US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Palo Alto Health Care System in California

Healthcare Facility Inspection	25-00241-73	March 12, 2026

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

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Executive Summary

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) established the Healthcare Facility Inspection program to review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle. The OIG inspected the three divisions (Palo Alto, Menlo Park, and Livermore) of the VA Palo Alto Health Care System (the facility) from June 2 through 5, 2025.

In fiscal year 2024, the facility provided care to 65,863 veterans. The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[1]

What the OIG Examined

- **Culture.** The OIG examined system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences. The OIG made no recommendations.
- **Environment of Care.** The OIG team inspected the main entrance and patient care areas. At the Palo Alto division, the team found that nursing staff could not access bathrooms shared between two single rooms when the doors were locked from the inside. At the Menlo Park division, the team found exterior doors propped open on a unit with patients known to wander. At both Palo Alto and Menlo Park, staff stored clean equipment and supplies with dirty equipment. The OIG made recommendations to address these deficiencies.
- **Patient Safety.** The OIG assessed the facility's processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The facility did not have workflows that describe staff members' roles in the test result communication process for each service, as required by VHA Directive 1088(1).[2] The OIG made a recommendation.
- **Primary Care.** The OIG determined whether primary care teams were staffed per VHA Directive 1406(2) and Handbook 1101.10(2).[3] The OIG made no recommendations.

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

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

[3] VHA Directive 1406(2), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 10, 2025; VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

- **Veteran-Centered Safety Net.** The OIG assessed programs that offer medical care and social support services to vulnerable veterans who are homeless or recently incarcerated. The OIG made no recommendations.

The OIG is aware of the transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiency of VA programs and services that improve the health and welfare of veterans and their families.

What the OIG Recommended

1. The Executive Medical Center Director ensures clinical staff can open all doors to shared bathrooms.
2. The Executive Medical Center Director ensures staff keep exterior doors closed to minimize risk to wandering patients.
3. The Executive Medical Center Director ensures staff store clean and dirty equipment and supplies separately.
4. The Executive Medical Center Director ensures each service has workflows to communicate test results.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the recommendations and provided acceptable action plans (see the responses in the report body and appendixes B and C for the full text of the directors' comments). The OIG continued communication with VHA regarding the findings, which resulted in the closure of recommendation 3. For the remaining open recommendations, the OIG will follow up on the planned actions until they are completed.

JULIE KROVIAK, MD
Principal Deputy Assistant Inspector General,
in the role of Acting Assistant Inspector General,
for Healthcare Inspections

Abbreviations

FY	fiscal year
HCHV	Health Care for Homeless Veterans
HRO	high reliability organization
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Contents

Introduction

The Office of Inspector General's (OIG's) Office of Healthcare Inspections focuses on overseeing the Veterans Health Administration (VHA), which offers care to more than nine million enrolled veterans through its 1,380 healthcare facilities.[1] VHA's vast care delivery structure requires sustained and thorough OIG scrutiny to ensure the nation's veterans receive high-quality care.

In 2018, VHA launched efforts to become a high reliability organization (HRO) and set goals to enhance accountability and reliability and reduce patient harm. The HRO framework provides the blueprint for VHA-wide practices to strengthen the culture of patient safety and high-quality care in medical facilities.[2] VHA has now implemented HRO principles at all VHA facilities.[3]

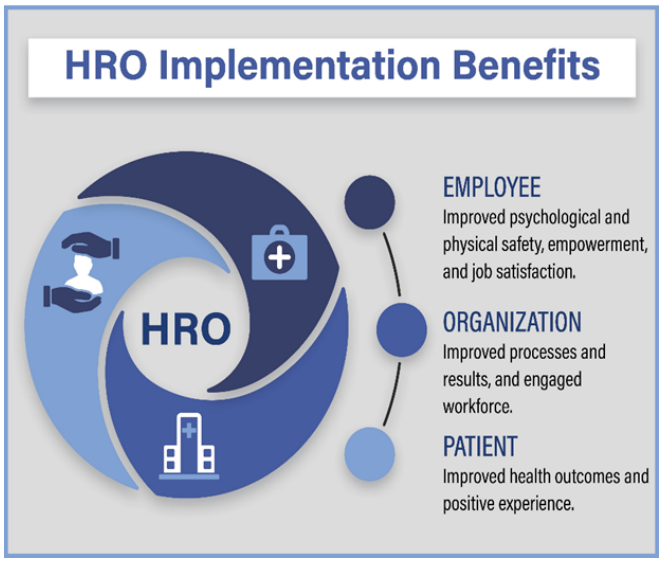

Figure 1. *Potential benefits of HRO implementation. Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.*

The OIG established the Healthcare Facility Inspection program to routinely evaluate VHA medical facilities on an approximately three-year cycle. Each inspection focuses on five domains: culture, environment of care, patient safety, primary care, and a veteran-centered safety net (comprising programs for veterans experiencing homelessness or recent incarceration).

Healthcare Facility Inspection reports provide insight into the experience of staff working in VHA facilities and veterans receiving care there. They inform veterans, the public, and Congress about the conditions for care delivery and patient safety and highlight specific corrective actions VHA leaders and staff can take.

[1] "About VHA," Department of Veterans Affairs, last updated January 20, 2025, https://www.va.gov/aboutvha.

[2] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Reference Guide*, March 2020, revised in April 2023.

[3] "VHA Journey to High Reliability, Frequently Asked Questions," Department of Veterans Affairs, https://dvagov.sharepoint.com/sites/vhahrojourney/SitePages/FAQ_Home.aspx. (This web page is not publicly accessible.)

Figure 2. *Healthcare Facility Inspection's five domains.*
**Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," BMJ Open 7, no. 11 (2017): 1–11.*
Sources: Boris Groysberg et al., "The Leader's Guide to Corporate Culture: How to Manage the Eight Critical Elements of Organizational Life," Harvard Business Review 96, no. 1 (January-February 2018): 44-52; Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review"; VHA Directive 1608(1), Comprehensive Environment of Care Program, June 21, 2021, amended September 7, 2023; VHA Directive 1050.01(1), VHA Quality and Patient Safety Programs, March 24, 2023, amended March 5, 2024; VHA Directive 1406(2), Patient Centered Management Module (PCMM) for Primary Care, June 20, 2017, amended April 10, 2025; VHA Homeless Programs Office, Fiscal Year 2022 Annual Report.

The VA Palo Alto Health Care System (the facility) has three divisions in Palo Alto, Menlo Park, and Livermore, California. In fiscal year (FY) 2024, the facility's operational budget was over $1.5 billion, and staff provided care to 65,863 veterans. The facility had 249 hospital, 100 domiciliary, 286 community living center, and 10 compensated work therapy/transitional residence beds.[4]

Figure 3. *Palo Alto VA Medical Center, part of the VA Palo Alto Health Care System.*
Source: Photo taken by OIG inspector.

The OIG inspected the facility from June 2 through 5, 2025. The executive leaders referred to throughout this report include the Executive Medical Center Director, Associate Director for Resources, Associate Director for Operations, Chief of Staff, Deputy Chief of Staff, Associate Chief of Staff, Associate Director for Patient Care Services/Nurse Executive, Deputy Nurse Executive for Clinical Practice, Deputy Nurse Executive for Nursing Operations, and the interim Deputy Executive Director. The team had worked together since January 2025, when the Associate Director for Operations was appointed.

CULTURE

The OIG examined the facility's culture across multiple dimensions, including unique circumstances and system shocks (planned or unplanned events that disrupt an organization's usual daily operations), and both employees' and veterans' experiences.[5] The OIG administered its own facility-wide questionnaire and reviewed VA's All Employee Survey scores for October 1, 2022, through September 30, 2024. The team also interviewed leaders and employees and considered data from patient advocates and veterans' feedback.[6]

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[4] A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, last updated May 1, 2025, https://www.va.gov/dchv. "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, last updated June 3, 2025, https://www.va.gov/VA_CLC. Compensated Work Therapy (CWT) "provides evidence based and evidence informed vocational rehabilitation services." "Compensated Work Therapy," Department of Veterans Affairs, last updated October 13, 2021, https://www.va.gov/health/cwt.

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

[6] The All Employee Survey is an annual, voluntary survey of VA workforce experiences. "AES Survey History, Understanding Workplace Experiences in VA," VHA National Center for Organization Development. Patient advocates are employees who help resolve veterans' concerns. "Patient Advocate," Department of Veterans Affairs, last updated May 9, 2022, https://www.va.gov/HEALTH/patientadvocate/. For more information on the OIG's data collection methods, see appendix A.

System Shocks

In an interview, executive leaders identified an intravenous fluid shortage as a system shock.[7] When Hurricane Helene hit North Carolina in September 2024, leaders said the storm flooded the manufacturer's production site, which caused a nationwide supply shortage. The facility experienced the effects of the deficiency beginning in November 2024, once they had used their inventory, and it took longer than usual to restock the supply; delays lasted until mid-January 2025.

In response to the shortage, leaders established a multidisciplinary Incident Command Center to address supply challenges and communicate with staff. The command center's team included representatives from acute care, surgery, patient safety, supply chain, pharmacy, ethics, and public affairs. Leaders said the team oversaw intravenous fluid use, monitored daily inventories, suspended elective surgeries, and developed contingency strategies to conserve remaining supplies.

At the time of the site visit in June 2025, leaders said the intravenous fluid supply continues to fluctuate, so the command center team still discusses available resources during daily meetings. Additionally, quality management staff assessed patient outcome data and found no harm had occurred. Leaders said employees' actions, especially in the Medicine Service, led to improved processes that decreased waste and resulted in cost savings of approximately $1 million.

Leaders discussed the effects of recent executive orders, such as contract terminations and the federal hiring freeze.[8] Leaders reported losing non-clinical staff (engineers, medical equipment planners, and interior designers) because of contract terminations. They also postponed four infrastructure projects: heating and air conditioning upgrades for the inpatient mental health unit, fire alarm replacement at the Menlo Park division, electronic keypad replacement across the facility, and renovations in the spinal cord injury unit.

Employee Experiences

All Employee Survey scores for communication, transparency, best places to work, no fear of reprisal, and psychological safety improved from FYs 2023 to 2024.[9] Executive leaders credited

[7] "IV [intravenous] fluids are specially formulated liquids that are injected into a vein to prevent or treat hydration." "IV Fluids," Cleveland Clinic, last updated August 3, 2021, https://my.clevelandclinic.org/treatments/iv-fluids.

[8] Implementing the President's "Department of Government Efficiency" Cost Efficiency Initiative, Exec. Order No. 14222, 90 Fed. Reg. 11095 (Feb. 26, 2025); Hiring Freeze, 90 Fed. Reg. 8247 (Jan. 28, 2025).

[9] "Psychological safety is an organizational factor that is defined as a shared belief that it is safe to take interpersonal risks in the organization." Jiahui Li et al., "Psychological Safety and Affective Commitment Among Chinese Hospital Staff: The Mediating Roles of Job Satisfaction and Job Burnout," *Psychology Research and Behavior Management* 15 (June 2022): 1573–1585, https://doi.org/10.2147/PRBM.S365311.

the rise in scores to visits in work areas; open-door policies; and employee engagement events such as holiday parties, annual picnics, and monthly town halls.

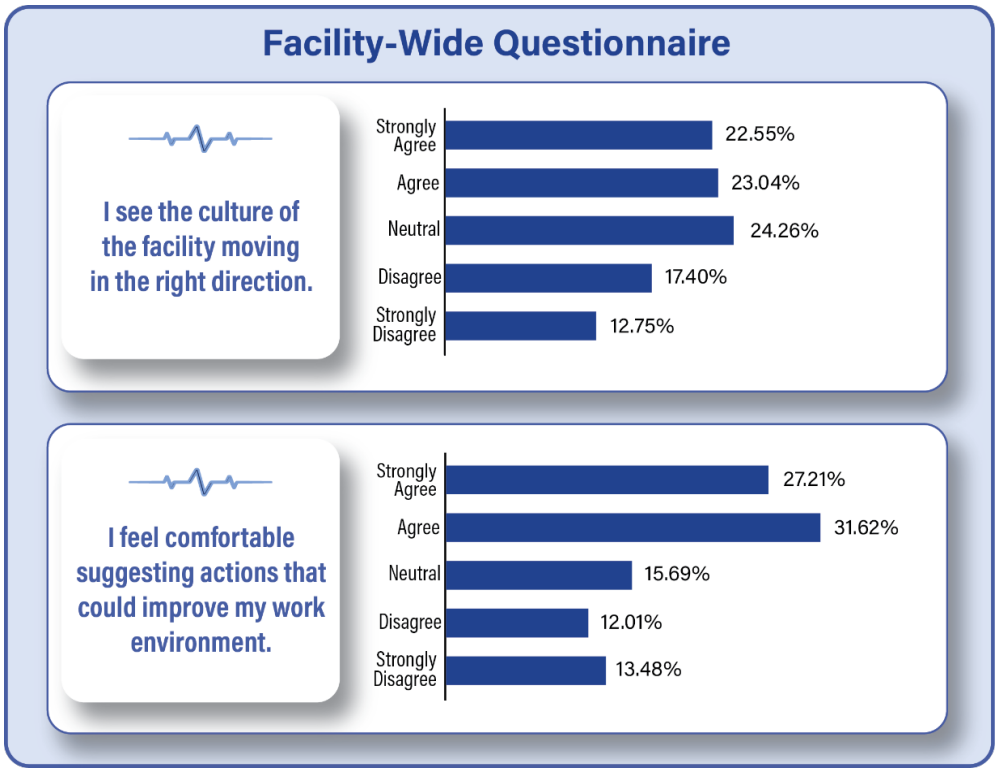

Figure 4. *Employees' perceptions of facility culture.*
Source: Analysis of OIG administered questionnaire.

Since February 2024, executive leaders and service chiefs have participated in approximately 13,000 visits to work areas. Employees also developed a computer application to track activities, such as which leader visited each unit. Leaders said that in FY 2024, their focus was to increase the visits. They acknowledged the physical distance and being a multi-division facility affects their ability to engage with employees and be present across the organization.

Leaders reported they implemented programs, including DAISY Awards and Pathway to Excellence, to acknowledge, motivate, and improve the overall culture. In 2025, the Palo Alto Nursing Service received the Pathway to Excellence Award. Executive leaders said this is a national recognition for nursing, and only 15 VA medical centers received the designation.[10]

[10] The DAISY Award "rewards and celebrates the extraordinary compassionate and skillful care given by nurses every day." "DAISY Award," Department of Veterans Affairs, last updated September 17, 2025, https://www.va.gov/daisyaward. The "Pathway to Excellence Program recognizes a health care organization's commitment to creating a positive practice environment that empowers and engages staff." "ANCC [American Nurses Credentialing Center] Pathway to Excellence Program," American Nurses Credentialing Center, accessed December 4, 2025, https://www.nursingworld.org/pathway/.

Veteran Experiences

In an interview, executive leaders said they meet monthly with the Veterans Focus Council, which is open to all veterans service organizations, and conduct quarterly veteran town halls to discuss challenges, changes, and other important matters.[11] Leaders said patient advocates meet monthly with the Executive Leadership Board to address veterans' concerns, collaborate with service chiefs to resolve clinical issues, and contact veterans directly to discuss and resolve their care issues.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[12] The OIG team assessed how a facility's physical features may shape the veteran's perception of the health care they receive. The team also inspected patient care areas and focused on safety, cleanliness, infection prevention, and privacy.

The OIG inspectors examined the facility's compliance with key VA and VHA guidelines and standards, as well as Architectural Barriers Act and Joint Commission standards. They also considered best practice principles from academic literature.[13]

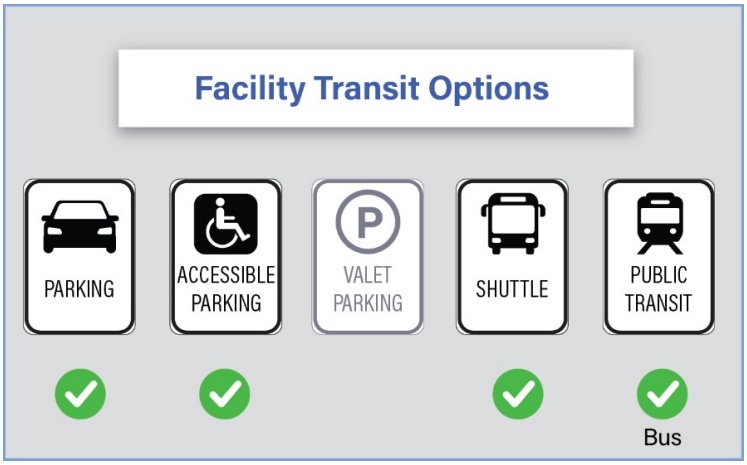

Figure 5. *Transit options for arriving at each division.*
Source: OIG analysis of facility documents and observations.

General Inspection

The facility had signs to direct veterans to parking areas, which had both standard and accessible parking spaces for those with disabilities. At the Palo Alto division, the parking

[11] "Veterans Service Organizations (VSOs) are organizations that aid and serve veterans, servicemembers, dependents, and survivors." Congressional Research Service, *Veterans Service Organizations (VSOs): Frequently Asked Questions*, updated February 6, 2024.

[12] "Informing Healing Spaces through Environmental Design: Thirteen Tips," Department of Veterans Affairs, last updated May 1, 2024, https://www.va.gov/WholeHealth/Healing-Spaces.

[13] Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*, December 2012; Department of Veterans Affairs, *VA Signage PG-18-10, Design Manual*, May 16, 2023, revised February 19, 2025; Department of Veterans Affairs, *VA Barrier Free Design Standard*, January 1, 2017, revised May 1, 2025; VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook*, 2025; Access Board, *Architectural Barriers Act (ABA) Standards*, 2015; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2025.

garage was well lit and had security cameras throughout the structure. The Menlo Park and Livermore divisions had open parking lots that offered shuttle services around each site and between each division.

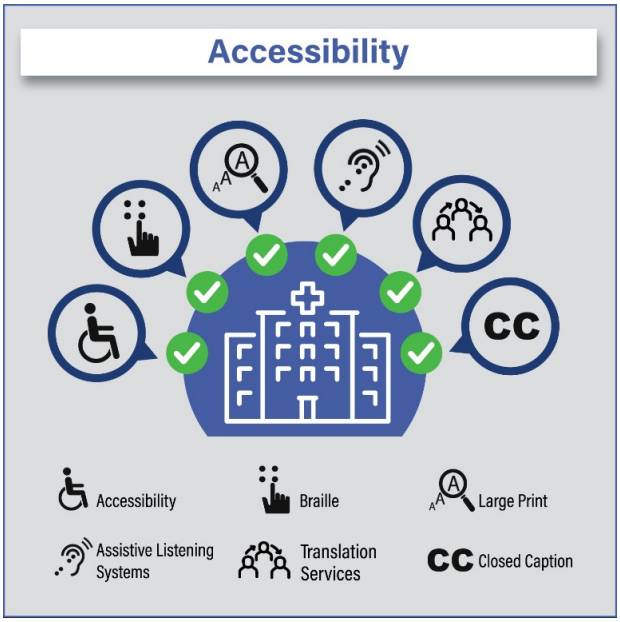

Figure 6. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG analysis of documents and observations.

The main entrances at all three divisions had wide sliding doors and covered passenger loading zones. Each division also had maps, posters, or signs to direct veterans to their destinations. The Palo Alto lobby had a large, open food court with multiple food options, including a weekly farmers' market. The OIG also observed greeters who provided information and directions, and escorts who transported veterans as needed.

The facility is home to the VA Western Blind Rehabilitation Center, which provides a range of services from training to use mobility devices to inpatient care. The facility also offers audiology and speech pathology services, which include assistive devices and sign language interpretation when needed. The OIG noted large print directional signs as well as braille text on signs and at the elevators.

In a Palo Alto patient care unit, nursing staff could not access bathrooms shared between two single patient rooms when doors were locked from inside the bathroom. VHA Directive 1330.01(7) requires all toilets, baths, and showers to have appropriate locking doors that allow staff access in emergencies.[14] This provides safety and security for patients. The OIG observed nursing staff make multiple attempts to unlock the doors using coins and small plastic cards.

Recommendation 1

The Executive Medical Center Director ensures clinical staff can open all doors to shared bathrooms.

__X__ Concur

[14] VHA Directive 1330.01(7), *Health Care Services for Women Veterans*, February 15, 2017, amended May 14, 2023.

_____Nonconcur

Target date for completion: March 31, 2026

Director Comments

The Acting Chief Nurse for Acute Care Hospital Operations, the Chief Nurse for Extended Care, and Quality Management staff reviewed the procedures in place for staff to open the coin-turn privacy locks. As part of their Life Safety orientation, new staff complete a return demonstration on the procedure to open the lock; however, there is not a recurring competency check. To address this, nurse managers (or designees) will conduct competency checks for frontline staff, requiring a return demonstration that includes locating the coin tool in a central unit location. The goal is for 90% or more staff to achieve competency by March 31, 2026. Competency will be maintained through annual reviews to ensure proper demonstration of coin-turn privacy locks.

While inspecting a Menlo Park community living center, the OIG observed an exterior door propped open by a garbage can near patient rooms. Staff said this was not a common practice because the unit has patients who wander. Staff immediately removed the garbage can and closed the door. Open doors present a risk for wandering patients to stray out of a protected area, be harmed by someone, or harm themselves. VHA Directive 2010-052(1) requires medical facilities to implement procedures to minimize risks to wandering patients, both on and off facility grounds. Procedures must include early interventions to minimize patient risk and ongoing training for staff who care for them.[15]

Recommendation 2

The Executive Medical Center Director ensures staff keep exterior doors closed to minimize risk to wandering patients.

__X__Concur

_____Nonconcur

Target date for completion: May 31, 2026

Director Comments

Service leaders utilized their staff huddles to emphasize the importance of keeping exterior doors closed to minimize risk to wandering residents. This education will continue on a recurring basis at staff meetings and/or huddles. To protect at-risk residents, the CLC

[15] VHA Directive 2010-052(1), *Management of Wandering and Missing Patients*, December 3, 2010, amended June 24, 2024.

[community living center] uses a wandering patient alert system that triggers an alarm when residents wearing wristbands approach exterior doors. The CLC charge nurses will incorporate door inspections in their daily safety rounds. During the rounds, they will ensure that the wandering patient alert system is operational and none of the exit doors are propped open. The CLC nurse managers or designee will conduct weekly environment of care rounds to inspect all exit doors until 90% or higher compliance rate has been achieved for three months.

Additionally, the OIG observed clean equipment and supplies stored with dirty equipment at Palo Alto and Menlo Park. VHA Directive 1608(1) requires facilities to maintain a safe, clean environment.[16] Facility staff attributed the improper storage to space limitations.

Recommendation 3

The Executive Medical Center Director ensures staff store clean and dirty equipment and supplies separately.

__X__Concur

_____Nonconcur

Target date for completion: January 30, 2026

Director Comments

Space limitations were a contributing factor in certain areas for incorrect storage of equipment and supplies. At the time of the OIG visit on June 3, 2025, there were 486 items awaiting warehouse pickup. Supply Chain Service (SCS) hired an additional driver in September 2025 to assist with retrieving excess equipment. As of January 29, 2026, the database shows there are 6 items awaiting pickup. The Environmental Management Service (EMS) Chief provided staff at Palo Alto and Menlo Park with a list of designated storage locations. The SCS and EMS Chiefs, in collaboration with Quality Management, developed a one-page "Fast Facts" sheet for frontline staff. This document provides clear guidelines on proper segregation of clean and dirty equipment/supplies and includes alternative strategies for managing cluttered storage spaces. Nurse managers have performed weekly environment of care rounds utilizing the audit tool to monitor whether staff appropriately store clean and dirty equipment and supplies separately. Audit results from July 1, 2025 to January 28, 2026 demonstrated a compliance rate of 98% or higher. The facility requests closure of this recommendation based on the supporting documentation provided.

[16] VHA Directive 1608(1).

OIG Comments

The OIG reviewed evidence sufficient to demonstrate that leaders had completed improvement actions and therefore closed the recommendation before the report's publication.

PATIENT SAFETY

The OIG team examined the facility's patient safety processes. They focused on communication procedures for urgent but noncritical test results; the sustainability of changes made by leaders in response to previous oversight recommendations, facility investigations, and improvement projects. The team also assessed how facility staff implemented continuous learning processes.

Communication of Urgent, Noncritical Test Results

Although the facility had a standard operating procedure and processes to communicate abnormal and critical test results to providers and patients, it did not have service-level workflows. VHA Directive 1088(1) requires facility staff to develop service-level workflows that describe staff's roles in the communication process.[17]

Recommendation 4

The Executive Medical Center Director ensures each service has workflows to communicate test results.

___X___Concur

_____Nonconcur

Target date for completion: April 15, 2026

Director Comments

The Chief of Staff (COS) and Quality Management (QM) reviewed VHA Directive 1088(1) *Communicating Test Results to Providers and Patients*, dated July 11, 2023 (amended September 20, 2024) to identify requirements for service level workflows. A template for Communication of Test Results Service Level Workflow was developed consistent with the Directive requirements. The template, and the Directive, will be sent as an action item to each identified clinical service to complete if they do not already have a workflow. Each service will be required to respond with their workflow document and confirmation the workflow was

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

shared with their staff. Compliance will be demonstrated by 100% of the identified services returning their service level workflow and attesting it was shared with staff.

Leaders confirmed the external peer review program coordinator monitors test result communication data, notifies leaders to develop corrective action plans as needed, and reports the information quarterly to the Quality, Patient, and Safety Committee.[18] Leaders said they also monitor test result communication through the Joint Patient Safety Reporting system.[19]

Action Plans and Process Improvements

The facility had no open OIG recommendations. At the time of the June 2025 inspection, facility leaders were actively developing action plans to address April 2025 Joint Commission survey recommendations; this survey reported no findings related to communication of test results.[20]

Leaders discussed a process improvement project to decrease the number of view alerts (notifications that prompt staff to act on a clinical event) that providers receive daily.[21] The chief of informatics reported teaching providers how to decrease unnecessary alerts and implementing additional initiatives over the past two years that decreased the number of alerts from 90 to 75 per day per provider.

The OIG found that quality management staff had processes to track patient safety concerns and monitor improvement actions. Quality management staff said they review adverse event reports daily, then meet with executive leaders to discuss any concerns. Additionally, patient safety managers engage frontline staff in the continuous learning process through new employee orientation, patient safety forums, patient safety awareness week activities, team huddles, and a safety newsletter. During patient safety forums, leaders and quality management staff discuss lessons learned from Joint Patient Safety Reporting system data and root cause analyses.[22]

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

[19] The Joint Patient Safety Reporting (JPSR) system is a database used at VA facilities to report patient safety events, such as adverse events and close calls. VHA National Center for Patient Safety, *JPSR Guidebook*, December 2023.

[20] The Joint Commission, *Final Accreditation Report VA Palo Alto Health Care System*, April 22, 2025.

[21] Department of Veterans Affairs Office of Information & Technology (OI&T), *Computerized Patient Record System (CPRS) User Guide; GUI Version*, October 2024.

[22] A root cause analysis is a "comprehensive team-based, systems-level investigation with a formal charter for review of health care adverse events and close calls." VHA Directive 1050.01(1).

The OIG determined whether primary care teams were staffed per VHA Directive 1406(2) and Handbook 1101.10(2).[23] The OIG interviewed staff, analyzed primary care team staffing data, and examined new patient appointment wait times.

Primary Care Teams

The OIG reviewed facility data from September 2022 through December 2024 and found primary care staffing levels had decreased. The facility had approximately 27 vacancies across the 42 primary care teams. The vacancies included approximately 5 providers, 3 registered nurses, 9 licensed vocational nurses, and 10 medical support assistants.

In FY 2025, staff left the facility, and leaders terminated three probationary supply technicians pursuant to executive orders. With the loss of staff, primary care leaders had to redistribute workload to the remaining team members. Staff told the OIG that nurses also took on additional administrative responsibilities, such as scheduling appointments, as well as some of the supply technician's responsibilities. As a result, staff worked overtime and experienced burnout.

In addition to the core team members, a primary care team is also assigned discipline-specific staff, including a clinical pharmacist, a registered dietitian, and a social worker. The OIG analyzed these staffing levels and found teams in all locations were understaffed, except for the Capitola community-based outpatient clinic. VHA Handbook 1101.10(2) suggests facilities have one social worker for every two primary care teams, but the Palo Alto division had only one on-site social worker.[24] Two social workers in the community-based outpatient clinics provide remote coverage, and social workers from other areas also help within primary care.

The OIG reviewed Primary Care Leadership and Access Committee meeting minutes and a Veterans Integrated Service Network (VISN) evaluation report from early 2025 and found that panel capacity, access to care, and productivity were below FY 2025 targets.[25] In response, the group practice manager developed an action plan in which leaders converted unused virtual

[23] VHA Directive 1406(2); VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

[24] VHA Handbook 1101.10(2).

[25] Panel size is the number of patients assigned to a care team. "Manage Panel Size and Scope of the Practice," Institute for Healthcare Improvement. On April 19, 2023, the Institute for Healthcare Improvement's website contained this information (it has since been removed from their website). Veterans Integrated Service Networks are "regional systems of care working together to better meet local health care needs and provides greater access to care." "Veterans Integrated Service Network (VISN)," Department of Veterans Affairs, last updated August 11, 2025, https:///www.va.gov/HEALTH/visns.

appointments to face-to-face, implemented standardized scheduling processes, and extended clinic hours to accommodate more patients.

The OIG reviewed Health Care for Homeless Veterans (HCHV), Housing and Urban Development–Veterans Affairs Supportive Housing, and Veterans Justice Programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The inspection team analyzed enrollment and performance data and interviewed program staff.

Health Care for Homeless Veterans

According to VHA, the HCHV program aims to reduce homelessness by improving access to health care, based on the premise that addressing health needs enables veterans to pursue broader life goals. Program staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.[26]

During this inspection, VHA used three performance measures to determine the success of each medical facility's program. The first, HCHV5, measured the percentage of homeless veterans who received an HCHV program intake assessment.[27] However, beginning this fiscal year (FY 2026), VHA no longer uses this intake percentage as a performance measure. The second measure used during the inspection, HCHV1, measured the percentage of veterans placed into permanent housing from contracted emergency residential services and low-demand safe haven programs.[28] Finally, HCHV2 (negative exits) measured the percentage of veterans who are discharged due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff."[29]

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

[27] VHA sets an escalating target each FY with the goal of 100 percent by the end of the FY. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*, October 1, 2023.

[28] VHA sets the target for HCHV1 at the national level each year. For FY 2023, the HCHV1 target was 55 percent or above. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*, October 1, 2022. Contracted emergency residential services provide stable living arrangements for veterans while they seek permanent housing. Low-demand safe haven programs are transitional residences for homeless veterans with mental illness or substance use issues. Department of Veterans Affairs, "Health Care for Homeless Veterans" (fact sheet), December 2024.

[29] VHA sets the target for HCHV2 at the national level each year. For FY 2023, the HCHV2 (negative exits) target was 20 percent or below. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*, October 1, 2022.

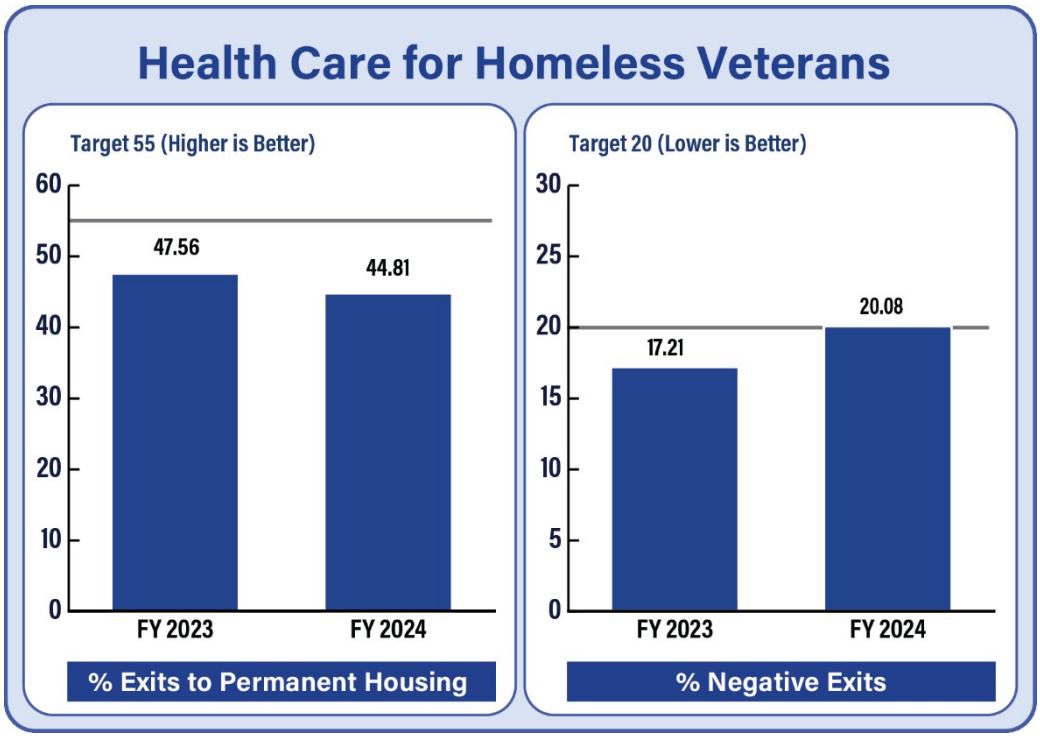

Figure 7. *HCHV program performance measures.*
Source: VHA Homeless Performance Measures data.

Program Highlights

- The program did not meet the HCHV5 target from FYs 2023 through 2024.[30] The chief of homeless programs said the area has around 800 homeless veterans, and staff have only enrolled 50 percent of them because many veterans do not want to answer all the required assessment questions. Without a complete intake assessment, veterans cannot access the homeless program services.
- The program also did not meet the HCHV1 target for FYs 2023 through 2024 because some veterans require more intensive post-hospitalization care such as a skilled nursing facility, which is not considered an exit to permanent housing.
- The program met the HCHV2 target for FY 2023 and almost met it in FY 2024. The program coordinator attributed the FY 2023 success to teaching methods of harm reduction to newly contracted agency staff and ending contracts with agencies that used outdated discharge practices.

[30] The facility reported 51.94 percent in FY 2023 and 43.32 percent in FY 2024.

Housing and Urban Development–Veterans Affairs Supportive Housing

The Housing and Urban Development–Veterans Affairs Supportive Housing program combines Department of Housing and Urban Development rental assistance with VA case management services to support veterans who face significant barriers to stable housing, including "serious mental illness, physical health diagnoses, and substance use disorders."[31] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[32]

VHA measures how well the program meets veterans' needs by using nationally determined targets, including the number of housing vouchers assigned to the facility currently used by veterans or their families (performance measure HMLS3) and the percentage of veterans who are employed (performance measure VASH3).[33]

Program Highlights

- The program met the HMLS3 target in FYs 2023 and 2024.[34] To increase housing access, the program manager detailed the program's partnership with public housing agencies to develop project-based housing units.[35] They have 26 project-based sites with 350 housing units throughout their service area, with more sites in development.
- The program met the VASH3 target for FYs 2023 and 2024.[36] The program manager attributed staff's success to teamwork and case managers' ability to help veterans formulate their employment goals and link them with community resources.

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

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

[33] VHA sets the HMLS3 target at 90 percent or above and the VASH3 target at 50 percent or above. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures,* October 1, 2022.

[34] For FYs 2023 and 2024, the HMLS3 targets were 90 percent. The facility's HMLS3 scores were 90.21 percent in FY 2023 and 90.9 percent in FY 2024. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*.

[35] For project-based properties, rental assistance "is attached to specific units in a building (often all the units of the building)." Department of Housing and Urban Development, "Fact Sheet #4: The Difference Between Project-Based Vouchers (PVB) and Project-Based Rental Assistance (PBRA)."

[36] The facility's VASH3 scores were 65.22 percent in FY 2023 and 56.94 percent in FY 2024.

Veterans Justice Program

VHA's Veterans Justice Program serves veterans at all stages of the criminal justice system, from contact with law enforcement to court settings and reentry into society after incarceration.[37] Recognizing incarceration as a strong predictor of homelessness, the program focuses on connecting veterans to VA health care, services, and benefits. VHA measures the number of veterans entering the Veterans Justice Program each FY (performance measure VJP1).[38]

Program Highlights

- The program exceeded the VJP1 target for FYs 2023 and 2024.[39] The assistant chief of homeless programs attributed their success to the team's focus and hard work, including tracking and monitoring all prison and jail outreach encounters.
- According to the assistant chief, veterans justice outreach specialists screen incarcerated veterans for admission to mental health residential rehabilitation treatment programs, and if appropriate, work with the justice system to transfer them directly from prison to treatment. The assistant chief described this as a best practice and program strength.

Conclusion

To assist leaders in evaluating the quality of care at their facility, the OIG conducted an inspection across five domains. The OIG provided recommendations on issues related to environment of care deficiencies and service-level workflows. Facility leaders have started to implement corrective actions, which resulted in the OIG closing recommendation 3. Recommendations do not reflect the overall quality of all services delivered within the facility. However, the OIG's findings and recommendations may help guide improvement at this and other VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

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

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

[38] VHA sets escalating targets for this measure at the facility level each year, with the goal to reach 100 percent by the end of the FY. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*.

[39] The facility's VJP1 scores were 125.60 percent in FY 2023 and 111.56 percent in FY 2024.

Appendix A: Methodology

Inspection Processes

The OIG inspection team reviewed facility policies and standard operating procedures, administrative and performance measure data, VA All Employee Survey results, and relevant prior OIG and accreditation survey reports.[1] The OIG distributed a voluntary questionnaire through the facility's all employee mail group to gain insight and perspective related to the organizational culture. Additionally, the OIG interviewed facility leaders and staff to discuss processes, validate findings, and explore reasons for noncompliance. Finally, the OIG inspected selected areas of the medical facility.

The inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's standards.[2] During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, questionnaire responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and took full responsibility for the content of the publication. All references are for original source material, not AI-generated content. The inspection teams do not use AI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget (OMB) Memorandum M-25-21, *Accelerating Federal Use of AI through Innovation, Governance, and Public Trust.*[3]

Potential limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[4] The OIG acknowledges potential bias because the facility liaison selected staff who participated in the interviews; the OIG requested this selection to minimize the impact of the OIG inspection on patient care responsibilities and primary care clinic workflows.

[1] The All Employee Survey and accreditation reports covered the time frame of October 1, 2022, through September 30, 2024.

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

[3] Director for the Office of Management and Budget, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust," memorandum to Heads of Executive Departments and Agencies, April 3, 2025.

[4] Self-selection bias is when individuals with certain characteristics choose to participate in a group, and response bias occurs when participants "give inaccurate answers for a variety of reasons." Dirk M. Elston, "Participation Bias, Self-Selection Bias, and Response Bias," *Journal of American Academy of Dermatology* (2021): 1-2, https://doi.org/10.1016/j.jaad.2021.06.025.

Healthcare Facility Inspection directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from June 2 through 5, 2025. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issues.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[5] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with OIG procedures and *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

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

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: February 2, 2026

From: Director, VA Sierra Pacific Network (10N21)

Subj: Healthcare Facility Inspection of the VA Palo Alto Health Care System in California

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

Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review the draft report for the Healthcare Facility Inspection of the VA Palo Alto Health Care System in California.
2. I concur with the findings, recommendations, and submitted action plans of VA Palo Alto Health Care System in California.
3. If you have any questions, please contact the VISN 21 Quality Management Officer.

(Original signed by:)

Ada Clark, FACHE, MPH
Network Director
VA Sierra Pacific Network (VISN 21)

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: February 3, 2026

From: Director, VA Palo Alto Health Care System (640)

Subj: Healthcare Facility Inspection of the VA Palo Alto Health Care System in California

To: Director, VA Sierra Pacific Network (10N21)

1. Thank you for the opportunity to review and respond to the draft report Healthcare Facility Inspection of the VA Palo Alto Health Care System in Palo Alto, California. I extend gratitude to the OIG and Healthcare Facility Inspection team for the collaboration during the inspection.
2. I concur with the draft report and OIG's recommendations.
3. I respectfully request closure of Recommendation #3 as we have successfully completed the necessary corrective actions and demonstrated sustainment.
4. The VA Palo Alto Health Care System is committed to providing the highest quality of care possible to the Nation's Veterans and is eager to incorporate these recommendations to further our journey to high reliability.
5. Comments or questions regarding the contents of this Memorandum may be directed to the VA Palo Alto Health Care System Chief of Quality, Safety, and Value.

(Original signed by:)

Jean J. Gurga, MA, OTR/L
Executive Medical Center Director
VA Palo Alto Health Care System

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