US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Central California Health Care System in Fresno

Healthcare Facility Inspection	25-00214-61	February 12, 2026

OUR MISSION

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

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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 examined the quality of care provided using five content domains: culture, environment of care, patient safety, primary care, and veteran-centered safety net.

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 efficiencies of programs and services that improve the health and welfare of veterans and their families. The OIG continued communication with VHA regarding the findings of this inspection, which resulted in the closure of two recommendations.

What the OIG Found

The OIG physically inspected the VA Central California Health Care System (facility) from April 28 through May 1, 2025.[1] Below is a summary of findings in each of the domains reviewed.

Culture

The OIG examined several aspects of the facility's culture, including unique circumstances and system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences. Executive leaders identified three system shocks: leadership staffing, a surgical stand-down (temporary halt to surgeries), and space constraints. Leaders said the facility director, chief of staff, and assistant director positions had been in transition since 2024 and it is difficult to recruit for the central California area.

During the same period, facility leaders said they paused surgeries for high-risk patients (initiated a stand-down) after a series of unexpected deaths. The stand-down led to updated surgical policies, additional team huddles and meetings, and extra surgical staff training.[2]

After January 2025, when employees were required to return to in-person work, space constraints halted plans to offer dialysis treatment at the facility and increase workspace for

[1] See appendix A for a description of the OIG's inspection methodology. Additional information about the facility can be found in the Facility in Context graphic below, with a detailed description of data displayed in appendix B.

[2] Huddles are daily meetings with all team members present to "identify and communicate the resolving [of] patient safety issues, deliver timely recognition and resolution of problems, and provide an increased focus on operational safety issues." "Patient Safety Huddle Board," VHA National Center for Patient Safety, accessed February 16, 2025, https://www.patientsafety.va.gov/Patient_Safety_Huddle_Board.asp.

primary care teams. Although leaders reported no delays in patient care, the interim Director said performing dialysis treatment at the facility had the potential to save them a few million dollars.

The facility's All Employee Survey scores decreased between fiscal year 2023 and fiscal year 2024 for communication, information sharing, transparency, and best places to work.[3] However, OIG questionnaire respondents generally reported leaders improved their communication, and the facility's culture was moving in the right direction. Executive leaders said they focused on in-person interactions with staff and held monthly town halls, attended huddles to obtain direct feedback, and scheduled individual meetings with staff to address their needs. Additionally, the interim Director established individual meetings with employees and responded to employees' questions and concerns. The feedback has generally been positive.

Environment of Care

The OIG examined transit and parking, the main entrance, and navigation support (features that help people find their way around). The OIG also inspected patient care areas and compared findings from prior inspections to determine if there were recurring issues.

The OIG found repeated instances of unsecured patient information and staff identification badges left unattended in computers. Additionally, there were inaccurate or missing signs in multiple areas; and worn patient privacy curtains in inpatient rooms. The OIG made recommendations to address these problems. In response, leaders are addressing the identified deficiencies and implementing audits to ensure compliance with corrective actions.

Patient Safety

The OIG assessed the facility's processes to communicate urgent, noncritical test results to providers and patients; sustain changes made in response to previous oversight recommendations; and implement continuous learning methods to identify opportunities for improvement. The facility had processes to communicate abnormal test results to providers and patients, including after-hours. The facility also used a software system to send automated test result letters to patients.

The OIG noted the facility's scores for test result communication had improved from fiscal year 2024 through the first quarter of fiscal year 2025. The facility had no open recommendations related to test result communication, and quality management staff said there were no barriers to long-term improvements in patient safety. Executive leaders said they support

[3] The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential." "AES Survey History, Understanding Workplace Experiences in VA," VHA National Center for Organization Development. Best places to work averages scores for "job satisfaction, organization satisfaction" and if the facility is "a good place to work." "VA All Employee Survey," Department of Veterans Affairs.

process improvements through efforts to decrease hospital-acquired infection rates and enhance patient experiences, primary care access, and patient flow in the emergency department.

Primary Care

The OIG determined whether primary care teams were staffed per VHA Directive 1406(2) and Handbook 1101.10(2).[4] Through interviews, the OIG learned that vacant positions for primary care did not increase appointment wait times. Leaders said Veterans Integrated Service Network staff approved to hire 90 percent of the open primary care positions.[5]

The facility had three social workers who covered 32 primary care teams, as well as teams in other services. VHA Handbook 1101.10(2) suggests staffing ratios of one social worker for every two teams.[6] Social work leaders said they were not actively recruiting for any positions. The OIG made one recommendation. In response, leaders are working with human resources specialists to review vacancies, position updates, hiring strategies, and onboarding status.

Veteran-Centered Safety Net

The OIG reviewed the facility's homeless programs to determine how staff identify and enroll veterans and assess how well the programs meet veterans' needs. Staff said they work to meet the veterans' needs and with community partners to identify and connect veterans to resources. Housing and Urban Development–Veterans Affairs Supportive Housing program staff said there was a significant staffing shortage. The OIG made one recommendation. In response, leaders and human resources specialists are evaluating program staffing.

What the OIG Recommended

1. The Executive Director ensures staff receive education about badge holders' responsibilities in preventing unauthorized access to VA facilities and computer systems and safeguarding electronic databases including electronic health care records.
2. The Executive Director ensures signs are present and accurate throughout the facility.

[4] 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.

[5] 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, accessed February 13, 2025, https://www.va.gov/HEALTH/visns.asp.

[6] VHA Handbook 1101.10(2).

3. The Executive Director ensures staff maintain privacy curtains, preventive maintenance on medical equipment, and splash resistant bottom shelves on supply carts.
4. The Executive Director ensures staff monitor patient care areas for expired, damaged, and contaminated medications and remove them as needed.
5. The Executive Director ensures staff store medications in pharmaceutical grade refrigerators.
6. The Executive Director ensures primary care staffing is sufficient for patients to receive appropriate health care.
7. The Executive Director reviews staffing levels for the Housing and Urban Development–Veterans Affairs Supportive Housing program and takes action as needed.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and Executive Director concurred with the inspection recommendations and provided acceptable action plans, and leaders are implementing corrective actions (see the responses in the body of the report and appendixes C and D for the full text of the directors' comments). The OIG considers recommendations 2 and 3 closed and will follow up on the planned actions for the open recommendations 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

FACILITY IN CONTEXT

VA Central California Health Care System
Fresno, California
Level 1c-High Complexity
Fresno County
Hospital Referral Region: Fresno

Description of Community

POPULATION

Female **1,685,606**	Male **1,723,125**
Veteran Female **13,857**	Veteran Male **116,045**

Homeless - State **171,521**
Homeless Veteran - State **10,395**

MEDIAN INCOME

$60,860

EDUCATION

73% Completed High School
49% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **493**

SUBSTANCE USE

35.6% Driving Deaths Involving Alcohol
18.1% Excessive Drinking
923 Drug Overdose Deaths

UNEMPLOYMENT RATE

9% Unemployed Rate 16+
7% Veterans Unemployed in Civilian Workforce

TRANSPORTATION

Drive Alone	1,031,471
Carpool	159,582
Work at Home	67,004
Other Means	36,859
Walk to Work	22,504
Public Transportation	10,984

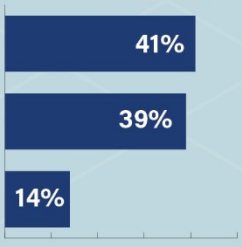
AVERAGE DRIVE TO CLOSEST VA

Primary Care	**20 Minutes, 16.5 Miles**
Specialty Care	**56 Minutes, 58.5 Miles**
Tertiary Care	**160 Minutes, 163 Miles**

Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **11,350**



Health of the Veteran Population

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

9,708

173 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

4.94 Days

30-DAY READMISSION RATE

13%

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
13	29

Health of the Facility

UNIQUE PATIENTS

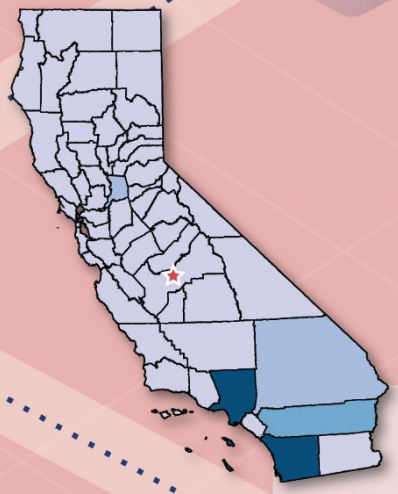
Unique Patients VA and Non-VA Care	32K
Unique Patients VA Care	31K
Unique Patients Non-VA Care	15K

COMMUNITY CARE COSTS

Unique Patient $47,328	Outpatient Visit $2,556
Line Item $2,339	Bed Day of Care $589

STAFF RETENTION

Onboard Employees Stay <1 Yr	10.25%
Facility Total Loss Rate	13.88%
Facility Retire Rate	1.65%
Facility Quit Rate	11.46%
Facility Termination Rate	0.77%



★ VA MEDICAL CENTER

VETERAN POPULATION

0.01% 3.39% 6.76% 10.13% 13.50% 16.87%

See Appendix B: Facility in Context Data Definitions for a detailed description of data displayed.

Contents

Background and Vision

The Office of Inspector General's (OIG's) Office of Healthcare Inspections focuses on the Veterans Health Administration (VHA), which provides care to over nine million veterans through 1,380 healthcare facilities.[1] VHA's vast care delivery structure requires sustained and thorough oversight to ensure the nation's veterans receive optimal care.

The OIG established the Healthcare Facility Inspection program to routinely evaluate VHA medical facilities on an approximately three-year cycle. Each review includes a set of content domains: culture, environment of care, patient safety, primary care, and veteran-centered safety net.

Healthcare Facility Inspection reports provide insight into the experience of working and receiving care at VHA facilities; inform veterans, the public, and Congress about the quality of care delivered; and highlight specific actions leaders and staff can take to improve patient safety and care.

Figure 1. *VHA's high reliability organization framework. Source: Department of Veterans Affairs (VA), "VHA's Journey to High Reliability."*

In 2018, VHA officially began the journey to become a high reliability organization (HRO) and set goals to improve accountability and reliability and reduce patient harm. The HRO framework provides the blueprint for VHA-wide practices to stimulate and sustain ongoing culture change.[2] VHA has now implemented HRO principles at all VHA facilities.[3]

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[1] "About VHA," Department of Veterans Affairs, accessed August 8, 2025, https://www.va.gov/health/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.)

Content Domains

Figure 2. *Healthcare Facility Inspection's five content 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 Central California Health Care System (facility) serves veterans across six counties in the San Joaquin Valley area. It includes a medical center in Fresno and three community-based outpatient clinics in Merced, Oakhurst, and Visalia. In fiscal year (FY) 2024, the facility's medical care budget was $628,753,230; it had a total of 112 operating beds (52 hospital and 60 community living center beds) and served more than 31,000 enrolled veterans.[4]

Figure 3. *Facility photo.*
Source: "VA Central California Health Care," Department of Veterans Affairs, accessed July 16, 2025, https://www.va.gov/fresno.

The OIG inspected the facility from April 28 through May 1, 2025. The facility's executive leaders consisted of the interim Executive Director/Chief Executive Officer (Director), Associate Director/Chief Operating Officer, interim Assistant Director, acting Chief of Staff, and Associate Director for Patient Care Services. The executive leadership team had worked together since October 2024, when the interim Assistant Director was detailed to the position from another VA medical center.

CULTURE

The OIG examined the facility's culture across multiple dimensions, including unique circumstances and system shocks, leadership communication, and both employees' and veterans' experiences.[5] The OIG administered a facility-wide questionnaire, reviewed VA's All Employee survey scores, interviewed leaders and employees, and reviewed data from patient advocates and veterans' feedback.[6]

[4] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed July 15, 2024, https://www.va.gov/VA_Community_Living_Centers.asp.

[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. The data are anonymous and confidential. "AES Survey History, Understanding Workplace Experiences in VA," VHA National Center for Organization Development. Patient Advocates are employees who receive feedback from veterans and help resolve their concerns. "Veterans Health Administration, Patient Advocate," Department of Veterans Affairs, accessed August 4, 2025, https://www.va.gov/HEALTH/patientadvocate/. For more information on the OIG's data collection methods, see appendix A. For additional information about the facility, see the Facility in Context graphic above and associated data definitions in appendix B.

System Shocks

During an interview, executive leaders reported three system shocks: turnover in executive leader positions, a surgical stand-down (temporary halt to surgeries) for high-risk patients, and space constraints due to the "Return to In-Person Work" presidential memorandum.[7] Respondents to an OIG-administered questionnaire also indicated leadership turnover as a system shock that disrupted daily operations.

Through a document review and the interview with the leaders, the OIG learned the director, chief of staff, and assistant director positions had all experienced instability; the director position had been in transition for approximately two years, and the other two positions since late 2024. Turnover in the director position started when an individual who served in the position for 13 years left the facility in early 2023. Subsequently, the facility had one short-term permanent Director and a series of interim Directors. Leaders said it is difficult to recruit for the central California area because of the lower pay at the facility than in the community and location in a less than desirable part of the state. Leaders added that temporary directors did not focus on improving or changing processes at the facility, but the current interim Director has changed processes.

Leaders explained and provided documents showing 12 unexpected deaths among high-risk surgical patients had occurred in 2023. In January 2024, leaders from the VHA National Surgery Office and the Veterans Integrated Service Network (VISN) office visited the facility, and in response to their findings, facility leaders implemented a surgical stand-down for two weeks.[8] During the stand-down, staff completed peer reviews on the 12 unexpected deaths, administrative investigative boards for both surgery and anesthesia services, and two root cause analyses.[9] The stand-down also led to updated surgical policies, additional huddles and meetings

[7] "Heads of all departments and agencies in the executive branch of Government shall, as soon as practicable, take all necessary steps to terminate remote work arrangements and require employees to return to work in-person at their respective duty stations on a full-time basis, provided that the department and agency heads shall make exemptions they deem necessary." Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025).

[8] 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, accessed February 13, 2025, https://www.va.gov/HEALTH/visns.asp. The VHA National Surgery Office "ensures the optimal delivery of surgical services to promote, preserve, and restore the health of the Veteran." VHA Directive 1102.01(2), *National Surgery Office*, April 24, 2019, amended April 19, 2022.

[9] A peer review "is a critical review of care performed by a peer." VHA Directive 1190(1), *Peer Review for Quality Management*, November 21, 2018, amended July 19, 2024. Administrative Investigation Boards "are conducted to determine what happened and why it happened so that any individual and systemic deficiencies can be identified and corrected." VA Directive 0700, *Administrative Investigation Boards and Factfindings*, August 10, 2021. 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).

before and after each surgery, and extra surgical staff training.[10] The interim Director told the OIG that after these changes, death rates decreased and communication within surgical teams improved. Additionally, the interim Director, Chief of Staff, and deputy Chief of Staff continued to meet with the surgical staff every two weeks.

Last, leaders described space constraints after 200 additional staff began reporting in person to the facility every day. In response, leaders assigned staff to any available space, which led to multiple staff working in shared conference rooms and offices.

Prior to the in-person work requirement, leaders planned to provide dialysis treatment for patients who were previously referred to community providers and to increase workspace for primary care teams. However, leaders could not implement those plans due to using all available spaces for staff who returned to work in person. Although leaders reported no delays in patient care, the interim Director expressed that treating dialysis patients at the facility would save them a few million dollars.

Employee Experiences

The OIG reviewed survey scores for best places to work and found they decreased from FY 2023 to FY 2024.[11] However, respondents to the OIG questionnaire generally indicated the facility's culture was moving in the right direction. Executive leaders attributed the difference in scores to the executive leadership team's increased stability and the interim Director's work to improve the facility's culture.

The OIG found that survey scores for communication, information sharing, and transparency decreased from FY 2023 to FY 2024. In the OIG questionnaire, respondents reported communication at the facility had improved. The OIG noted staff completed the VA survey during multiple executive leader transitions, whereas they completed the OIG questionnaire after the interim Director's efforts to improve communication.

[10] Huddles are daily meetings with all team members present to "identify and communicate the resolving [of] patient safety issues, deliver timely recognition and resolution of problems, and provide an increased focus on operational safety issues." "Patient Safety Huddle Board," VHA National Center for Patient Safety, accessed February 16, 2025, https://www.patientsafety.va.gov/Patient_Safety_Huddle_Board.asp.

[11] The best places to work score is comprised of "job satisfaction, organization satisfaction" and if the facility is "a good place to work." "VA All Employee Survey," Department of Veterans Affairs. The facility's All Employee Survey best places to work score for FY 2023 was 70.28, and the VHA average was 71.68; for FY 2024, the facility's score was 67.38, compared to the VHA average of 71.25.

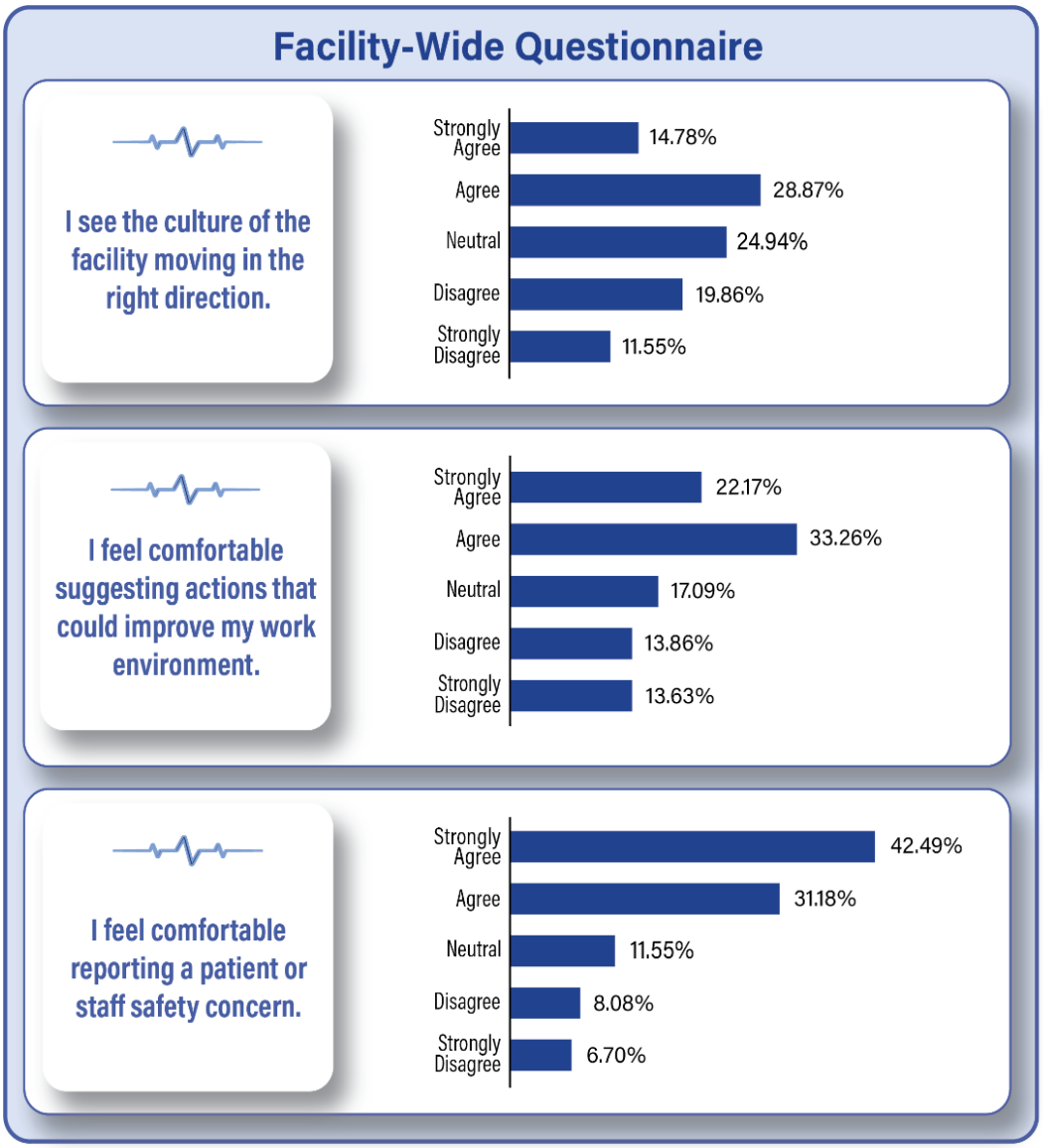

Figure 4. *Employees' perceptions of facility culture.*
Source: OIG analysis of questionnaire responses. The OIG received 433 responses to the questionnaire.

The interim Director explained the facility's culture previously involved virtual methods of communication, but current leaders have refocused on in-person, direct, and consistent communication with employees. For example, the interim Director initiated monthly in-person town hall meetings for all facility employees, as well as frequent in-person town halls at the community-based outpatient clinics to address their specific needs.

Additionally, the interim Director described meeting with employees in different units on Fridays, without supervisors, to gain direct feedback. Every two weeks the interim Director met with senior and service leaders; it evolved into weekly meetings following the increased number of presidential actions (executive orders and memorandums) in late January 2025.

To obtain regular feedback from staff, leaders said they send out a quarterly questionnaire to employees on whether supervisors communicate survey scores and collaborate on plans for improvement. Leaders then use the information to improve processes and share best practices. In addition, leaders said they review each service's action plans quarterly and provide feedback to the service leaders, who then share it with employees to ensure they are included in the change process.

The OIG also reviewed survey questions and leaders' interview responses related to psychological safety and found employees were comfortable suggesting ways to improve the work environment and reporting concerns.[12] Employees schedule individual sessions to discuss concerns or ideas with the interim Director and their executive leader.

Veteran Experiences

The OIG noted veterans commonly submitted complaints about community care appointments and requests for information about their care. The interim Director confirmed that scheduling community care appointments and receiving documents after veterans complete their appointments were ongoing challenges. Clinic staff encouraged veterans to bring their medical documents from community providers to the facility for their next appointment. Additionally, facility staff continue to remind community providers about the importance of sending the documents to the facility promptly to ensure patients receive follow-up, as needed.

The interim Director said leaders personally respond to veterans' emails and refer them to the correct person, team, or program to resolve the issue. For example, if veterans have questions about their benefits, leaders connect them to Veterans Benefits Administration. The leaders also conduct monthly in-person veteran town halls that provide information about services, such as primary care and women's health. The interim Director said veterans have expressed surprise and appreciation about how quickly staff resolved their issues.

[12] "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.[13] The OIG assessed how a facility's physical features may shape the veteran's perception of the health care they receive. The OIG also inspected patient care areas and focused on safety, cleanliness, infection prevention, and privacy.

The OIG applied selected VA and VHA guidelines and standards, and Architectural Barriers Act and Joint Commission standards when evaluating the facility's environment of care. The OIG also considered best practice principles from academic literature.[14]

General Inspection

In response to an OIG questionnaire, a facility liaison stated the Fresno Area Express public bus line is located less than one and a half miles from the facility and stops there several times a day. Facility documents demonstrated adequate parking spots accessible for veterans with limited mobility.

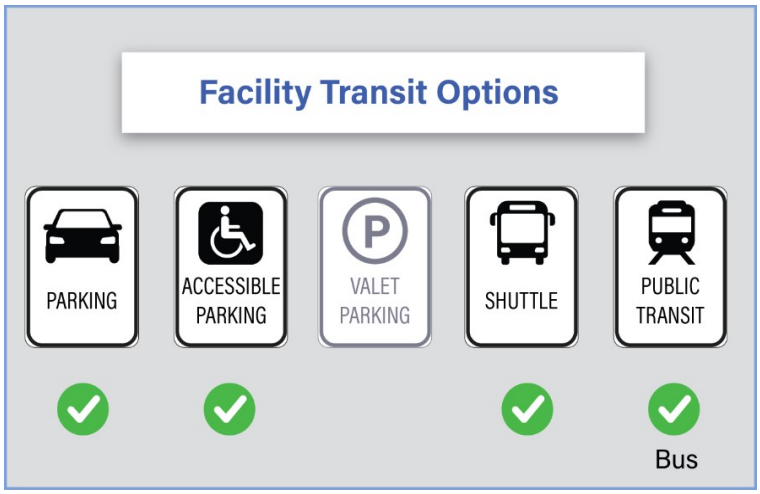

Figure 5. *Transit options for arriving at the facility.*
Source: OIG analysis of documents and observations.

However, the OIG also reviewed several complaints veterans had about the limited number of accessible spaces, and some stated the general parking spaces were too narrow. The OIG observed limited overall parking at the facility due to construction. The Accreditation Specialist told the OIG that shuttles and contracted security services transport staff and veterans from three nearby parking lots during business hours.

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

[14] 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.

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

The OIG noted clear signs, smooth transitions on walking surfaces, and available wheelchairs at the entrance. The entrance had motion-activated, double sliding doors and a covered loading zone. Upon entering, the OIG noted the area was clean, with windows allowing ample natural light. Employees stationed near the door helped guide veterans to their destination.

The OIG noted maps and directional signs to guide veterans around the facility. Through the OIG questionnaire, the facility liaison indicated that Visually Impaired Services staff offered accessibility services, and volunteers escorted veterans with visual or hearing impairments through the facility.

The OIG found private health information displayed on unattended computers two days in a row in the emergency department, and on one day in the medical-surgical department, each time with staff identification badges left in the computers. Although the OIG told a leader about the badges left in the computers on the first day, the problem continued. VA Handbook 0735 requires employees to maintain possession of their credentials (badges) while on official duty.[15]

Recommendation 1

The Executive Director ensures staff receive education about badge holders' responsibilities in preventing unauthorized access to VA facilities and computer systems and safeguarding electronic databases including electronic health care records.

_X_ Concur

____ Nonconcur

Target date for completion: March 1, 2026

[15] VA Handbook 0735, *Homeland Security Presidential Directive 12 (HSPD-12) Program*, March 14, 2014, (VA rescinded and replaced this handbook with VA Handbook 0735, *Homeland Security Presidential Directive 12, Personal Identity Verification, Credential Management Program*, September 18, 2025. The updated handbook contains similar language to the rescinded handbook.

Director Comments

All employees are required to complete the Talent Management System (TMS): VA Privacy and Information Security Awareness and Rules of Behavior annually. Facility-wide compliance is tracked by the Privacy Office and the Information System Security Officer. As of December 9, 2025, VA Fresno is at a 97.55% compliance rate with the TMS course.

In May 2025, the Privacy Office began conducting weekly personal identity verification (PIV) inspections throughout the entire facility, specifically to search for any PIV violations. When an unsecured badge is discovered, the employee is provided with verbal reeducation. If a second violation is discovered, the employee is sent an email reminding them of their PIV responsibilities and basic privacy concepts. If a third violation is discovered, the employee, their supervisor, and the service line's executive leadership team (ELT) member are notified of the violation.

The facility will continue to conduct weekly PIV compliance audits. In addition, TMS completion rates will be monitored on a quarterly basis. These compliance data sets will be reported quarterly at the Compliance and Integrity Committee until the facility demonstrates a ≥ 90% compliance rate for two consecutive quarters.

Previous oversight reports listed lack of cleanliness, lack of clear signs, and obstructed exits as chronic issues throughout the facility.[16] During this site visit, the OIG observed concerns with signs but not with cleanliness or obstructed exits. The OIG observed either inaccurate or missing signs in multiple areas, including the emergency department, intensive care and surgical units, medical-surgical temporary unit, and in the community living center. There were mislabeled storage, clean, and soiled utility rooms, and rooms with no identifiers. The VA design manual recommends that signs are accurate, legible, and functional.[17] Inefficiencies occur when signs are inaccurate or missing.

Recommendation 2

The Executive Director ensures signs are present and accurate throughout the facility.

_X_ Concur

____ Nonconcur

Target date for completion: Completed

[16] Annual Facility Evaluation, *VA Central California Health Care System Survey*, March 18-22, 2024; The Joint Commission, *Final Accreditation Report: VA Central California Health Care System*, April 11, 2022; Ascellon, *Department of Veterans Affairs Community Living Center Survey Report*, June 28, 2024. (These reports are not publicly accessible.)

[17] Department of Veterans Affairs, *VA Signage PG-18-10, Design Manual*.

Director Comments

As identified in the OIG report, the signage was corrected as of May 19, 2025. Signage compliance will be monitored during the facility's Environment of Care (EOC) rounds, with deficiencies tracked in Performance Logic and reported quarterly. Sustained compliance will be defined as greater than 90% signage compliance for two consecutive quarters, with results reviewed by the EOC Council. Any deficiencies will prompt immediate corrective action.

OIG Comments

The OIG closed the recommendation as leaders completed improvement actions before publication of the report.

The OIG found worn privacy curtains in patient rooms, and medical equipment with overdue preventive maintenance in several areas. The OIG also found medical supply carts without a splash resistant bottom shelf.[18] These findings compromise staff's ability to provide safe, clean, and quality care. The Code of Federal Regulations states that hospitals, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.[19]

Recommendation 3

The Executive Director ensures staff maintain privacy curtains, preventive maintenance on medical equipment, and splash resistant bottom shelves on supply carts.

_X_ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

Environmental Management Service (EMS), standard operating procedures, Patient Room Cleaning, Discharge Cleaning, and Exam Room cleaning dictate the trigger and maintenance schedule for patient privacy curtain removal, laundry processing, and re-installation. The facility has two types of curtains, disposable, which are located in the Emergency Department, Intensive Care Unit (ICU), and the Medical Surgical (Med/Surg) unit. The disposable curtains include an integrated timer that clearly indicates when they are due to be changed. Reusable curtains are used in all other clinical areas. Reusable curtains are maintained with a quarterly

[18] The lowest shelf must be solid to allow staff to clean and avoid contamination. VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

[19] 42 C.F.R. § 482.41.

privacy curtain audit sheet managed by EMS Supervisors. EMS Staff undergo yearly competency training, which addresses the process of managing both disposable and reusable curtains.

Quarterly privacy curtain audits will continue until the facility achieves 90% or greater compliance for two consecutive quarters, with results reported to the EOC Council. Ongoing random checks during EOC rounds will validate continued compliance.

As of April 29, 2025, VA Fresno follows local Policy "MCP 138B-24-002" Medical Equipment Management Program (MEMP). In addition, during the Weekly Environment of Care rounds, Designated Biomedical Engineering staff conducting the space audit actively look for any non-compliant stickers and submit all deficiencies when found. These deficiencies are prioritized and require staff to complete within 14 days of submission. Preventive maintenance (PM) compliance will be monitored monthly through MEMP reports until the facility maintains ≥ 90% PM completion for two consecutive quarters. PM deficiency trends will continue to be reviewed through the EOC Council.

As of June 1, 2025, the bottom shelves on all of the cited wire carts were covered with plastic liners. Supply cart inspections during EOC rounds will verify that splash-resistant liners remain in place, with sustainment showing 90% for two consecutive quarters. Compliance rates will be reported quarterly during the EOC Council.

OIG Comments

The OIG also closed this recommendation as leaders completed improvement actions before publication of the report.

During inspection of the operating rooms, the OIG found expired medications inside an inappropriate (non-pharmaceutical grade) refrigerator, which does not ensure precise temperature. VHA Directive 1108.07 requires staff to inspect all refrigerators that store medications to ensure they meet standards.[20] Expired medications, or medications stored in a non-pharmaceutical grade refrigerator can be less effective or harmful due to a change in chemical composition.

Recommendation 4

The Executive Director ensures staff monitor patient care areas for expired, damaged, and contaminated medications and remove them as needed.

_X_ Concur

____ Nonconcur

[20] VHA Directive 1108.07, *General Pharmacy Service Requirements*, November 28, 2022.

Target date for completion: June 1, 2026

Director Comments

A standardized daily rounding process will be implemented in all patient care areas. Rounding will include identifying and removing expired, damaged, or contaminated medications and supplies. Daily rounding logs and weekly audit findings will be monitored until patient care areas demonstrate 90% removal of expired, damaged, or contaminated medications for six consecutive months. Monthly results will be presented to the Patient Care Services Council.

Recommendation 5

The Executive Director ensures staff store medications in pharmaceutical grade refrigerators.

_X_ Concur

____ Nonconcur

Target date for completion: March 1, 2026

Director Comments

Pharmacy Service routinely audits all pharmacy-grade refrigerators where medications are stocked. As identified in the OIG report, the deficient refrigerator was replaced by a pharmaceutical-grade refrigerator. All required medications are stored in medical-grade refrigerators. Monthly audits of all Pharmacy-grade refrigerators will be conducted by Pharmacy staff, with sustainment defined as zero improper storage findings for three consecutive months. Compliance results will be reported to the Nurse Pharmacy Committee.

The OIG explored VHA facilities' patient safety processes. The OIG assessed communication procedures for urgent, noncritical test results; the sustainability of changes made by leaders in response to previous oversight recommendations, facility investigations, and improvement projects; and implementation of continuous learning processes to identify opportunities for improvement.

Communication of Urgent, Noncritical Test Results

The facility had processes to communicate abnormal test results to providers and patients, identify a surrogate (substitute) when a provider was unavailable or had left the facility, and communicate test results outside regular clinic hours. Clinical application coordinators also assigned a back-up reviewer to receive test results when the provider and surrogate are

unavailable or do not act when test result view alerts are received.[21] The Chief of Staff added that facility staff use software to send out automated test result letters to patients.

The Chief of Staff and quality management staff said facility leaders and staff review and discuss External Peer Review Program data for test result communication measures each quarter.[22] The facility received low scores for this measure in the third quarter of FY 2024. The Chief of Quality and Patient Safety said providers did not timely notify patients of lung cancer screening test results, including those patients needing a repeat screening in six months. In response, the chief said service chiefs educated providers about test result communication requirements. The OIG noted the facility's scores improved in the last quarter of FY 2024 and first quarter of FY 2025.

Action Plans and Process Improvements

The facility had no open recommendations related to test result communication from the previous three years. The Chief of Staff and quality management staff explained the accreditation team monitors oversight recommendations and tracks action plans until staff resolve the deficiency, then monitors the actions for sustained improvement. The quality management staff said there were no barriers to long-term improvements related to general patient safety.

In an interview, the Chief of Staff and quality management staff described using various methods to identify opportunities for improvement, including reviewing the Joint Patient Safety Reporting system and attending patient safety forums.[23] Staff also shared safety stories across services in town halls and huddles, and during leaders' visits to units. Leaders said they inform staff about patient safety and process improvements through the Quality and Patient Safety Committee, service chief meetings, and emails.

In addition, systems redesign staff showcased process improvement projects from the previous year during Patient Safety Awareness Week in March 2025.[24] For example, in 2024, quality management staff determined nursing staff did not properly or accurately complete blood transfusion forms or return the forms to the blood bank within a reasonable period of time. In

[21] A view alert is a brief interactive electronic notification in an electronic health record system designed to inform the user about clinical events. Department of Veterans Affairs Office of Information & Technology (OIT), *Computerized Patient Record System (CPRS) Technical Manual: List Manager Version*, October 2024.

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

[23] 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.

[24] "Systems Redesign and Improvement is the VHA practice of utilizing improvement tools to conduct Continuous Process Improvement (CPI)." VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

response, the lab established a workgroup to develop an action plan to address these issues. The workgroup developed a dashboard to track actions in real time to monitor and ensure proper documentation and return of the blood bank forms. In six months, the noncompliance rate decreased by almost 50 percent.

Quality management staff agreed that executive leaders support improvement projects. The Chief of Staff added that facility staff have current projects to decrease the rate of hospital-acquired infections and improve patient experiences, access to primary care, and patient flow in the emergency department.

The OIG determined whether primary care teams were staffed per VHA Directive 1406(2) and Handbook 1101.10(2) and received support from leaders.[25] The OIG also examined actual and expected primary care panel sizes (number of veterans assigned to a care team) relative to VHA guidelines.[26]

Primary Care Teams

Primary care leaders listed the following primary care vacancies: three primary care providers, five registered nurses, three licensed vocational nurses, and six medical support assistants. Primary care leaders said they had been unable to fill vacant positions due to the hiring freeze.[27] As a result of the vacancies, medical support assistants and nurses cover multiple primary care teams, which increased their workload.

At the time of the site visit in April 2025, primary care leaders said VISN leaders approved them to fill 90 percent of their vacant positions, so they are actively recruiting and onboarding candidates. The Resource Management Committee is reviewing the remaining 10 percent, and leaders hope to receive approval soon.

The OIG determined the Primary Care Social Work Service is understaffed. Primary care staff stated there were three social workers covering 32 primary care teams, as well as teams in other services. VHA Handbook 1101.10(2) requires primary care staffing to be sufficient to ensure all

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

[26] VHA Directive 1406(2).

[27] "I hereby order a freeze on the hiring of Federal civilian employees, to be applied throughout the executive branch. As part of the freeze, no Federal civilian position that is vacant at noon on January 20, 2025, may be filled, and no new position may be created except as otherwise provided for in this memorandum or other applicable law." "Contracting outside the Federal Government to circumvent the intent of this memorandum is prohibited." Hiring Freeze, 90 Fed. Reg. 8247 (Jan. 20, 2025).

patients receive appropriate health care.[28] VHA further suggests staffing ratios of one social worker for every 2 primary care teams.[29] Social work staff asserted they mostly address urgent patient needs such as emergency housing, community nursing home placements, and transportation, rather than working with patients to create short- and long-term plans of care.

Primary care leaders explained that social worker salaries are not robust, so it is challenging for leaders to hire staff. Additionally, the service lost a significant number of staff to neighboring cities when private sector salaries increased by 33 percent. Despite the staffing shortages, social work leaders said they have no positions in active recruitment.

Recommendation 6

The Executive Director ensures primary care staffing is sufficient for patients to receive appropriate health care.

_X_ Concur

____ Nonconcur

Target date for completion: March 31, 2026

Director Comments

Social Work Service [SWS] and Primary Care [PC]leadership meet with HR Specialists weekly to review vacancies, position updates, hiring strategies, onboarding status, and certification updates. Positions are announced on an open and continuous basis. Social Work leadership reports monthly to the Executive Leadership Team, which removes barriers and provides guidance, as appropriate, keeping this important staffing issue at the forefront for the health care system. Recruitment, relocation, and retention incentives (3R's) have been used and Social Workers are on a Special Salary Rate (SSR) due to difficulties in recruiting and the disparity between VA and community wages for this job class. Position status is reported regularly to VISN leadership. Vacancy rate monitoring will continue indefinitely, compliance will be demonstrated by ≥ 90% attendance of weekly staffing meetings with HR and ≥ 90% attendance by SWS and PC at the monthly Recruitment and Placement ELT meeting over a 90-day consecutive period. Compliance results will be reported to the Quality and Patient Safety Committee.

[28] VHA Handbook 1101.10(2).

[29] VHA Handbook 1101.10(2).

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 OIG analyzed enrollment and performance data and interviewed program staff.

Health Care for Homeless Veterans

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. Staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.[30]

VHA uses performance measures to determine the success of each facility's program. The first, HCHV5, measures the percentage of homeless veterans who receive a program intake assessment.[31] Next, HCHV1 measures the percentage of veterans who are discharged from contracted residential services and low-demand safe haven programs into permanent housing.[32] Finally, HCHV2 (negative exits) measures 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."[33]

Program Highlights

- The program met the HCHV5, HCHV1, and HCHV2 targets in FYs 2023 and 2024. The program manager attributed the success to the team members who meet weekly with community partners to discuss available resources and attend outreach events to identify homeless veterans and connect them with services. Staff also meet with veterans two or three times a week to review treatment plans and address any issues. In addition, the program runs a daily walk-in clinic that serves 300 to 400 veterans per month.

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

[31] VHA sets targets at the individual facility level. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*, October 1, 2022.

[32] Low-demand safe havens are transitional residences with minimal restrictions for veterans with mental health or substance use issues. VHA Directive 1501, *VHA Homeless Programs*, October 21, 2016.

[33] VHA sets targets for HCHV1 and HCHV2 at the national level each year. For FY 2023, the HCHV1 target was 55 percent or above and the HCHV2 (negative exits) target was 20 percent or below. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

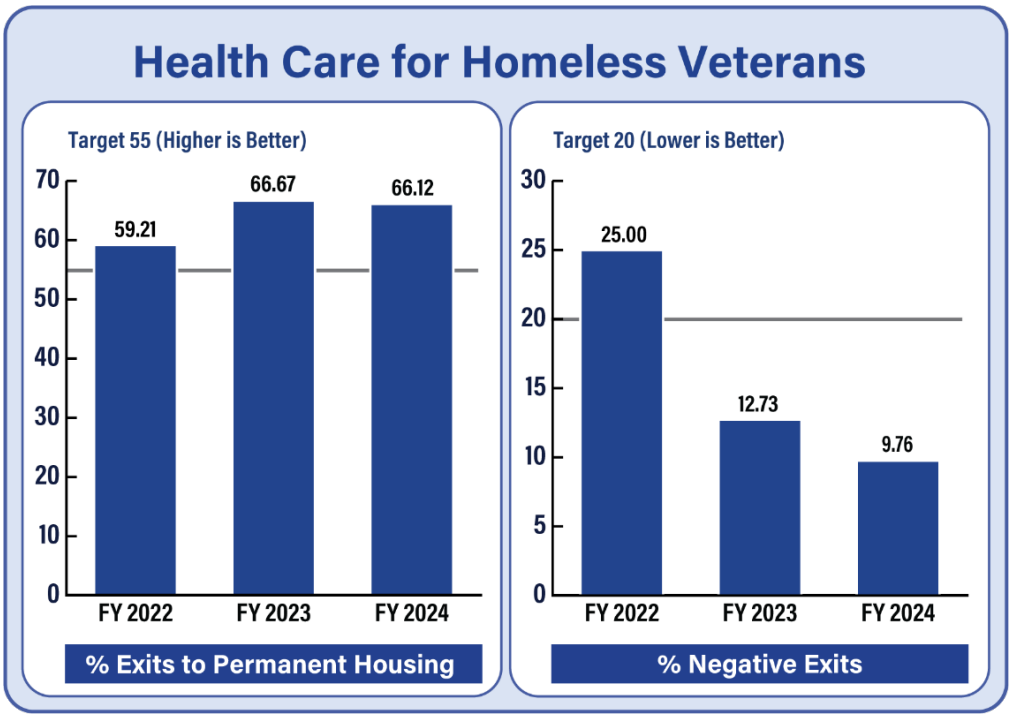

Figure 7. *HCHV program performance measures.*
Source: VHA Homeless Performance Measures data.

- Staff acknowledged challenges with veterans' access to VA mental health services and transportation. To improve access to mental health care, staff presented information about the program to the clinicians and included them in case conferences about the veterans, which have strengthened interdepartmental relationships. Staff also explained that public transportation is free for veterans, but service hours are limited; therefore, a community partner provides bicycles to veterans to help get around town and commute to work.

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."[34] The program uses the housing first approach to prioritize rapid placement into housing followed by individualized services.[35] VHA measures how well the program meets veterans' needs by using nationally

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

determined targets, including the number of housing vouchers assigned to the facility currently used by veterans or their families (performance measure HMLS3) and the percentage of veterans who are employed (performance measure VASH3).[36]

Program Highlights

- The program did not meet HMLS3 target for FYs 2023 and 2024. The program coordinator reported the program has 794 housing vouchers, and of those, 93 are currently unassigned. They currently operate at approximately 50 percent staffing capacity and have 22 positions in which 11 are vacant.
- The coordinator said the program has a high turnover rate because staff manage veterans with complex needs, have safety concerns with home visits in low-income neighborhoods, experience stress from driving long distances, and have high caseloads. The coordinator added that there was a lack of qualified applicants, which was due to pay disparity, competition with community hospitals and organizations, and the requirement for advanced licensure.

Recommendation 7

The Executive Director reviews staffing levels for the Housing and Urban Development–Veterans Affairs Supportive Housing program and takes action as needed.

_X_ Concur

____ Nonconcur

Target date for completion: June 1, 2026

Director Comments

Social Work Service supervisors meet weekly with HR to review each vacancy, position updates, hiring strategies, onboarding status, and certification updates. These positions are announced on an open and continuous basis. Social Work leadership reports monthly to the Executive Leadership Team at the Recruitment and Placement meeting. The ELT removes barriers and provides guidance, as appropriate, keeping this important staffing issue at the forefront for the health care system. Recruitment, relocation, and retention incentives (3R's) are offered, and social workers are on an SSR due to difficulties in recruiting and the disparity between VA and community wages for this job class. Position status is regularly reported to and discussed with the VISN homeless leaders. Vacancy rate monitoring will continue

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

indefinitely, compliance will be demonstrated by ≥ 90% attendance of weekly status meetings with HR and ≥ 90% attendance by SWS at the monthly ELT R&P meeting over a 90-day consecutive period. Compliance results will be reported to the Quality and Patient Safety Committee.

- Aside from staffing shortages, program staff identified several barriers to voucher use, including lack of housing, landlords' unwillingness to accept vouchers, and housing authority's reluctance to use vouchers for alternative housing, such as assisted living facilities. In response, staff said they work with developers to increase the number of housing units, establish relationships with landlords, and educate housing authority staff on voucher use for alternative housing.
- The program met the VASH3 target in FY 2024. Facility leaders attributed this accomplishment to the Employment Specialist, who hosts hiring events in addition to working with veterans to get jobs.

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 Veterans Justice Programs each FY (performance measure VJP1).[38]

Program Highlights

- Although the program met the target for FY 2023 and FY 2024, the supervisor noted an opportunity for staff to improve outreach to jails. Staff said the veterans treatment courts want them involved; however, by focusing on the courts, staff are less able to do outreach to jails and the community.[39]
- A veterans justice program specialist covers the seven state and federal prisons within the service area. Program staff explained that mentors, who are veterans, support other veterans through the veterans treatment court process and advocate

[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 2023 Homeless Performance Measures*.

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

for them in court. They shared several success stories that include veterans who graduate from the program and those who return to mentor other veterans.

Conclusion

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 efficiencies of programs and services that improve the health and welfare of veterans and their families.

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains. The OIG provided recommendations on issues related to privacy, directional signs, safety, medication safety, and staffing levels. Facility leaders have started to implement corrective actions, which resulted in OIG closing two recommendations. 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.

Appendix A: Methodology

Inspection Processes

The OIG inspection team reviewed selected 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 to employees 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 OIG's analyses relied on inspectors identifying significant information from questionnaires, surveys, interviews, documents, and observational data, based on professional judgment, as supported by Council of Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation*.[2]

Potential limitations include self-selection bias and response bias of respondents.[3] The OIG acknowledges potential bias because the facility liaison selected staff who participated in the primary care panel discussion; the OIG requested this selection to minimize the impact of the OIG inspection on patient care responsibilities and primary care clinic workflows.

Healthcare Facility Inspection directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from April 28 through May 1, 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.[4] The OIG reviews available evidence within a specified

[1] The All Employee Survey and accreditation reports covered the time frame of October 1, 2021, through September 30, 2024.

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

[3] 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.

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

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.

Appendix B: Facility in Context Data Definitions

Table B.1. Description of Community*

Category	Metric	Metric Definition
Population	Total Population	Population estimates are from the US Census Bureau and include the calculated number of people living in an area as of July 1.
	Veteran Population	2018 through 2022 veteran population estimates are from the Veteran Population Projection Model 2018.
	Homeless Population	Part 1 provides point-in-time (PIT) estimates, offering a snapshot of homelessness—both sheltered and unsheltered—on a single night.
	Veteran Homeless Population	Part 1 provides point-in-time (PIT) estimates, offering a snapshot of homelessness—both sheltered and unsheltered—on a single night.
Education	Completed High School	Persons aged 25 years or more with a high school diploma or more, and with four years of college or more are from the US Census Bureau's American Community Survey Summary File. High School Graduated or More fields include people whose highest degree was a high school diploma or its equivalent. People who reported completing the 12th grade but not receiving a diploma are not included.
	Some College	Persons aged 25 years or more with a high school diploma or more and with four years of college or more are from the US Census Bureau's American Community Survey Summary File. High School Graduated or More fields include people who attended college but did not receive a degree, and people who received an associate's, bachelor's, master's, or professional or doctorate degree.
Unemployment Rate	Unemployed Rate 16+	Labor force data are from the Bureau of Labor Statistics' Local Area Unemployment Statistics File for each respective year. Data are for persons 16 years and older, and include the following: Civilian Labor Force, Number Employed, Number Unemployed, and Unemployment Rate. Unemployment rate is the ratio of unemployed to the civilian labor force.
	Veteran Unemployed in Civilian Work Force	Employment and labor force data are from the US Census Bureau's American Community Survey Summary File. Veterans are men and women who have served in the US Merchant Marines during World War II; or who have served (even for a short time), but are not currently serving, on active duty in the US Army, Navy, Air Force, Marine Corps, or Coast Guard. People who served in the National Guard or Reserves are classified as veterans only if they were ever called or ordered to active duty, not counting the 4-6 months for initial training or yearly summer camps.

Category	Metric	Metric Definition
Median Income	Median Income	The estimates of median household income are from the US Census Bureau's Small Area Income Poverty Estimates files for the respective years.
Violent Crime	Reported Offenses per 100,000	Violent crime is the number of violent crimes reported per 100,000 population. Violent crimes are defined as offenses that involve face-to-face confrontation between the victim and the perpetrator, including homicide, forcible rape, robbery, and aggravated assault.
Substance Use	Driving Deaths Involving Alcohol	Alcohol-impaired driving deaths directly measures the relationship between alcohol and motor vehicle crash deaths.
	Excessive Drinking	Excessive drinking is a risk factor for several adverse health outcomes, such as alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, interpersonal violence, and motor vehicle crashes.
	Drug Overdose Deaths	Causes of death for data presented in this report were coded according to International Classification of Diseases (ICD) guidelines described in annual issues of Part 2a of the National Center for Health Statistics Instruction Manual (2). Drug overdose deaths are identified using underlying cause-of-death codes from the Tenth Revision of ICD (ICD–10): X40–X44 (unintentional), X60–X64 (suicide), X85 (homicide), and Y10–Y14 (undetermined).
Access to Health Care	Transportation	Employment and labor force data are from the US Census Bureau's American Community Survey Summary File. People who used different means of transportation on different days of the week were asked to specify the one they used most often or for the longest distance.
	Telehealth	The annual cumulative number of unique patients who have received telehealth services, including Home Telehealth, Clinical Video Telehealth, Store-and-Forward Telehealth and Remote Patient Monitoring - patient generated.
	< 65 without Health Insurance	Estimates of persons with and without health insurance, and percent without health insurance by age and gender data are from the US Census Bureau's Small Area Health Insurance Estimates file.
	Average Drive to Closest VA	The distance and time between the patient residence to the closest VA site.

**The OIG updates information for the Facility in Context graphics quarterly based on the most recent data available from each source at the time of the inspection.*

Table B.2. Health of the Veteran Population*

Category	Metric	Metric Definition
Mental Health Treatment	Veterans Receiving Mental Health Treatment at Facility	Number of unique patients with at least one encounter in the Mental Health Clinic Practice Management Grouping. An encounter is a professional contact between a patient and a practitioner with primary responsibility for diagnosing, evaluating, and treating the patient's condition. Encounters occur in both the outpatient and inpatient setting. Contact can include face-to-face interactions or telemedicine.
Suicide	Suicide Rate	Suicide surveillance processes include close coordination with federal colleagues in the Department of Defense (DoD) and the Centers for Disease Control and Prevention (CDC), including VA/DoD searches of death certificate data from the CDC's National Death Index, data processing, and determination of decedent Veteran status.‡
	Veterans Hospitalized for Suicidal Ideation	Distinct count of patients with inpatient diagnosis of ICD10 Code, R45.851 (suicidal ideations).
Average Inpatient Hospital Length of Stay	Average Inpatient Hospital Length of Stay	The number of days the patient was hospitalized (the sum of patient-level lengths of stay by physician treating specialty during a hospitalization divided by 24).
30-Day Readmission Rate	30-Day Readmission Rate	The proportion of patients who were readmitted (for any cause) to the acute care wards of any VA hospital within 30 days following discharge from a VA hospital by total number of index hospitalizations.
Unique Patients	Unique Patients VA and Non-VA Care	Measure represents the total number of unique patients for all data sources, including the pharmacy-only patients.
Community Care Costs	Unique Patient	Measure represents the Financial Management System Disbursed Amount divided by Unique Patients.
	Outpatient Visit	Measure represents the Financial Management System Disbursed Amount divided by the number of Outpatient Visits.
	Line Item	Measure represents the Financial Management System Disbursed Amount divided by Line Items.
	Bed Day of Care	Measure represents the Financial Management System Disbursed Amount divided by the Authorized Bed Days of Care.
Staff Retention	Onboard Employees Stay < 1 Year	VA's AES All Employee Survey Years Served <1 Year divided by total onboard. Onboard employee represents the number of positions filled as of the last day of the most recent month. Usually one position is filled by one unique employee.
	Facility Total Loss Rate	Any loss, retirement, death, termination, or voluntary separation that removes the employee from the VA completely.

Category	Metric	Metric Definition
	Facility Quit Rate	Voluntary resignations and losses to another federal agency.
	Facility Retire Rate	All retirements.
	Facility Termination Rate	Terminations including resignations and retirements in lieu of termination but excluding losses to military, transfers, and expired appointments.

**The OIG updates information for the Facility in Context graphics quarterly based on the most recent data available from each source at the time of the inspection.*

‡*A September 5, 2025, executive order designated the Department of War as a secondary title for the Department of Defense. Restoring the United States Department of War, 90 Fed. Reg. 43893 (Sep. 10, 2025).*

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: December 19, 2025

From: Director, Sierra Pacific Network (10N21)

Subj: Healthcare Facility Inspection of the VA Central California Health Care System in Fresno

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 Central California Health Care System in Fresno.
2. I concur with the findings, recommendations, and submitted action plans of VA Central California Health Care System in Fresno.
3. If you have any questions, please contact the VISN 21 Quality Management Officer.

(Original signed by:)

Jerry Mills
Interim Deputy Network Director
(for) Ada Clark, FACHE, MPH
Network Director
VA Sierra Pacific Network (VISN 21)

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: December 10, 2025

From: Executive Director (00), VA Central California Health Care System (570/VACCHCS)

Subj: Healthcare Facility Inspection of the VA Central California Health Care System in Fresno

To: Director, Sierra Pacific Network (10N21)

1. We appreciate the opportunity to review the draft report and the recommendations from the OIG Healthcare Facility Inspection of the VA Central California Health Care System in Fresno, CA conducted at the VA Central California Health Care System from April 28, 2025, through May 1, 2025.
2. Please find the attached response to the recommendation outlined in the report. We have either completed or are actively implementing the necessary actions to address and resolve the identified issue.

(Original signed by:)

Froy Garza
Executive Director/CEO
VA Central California Health Care System

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