US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Sierra Nevada Health Care System in Reno

Healthcare Facility Inspection	25-00243-56	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.

CONNECT WITH US

Subscribe to receive updates on reports, press releases, congressional testimony, and more. Follow us at @VetAffairsOIG.

PRIVACY NOTICE

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Executive Summary

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) established the Healthcare Facility Inspection program to review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle. The OIG inspected the VA Sierra Nevada Health Care System (facility) from June 24 through 26, 2025, and examined the quality of care provided using five content domains.[1]

What the OIG Found

- **Culture.** The OIG examined system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences. The OIG made no recommendations.
- **Environment of Care.** The OIG inspected the main entrance and patient care areas and compared findings from prior inspections to determine if there were recurring issues. The OIG found that a clean storage area contained soiled items, and some reusable medical equipment was covered with plastic bags, while other equipment was uncovered.[2] Although staff removed the dirty equipment and plastic bags, the OIG was concerned they were unaware of the storage process and made a recommendation. In response, leaders replaced the old standard operating procedure with a new one, clarifying roles and requirements.
- **Patient Safety.** The OIG assessed the facility's processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The facility did not have service-level workflows that designated the roles of providers and staff in communicating test results to patients, as required by VHA Directive 1088(1).[3] The OIG made a recommendation. In response, leaders republished the facility policy with a workflow chart defining responsibilities for communicating test results, and therefore, the OIG closed the recommendation.

[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] "Reusable medical devices [or equipment] are devices that health care providers can reprocess and reuse on multiple patients." "What are Reusable Medical Devices?," Food & Drug Administration, accessed July 9, 2025, https://www.fda.gov/rme; An infusion pump delivers fluids directly into a patient's bloodstream. "What is an Infusion Pump?," Food & Drug Administration, accessed June 10, 2025, https://www.fda.gov/infusion-pumps.

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

- **Integrated Veteran Care.** The OIG evaluated primary and community care team staffing and access to care.[4] The OIG made no recommendations.
- **Veteran-Centered Safety Net.** The OIG assessed programs that offer medical care and social support services to vulnerable veterans who are homeless and recently incarcerated. The OIG made no recommendations.

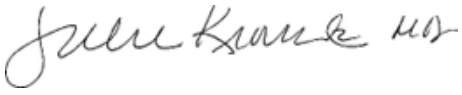
The OIG is aware of the transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

What the OIG Recommended

1. The Medical Center Director ensures staff properly store clean medical equipment.
2. Facility leaders develop written workflows for each service to ensure timely communication of test results to providers and patients.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the findings and recommendations and provided acceptable improvement plans (see the responses in the report body and appendixes C and D for the full text of the directors' comments). The OIG continued communication with VHA regarding the findings, which resulted in the closure of recommendation 2. The OIG will follow up on the planned actions for the open recommendation until they are completed.



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

[4] "VA provides care to veterans through community providers when VA cannot provide the care needed." "Community Care," Department of Veterans Affairs, accessed August 7, 2025, https://www.va.gov/communitycare.

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 Sierra Nevada Health Care System
Reno, Nevada
Level 1c-High Complexity
Washoe County
Hospital Referral Region: Reno

Description of Community

POPULATION

Female **768,564**	Male **775,947**
Veteran Female **9,807**	Veteran Male **102,352**

Homeless - State **7,618**
Homeless Veteran - State **752**

MEDIAN INCOME

$64,542

EDUCATION

89% Completed High School
61% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **327**

SUBSTANCE USE

26.3% Driving Deaths Involving Alcohol
21.2% Excessive Drinking
435 Drug Overdose Deaths

UNEMPLOYMENT RATE

5% Unemployed Rate 16+
5% Veterans Unemployed in Civilian Workforce

TRANSPORTATION

Drive Alone	521,042
Carpool	65,716
Work at Home	65,159
Walk to Work	14,062
Other Means	11,756
Public Transportation	11,040

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**65 Minutes, 61 Miles**
Specialty Care	**81 Minutes, 80 Miles**
Tertiary Care	**250 Minutes, 254 Miles**

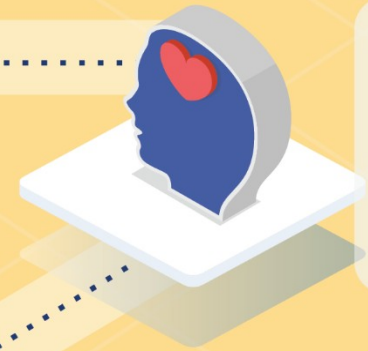
Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **10,638**

Veterans Receiving Telehealth (VHA)	41%
Veterans Receiving Telehealth (Facility)	40%
<65 without Health Insurance	15%

Health of the Veteran Population



VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

7,239

188 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

4.40 Days

30-DAY READMISSION RATE

11%

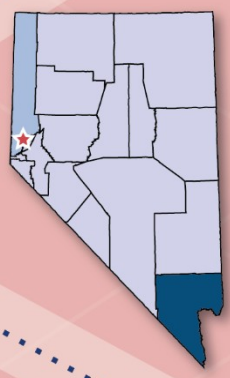
SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
27	51

Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	30K
Unique Patients VA Care	29K
Unique Patients Non-VA Care	14K



COMMUNITY CARE COSTS

Unique Patient $24,201	Outpatient Visit $270
Line Item $1,135	Bed Day of Care $411

STAFF RETENTION

Onboard Employees Stay <1 Yr	12.61%
Facility Total Loss Rate	13.38%
Facility Retire Rate	2.09%
Facility Quit Rate	10.83%
Facility Termination Rate	0.46%

★ VA MEDICAL CENTER

VETERAN POPULATION

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, integrated veteran 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]

---

[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.)

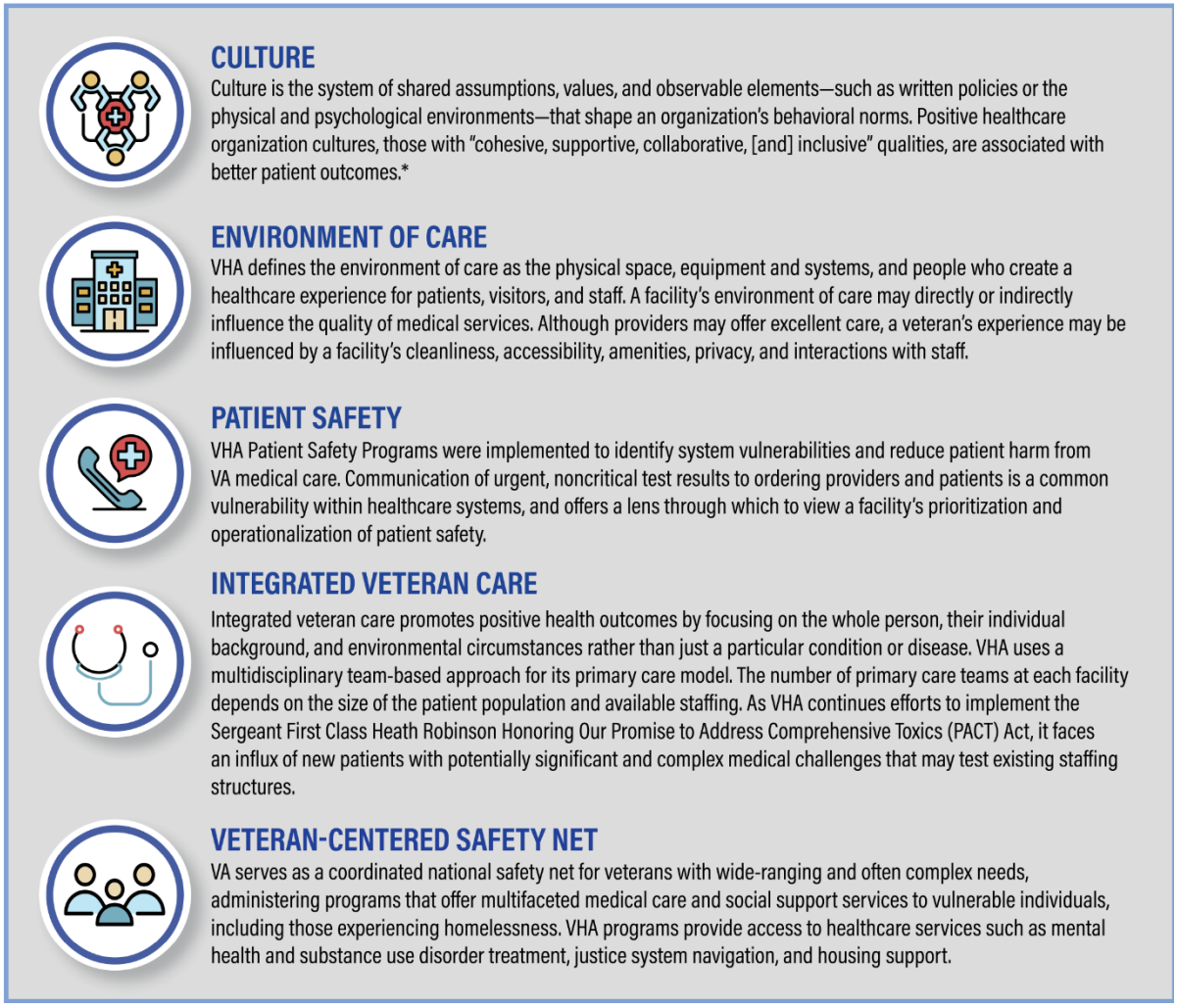


Figure 2. *Healthcare Facility Inspection's five content domains.*
**Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," BMJ Open 7, no. 11 (2017): 1–11.*
Sources: Boris Groysberg et al., "The Leader's Guide to Corporate Culture: How to Manage the Eight Critical Elements of Organizational Life," Harvard Business Review, (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; VHA Directive 1088(1), Communicating Test Results to Providers and Patients, July 11, 2023, amended September 20, 2024.

The VA Sierra Nevada Health Care System (facility) provides outpatient and inpatient services to veterans residing in northern Nevada and northeastern California. The facility had 129 operating beds, which included 69 hospital and 60 community living center beds, and a fiscal year (FY) 2023 medical care budget of about $553 million.[4]

Figure 3. *Facility photo.*
Source: "VA Sierra Nevada Health Care," Department of Veterans Affairs, accessed August 26, 2025, https://www.va.gov/sierra-nevada-health-care/.

The OIG inspected the facility from June 24 through 26, 2025. According to quality management staff, the executive leaders consisted of the Medical Center Director (Director), Associate Director, Chief of Staff, Associate Director of Patient Care Services, Deputy Chief of Staff, and Deputy Associate Director of Patient Care Services.

CULTURE

The OIG examined the facility's culture across multiple dimensions, including unique circumstances and system shocks (planned or unplanned events that disrupt an organization's usual daily operations), and both employees' and veterans' experiences.[5] The OIG administered a facility-wide questionnaire, reviewed VA's All Employee Survey and Veterans Signals (VSignals) survey scores (which provide information about veterans' experiences after an appointment and their level of trust in VA), 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 September 15, 2025, https://www.va.gov/communitylivingcenter.

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

[6] The All Employee Survey is an annual, voluntary survey of VA workforce experiences. "AES Survey History, Understanding Workplace Experiences in VA," VHA National Center for Organization Development. Patient Advocates are employees who receive feedback from veterans and help resolve their concerns. "Patient Advocate," Department of Veterans Affairs, accessed August 4, 2025, https://www.va.gov/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

In response to the OIG questionnaire, employees identified leadership turnover and significant organizational changes that resulted from presidential actions (executive orders and memorandums) as system shocks. The OIG learned that of the six executive leaders, five began their full-time roles in 2024 or later, after previous leaders retired, resigned, or transferred to another VA facility. Although the leaders were new to their positions, responses to the OIG questionnaire and VA All Employee Survey reflected positive changes in the organization. The Deputy Chief of Staff believed the current Director and new executive team brought needed stability and improvements to the organization.

OIG questionnaire respondents were also concerned about possible workforce reductions, a hiring freeze, increasing workload, and mandates to return to the office.[7] Executive leaders said it was difficult to address employees' concerns because VHA did not provide immediate guidance on implementing the actions. Leaders increased communication through twice weekly town halls and visits to work areas to address the concerns.

Executive leaders said VHA terminated the facility's medical coding contract when it implemented the President's "Department of Government Efficiency" Cost Efficiency Initiative.[8] Employee coders assumed the contract coders' workload; however, the volume became too large for them to handle, which resulted in a growing backlog of uncoded medical records. Medical coding ensures medical records are accurate and supports proper billing for treatment.[9] Leaders received support from six VA medical centers, and the consolidated coding unit from two other Veterans Integrated Service Networks (VISNs) to assist with the backlog.[10] According to leaders, there was a considerable potential financial loss to the facility for missed inpatient medical coding for FY 2025. The Associate Director said VHA's central office approved a FY 2026 replacement contract.

[7] Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025); Hiring Freeze, 90 Fed. Reg. 8247 (Jan. 28, 2025).

[8] Implementing the President's "Department of Government Efficiency" Cost Efficiency Initiative, 90 Fed. Reg.11095 (March 3, 2025).

[9] VHA HIM [Health Information Management], *Clinical Coding Program Guide Version 1.9*, February 2024.

[10] Veterans Integrated Service Networks (VISNs) 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 June 4, 2024, https://www.va.gov/visns.

Employee Experiences

The OIG noted scores for transparency, communication, and information sharing improved between FYs 2023 and 2024. The facility also showed improvement for the survey's best places to work score from FYs 2023 to 2024. OIG questionnaire respondents also indicated they experienced positive changes in executive leaders' communication and described it as clearer and more frequent.

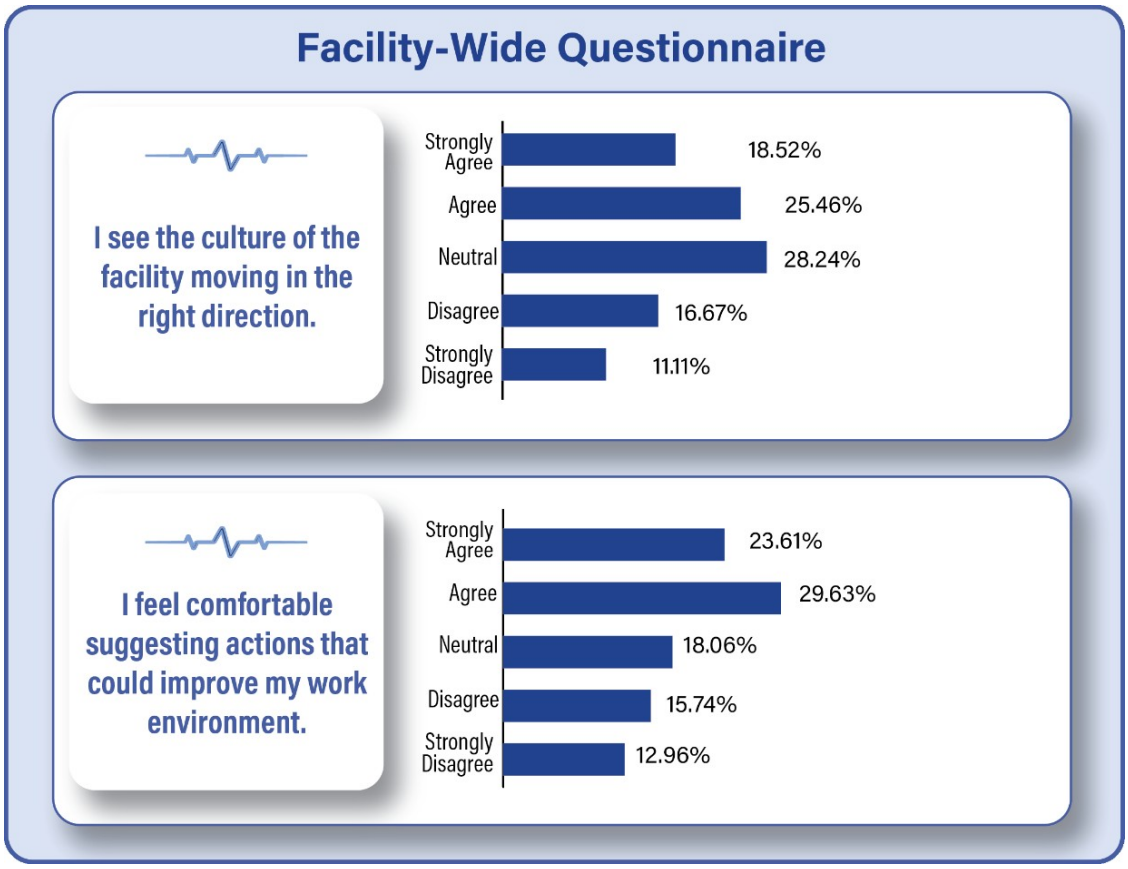


Figure 4. *Employee and leaders' perceptions of facility culture.*
Source: OIG analysis of questionnaire responses.

Survey scores showed improvement in psychological safety measures, and most OIG questionnaire respondents agreed they felt comfortable reporting safety concerns and suggesting actions to improve the work environment.[11] The Director reported a 40 percent increase in patient safety reports over one year, which suggests leaders emphasized that employees would not face retaliation for reporting concerns.

[11] "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.

Veteran Experiences

Patient advocate responses to the OIG questionnaire described appreciation for leaders' support and a team-based approach to resolving veterans' concerns; staff from each department participate in the resolution process. The advocates trained department-level representatives to help them respond more effectively to veterans' concerns. Additionally, the advocates received training on department-specific policies to help them answer veterans' questions.

Patient advocates said veterans' most common concerns were related to community care, including coordination of care and billing.[12] To improve care coordination, the chief of community care hired additional staff. Leaders also noted that most comments veterans submitted through the patient advocate tracking system were compliments.[13]

VSignals survey results validated leaders' comments about veterans' experiences. The scores had increased since FY 2023 and, during the first two quarters of FY 2025, showed 96 percent of veterans trust the facility.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[14] 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

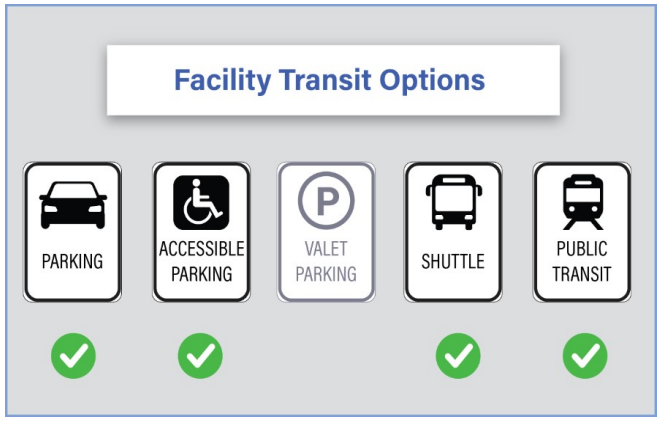


Figure 5. *Transit options for arriving at the facility.*
Source: OIG observations and analysis of documents.

[12] "VA provides care to veterans through community providers when VA cannot provide the care needed." "Community Care," Department of Veterans Affairs, accessed August 7, 2025, https://www.va.gov/communitycare.

[13] The Patient Advocate Tracking System "tracks patient complaints, compliments and other key program data." VHA Directive 1003.04, *VHA Patient Advocacy*, November 9, 2023.

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

environment of care. The OIG also considered best practice principles from academic literature.[15]

General Inspection

The OIG observed several parking options, including two parking garages and multiple parking lots, with one designated as accessible for individuals with disabilities. The parking areas had sufficient lighting and emergency call boxes. The OIG further noted a public bus stop located a short walk from the main entrance.

The main entrance had a passenger loading zone and was accessible by both stairs and a wheelchair ramp. Near the entrance, the OIG noted a café with seating available and multiple wheelchairs for veterans to use.

The OIG observed signs that were large and easy to read, and color-coded wall maps that identified the location of various departments.

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

The OIG also observed braille on signs and in elevators. An information desk volunteer reported that escorts are available to help veterans with sensory impairments reach their destinations.

In the community living center, staff stored pillows, a weighing scale, and soiled wheelchairs in a clean storage area. Clean storage areas in the Emergency Department and community living center also contained reusable medical equipment, such as infusion pumps, covered with plastic bags, while other equipment was uncovered.[16] VHA Directive 1131 requires staff to store clean and soiled items separately to prevent infections.[17]

---

[15] 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.

[16] "Reusable medical devices [or equipment] are devices that health care providers can reprocess and reuse on multiple patients." "What are Reusable Medical Devices?," Food & Drug Administration, accessed July 9, 2025, https://www.fda.gov/rme; An infusion pump delivers fluids directly into a patient's bloodstream. "What is an Infusion Pump?," Food & Drug Administration, accessed June 10, 2025, https://www.fda.gov/infusion-pumps.

[17] VHA Directive 1131, *Management of Infectious Diseases and Infection Prevention and Control Programs*, November 27, 2023.

The Chief of the Community Living Center and Chief of Facility Management Support could not explain why staff stored soiled items in a clean storage area. When the OIG asked about the process to store clean, noncritical reusable medical equipment, the nurse manager for the Emergency Department and chief nurse for the community living center could not explain it or confirm whether the uncovered equipment was clean or dirty.

The infection preventionist explained that facility guidelines for cleaning and disinfecting reusable medical equipment did not require staff to cover clean equipment in plastic bags and could not explain why staff covered some equipment. The infection preventionist further stated that staff received education on the topic during new employee orientation, staff meetings, environment of care inspections, and through updated policies sent to department chiefs. When some equipment is covered by plastic bags, staff may be confused about what is clean and unintentionally use dirty or non-sterile equipment. Although staff removed dirty equipment and plastic bags from clean equipment during the inspection, the OIG remains concerned that staff were unaware of the process to store the equipment.

Recommendation 1

The Medical Center Director ensures staff properly store clean medical equipment.

_X_ Concur

____ Nonconcur

Target date for completion: July 30, 2026

Director Comments

Chief of Staff, Deputy Associate Director of Patient Care Services (DADPCS), and Interim Associate Director collaborated with the Chief of Quality and Patient Safety to review the OIG recommendation.

DADPCS initiated a workgroup with Nursing Leadership, Chief of Environmental Service (EMS), and Chief of Sterile Processing to review current clean storage process. They reviewed the Standard Operating Procedure (SOP) SPS-NON-1000, "Cleaning, Disinfection, and Storage of Non-Critical Reusable Medical Devices," dated July 9, 2025, and replaced it with SOP 133-002, "Cleaning, Disinfecting, and Storing Non-Critical Reusable Medical Devices," effective November 25, 2025, to clarify the requirement that only clean equipment is stored in the clean storage areas, outline roles and responsibilities.

EMS staff will complete weekly audits of clean storage areas ensuring no comingling of clean and dirty items and will report monthly to the Environment of Care Council (EOCC). Compliance will be monitored until the facility maintains 90 percent or greater adherence for three consecutive months.

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 OIG interviewed service chiefs and determined providers had a process to communicate urgent, noncritical test results to patients. However, the facility's written service-level workflows did not identify the providers and staff responsible for communicating urgent, noncritical test results that require action to patients. VHA Directive 1088(1) requires workflows for each clinical service to identify those who can notify patients of the results.[18]

Recommendation 2

Facility leaders develop written workflows for each service to ensure timely communication of test results to providers and patients.

_X_ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

Chief of Staff, Chief of Quality and Patient Safety Service, and External Peer Review Process Liaison reviewed VHA Directive 1088(1), Communicating Test Results to Providers and Patients, dated July 11, 2023, and amended September 20, 2024, and the VASNHCS Medical Center Policy (MCP) 113-04, Communicating Test Results to Providers and Patients, dated June 2, 2025. After review and consultation with all services, MCP 113-04 was republished on September 8, 2025, to include the attachment FLOW 11-04, defining provider & staff responsibilities and procedures for communicating test results to the ordering provider and to patients in a workflow flow chart format for each service. Facility is requesting closure for this recommendation.

[18] VHA Directive 1088(1).

OIG Comments

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

Action Plans and Process Improvements

The OIG reviewed the Comprehensive Healthcare Inspection Program report and Joint Commission surveys and found no open recommendations related to test result communication.[19] However, a 2025 audit from VA's National Pathology and Laboratory Medicine office resulted in six recommendations related to test results. Staff were implementing the action plans at the time of OIG's site visit in June 2025.

The patient safety manager said quality management staff review events in the Joint Patient Safety Reporting system to identify improvement opportunities. Patient safety staff communicate action plans or preventive measures to the person who reported the event. The systems redesign coordinator said patient safety staff consult with systems redesign staff about next steps for improvement projects. The Director also allocates time during town halls to communicate process improvement efforts to all staff.

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities. Its mission is to ensure "every Veteran and family member has access to high value care where they need it, when they need it."[20] The OIG evaluated facilities' primary care and community care staffing, veterans' access to care, actions staff took to improve processes, and how leaders supported improvements. The OIG also examined actual and expected primary care panel sizes (number of veterans assigned to a care team) relative to VHA guidelines, and community care referral processing timelines and program effectiveness in improving access to care.

[19] VA OIG, *Comprehensive Healthcare Inspection of the VA Sierra Nevada Healthcare System in Reno*, Report No. 22-00230-190, September 14, 2023; The Joint Commission, *Final Accreditation Report, VA Sierra Nevada Healthcare System-Laboratory*, April 12, 2024; The Joint Commission, *Final Accreditation Report, VA Sierra Nevada Healthcare System*, April 28, 2025.

[20] "Office of Integrated Veteran Care," Department of Veterans Affairs, accessed August 4, 2024, https://dvagov.sharepoint.com/sites/vhaoivc. (This website is not publicly accessible.)

Primary Care Staffing and Access to Care

The ambulatory care service chief reported 20 vacant positions across 40 primary care teams: 4 physicians, 1 advanced practice registered nurse, 3 registered nurses, 5 licensed practical nurses, 3 medical support assistants, and 4 social workers. The service chief said physician recruitment remained difficult because some community-based outpatient clinics are in rural areas. Patients receive care through the Clinical Resource Hub, and the service chief is considering hiring an advanced practice registered nurse instead of a physician.[21]

The service chief described meeting weekly with staff from ambulatory care, nursing, and health administration services to address panel capacity, wait times, and productivity, which helped staff maintain reasonable workloads. Facility staff provided data that indicated new patient appointment wait times averaged under 21 days for May 2025.

Community Care Staffing and Access to Care

Facility community care staff identified higher workload, insufficient staffing, and increased numbers of referrals as their top concerns. According to community care staff, referrals increased when providers left the facility or took extended leave. The chief of community care reported a 20 percent increase in community care referrals between May 2024 and May 2025.

The OIG noted the average new patient wait time for primary care appointments in the community was 44 days, which was longer than the average wait time at the facility. However, the chief said most patients who received primary care in the community were eligible because they lived far away from the facility.

The chief described sending out a weekly report to VHA that providers use to explain wait times to patients and discuss referral options. For example, cardiology appointments had a 35-day wait time at the facility and a 60-day wait time in the community.

The chief added the community provider network lacked specialists in ear, nose, and throat; endocrine; pulmonary; and mental health care, which potentially decreased access to care and increased appointment wait times. Staff informed the third-party administrator (contracted by VA to develop and administer regional networks of community providers) of specialty care provider needs. The chief said the third-party administrator conducted outreach with specialty care providers and invited them to join the network, which has increased the number of available community providers.

[21] Clinical resource hubs are VISN programs that assist local VA facilities by providing services to veterans through telehealth or in-person visits. "Patient Care Services Clinical Resource Hubs (CRH)," Department of Veterans Affairs, accessed December 9, 2024, https://www.patientcare.va.gov/CRH.

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.[22]

During this inspection, VHA used three 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.[23] However, beginning in FY 2026, VHA no longer uses this as a performance measure. Next, HCHV1 measures the percentage of veterans who are discharged from contracted residential services and low-demand safe haven programs into permanent housing.[24] 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."[25]

Program Highlights

- The program did not meet the HCHV5 target from FY 2022 through the second quarter of FY 2025. The program supervisor explained it was difficult to locate veterans due to encampment sweeps (forced removal of homeless campsites) by

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

[23] 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,* October 1, 2022; VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures,* October 1, 2023; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures,* November 2024.

[24] 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.

[25] VHA sets targets for HCHV1 and HCHV2 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures.*

city or county police. Therefore, program staff increased outreach in rural areas and began early morning street outreach, when they were more likely to find veterans.

- The program missed the HCHV1 target in FYs 2022 and 2023 but exceeded it in FY 2024. The supervisor said staff revised the contract emergency provider agreements to prioritize transitioning veterans to permanent housing, which contributed to program success in FY 2024.
- The program also did not meet the HCHV2 target in FYs 2022 through 2024. The supervisor reported challenges with contract providers' discharge policies for veterans' violating rules and therefore increased meetings between program staff and contract providers to improve collaboration.

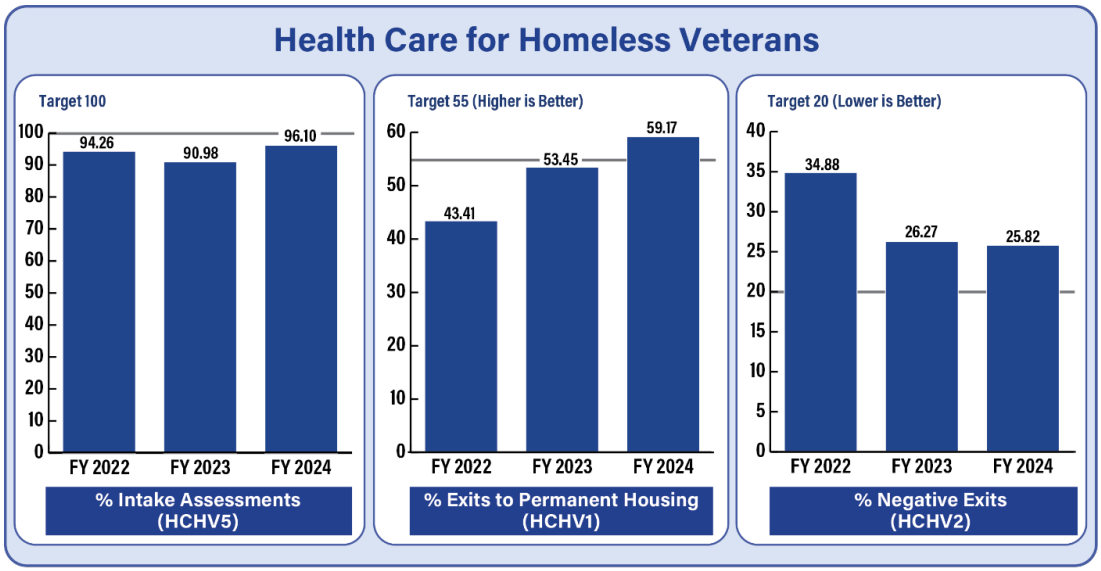


Figure 7. *HCHV program performance measures.*
Source: VHA Homeless Performance Measures data.

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."[26] The program uses the housing first approach to prioritize rapid placement into housing followed by individualized services.[27]

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

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).[28]

Program Highlights

- The program did not meet the HMLS3 target from FYs 2022 through 2024. The program supervisor attributed it to a reduction in affordable housing and fewer landlords willing to accept vouchers. To address this challenge, the supervisor hired an additional housing assistant to build relationships with landlords and partnered with community developers to expand project-based housing (rental units with assigned vouchers), resulting in seven housing sites and three more under development.
- The program also did not meet the VASH3 target in FYs 2022 through 2024. The supervisor said the team could not determine why they missed the target.
- The supervisor emphasized that enrolled veterans often needed medical care, mental health support, and social engagement due to isolation and loneliness. Therefore, the supervisor hired a social work associate to coordinate medical care and a psychologist to address mental health concerns, and peer specialists referred veterans to services that reduce social isolation.

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.[29] 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).[30]

[28] VHA sets the HMLS3 target at 90 percent or above and the VASH3 target at 50 percent or above. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures.*

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

[30] 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*; VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures.*

Program Highlights

- The program exceeded the target during FY 2023 but did not meet it in FY 2024. The program supervisor said to identify veterans to enroll in the program, staff conduct outreach twice weekly at the Washoe County jail near Reno.
- Staff provide outreach to jails and law enforcement agencies in more rural areas. They also receive referrals from two veterans treatment courts, veterans service organizations, public defenders, and judges in the service area.[31]

Conclusion

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 medical equipment storage and test result communication. Facility leaders have started to implement corrective actions, and the OIG closed recommendation 2. 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 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 appreciates the participation and cooperation of VHA staff during this inspection process.

[31] A veterans treatment court is "a treatment court model that brings Veterans together on one docket to be served as a group." VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024. Veterans service organizations provide outreach and education about VA benefits to veterans and their families. Edward R. Reese Jr., "Understanding Veterans Service Organizations Roles" (PowerPoint presentation, November 19, 2008), https://www.va.gov/gulfwaradvisorycommittee/docs/VSO.pdf.

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.

Health Facility Inspection directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from June 24 through 26, 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: January, 23, 2026

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

Subj: Healthcare Facility Inspection of the VA Sierra Nevada Health Care System in Reno

To: Director, Office of Healthcare Inspections (54HF04)

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

(Original signed by:)

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

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: January 15, 2026

From: Director, VA Sierra Nevada Health Care System (654)

Subj: Healthcare Facility Inspection of the VA Sierra Nevada Health Care System in Reno

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

1. We appreciate the opportunity to review the draft report and the recommendation from the OIG Healthcare Facility Inspection of the VA Sierra Nevada Health Care System (654) in Reno, NV conducted at the VA Sierra Nevada Health Care System (654) from June 24 through June 26, 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 issues.

(Original signed by:)

Thomas R. Talamante, MS, MBA
Executive Director

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Joseph Giries, MHA, Director Robert Ordonez, MPA, Project Leader Kinh-Luan Nguyen, PharmD, MBA, Team Leader Laura Harrington, DBA, MSN Nancy Krzanik, MSN, RN Veronica Leon, PhD, MSN Rondina Marcelo, LCSW Laura Pond, MSW, LCSW Shelia Farrington-Sherrod, MSN, RN Stephanie Stall, MSN, RN
Other Contributors	Kevin Arnhold, FACHE Jolene Branch, MS, RN Richard Casterline Kaitlyn Delgadillo, BSPH Jennifer Frisch, MSN, RN LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Christopher D. Hoffman, LCSW, MBA Amy McCarthy, JD Scott McGrath, BS Daphney Morris, MSN, RN Sachin Patel, MBA, MHA Ronald Penny, BS Joan Redding, MA Larry Ross Jr., MS April Terenzi, BA, BS Temekia Toney, LCSW, MSW Dan Zhang, MSC

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Office of Accountability and Whistleblower Protection
Office of Public and Intergovernmental Affairs
Office of General Counsel
Office of Congressional and Legislative Affairs
Director, VISN 21: VA Sierra Pacific Network
Director, VA Sierra Nevada Health Care System (654)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
US Senate
  California: Alex Padilla, Adam Schiff
  Nevada: Catherine Cortez Masto, Jacky Rosen
US House of Representatives
  California: Kevin Kiley
  Nevada: Mark Amodei

OIG reports are available at www.vaoig.gov.

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