Digital Divide and Access-Condition Indicators

Digital-access conditions were evaluated as a supplemental component of the broader service-access analysis framework. Review of Digital Divide Index (DDI) indicators was conducted in order to identify potential technology-access considerations affecting communication, telehealth accessibility, information access, and broader service connectivity within portions of the assessed region.

Digital-access indicators were interpreted in conjunction with rurality, transportation considerations, and stakeholder observations regarding service accessibility. These indicators were not independently determinative but were evaluated as part of the broader assessment of access-related conditions potentially affecting veteran populations across the region. The following indicators summarize observed service-access delays, provider-capacity limitations, and system-friction conditions affecting portions of the assessed region.

Table E.2 - Behavioral Health Wait Times and Availability Constraints

Metric	Observed Value	Source	Analytical Relevance
Typical Wait Time (VA Services)	2–3 months	County Veteran Service Officer Data	Indicates delayed access to care
Typical Wait Time (Community Care)	Comparable (2–3 months)	County Veteran Service Officer Data	Suggests system-wide capacity constraint
Initial Scheduling Delay	6–8 weeks	Stakeholder Roundtable Input	Reflects operational backlog
Appointment Reliability	Frequent cancellations/rescheduling	Stakeholder Roundtable Input	Reduces continuity of care
Standard Compliance	Exceeds 30-day Mission Act standard	Comparative Analysis	Indicates failure to meet access benchmarks
Impact on Engagement	Veterans disengage due to delays	Assessment Analysis	Demonstrates behavioral impact of system constraints

Source: County Veteran Service Officer observations; stakeholder roundtable input; assessment-derived comparative analysis.

Note: For contextual reference only, the VA MISSION Act community care access standards identify routine specialty care drive-time thresholds of approximately 60 minutes for designated rural areas.² This benchmark is not

² U.S. Department of Veterans Affairs MISSION Act community care access standards referenced solely as comparative contextual access benchmarks and not as formal Vet Center placement criteria.

a formal Vet Center placement criterion and is included solely as a comparative access-reference framework when evaluating regional travel burden conditions within the assessed area.

Table E.2 summarizes observed wait times and service availability constraints within the behavioral health system. These indicators reflect delays in access and variability in appointment availability across service providers.

Table E.3 - Behavioral Health Provider Capacity and Availability Constraints

Metric	Observed Value	Source	Analytical Relevance
Provider Intake Capacity	Providers not accepting new patients	Stakeholder Roundtable Input	Indicates system saturation
Staffing Levels	Behavioral health staffing shortages	Stakeholder Roundtable Input	Contributes to delays and reduced access
Service Availability	Limited local behavioral health services	Stakeholder Roundtable Input	Reinforces geographic and capacity gaps
Cultural Competency	Limited military-specific expertise	Stakeholder Roundtable Input	Affects appropriateness of care
Continuity of Care	Disruptions when providers leave	Stakeholder Roundtable Input	Impacts treatment stability
Impact on Access	Capacity limits availability and appropriateness	Assessment Analysis	Links provider constraints to system performance

Source: Stakeholder roundtable input; assessment-derived provider-capacity and service-access analysis.

Table E.3 summarizes observed provider capacity and availability constraints within the assessed region. These indicators reflect limitations in provider availability, intake capacity, and service specialization.

E.5 – Provider Capacity and Service-System Context

Stakeholder engagement and supplemental provider observations identified recurring themes associated with behavioral health provider availability, service-capacity limitations, referral-system burden, and continuity-of-care considerations affecting portions of the assessed region.

These observations included discussion related to:

- Behavioral health provider availability
- Service wait times and referral burden
- Transportation and travel-related access considerations
- Crisis-system interaction involving veterans
- Service coordination challenges across regional systems
- Rural and non-metropolitan access considerations

Provider-capacity observations were evaluated qualitatively and incorporated into the broader integrated assessment methodology utilized throughout the report.

The following table summarizes observed clinical indicators among Veterans Treatment Court participants representing a high-acuity subset of veterans engaged in structured intervention programs.

Table E.4 - Clinical Indicators from Veterans Treatment Court Participants

Metric	Observed Value	Source
PTSD Prevalence	Approximately 90% within high-acuity program participants	Veterans Treatment Court Program Data
Substance Use Disorder (SUD)	Approximately 95% prevalence among participants	Veterans Treatment Court Program Data
Co-Occurring PTSD and SUD	Approximately 95% co-occurrence rate	Veterans Treatment Court Program Data
Depression/Anxiety	Widely present across participants	Veterans Treatment Court Program Data
Traumatic Brain Injury (TBI)	Present within a significant subset (~50%)	Veterans Treatment Court Program Data
Population Context	Represents high-acuity subset engaged in structured intervention programs	Assessment Analysis
Interpretation Context	Not representative of general population; reflects elevated-need cases	Assessment Methodology

Source: Veterans Treatment Court program observations and stakeholder-provided program context utilized during assessment development.

These data reflect a population experiencing multiple co-occurring behavioral health conditions with high levels of clinical complexity. While Veterans Treatment Court participants represent a high-acuity subset and are not representative of the broader veteran population, these observations provide insight into conditions present among veterans experiencing elevated behavioral health need.

E.6 – Socioeconomic and Environmental Context

The following indicators provide supplemental socioeconomic and environmental context relevant to behavioral health access, service engagement, and continuity-of-care conditions within the assessed region.

Table E.5 - Socioeconomic Indicators Summary

Metric	Observed Value	Source
Income Variation	Variation observed across counties within the service area	Purdue University Military Family Research Institute Data
Poverty Presence	Veteran poverty present across portions of the population	Purdue University Military Family Research Institute Data
Employment Variability	Differences observed between veteran and non-veteran employment conditions	Purdue University Military Family Research Institute Data
Housing Stability	Housing instability present within a subset of veterans	Purdue University Military Family Research Institute Data
Rural Characteristics	Mixed rural and semi-urban conditions influencing access	Comparative Analysis
Impact on Engagement	Socioeconomic conditions influence ability to access and sustain care	Assessment Analysis

Source: Purdue University Military Family Research Institute (MFRI); assessment-derived comparative socioeconomic analysis.

Table E.6 summarizes key socioeconomic indicators relevant to the assessed region, including measures related to income, employment, housing stability, and community characteristics.

Table E.6 - Veteran and Non-Veteran Population Below Poverty Line

Metric	Observed Value	Source
Veteran Poverty Rates	Present across multiple counties with varying intensity	Purdue University Military Family Research Institute Data
Non-Veteran Poverty Rates	Present across general population	Purdue University Military Family Research Institute Data
Comparative Trends	No uniform pattern; variation by county	Comparative Analysis
Geographic Distribution	Higher burden observed in certain rural areas	Purdue University Military Family Research Institute Data
Impact on Access	Financial constraints affect service utilization and engagement	Assessment Analysis

Source: Purdue University Military Family Research Institute (MFRI), county-level poverty and demographic datasets.

The table above provides comparative data regarding poverty levels among veteran and non-veteran populations, supporting evaluation of financial conditions that may influence service access and utilization.

Table E.7 - Veteran and Non-Veteran Unemployment Rates

Metric	Observed Value	Source
Veteran Unemployment	Present across counties with regional variation	Purdue University Military Family Research Institute Data
Non-Veteran Unemployment	Comparable but varies by locality	Purdue University Military Family Research Institute Data
Employment Stability	Inconsistent across service area	Purdue University Military Family Research Institute Data
Economic Stress Indicators	Employment instability contributes to financial strain	Assessment Analysis
Impact on Care Engagement	Employment conditions affect ability to seek and maintain treatment	Assessment Analysis

Source: Purdue University Military Family Research Institute (MFRI), county-level employment and unemployment datasets.

The table above summarizes employment-related indicators within the assessed region, providing context for economic conditions that may influence behavioral health and service engagement.

Table E.8 - Housing Stability and Support Indicators

Metric	Observed Value	Source
Housing Instability	Veterans experiencing prolonged instability, including extended periods without housing	Stakeholder Roundtable Input
Homelessness Link to Behavioral Health	Approximately 80% of homeless veterans reported to have behavioral health conditions	Stakeholder Roundtable Input
Housing Support Limitations	Limited availability of housing resources and strict eligibility requirements	Stakeholder Roundtable Input
Transportation + Housing Interaction	Lack of stable housing contributes to access barriers	Assessment Analysis
Impact on Continuity of Care	Instability reduces ability to maintain consistent engagement with services	Assessment Analysis

Source: Stakeholder roundtable input; assessment-derived housing and continuity-of-care contextual analysis.

The table above summarizes housing-related indicators relevant to the assessed region, providing context for environmental conditions that may influence behavioral health risk and continuity of care.

E.7 – Behavioral Health and Access Indicator Limitations

Behavioral health and access indicators utilized throughout this appendix are subject to limitations associated with publicly available datasets, generalized shortage-area classifications, and regional contextual analysis. Certain provider-capacity metrics and utilization data are either unavailable publicly or not consistently reported across all organizations and jurisdictions.

Additionally, behavioral health indicators reviewed within this appendix reflect generalized community-level conditions and are not exclusively veteran-specific unless otherwise identified.

These indicators should therefore be interpreted as contextual evidence contributing to the broader analytical framework rather than definitive measurements of veteran behavioral health outcomes.

Consistent with the overall assessment methodology, findings associated with behavioral health and access indicators were evaluated collectively with geographic analysis, demographic conditions, and stakeholder observations in order to support balanced, evidence-informed assessment of regional Vet Center accessibility conditions.

Appendix F — Source Documentation & Reference Framework

This appendix provides a structured overview of the primary data sources, institutional references, mapping resources, and supporting materials utilized throughout the North Central Indiana Regional Vet Center Feasibility Assessment.

The purpose of this appendix is to support methodological transparency, evidentiary traceability, and analytical consistency by documenting the principal reference frameworks informing the assessment process. Sources identified within this appendix were utilized for contextual analysis, geographic evaluation, demographic review, behavioral health assessment, stakeholder support, and supplemental service-system reference throughout the report.

The inclusion of a source or reference within this appendix does not imply endorsement, authorship, sponsorship, or formal participation in the assessment process unless explicitly stated elsewhere within the report.

F.1 – Federal Veteran-Service and Readjustment References

The assessment incorporated publicly available federal veteran-service and readjustment reference materials relevant to Vet Center accessibility, veteran behavioral health considerations, and broader service-system context. These references were utilized to support contextual understanding of existing Vet Center structures, referral systems, and veteran support environments.

Primary federal references included:

- U.S. Department of Veterans Affairs (VA)
- Readjustment Counseling Service (RCS)
- Veterans Health Administration (VHA)
- VA facility and Vet Center public-reference materials
- Publicly available veteran demographic and behavioral health reference materials

These references informed analysis associated with Vet Center service structure, readjustment counseling access considerations, behavioral health context, and community-based service-delivery frameworks relevant to the assessment.

F.2 – Purdue University Military Family Research Institute (MFRI) References

Veteran demographic, population-distribution, and selected socioeconomic indicators utilized throughout the assessment were substantially informed by publicly available materials published through the Purdue University Military Family Research Institute (MFRI), including the Measuring Communities initiative and associated regional veteran datasets.

MFRI-derived information was utilized to support:

- Veteran population estimation
- Age and sex distribution analysis
- Era-of-service distribution analysis
- Household-composition analysis
- Supplemental socioeconomic and community-access context

MFRI materials were utilized as regional demographic-reference resources and were evaluated in conjunction with additional public-source materials and assessment-specific analytical methodology.

F.3 – Behavioral Health and Access-Condition References

Behavioral health and service-access indicators incorporated into the assessment utilized publicly available federal and institutional reference materials associated with provider availability, shortage-area classifications, and regional behavioral health context.

Primary behavioral health and access-condition references included:

- Health Professional Shortage Area (HPSA) datasets
- Publicly available behavioral health workforce references
- Veteran suicide and behavioral health reference materials
- Indiana behavioral health and access-condition reference sources
- Supplemental public-source behavioral health context materials

These materials were utilized as contextual indicators supporting broader multi-factor assessment of regional service-access conditions.

F.4 – Geographic and Mapping References

Geographic analysis and mapping products developed throughout the assessment utilized publicly available mapping systems, routing-analysis tools, and geographic-reference resources intended to support generalized regional travel-time and service-access evaluation.

Primary geographic and mapping references included:

- Google Earth Pro
- Google Maps routing analysis
- Publicly available GIS reference materials

- Regional roadway and transportation-reference systems
- Census-based geographic reference materials
- Supplemental public mapping and geographic-overlay tools

Mapping products contained within the assessment are intended to reflect generalized regional access conditions rather than precise route-validated operational measurements.

F.5 – Community and Service-System References

Supplemental community and service-system references were incorporated throughout the assessment to support contextual understanding regarding regional veteran support systems, referral environments, and broader service-access conditions.

These references included:

- Indiana 211 service-request information
- Community behavioral health reference materials
- Housing and homelessness-support context references
- Crisis-intervention and public-safety contextual information
- Veteran-support organizational and referral-environment references
- Regional service-network observational materials

These resources were utilized to support broader contextual understanding of service-access conditions affecting veterans within the assessed region.

F.6 – Stakeholder and Consultation Support

The assessment additionally incorporated stakeholder-informed observations, consultation visibility, and structured engagement activities conducted throughout the project period. These interactions supported contextual understanding regarding observed service-access conditions, referral-system behaviors, provider-capacity observations, and transportation-related barriers affecting portions of the assessed region.

Stakeholder-informed observations were organized into recurring thematic categories and evaluated collectively with quantitative, geographic, behavioral health, and service-access indicators throughout the assessment process.

F.7 – Source and Reference Limitations

The assessment relied substantially upon publicly available reference materials, institutional datasets, stakeholder observations, and generalized regional analysis tools. As with all community-based feasibility assessments, variations in publication dates, update cycles, extraction methodologies, and data availability may result in differences among referenced materials.

Certain provider-capacity metrics, utilization statistics, and operational datasets were either unavailable publicly or outside the scope of this assessment. Accordingly, all references contained within this appendix should be interpreted within the broader context of the integrated analytical methodology utilized throughout the report.

The assessment methodology intentionally emphasizes convergence across multiple independent reference domains rather than reliance upon any single source, dataset, or institutional publication.

Appendix G — Supplemental Stakeholder & Qualitative Documentation

This appendix provides supplemental qualitative and stakeholder-support documentation associated with the North Central Indiana Regional Vet Center Feasibility Assessment. The materials summarized within this appendix are intended to provide additional transparency regarding recurring themes, operational observations, and generalized stakeholder perspectives identified throughout the assessment process.

Qualitative information contained within this appendix is presented in generalized and aggregated form consistent with the methodological framework established throughout the assessment. Stakeholder observations are included to support contextual understanding of regional service-access conditions and are not intended to function as independently determinative evidence.

G.1 – Roundtable Engagement Context

Structured stakeholder engagement activities conducted throughout the assessment included roundtable discussion, supplemental outreach, follow-up coordination, and structured qualitative information gathering involving organizations associated with veteran services, behavioral health systems, community support, housing support, crisis response, and related regional service systems.

The stakeholder roundtable process was designed to support operational discussion regarding observed veteran access conditions, regional travel burden, provider-capacity considerations, referral-system interaction, and broader service-access observations affecting communities within the North Central Indiana assessment region.

G.2 – Generalized Qualitative Themes

Review of stakeholder input, observational information, and supplemental qualitative engagement identified several recurring themes associated with regional service-access conditions affecting veteran populations within the assessed region.

Recurring generalized themes included:

- Geographic travel burden associated with access to existing Vet Center services
- Transportation-related barriers affecting portions of the regional veteran population
- Behavioral health provider-capacity constraints
- Rural and nonmetropolitan service-access challenges

- Continuity-of-care and referral-system coordination concerns
- Veteran preference for culturally competent veteran-specific support environments
- Challenges associated with recurring travel requirements for ongoing services
- Community-level observations regarding behavioral health and crisis-support demand
- System-level coordination considerations involving multiple regional support organizations

These qualitative themes were evaluated in conjunction with geographic analysis, quantitative indicators, and behavioral health contextual information throughout the broader assessment framework.

G.3 – Service-System and Referral Observations

Stakeholder engagement and supplemental consultation activities additionally identified recurring observations associated with referral-system coordination, transportation burden, and continuity-of-care considerations affecting portions of the regional veteran population.

Generalized operational observations included:

- Reliance upon distant regional referral systems for certain behavioral health services
- Transportation burden associated with recurring appointment requirements
- Coordination complexity involving multiple provider systems and support organizations
- Challenges affecting veterans residing within rural or geographically dispersed communities
- Increased logistical considerations associated with long-distance access to recurring support services

These observations were evaluated qualitatively and incorporated into the integrated multi-factor methodology utilized throughout the assessment.

G.4 – Community and Veteran-Support Context

Supplemental stakeholder engagement additionally reflected broader community-level support interest associated with veteran behavioral health accessibility, regional service coordination, and expanded awareness regarding veteran-support resources.

Community-support observations included:

- Interest in improving regional awareness of veteran-support resources
- Support for improved coordination among veteran-support stakeholders
- Recognition of transportation and access-related challenges affecting portions of the region
- Generalized support for continued evaluation of regional Vet Center accessibility conditions

- Community-level interest in strengthening referral visibility and veteran-service connectivity

These observations were treated as contextual support information rather than independently determinative findings.

G.5 – Qualitative Methodology Controls

Consistent with the broader methodological framework established throughout the assessment, qualitative observations and stakeholder perspectives were evaluated using generalized aggregation and thematic synthesis rather than attribution-based narrative reporting.

Where possible, stakeholder observations were grouped by recurring operational themes rather than associated with individual organizations or specific participants unless direct attribution was analytically necessary and independently verifiable.

This approach was utilized to support:

- Methodological consistency
- Reduction of over-attribution risk
- Protection against disproportionate weighting of isolated observations
- Broader system-level interpretation of recurring themes
- Integration of qualitative observations into the multi-factor assessment framework

G.6 – Qualitative and Stakeholder Limitations

Qualitative observations summarized throughout this appendix are inherently dependent upon stakeholder participation, engagement scope, and operational visibility available during the assessment period. Observations may reflect localized or role-specific experiences and should therefore be interpreted within the broader context of the integrated assessment methodology.

The inclusion or exclusion of any individual observation, organization, or operational perspective should not be interpreted as definitive validation or rejection of any specific assessment finding. Qualitative observations were evaluated collectively with quantitative, geographic, and behavioral health evidence to identify recurring patterns across multiple independent domains.

Consistent with the overall assessment methodology, qualitative information contained within this appendix is intended to support contextual understanding and methodological transparency rather than serve as independently determinative evidence.

Appendix H — Comparative Vet Center Infrastructure Context

H.1 – Purpose and Context

This appendix provides supplemental comparative context regarding observed variability in Vet Center infrastructure distribution, operational configurations, and regional access environments across multiple states. The comparative observations contained within this appendix are intended solely to provide broader contextual perspective regarding the range of Vet Center service-distribution environments that may exist nationally.

The information presented within this appendix is not intended to function as a formal interstate ranking system, comparative adequacy determination, or independently determinative justification for Vet Center placement within Indiana or the North Central Indiana assessment region. Differences in Vet Center distribution patterns, operational structures, geographic coverage conditions, satellite-service configurations, transportation environments, population density, and regional access characteristics may be influenced by numerous historical, administrative, demographic, geographic, and operational factors not independently evaluated within this assessment.

Consistent with the analytical framework established throughout the primary report, the principal findings and conclusions of this assessment remain grounded in the observed geographic access conditions, travel-burden patterns, behavioral health access considerations, stakeholder observations, provider-capacity conditions, and veteran-service environment characteristics identified within the evaluated 17-county North Central Indiana assessment region.

This appendix is intended to provide supplemental contextual perspective regarding broader national Vet Center infrastructure variability while reinforcing the distinction between statewide Vet Center inventories and the specific regional access conditions evaluated within the scope of this assessment. While multiple Vet Center locations may exist within a state, not all operational locations necessarily exert material influence upon the predominant access conditions affecting a defined regional study area.

Accordingly, the comparative observations presented within this appendix are intended to function as supplemental contextual reference material supporting broader interpretation of the regional access conditions discussed throughout the assessment rather than as standalone placement criteria or independently dispositive analytical findings.

H.2 – Comparative Vet Center Infrastructure Overview

This section provides limited comparative infrastructure context using selected state-level veteran population and Vet Center distribution indicators. The comparative observations presented within this section are intended to provide supplemental contextual perspective regarding the variability of Vet Center infrastructure configurations and statewide service environments across multiple states with differing geographic and demographic conditions.

The comparison states utilized within this appendix were selected to provide regional and rural-access contextual comparison environments relevant to portions of the Midwest and surrounding geographic regions. The selected comparison states are not intended to represent exhaustive national comparison categories or direct equivalency models. Rather, they provide illustrative examples of differing Vet Center distribution environments and statewide infrastructure configurations.

Consistent with the broader analytical limitations established throughout this assessment, statewide Vet Center inventories do not independently determine regional access conditions within a localized service area. While statewide operational inventories provide useful contextual perspective, the practical accessibility of individual Vet Center locations may vary significantly based upon travel distance, transportation corridors, geographic barriers, population distribution, regional service demand, and local infrastructure conditions.

For purposes of comparative consistency within this appendix, operational Vet Center inventories are distinguished from broader VA healthcare infrastructure systems. Accordingly, the primary comparative metrics presented within this section focus specifically upon Vet Center locations and related Readjustment Counseling Service infrastructure rather than the totality of VA medical, benefits, or cemetery operations within a given state.

Additionally, the presence of satellite, outstation, or affiliated service configurations may not necessarily indicate equivalent operational capacity, staffing structure, scheduling availability, or regional accessibility conditions across all states or service environments. As such, statewide operational inventories should be interpreted as contextual infrastructure indicators rather than direct measures of localized service accessibility or service adequacy.

The comparative metrics presented within this section are therefore intended to provide restrained contextual perspective regarding broader Vet Center infrastructure distribution patterns while maintaining the report's primary analytical focus upon the observed regional access conditions affecting the North Central Indiana assessment region.

H.2.1 Comparative Infrastructure Metrics

Table H.1 provides a limited comparative overview of selected state-level veteran population estimates and operational Vet Center inventories. The metrics presented are intended to provide supplemental contextual perspective regarding variability in statewide Vet Center distribution

environments and are not intended to function as formal interstate adequacy determinations or independently determinative placement criteria.

For purposes of comparative consistency, the operational Vet Center inventories reflected within this section are based upon publicly identifiable Vet Center service locations associated with Readjustment Counseling Service infrastructure. Satellite and affiliated service configurations may vary operationally between states and may not necessarily reflect equivalent staffing structures, scheduling availability, or service-delivery capacity.

Table H.1 - Comparative Vet Center Infrastructure Distribution by State

State	Approximate Veteran Population	Primary Vet Center Locations	Approximate Veterans per Primary Vet Center
Indiana	388,000	4	97,000
Kentucky	272,000	4	68,000
Tennessee	444,000	2	222,000
Iowa	183,000	2	91,500
Missouri	399,000	3	133,000
Minnesota	294,000	6	49,000

Note: Veteran population figures are approximate statewide estimates¹ derived from publicly available VA demographic reporting and related veteran population datasets. Primary Vet Center inventories reflected within this appendix include primary/full operational Vet Center locations² only and exclude satellite sites, mobile Vet Centers, outreach configurations, and limited-service affiliated locations. Comparative figures are illustrative and contextual in nature and are not intended to function as formal interstate ranking methodology, interstate adequacy determinations, or independently determinative facility-placement criteria. Operational configurations and administrative classifications may vary between states and service regions.

The comparative metrics demonstrate that statewide Vet Center infrastructure configurations vary considerably across states with differing veteran population sizes, geographic conditions, and regional service environments. These observations provide contextual perspective only and should not be interpreted as standalone measures of localized service accessibility, operational sufficiency, or regional service adequacy.

¹ Veteran population estimates were derived from publicly available U.S. Department of Veterans Affairs National Center for Veterans Analysis and Statistics (NCVAS) state-level demographic reporting and associated veteran population summary datasets.

² Operational Vet Center inventories utilized for comparative consistency within Table H.1 were normalized to include primary/full operational Vet Center locations only. Satellite locations, affiliated service sites, mobile Vet Centers, outreach configurations, and limited-service extensions were excluded due to operational variability and inconsistent administrative classification practices across publicly available inventories.

Consistent with the broader findings of this assessment, the existence of statewide Vet Center infrastructure does not independently eliminate the potential for localized regional access burdens within specific portions of a state. Practical accessibility conditions may continue to vary significantly based upon geographic proximity, transportation conditions, regional population distribution, and travel-distance considerations affecting individual service areas.

H.2.2 Supplemental VA Infrastructure Context

The following supplemental infrastructure indicators provide generalized statewide context regarding broader VA healthcare-service environments and veterans-benefits infrastructure across the selected comparison states. These indicators are presented solely for contextual reference and are not interpreted as direct substitutes for Vet Center accessibility, Readjustment Counseling Service availability, or localized behavioral health access conditions within specific regional service environments.

Table H.2 - Supplemental VA Infrastructure Context

State	VA-Reported Vet Center Sites	Outpatient Care Sites	Inpatient Care Sites	VBA Regional Offices
Indiana	5	26	4	1
Kentucky	2	25	3	1
Tennessee	6	40	4	1
Iowa	3	25	2	1
Missouri	4	37	5	1
Minnesota	3	20	2	1

Note: VA-reported infrastructure counts³ are derived from publicly available VA National Center for Veterans Analysis and Statistics (NCVAS) state summary datasets and associated VA facility reporting inventories. Reported Vet Center totals may include satellite, affiliated, administratively grouped, or operationally linked service locations depending upon VA reporting methodology. Table H.1 utilizes a normalized comparative methodology limited to primary/full operational Vet Centers only for cross-state analytical consistency. Broader VA infrastructure metrics presented within this table are provided solely for supplemental contextual reference and are not interpreted as direct substitutes for localized Vet Center accessibility or Readjustment Counseling Service availability.

³ Broader VA infrastructure indicators reflected within Table H.2, including outpatient care sites, inpatient care sites, and VBA regional office inventories, were derived from publicly available VA National Center for Veterans Analysis and Statistics (NCVAS) state summary datasets and associated VA facility reporting inventories available at the time of assessment development.

Taken together, the comparative infrastructure observations presented within Tables H.1 and H.2 demonstrate that broader statewide VA infrastructure environments and localized Vet Center accessibility conditions may not necessarily align uniformly⁴ across differing geographic regions.

H.3 – Comparative Contextual Observations

The comparative infrastructure observations presented within this appendix provide broader contextual perspective regarding variability in Vet Center distribution environments and statewide operational configurations across multiple states. These observations reinforce that Vet Center infrastructure systems may develop differently across varying geographic, demographic, transportation, and administrative environments and that statewide operational inventories do not necessarily produce uniform regional accessibility conditions within every portion of a state.

The comparison metrics additionally demonstrate that generalized statewide infrastructure counts alone may not fully reflect the practical accessibility conditions experienced within localized service regions. Geographic proximity, transportation corridors, travel burden, rural-access characteristics, provider-capacity conditions, and regional service-demand environments may all influence the practical accessibility of Vet Center services within a defined geographic area.

Within the context of the North Central Indiana Regional Vet Center Feasibility Assessment, the comparative observations contained within this appendix support the broader analytical distinction between statewide infrastructure presence and localized regional accessibility conditions. While Indiana maintains multiple operational Vet Center locations statewide, the assessment remained focused specifically upon the observed access conditions affecting the evaluated 17-county North Central Indiana regional service environment.

Consistent with the methodology established throughout this report, the assessment did not evaluate statewide Vet Center inventories in isolation. Rather, the analysis focused upon the practical geographic accessibility conditions affecting the assessed region, including observed travel-distance considerations, regional transportation patterns, provider-capacity limitations, behavioral health access conditions, and stakeholder-reported service-environment characteristics identified during the assessment process.

Accordingly, the comparative observations presented within this appendix are intended solely as supplemental contextual reference material and are not intended to function as formal interstate ranking methodology, comparative adequacy determinations, or independently dispositive placement findings. The primary findings and conclusions of this assessment therefore remain grounded in the regional quantitative indicators, geographic access observations, behavioral

⁴ Comparative infrastructure observations presented within this appendix are intended solely for supplemental contextual interpretation and are not intended to function as formal interstate adequacy determinations, comparative ranking methodology, or independently dispositive placement criteria.

health access conditions, stakeholder input, and service-environment characteristics evaluated throughout the primary report narrative.

H.4 – Analytical Limitations and Interpretive Considerations

The comparative observations presented within this appendix are subject to several important analytical limitations and interpretive constraints. The infrastructure comparisons contained herein were developed solely to provide supplemental contextual perspective regarding broader Vet Center distribution variability and were not designed to function as a comprehensive national infrastructure assessment or formal interstate comparative methodology.

Operational Vet Center configurations, staffing structures, satellite-service models, scheduling practices, geographic coverage arrangements, and regional service-delivery environments may vary considerably across states and administrative regions. Additionally, publicly available infrastructure inventories may classify operational locations differently depending upon administrative designation, reporting structure, or organizational categorization within specific datasets. As such, comparative infrastructure figures should be interpreted as generalized contextual indicators rather than precise operational equivalency measurements.

The comparative metrics presented within this appendix additionally do not independently account for numerous factors that may influence practical service accessibility, including transportation-network conditions, population-density variation, roadway connectivity, localized provider-capacity environments, weather conditions, regional travel behaviors, or evolving operational service-delivery practices. Accordingly, statewide infrastructure counts should not be interpreted as standalone indicators of localized accessibility or service adequacy within any specific geographic region.

Furthermore, this appendix was not intended to establish comparative entitlement, comparative deficiency, or formal interstate equity findings regarding Vet Center placement or infrastructure distribution. The observations presented herein are contextual and illustrative in nature and are intended solely to supplement broader interpretation of the regional access conditions evaluated throughout the primary assessment narrative.

Consistent with the overall analytical framework of this assessment, the principal findings and conclusions of the North Central Indiana Regional Vet Center Feasibility Assessment remain grounded in the direct evaluation of regional geographic access conditions, travel-burden observations, behavioral health access considerations, provider-capacity indicators, stakeholder engagement findings, and veteran-service environment characteristics identified within the defined 17-county assessment region.

Accordingly, the comparative observations contained within this appendix should be interpreted as supplemental contextual reference material supporting broader understanding of Vet Center infrastructure variability rather than as independently determinative analytical conclusions or formal placement recommendations.

H.5 – Appendix H Summary

This appendix provided supplemental comparative context regarding observed variability in Vet Center infrastructure distribution, statewide operational configurations, and regional access environments across multiple states. The comparative observations contained herein were intended solely to provide broader contextual perspective regarding the range of Vet Center service-distribution environments that may exist nationally and were not designed to function as formal interstate adequacy determinations or independently dispositive placement criteria.

The comparative metrics and interpretive observations presented throughout this appendix reinforce the broader analytical distinction between statewide infrastructure inventories and the practical regional accessibility conditions affecting localized veteran-service environments. While statewide operational Vet Center inventories provide useful contextual reference points, the practical accessibility of Vet Center services within a defined geographic region may continue to be influenced by travel burden, transportation conditions, geographic proximity, rural-access characteristics, provider-capacity limitations, and broader regional service-environment factors.

Within the context of the North Central Indiana Regional Vet Center Feasibility Assessment, the comparative observations presented within this appendix support the broader methodological approach utilized throughout the report, which emphasized evaluation of observed regional access conditions rather than reliance solely upon statewide infrastructure counts or generalized facility inventories. Consistent with the report's analytical framework, the assessment findings remained grounded in the direct evaluation of geographic access conditions, behavioral health access indicators, stakeholder observations, provider-capacity environments, and veteran-service characteristics affecting the assessed 17-county regional service area.

Accordingly, the comparative observations contained within this appendix should be interpreted as supplemental contextual reference material supporting broader understanding of Vet Center infrastructure variability and regional access environments rather than as standalone analytical findings or independently determinative placement conclusions.