US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the San Francisco VA Health Care System in California

Healthcare Facility Inspection	26-00032-248	August 26, 2026

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Executive Summary

The VA Office of Inspector General (OIG) established the Healthcare Facility Inspection program to review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle. The OIG inspected the San Francisco VA Health Care System (the facility) from February 3 through 5, 2026. The facility is rated as *highest complexity* and in fiscal year 2025, provided direct care to about 125,000 patients.[1] The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[2]

What the OIG Examined

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences. The OIG made no recommendations.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy. The OIG observed a fire door (designed to resist fire) that did not close completely or latch as required by *National Fire Protection Association 80 Standard for Fire Doors and Other Opening Protectives* and made a recommendation to fix it.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The OIG found staff had not updated the facility's test result communication policy and some services lacked workflows (which outline staff member roles in the communications process), as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[3] The OIG made two related recommendations.
- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.[4] The OIG found that most primary care panel sizes (the number of

[1] VHA classifies facilities based on their complexity level. Highest-complexity facilities have "high-volume, high-risk patients, most complex clinical programs, and large research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." San Francisco VA Health Care System, "San Francisco VA Health Care System" (fact sheet), January 2026.

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

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

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

patients assigned to a primary care team) were below the capacity recommended in VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, and leaders did not consistently monitor panel efficiency, capacity, and staffing.[5] The OIG made one recommendation to use the required tracking tool to evaluate and revise panels.

- **Veteran-Centered Safety Net.** The inspection also evaluated facility programs that offer support services to vulnerable veterans who are experiencing or at risk of homelessness or have recently been incarcerated. The OIG made no recommendations.

What the OIG Recommended

1. The Director takes appropriate actions so fire doors close completely and latch, as required by *National Fire Protection Association 80 Standard for Fire Doors and Other Opening Protectives*.
2. The Director takes appropriate actions so staff update the facility policy on test result communications to meet the requirements of Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.
3. The Chief of Staff and Associate Director for Patient Care Services/Nurse Executive take appropriate actions so staff develop, for each service, written workflows consistent with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.
4. The Director takes appropriate actions for the Chief of Staff to review Patient Centered Management Module data and address efficiency, capacity, and staffing needs, in accordance with Veterans Health Administration Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*.

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

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). Based on information provided, the OIG considers recommendations 1 and 4 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until they are completed.[6]

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[6] In December 2025, VA announced plans to reorganize the management structure of the Veterans Health Administration. On May 1, 2026, the Under Secretary for Health announced the consolidation of the Veterans Integrated Service Networks (VISNs) from 18 networks to 5. On July 15, 2026, the Acting Under Secretary for Health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise.

Abbreviations

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

Contents

Introduction

The Office of Inspector General'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.[7] VHA's vast care delivery structure requires sustained and thorough OIG oversight to ensure the nation's veterans receive high-quality care.

The OIG established the Healthcare Facility Inspection program to routinely evaluate VHA medical facilities on an approximately three-year cycle. Healthcare Facility Inspection reports provide insight into the experience of staff working in VHA facilities and veterans receiving care. They inform veterans, the public, and Congress about the conditions for care delivery and patient safety and highlight specific corrective actions leaders and staff can take. Each inspection focuses on five domains and assesses facilities' adherence to VA standards and other governing authorities:

Culture: VA supports a system of shared values that shape an organization's behavioral norms. Effective responses to system shocks as well as favorable employee and veteran experiences are elements of positive organizational culture.[8]

Environment of Care: Medical facilities must maintain safety, cleanliness, and accessibility. VHA established a comprehensive program that addresses physical spaces, equipment and systems, privacy, and other concerns.[9]

Patient Safety: VHA has programs to identify and reduce system vulnerabilities and risks of harm to veterans.[10]

Integrated Veteran Care: Facilities must comply with directives and guidance governing the VHA multidisciplinary care model.

Veteran-Centered Safety Net: VA offers coordinated medical care and social support services to vulnerable individuals, including those experiencing homelessness or recent incarceration.[11]

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

[8] Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," BMJ Open 7, no. 11 (2017): 1–11, https://doi.org/10.1136/bmjopen-2017-017708.

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

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

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

The San Francisco VA Health Care System (the facility) established in November 1934, operates 10 locations in California.[12] In fiscal year (FY) 2025, its budget was approximately $1.4 billion, which included $235 million for care in the community.[13] The facility had 116 community living center, 105 acute care, and 11 domiciliary beds.[14] It also maintains a comprehensive research program focused on neuroscience (nervous system), cardiovascular health (heart and blood vessels), cancer, post-traumatic stress disorders, infectious diseases, and other critical areas.

Figure 1. *Facility photo.*
Source: "San Francisco VA Medical Center," VA, accessed January 13, 2026, https://www.va.gov/san-francisco-health-care/locations.

The OIG team inspected the facility from February 3 through 5, 2026. The executive leaders referred to throughout this report include the Interim Executive Director, Chief of Staff, Deputy Chief of Staff, Deputy Chief of Staff of Quality and Access, Associate Director for Patient Care Services/Nurse Executive, Deputy Associate Director for Patient Care Services/Nurse Executive, Associate Director, and Associate Director for Operations.[15] The Chief of Staff, assigned in August 2018, had the longest tenure, and the Interim Executive Director, who started in January 2026, was the newest leader. Also, facility leaders referred to in this report may include managers, supervisors, and service chiefs who implement policies and maintain daily operations.

[12] The facility includes the San Francisco VA Medical Center; clinics in Clearlake, Eureka, San Bruno, San Francisco, and Ukiah; and two clinics in both Santa Rosa and Oakland.

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

[14] A community living center is also referred to as a VA nursing home. "Geriatrics and Extended Care," VA, last updated March 27, 2026, https://www.va.gov/VA_CLC. A domiciliary is a residential "clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans," VA, accessed June 29, 2026, https://department.va.gov/homeless/dchv.

[15] The Chief of Staff was out of the office from February 3 through 5, 2026, so the OIG interviewed the Deputy Chief of Staff of Quality and Access, who was the acting Chief of Staff at the time.

The OIG team examined the facility's culture across multiple dimensions, including unique circumstances and system shocks (planned or unplanned events that disrupt an organization's daily operations), and both employees' and veterans' experiences.[16] The OIG administered its own facility-wide questionnaire and reviewed Veterans Signals (VSignals) survey scores (which summarize real-time information from veterans about their experiences after an appointment and assess their level of trust in VA).[17] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[18]

System Shocks

In interviews, executive leaders described ongoing organizational changes that resulted from January 2025 executive orders and presidential memorandums as system shocks. These changes included implementing the return to in-person work requirement and experiencing delays in filling vacancies caused by the 2025 hiring freeze (in effect from January 20, 2025, to October 15, 2025), which they reported increased pressure on remaining employees.[19] Executive leaders stated they rescinded tentative job offers during the hiring freeze, although they later received approval to hire for some of those positions. When the freeze ended, they prioritized hiring for clinical positions—for example, radiologists (imaging), cardiologists (heart and blood vessels), and an orthopedic physician (treating bones or muscles)—and implemented special salary rates or retention incentives for hard-to-fill or critical positions such as engineering staff, police, housekeeping aides, and advanced medical support assistants.

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[16] 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.

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

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

[19] Hiring Freeze, 90 Fed. Reg. 8247 (Jan. 28, 2025). Shortly after the hiring freeze memorandum was issued, the Acting Secretary provided guidance and identified a list of exempted "positions critical to delivering care to Veterans in" VHA. Acting Secretary, "Hiring Freeze Guidance," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, January 21, 2025. As of December 1, 2025, VA adopted new policies for filling vacancies and creating new positions in compliance with the executive order for Ensuring Continued Accountability for Federal Hiring. Executive Order 14356, 90 Fed. Reg. 48387 (Oct. 20, 2025); Assistant Secretary for Human Resources and Administration (006), "Updated Department of Veterans Affairs Hiring Guidance (VIEWS 13474675)," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, December 1, 2025; Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025); Acting Chief Operating Officer, VA, "Position and Organizational Chart Management (VIEWS 13223853)," memorandum to Veterans Integrated Service Network (VISN) Directors, November 20, 2025.

To accommodate employees returning to in-person work, the Associate Director for Operations reported executive leaders paid for off-site parking and implemented a staggered return schedule, so they had time to review workspace capacity. Executive leaders also converted non-patient care areas into cubicles, replaced oversized desks with smaller ones, and created a portable building for 120 employees to mitigate space concerns.

Employee Experiences

OIG questionnaire respondents indicated that executive leaders' communications were clear and useful.[20] However, when asked whether they considered leaving, approximately 41 percent cited stress and burnout that made them think about leaving the facility. During interviews, executive leaders stated further that employees told them they felt stressed and burned out because of unfilled vacancies and the resulting increased workload. To address burnout, the leaders reduced overtime by using contract employees and leveraged technology (artificial intelligence programs) to lessen the administrative burden.

Additionally, a nurse coordinator said a facility workgroup launched a program in February 2025 to reduce stress and burnout through interventions, including access to peer mentors. A Pathways to Excellence evaluation (an external program that assesses the nursing environment) was conducted before and after the intervention program's implementation. It showed improved well-being among nurses. The facility later received the Pathway to Excellence designation in January 2026.[21]

Executive leaders noted two incidents close to the time of the inspection in February 2026 involving healthcare workers that caused shock and anxiety among their employees—an attack on a social worker at a local hospital and the killing of a VA nurse in Minnesota. In response, the Interim Executive Director visited patient care units to provide emotional support to staff, issued an all-employee message with counseling resources, and formed a multidisciplinary safety team to address concerns, including installing additional panic alarms requested by employees.

To better understand employee needs, the executive leaders reported they distributed a questionnaire in January 2026 to measure employee engagement, satisfaction, workload, and

[20] The facility had 3,723 employees at the time of the questionnaire, with a response rate of approximately 10 percent.

[21] The American Nurses Credentialing Center's Pathway to Excellence Program recognizes healthcare organizations that create healthy work environments, support nurse satisfaction, and promote nursing excellence. "About Pathway," American Nurses Credentialing Center, accessed October 9, 2025, https://www.nursingworld.org.

psychological safety.[22] The Interim Executive Director stated they were still reviewing results and they planned to develop strategies to improve employee experiences based on responses.

Veteran Experiences

Patient advocate responses to an OIG questionnaire indicated facility employees were generally responsive to and effectively addressed veterans' concerns. The patient advocates identified veterans' most common concern was lack of communication, including delays in facility employees returning phone calls. The Deputy Chief of Staff reported that employees monitored dropped calls (lost connections) data, wait times, and failed contact attempts, and used the information to reroute calls to locations with more capacity. The deputy chief added that facility leaders also promoted patients' use of a secure messaging system by deploying telehealth employees to clinics to help veterans set up accounts and learn the system. As shown in figure 2, the facility's VSignals scores exceeded VHA's national average, indicating veterans trust the outpatient care they receive.

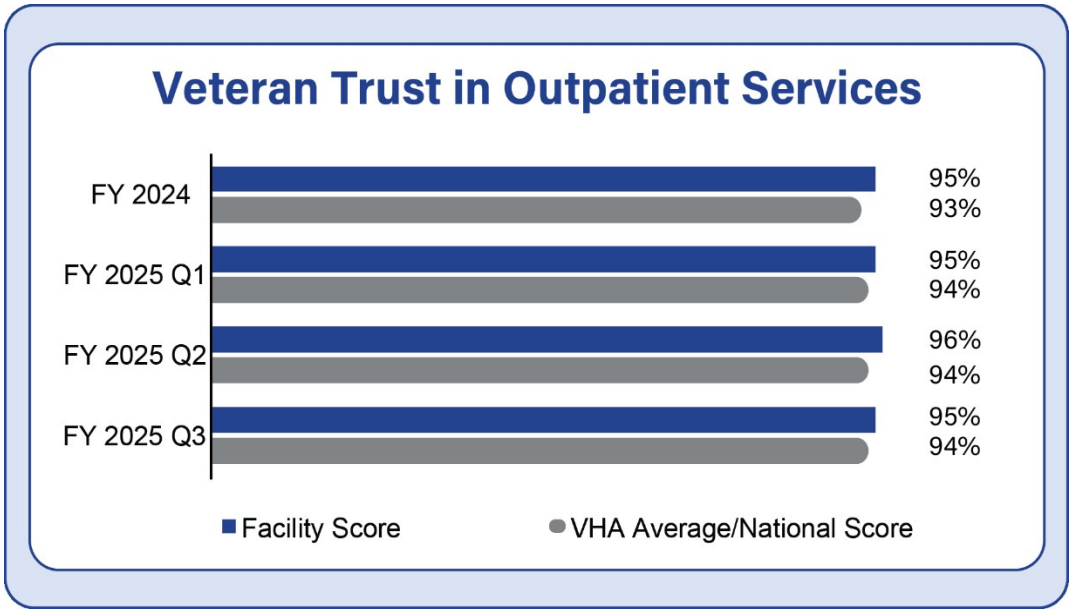

Figure 2. *Veteran trust in outpatient services.*
Source: VSignals data.

[22] "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.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[23] The OIG team assessed how a facility's physical features may shape the veteran's perception of the health care they receive. The team also inspected patient care areas and focused on safety, cleanliness, infection prevention, and privacy.

The inspectors examined compliance with key VA and VHA guidelines and standards, as well as with Architectural Barriers Act and Joint Commission standards. Best practice principles from academic literature were also considered.[24]

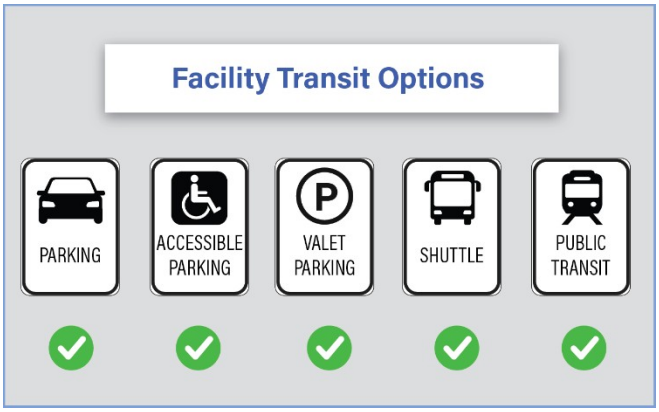

Figure 3. *Transit options for arriving at the facility. Source: Observations, transportation schedule, parking map, valet contract, and bus route schedule.*

General Inspection

At the San Francisco VA Medical Center, the OIG team observed several parking options, including multiple parking garages. There was also a public bus stop located a short walk from the main entrance.

The main entrance was covered to shelter veterans from adverse weather conditions, and accessible by both stairs and a wheelchair ramp. However, inspectors noted a crosswalk leading to the main entrance lacked detectable warning surfaces for individuals with visual impairments. VA's *Site PG 18-10*, *Design Manual*, requires detectable warning surfaces to alert visually impaired pedestrians of potential hazards before they transition onto a roadway.[25] The OIG did not make a recommendation because the chief of engineering reported there was a plan to install the detectable warning surfaces as part of ongoing facility improvement efforts.

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

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

[25] VA, *Site PG-18-10*, *Design Manual*, March 1, 2024.

Figure 4. *Accessibility tools available to veterans with impairments.*
Source: Observations, questionnaire responses, and parking map.

Other areas of concern were also noted: The OIG team observed a key in a door lock that led to the intensive care unit construction area that should have been secured. Also, there was debris on the ground around the doorway and on a sticky mat intended to remove dust and soil from shoes. The *San Francisco VA Health Care System Environmental Health & Safety Manual* requires staff to ensure all construction sites are secured to prevent unauthorized access. The manual also requires facility staff to change or vacuum mats when necessary.[26] After the OIG notified facility staff, they removed the key from the lock immediately, and when inspectors returned to the construction area later that day, the debris was gone and the mat was clean.

However, the team determined facility staff did not perform facility construction safety surveillance activities at least weekly, as required by VHA Directive 7715(1), *Safety and Health During Construction*; staff had completed only one week of surveillance for the intensive care unit renovation.[27] The OIG did not make a recommendation because the chief of environmental health and safety reported staff had started the surveillance the week before the site visit in February 2026, and an action plan was in place to ensure staff performed the activities as required.

In an outpatient clinical area, the inspectors observed an emergency exit sign pointing to a set of double doors blocked by a desk. A staff member was sitting at the desk, further blocking the exit. The *National Fire Protection Association 101 Life Safety Code* requires facilities to ensure exits are free of obstructions in the event of fire or other emergency.[28] The OIG brought this safety

[26] VA, *San Francisco VA Health Care System Environmental Health & Safety Manual*, revised December 16, 2020.

[27] VHA Directive 7715(1), *Safety and Health During Construction*, June 22, 2023, amended September 5, 2023. The intensive care unit construction began on January 5, 2026, and construction surveillance on the project occurred on January 29, 2026.

[28] The National Fire Protection Association, *NFPA 101: Life Safety Code*, 7.1.10.1, 2024 ed., September 14, 2023. "The Public Buildings Amendment Act (PL 100-678) requires all federal agencies to follow the latest editions of nationally recognized fire and life safety codes…VA has adopted the National Fire Codes (NFC) published by the National Fire Protection Association (NFPA), which establish a minimum acceptable level of life safety and property protection. Life safety requirements are specifically addressed in NFPA 101." VA, *Fire Protection Design Manual Ninth Edition*, November 1, 2023.

issue to the attention of the Associate Director for Operations, and when inspectors returned to the area later that day, there was no longer a desk blocking the exit.

The OIG team also observed a corridor fire door (designed to resist fire) near an inpatient unit that did not latch when closed. According to the *National Fire Protection Association 80 Standard for Fire Doors and Other Opening Protectives*, fire doors must latch to contain fire in the event of an emergency.[29] The chief of environmental health and safety explained the door had a history of either slamming shut or not shutting completely due to air pressure issues. The chief of engineering told the OIG that staff had adjusted the door multiple times but it continued to malfunction. During the week of the inspection in February 2026, facility staff completed an assessment of the area and determined no actions were needed to ensure safety while waiting for the door to be repaired.

Recommendation 1

The Director takes appropriate actions so fire doors close completely and latch, as required by *National Fire Protection Association 80 Standard for Fire Doors and Other Opening Protectives*.

__X__Concur

_____Nonconcur

Target date for completion: Completed

Director Comments

During the investigation, it was determined that pressure differentials associated with nearby construction activities were contributing to the corridor fire door's performance issues and recurring malfunctions. Further evaluation identified excessive pressurization from the Air Handling Unit (AHU) system. An Interim Life Safety Measure (ILSM) was implemented upon initial identification of the deficiency to ensure a safe environment while corrective actions were underway.

On February 18, 2026, repairs and adjustments were completed on the corridor fire door's AHU, including corrective work to the door and latching mechanisms, with multiple functional checks to confirm the corrections. Furthermore, the annual fire door inspection, completed on February 28, 2026, replicated the corrective actions. Any deficiencies identified between scheduled inspections are reported by hospital staff, Engineering Services, or through Environment of Care (EOC) rounds. Ongoing oversight and maintenance responsibility rest with the Chief of Engineering and the Maintenance and Operations Chief.

Facility is requesting closure for this recommendation.

[29] National Fire Protection Association, *NFPA 80 Standard for Fire Doors and Other Opening Protectives,* 5.2.3.7.2, 2025 ed., September 18, 2024.

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.

The OIG inspectors examined the facility's patient safety processes. They focused on communication procedures for urgent but noncritical test results, the sustainability of changes made by leaders in response to previous oversight recommendations, and improvement projects.

Communication of Urgent but Noncritical Test Results

The inspectors found the facility's April 2023 test results communication policy had not been updated to include all elements required by VHA Directive 1088, *Communicating Test Results to Providers and Patients*, and subsequent directive amendment, such as updated definitions for abnormal results. Further, some services had workflows (which detail how staff obtain test results and share them with patients) as required, but others did not.[30] The OIG team shared these findings with facility leaders and staff during the inspection. These gaps increase the risk of delayed or missed communication of abnormal test results, which could cause lapses in patient follow-up, reduced care coordination, and compromised patient safety.

On July 11, 2023, VHA published Directive 1088, which required the facility to develop a local policy and service-level workflows within 6 to 12 months. The OIG identified several missed opportunities for the facility to recognize the need to revisit its policy and create service-level workflows which included the following:

- On September 20, 2024, VHA amended the directive clarifying expectations for service-level workflow content but did not detail those service-specific roles.[31]
- In December 2025, the OIG requested facility policies and service-level workflows related to test result communications, which did not prompt corrective action.

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

[31] VHA Directive 1088(1).

- Additionally, the OIG published reports that cited other facilities' identified problems with VHA requirements for test result communications that should be considered by all VHA facilities.[32]

During interviews, the Deputy Chief of Staff and the Associate Director for Patient Care Services/Nurse Executive acknowledged they had not ensured that each service developed written workflows and said they would close this gap. Accordingly, staff began to draft an updated test result communications policy during the OIG February 2026 inspection. The OIG will review that policy when determining whether to close the following recommendation as implemented.

Recommendation 2

The Director takes appropriate actions so staff update the facility policy on test result communications to meet the requirements of Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

__X__ Concur

_____ Nonconcur

Target date for completion: August 31, 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), and the San Francisco Veterans Affairs Health Care System (SFVAHCS) Medical Center Policy (MCP) 11-90, *Communicating Test Results to Providers and Patients*, dated April 28, 2023. A gap analysis was completed to ensure that the local policy (MCP 011-090) is compliant with VHA Directive 1088(1), which includes added responsibilities, definitions on critical/emergent/imminently life-threatening test results, reporting timeframes, documentation requirements, provider and patient notification requirements, escalation process, and accountability factors. The policy was updated to be in compliance with the directive. In addition, the workflow process for each service was incorporated into the policy and will be approved through the local governance process.

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

Recommendation 3

The Chief of Staff and Associate Director for Patient Care Services/Nurse Executive take appropriate actions so staff develop, for each service, written workflows consistent with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

__X__Concur

_____Nonconcur

Target date for completion: August 31, 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), and the SFVAHCS Medical Center Policy (MCP) 11-90, *Communicating Test Results to Providers and Patients*, dated April 28, 2023. A gap analysis was completed to ensure that the local policy (MCP 011-090) is compliant with VHA Directive 1088(1). After review and consultation with all services involved, MCP 011-090 was updated to include requirements for service-level workflows, clearly defined provider and staff responsibilities, and procedures for communicating test results to ordering providers and to patients. The policy was updated to be in compliance with the directive. In addition, the workflow process for each service was incorporated into the policy and will be approved through the local governance process.

In accordance with the updated MCP 011-090—service level workflow process were created for the following: (a) Nursing Services -Inpatient Acute Care Units service level workflow (b) Outpatient Clinics and service level workflow (c) Radiology service level workflow (d) Surgical service level workflow (e) Cardiology Service workflow and (f) Laboratory service workflow (Lab Medicine 113A SOP dated April 2025).

VHA Directive 1088(1) also requires providers to communicate test results that require action to patients within seven days of the results becoming available. The OIG reviewed the facility's test result communications metrics and found some improvement for providers complying with this requirement from FY 2024 through FY 2025. A quality improvement nurse attributed the improvement to educating providers on timeliness requirements. The nurse also reported that quarterly metrics on test result communications were conveyed to executive leaders at the Quality and Patient Safety Council.

Action Plans and Process Improvements

In July 2025, Veterans Integrated Service Network (VISN) 21 conducted an annual review of the facility and found it lacked a peer review coordinator and permanent patient safety

coordinators.[33] Vacancies in peer review and patient safety positions could limit the facility's capacity to maintain consistent oversight of the quality of care provided to veterans. The facility's corrective action plan included hiring a peer review coordinator and recruiting three patient safety staff. During the February 2026 inspection, the chief of quality and patient safety reported recently hiring the three patient safety managers and said they still planned to appoint a peer review coordinator.

All facility actions taken in response to OIG recommendations made from its May 2022 comprehensive health inspection were completed.[34] During the 2026 site visit, the OIG asked quality and patient safety staff how they sustained prior action plans. The chief of quality and patient safety detailed an example of how a 2025 OIG recommendation from an oversight report on improving the credentialing of sleep medicine physicians was addressed through improved and sustained communications between the VISN and facility credentialing staff.[35] The chief explained that executive leader meetings with service chiefs clarified credentialing expectations and that regular meetings improved the credentialing and privileging process.

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[36] The OIG evaluated facilities' primary care and community care staff vacancies, veterans' access to care, actions staff took to enhance processes, and how leaders supported improvements. The inspection team also examined community care referral processing timelines and program effectiveness in improving access to care.

Primary Care Staffing and Access to Care

Primary care leaders reported that 87 teams delivered primary care services at the facility. At the time of the inspection in February 2026, the leaders stated vacancies included one physician,

[33] VA administers healthcare services through a nationwide network of regional systems referred to as Veterans Integrated Service Networks (VISNs). "Veterans Integrated Service Networks," VA, last updated July 24, 2026, https://department.va.gov/visns. In December 2025, VA announced plans to reorganize the management structure of the Veterans Health Administration. On May 1, 2026, the Under Secretary for Health announced the consolidation of the VISNs from 18 networks to 5. On July 15, 2026, the Acting Under Secretary for Health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise.

[34] VA OIG, *Comprehensive Healthcare Inspection of the San Francisco VA Health Care System in California*, Report No. 22-00231-176, August 3, 2023.

[35] VA OIG, *Review of VISN 21 Clinical Resource Hub Sleep Medicine Physician Privileging*, Report No. 25-00302-243, December 2, 2025.

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

three nurse practitioners, three registered nurses, one licensed vocational nurse, and five medical support assistants. The primary care chief said one nurse practitioner position at a rural community-based outpatient clinic had been vacant for over a year because recruiting in the area was difficult. To ensure access to care, the director of ambulatory care/group practice manager explained they sent a provider to the clinic once a week and transported patients to other clinics.

Inspectors found that new patient appointment wait times averaged under 17 days and established patient wait times averaged under 5 days for the third quarter of FY 2025, exceeding VHA expectations set out in regulations. The Code of Federal Regulations (title 38, section 17.4040) states that patients may be referred to community providers if the wait time is greater than 20 days.[37]

The OIG team reviewed facility records and VHA reports and found that about two-thirds of primary care providers had panels (patients assigned to a primary care team) that were smaller than recommended by VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care* (the guidelines state primary care panel capacity is based on variables such as staffing, number of rooms, and provider types).[38] The directive requires staff to use the Patient Centered Management Module (a tool that tracks primary care teams, staffing and patient panels); it also assigns responsibility to the chief of staff, or a delegate, for reviewing data on efficiency, capacity, and staffing. The OIG reviewed facility documents that showed panel capacity at 81 percent, which raises the question of whether leaders could more effectively manage staffing in primary care teams. The director of ambulatory care/group practice manager affirmed providing monthly panel metrics to executive leaders. However, the Deputy Chief of Staff reported the facility lacked a process to evaluate panel efficiency or take corrective actions.

Recommendation 4

The Director takes appropriate actions for the Chief of Staff to review Patient Centered Management Module data and address efficiency, capacity, and staffing needs, in accordance with Veterans Health Administration Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*.

__X__ Concur

_____ Nonconcur

Target date for completion: Completed

[37] 38 C.F.R. § 17.4040 (2025).

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

Director Comments

The San Francisco VA Health Care System has established a comprehensive Patient-Centered Management Module (PCMM) standard operating procedure (SOP) fully compliant with VHA Directive 1406 through a local governance structure.

The SOP addresses the following: the requirement of regular COS review of PCMM metrics related to efficiency, capacity, and staffing; defines key responsibilities for the facility PCMM Coordinator, Primary Care leads, and facility leadership; establishes frequency and methods for oversight and monitoring (e.g., regular recurring reviews and escalation processes through the local governance structure).

The SOP received full local governance approval and was officially signed on July 22, 2026.

Facility is requesting closure for this recommendation.

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.

Community Care Staffing and Access to Care

The OIG team reviewed the facility's community care program staffing for the fourth quarter of FY 2025, and found the program had both administrative and clinical staffing vacancies. The assistant director of community care reported no recruitment or retention issues for nurses. However, the assistant director noted that it was a challenge to retain medical support assistants because once trained, they often transition to higher-paying positions.

Facility documents showed that community care consults (requests for care outside the facility) increased by 17 percent from January 29, 2025, to January 29, 2026. The assistant director of community care stated that facility community care leaders were actively recruiting to fill vacant positions, but in the meantime, they required staff to work beyond their scheduled hours to manage the higher workload. A staff member stated the increased workload and mandatory overtime contributed to burnout.

The OIG inspectors also reviewed community care data for the second quarter of FY 2025 and found staff averaged 65 days to schedule appointments, which far exceeds the 7-day target in VHA's *Consult Timeliness Standard Operating Procedure*.[39] The OIG found specialty services such as radiology, complementary and integrative health, and rehabilitation generated the highest number of community care consults. Long drive times were the primary reason for consults, due to the clinics' rural locations. The Code of Federal Regulations (title 38, section 17.4040) states

[39] VHA, Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," updated June 12, 2025.

that patients may be referred to community providers if the drive time from the veteran's residence is on average greater than 30 minutes for primary and mental health care and 60 minutes for specialty care.[40] Facility community care leaders stated there were insufficient numbers of community providers available locally, which delayed scheduling. Additionally, some community providers had limited administrative capacity and relied on outdated methods such as paper and faxed documents, which delayed appointment scheduling and patient record retrieval for care coordination.

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

Health Care for Homeless Veterans

According to VHA, the HCHV program aims to reduce homelessness by improving access to health care, based on the premise that addressing health needs enables veterans to pursue broader life goals. Program staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.[41]

VHA uses performance measures to determine the success of each medical facility's program. HCHV1 measures the percentage of veterans placed into permanent housing from contracted emergency residential services (stable living arrangements for veterans while they seek permanent housing) as well as those from low-demand safe haven programs (transitional residences for veterans with mental health or substance use conditions).[42] HCHV2 measures the percentage of veterans who are discharged from program's contracted emergency residential services or low-demand safe haven beds due to a "violation of program rules…failure to comply

[40] 38 C.F.R. § 17.4040 (2025).

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

[42] VHA sets targets for HCHV1 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*, November 2024. Contract residential services programs include both contracted emergency residential services and low-demand safe haven programs. For contracted emergency residential services, veterans can usually stay from 30 to 90 days. For low-demand safe havens a veteran can typically stay between 4 to 6 months. VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

with program requirements…or [who] left the program without consulting staff (referred to as negative exits)."[43]

Performance and Improvement Highlights

- The facility did not meet the discharge to permanent housing (HCHV1) target for FY 2025. The facility's homeless programs director stated they missed the target because the program lacked sufficient staff to help veterans find permanent housing after discharge from transitional (temporary) housing. The director explained that it was difficult to retain social workers because two nearby VA medical centers offered higher salaries; however, the facility implemented a special salary increase in December 2025, and the director believed it would improve staffing.
- The program also did not stay at or below the negative exit (HCHV2) target for FY 2025. Program staff attributed this to veterans leaving transitional housing without providing follow-up contact information, and to low staffing levels that prevented effective outreach and the engagement needed to support veterans in transitional housing.
- To coordinate and plan for veterans' care needs, the facility's homeless programs director stated that staff at the facility's community referral and resource center (a walk-in clinic for veterans experiencing or at risk of homelessness) in downtown San Francisco meet with the facility's homeless medical team three times per week.[44]
- Facility program staff also participated in an event to reduce homelessness targeting five city areas in August 2025, along with facility suicide prevention staff, medical providers, pharmacists, and community partners. At the event, staff engaged with 33 veterans experiencing homelessness. By February 2026, 28 of the veterans had housing and the remaining 5 did not use available program services.

Housing and Urban Development–Veterans Affairs Supportive Housing

The HUD-VASH program combines HUD rental assistance with VA case management services to support veterans who face significant barriers to stable housing, including "serious mental

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

[44] "VA Homeless Programs," VA, last updated August 11, 2026, https://department.va.gov/homeless/hchv/crrc.

illness, physical health diagnoses, and substance use disorders."[45] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[46]

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).[47]

Performance and Improvement Highlights

- The facility did not meet the target for voucher use (HMLS3) for FY 2025. The associate chief of social work services reported one barrier: the contractor for case management services in San Francisco did not renew their contract at the end of FY 2023, and the facility did not award new proposals because costs were too high. The associate chief stated a new contract, awarded in May 2025, became operational in December 2025.
- The associate chief also stated facility program staff at community-based outpatient clinics needed access to additional vehicles to provide veteran care. The OIG team discussed this issue with executive leaders, who said they would work with social work services to address these needs.
- The facility met the employment (VASH3) target for FY 2025. The associate chief attributed this success to staff efforts to review and update each veteran's employment status in VHA's national homeless data reporting system for accuracy.
- Additionally, the associate chief said two facility providers deliver medical outreach at four large public housing agency sites every other week. Program staff also partnered with a community organization to develop an 11-unit facility that houses veterans with serious medical needs.

Veterans Justice Program

The Veterans Justice Program serves veterans throughout all stages of the criminal justice process—from contact with law enforcement to court appearances and their reentry into life in the community after incarceration.[48] Recognizing incarceration as a strong predictor of homelessness on release, the program focuses on connecting veterans to VA health care,

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

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

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

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

services, and benefits. VHA sets a target for the number of veterans entering the Veterans Justice Program each fiscal year (performance measure VJP1).[49]

Performance and Improvement Highlights

- The facility did not meet the veteran enrollment (VJP1) target for the first and second quarter of FY 2025. Veteran justice outreach specialists reported that two vacant program positions were eliminated in December 2025, but program leaders were recruiting for another position during the OIG inspection in February 2026.
- The homeless programs director said the facility program has a forensic psychiatry clinic—which treats individuals involved in the criminal justice system. Through the clinic, facility program staff and providers from the University of California, San Francisco, hold weekly sessions to evaluate and address veterans' care needs, including addiction.[50]
- The director also described a community partnership with Warrior Canine Connection—a local nonprofit organization. Veterans enrolled in a treatment court (a court model that requires participants to complete treatment and case management services) train service dogs to assist other veterans with mobility and psychiatric needs.[51]

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

[50] Robert I. Simon and Liza H. Gold, "The American Psychiatric Publishing Textbook of Forensic Psychiatry," *Journal of the American Medical Association* 292, no.18 (November 10, 2004): 2276-2280, https:/doi.org/10.1001/jama.292.18.2279.

[51] VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024.

Conclusion

To assist leaders in evaluating the quality of care at the San Francisco VA Health Care System, the OIG conducted an inspection across five domains. The OIG made four recommendations related to the proper closure of fire doors; updates to the facility policy for test result communications, including defining all service-level workflows; and primary care panel management. Facility leaders have started to implement corrective actions, which resulted in the OIG closing recommendations 1 and 4. The OIG's findings and recommendations may help guide improvement at this and other VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

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

Appendix A: Methodology

The OIG team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports.[52] The OIG administered voluntary questionnaires to all employees through the facility's email distribution lists to gain insight and perspective related to the organizational culture. The OIG interviewed facility leaders and employees to discuss processes, validate findings, and explore reasons for identified problems. Finally, the OIG physically inspected various areas of the medical facility from February 3 through 5, 2026. During site visits, the team refers concerns that are beyond the scope of the inspections to the OIG's hotline management personnel for further review.

The inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's standards.[53] 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.*[54]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[55] The OIG acknowledges potential bias because the facility liaison selected employees who participated in the interviews; the OIG asked for this selection to minimize the impact of the inspection on patient care responsibilities and primary care clinic workflows.

[52] The accreditation reports covered the time frame of January 29, 2024, through October 3, 2025—the most recent available at the time of the inspection.

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

[54] 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.

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

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.[56] 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.

[56] 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: July 24, 2026

From: VISN 5–Health Service Area 5.2 Director

Subj: Healthcare Facility Inspection of the San Francisco VA Health Care System in California

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

Chief Integrity and Compliance Officer (10OIC)

The VA Sierra Pacific (VISN 21) Network Director has reviewed and concurs with the response submitted by the San Francisco Health Care System, San Francisco, CA in response to the OIG Healthcare Facility Inspection of the San Francisco VA Health Care System in California.

If you have any questions regarding the information submitted, please contact VISN 21 Acting Quality Management Officer.

(Original signed by:)

Ada YC Clark, FACHE, MPH
VISN 5 – Health Service Area 5.2 Director

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: July 13, 2026

From: Interim Director, San Francisco VA Health Care System (662)

Subj: Healthcare Facility Inspection of the San Francisco VA Health Care System in California

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

Thank you for the opportunity to review and comment on the Office of Inspector General Healthcare Facility Inspection of the San Francisco VA Health Care System in California. I concur with the findings and recommendations in the report.

San Francisco VA Health Care System remains committed to ensuring our Veterans receive exceptional health care.

(Original signed by:)

Barbara Forsha, MSN, RN, CPHQ, CPPS, ET
Interim Executive Director
San Francisco VA Health Care System

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Pursuant to Pub. L. No. 117-263 § 5274, codified at 5 U.S.C. § 405(g)(6), nongovernmental organizations, and business entities identified in this report have the opportunity to submit a written response for the purpose of clarifying or providing additional context to any specific reference to the organization or entity. Comments received consistent with the statute will be posted on the summary page for this report on the VA OIG website.