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Office of Audits and Evaluations

VETERANS HEALTH ADMINSTRATION

Review of Medical Facilities' Management of Specialty Care Calls

Review | 25-03621-145 | July 23, 2026

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Executive Summary

The VA Office of Inspector General (OIG) launched a national review in November 2025 to assess whether VA medical facility leaders ensured staff answered phone calls from veterans seeking specialty care from August 2024 through July 2025 (the review period) consistent with performance standards. The standards are designed to support timely access to care for veterans, who primarily schedule and manage specialty care appointments by phone. Veterans Health Administration (VHA) Directive 1090 and related guidance require veterans' telephone access "to all service lines providing clinical care." This includes resolving the veteran's reason for calling VA the first time they call, reliably monitoring performance, and identifying opportunities to improve.[1] Implementing these standards is meant to optimize opportunities for veterans to receive swift, seamless assistance. During the review period, veterans scheduled about 42 million specialty care appointments.

What the Review Found

The OIG examined clinics for six specialty care services at 15 facilities based on the ratio of patient complaints to specialty appointments and found contact numbers were wrong, phone systems did not connect veterans to the right staff, and poor or missing call tracking and management. The OIG found that 78 of 219 tested specialty care phone numbers (36 percent) led to misrouted or disconnected calls or nonfunctional lines. According to VA call data, about 573,000 of 2.9 million veteran calls to the reviewed clinics went to inaccurate numbers during the review period. In addition, 11 facilities lacked interactive options to route veterans directly to specialty care clinics, undermining first-call resolution and causing delays and repeat calls. About 530,000 of the 2.9 million calls went to voicemail; many veterans complained in the patient advocate system about full voicemail boxes and unreturned messages.

The lack of required data on call performance made effective VA oversight challenging. As of January 2026, 13 of the 15 facilities handled specialty care calls primarily through individual or shared lines, which could not track required metrics. Across the specialty care services reviewed, more than 1.3 million call attempts (45 percent) were not tracked—including about 468,000 to radiology and 125,000 to mental health, which are high-risk groups. This limited leaders' ability to monitor timeliness and identify and correct access issues. In contrast, specialty care clinics that used centralized, trackable phone queues generally met performance metrics.

Most program office, regional network, and facility leaders said they initially interpreted that the directive's national call performance standards applied only to clinical call centers because it does not specifically refer to specialty care. As a result, these leaders did not provide effective

[1] VHA Directive 1090, *Telephone Access for Clinical Care*, September 20, 2023.

oversight or clear guidance for managing specialty care calls. Facilities also inconsistently implemented VA's related policies. Leaders later acknowledged to the OIG that the directive's call performance standards do apply to specialty care clinics. Without reliable call data, defined responsibilities, and routine reviews, VHA cannot determine whether veterans receive timely access to specialty care.

The OIG briefed leaders in VHA and the Office of Information and Technology in January 2026 and issued a preliminary memorandum in February 2026 informing them that 13 of the 15 reviewed facilities lacked required call performance data for specialty care.[2] The team followed up with facility leaders in May 2026 to identify further actions, such as updates to phone lines.

In response to OIG briefings and initial findings, VA implemented several early corrective actions, including facility-level updates to inaccurate phone numbers on websites and internal directories, adjusting interactive automated prompts to add specialty care options, and adding call queueing systems in fiscal year 2026 (ending September 30, 2026) instead of sending unanswered calls to voicemail. To improve oversight of specialty care voicemails, the Office of Information and Technology launched a national dashboard in February 2026 that shows facilities the number of voicemails received and retrieved. VHA is reorganizing to improve overall care delivery and operations, but VHA leaders told the OIG it is not expected to alter specialty care call operations or management.

The OIG made five recommendations to help VA continue to improve service for veterans and their families by reducing delays, uncertainty about when they will receive care, and frustration when they attempt to schedule or manage specialty care by phone. The under secretary for health concurred with two recommendations, concurred in principle with the other three, and provided action plans to address all recommendations.

Next Steps

The OIG will continue to monitor VHA's corrective actions and will close the recommendations once VHA provides sufficient evidence that it has addressed the risks identified in this report.

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[2] VA OIG, *VHA Facilities' Collection and Oversight of Specialty Care Call Data*, Report No. 25-03621-68, February 19, 2026.

Contents

Abbreviations

I CARE	Integrity, Commitment, Advocacy, Respect, Excellence
OIG	Office of Inspector General
OIT	VA Office of Information and Technology
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

VA's provision of timely and effective phone assistance is critical to veterans' access to care. This includes specialty care, which is advanced care specific to a demographic, disease, or skill set, and includes all services not provided through primary care such as mental health treatment, dentistry, or radiology. Though some veterans may schedule their specialty care through VA's online patient portal, appointment options there may be limited to certain specialties.[3] Phone assistance remains the primary way veterans schedule and manage specialty care appointments, and it is often the first step for veterans seeking this type of care.

Unlike primary care calls, which VA coordinates at its regional clinical contact centers, calls for specialty care clinics are handled at VA medical facilities. Prior work conducted in 2025 by the VA Office of Inspector General (OIG) identified concerns with the capacity of systems that veterans use to access specialty care clinics via phone.[4] Those concerns prompted this review to determine whether leaders at VA medical facilities ensure staff answer veterans' calls for specialty care consistent with established performance standards so that veterans have access to timely care.

According to 38 C.F.R. § 0.600 (2019), the Veterans Health Administration (VHA) is responsible for administering calls to specialty care clinics in furtherance of VA's Integrity, Commitment, Advocacy, Respect, Excellence (I CARE) core values. Section 0.603 of the regulation requires VA programs to provide "exceptional customer experience," including seamless access to health care. To help achieve this and to promote a positive patient experience and reduce delays in care, VHA Directive 1090 requires medical facilities to use standardized automated interactive phone response systems to help veterans navigate access to "all service lines providing clinical care" and have their needs addressed during the initial call.[5] This directive establishes national call performance standards including limits on call abandonment (patient hang-ups before calls can be answered) and expectations for acceptable response times for "all service lines providing clinical care." The OIG interprets "all service lines providing clinical care" to include specialty care.

There were 132 VA facilities that provided specialty care clinics during the OIG review period from August 2024 through July 2025. These facilities were identified using complaints in VA's patient advocate system related to unanswered calls.[6] During this time, veterans scheduled about

[3] Each facility can decide which specialty care they schedule or do not schedule online.

[4] VA OIG, *Review of Clinical Contact Centers to Assess Leadership and Oversight*, Report No. 25-00228-214, October 8, 2025; VA OIG, *Atlanta Call Center Staffing and Operational Challenges Provide Lessons for the New VISN 7 Clinical Contact Center*, Report No. 23-01609-14, January 30, 2025.

[5] VHA Directive 1090, *Telephone Access for Clinical Care*, September 20, 2023.

[6] Appendix A has additional information about this review's scope and methodology.

42 million specialty care appointments across these facilities. The team selected a sample of 15 facilities to determine whether VA facility leaders made sure staff answered calls within prescribed times.

Specialty Care Call Operations

Veterans who call a VA facility typically start with the main phone number. When connected, an automated interactive response system greets them and provides menus and submenus with options for veterans to navigate with their phone keypad. According to VHA Directive 1090, this interactive system is meant to guide veterans to the right services and "support First Contact Resolution." For the purposes of this report, first-*contact* resolution would refer to meeting a patient's needs in a clinically appropriate way during their first call for specialty care (or first-*call* resolution*)*.[7] The directive (section 7 b (3)) also states that phone service must provide "ready access for appointment management, pharmacy, eligibility information, health care information (non-clinical information), health care delivery, patient education, and other concerns related to the clinical care being provided to the patient." The directive assigns Veterans Integrated Service Network (VISN) directors the responsibility to ensure phone service for clinical care is available to all patients across all clinical service lines and that local interactive response systems include "secondary prompts or sub-menus" to route callers to the services they need to achieve first-call resolution (sections 2 e (2) and (6)).

In addition, a 2023 VHA memorandum on standardizing telephone systems says facilities must include a menu prompt option that connects veterans to the clinical contact center for primary care scheduling. Though this memo does not explicitly list all specialty care services that require separate prompts to enable first-call resolution, it states that facilities must have secondary prompts and provides examples for accessing mental health and specialty care.[8] The memo also requires facilities and regional networks to regularly review menu options. In addition, VHA Directive 1231(4) requires clinical and administrative staff to work as a team to improve phone access, resolve issues quickly, and reduce delays in care.[9]

As an alternative to using the interactive system, veterans seeking specialty care can call a facility's main phone number and speak to an operator who will manually route the call to the appropriate clinic. Veterans can also call clinics directly if they have the correct phone number.

[7] VHA Directive 1090, Section 8 a, defines "first contact resolution" as "the satisfaction of a patient's concerns during their initial contact with a VA health care system."

[8] Assistant under secretary for health for the Office of Integrated Veteran Care, "INFORMATIONAL: Veterans Integrated Service Network (VISN) Interactive Voice Response (IVR) Standardization and Coordination with VA Health Connect Clinical Contact Centers (VIEWS #10924531)," memorandum to Veterans Integrated Service Network directors (10N1-23), October 27, 2023.

[9] VHA Directive 1231(4), *Outpatient Clinic Practice Management*, amended February 7, 2024.

Within each specialty care clinic, a facility can configure its phone system in many ways: for example, calls can go to an individual phone line; incoming calls can ring at numerous (shared) phones; or callers can be placed in a queue to be answered in the order received. Facilities can also set up voicemail for specialty care clinics.

Regardless of the setup, VHA Directive 1090 says the phone configuration should provide veterans with seamless access to all clinical care for first-call resolution when possible. Administrative staff at specialty care clinics are generally responsible for answering veterans' calls to discuss care options. These staff are often the first—and sometimes only—point of contact for veterans seeking specialty care.

Call Performance Metrics

VHA Directive 1090 requires medical facilities and their regional network office to collect and report four performance metrics for calls answered by staff to ensure veterans have ready access to assistance. These metrics can reveal phone access issues and can be used to monitor process improvements. Figure 1 lists the performance metrics, their operational definitions, and standard metrics as outlined in the directive and other guidance.

Key performance metrics required by VHA Directive 1090

Performance	Definition	Standard
Call volume	Number of calls coming into a clinic	N/A
Abandonment rate	Percentage of callers that hang up before staff answers	5% or less per year
Average speed of answer	Average time callers wait before staff answers	30 seconds
Timeliness	Percentage of calls answered within speed-of-answer goal	80% within 30 seconds

Figure 1. *Call performance metrics that regional and facility leaders are required to monitor. Source: VHA Directive 1090,* Telephone Access for Clinical Care*, September 20, 2023; VHA Clinical Contact Center Modernization Data and Metrics Guidance, January 14, 2021 (not publicly accessible).*

At first, facility and national program office leaders were generally not aware that VHA call performance standards apply to specialty care clinics, since they are not specifically mentioned in the directive and generally only call centers would have performance data. Following initial discussions with the OIG, VHA leaders at the program, regional, and facility level acknowledged

that Directive 1090 states that metrics for phone service "applies to all service lines providing clinical care" and agreed that it is applicable to specialty care clinics.

Phone Queues and Systems

At some facilities and specialty care clinics, incoming calls on VA's primary Cisco telephone system place callers in a queue, and their calls are answered in the order received. For these calls, VHA uses Cisco Finesse, a software application that routes calls to designated staff through these queues. This system allows centralized call handling, which reduces the number of staff needed to manage incoming calls. It also collects past and real-time call performance data, which gives managers oversight through the system's dashboard.

Before the start of the OIG review in November 2025, VA's Office of Information and Technology (OIT) staff gave the team access to Variphy, a system that pulled call analytics and reports on the Cisco data. The OIG used Variphy to analyze call-volume data for specialty care clinics that were not set up with queues. Only systems with queues provided readily available data through Cisco Finesse. However, during this review, VA phased out its use of Variphy. In December 2025, OIT staff instructed the OIG team to instead rely on call-volume analytics collected from a TeleMate system.

The team determined that TeleMate captured more incoming calls from the Cisco telephone system across specialty care services because it identifies unique calls by facility nationwide more accurately, while Variphy was limited to capturing calls by region only, according to information provided by VA OIT. However, neither Variphy nor TeleMate provided call performance data like Cisco Finesse. They were limited to call-volume data and could not provide performance data such as for answered and abandoned calls. The issues described later in this report related to missing performance data and untracked calls due to shared lines or other impediments still apply.

VHA Governance Structure and Responsibilities

VHA is reorganizing to improve overall delivery of care and operations, effective May 1, 2026. According to officials from both OIT and VHA, the planned reorganization is not expected to change specialty care call operations or management, and the responsibility will primarily remain at the facility level.

At the time of this review, VHA's Office of Integrated Veteran Care had primary responsibility for overseeing veterans' timely and appropriate access to health care. This program office was tasked with planning, implementing, and overseeing facility and regional compliance with VHA Directive 1090. It was also charged with planning, implementing, and overseeing VHA Directive 1231(4), which requires clinical and administrative staff to collaborate to ensure phone access across facilities and clinics, including first-call resolution and the monitoring of phone

performance data.[10] The review team also reached out to VA's Veterans Experience Office to discuss any role they have in veterans calls to VA medical facility specialty call services. A program analyst from this office informed the OIG team that the office does not oversee calls to local facilities, including calls to specialty care clinics.

VHA Directive 1217(1) assigns leadership and oversight responsibilities to the regional networks and to VA medical facility directors.[11] While the regional networks have some oversight duties, specialty care call management primarily occurs at the facility level. Regional network directors must generally make certain that facilities implement directives, monitor performance, identify compliance barriers, and report challenges to VHA leaders. Facility directors are responsible for complying with directives, taking corrective action when needed, and having sufficient qualified clinical and administrative staff available to respond to patient care concerns. Business or administrative offices within facilities (typically reporting to the associate facility director) manage clinic support operations and oversee administrative staff. In some facilities, however, specialty care clinic chiefs may directly manage administrative staff in their clinics.

OIT collaborates with all levels of VHA governance to establish and improve technological systems and practices. For instance, this office helped medical facilities create and update the interactive systems and phone configurations for specialty care clinics.

[10] VHA Directive 1231(4), *Outpatient Clinic Practice Management*.

[11] VHA Directive 1217(1), *VHA Operating Units*, amended January 19, 2025.

Results and Recommendations

Finding: VHA Could Improve Veterans' Phone Access to Specialty Care Clinics by Ensuring Facilities Comply with Directives

Though veterans need timely phone access to specialty care clinics for managing appointments and care, the OIG found that many calls to these clinics went unanswered or experienced significant delays. This occurred due to inaccurate contact information on some facility directories and websites, interactive phone systems that did not direct calls to specialty care clinics, and ineffective phone management practices. Veterans' access to care is impeded when their needs are not addressed during their first call, as outlined in VHA Directive 1090.

Furthermore, the OIG determined from interviews and email correspondence that facility and national program office leaders were generally not aware that VHA call performance standards apply to specialty care clinics, since they are not specifically mentioned in the directive and generally only call centers would have performance data. However, the directive states that phone performance "applies to all service lines providing clinical care," and VHA officials agreed with the OIG team that the directive does include specialty care clinics.

Without reliable performance data and consistent oversight of calls to specialty care clinics to ensure timeliness and first-call resolution, facilities cannot sufficiently identify noncompliance with standards and take corrective action to improve how quickly and effectively they serve veterans phoning for specialty care.

What the OIG Did

To determine whether facility leaders made sure staff answered veterans' calls consistent with performance standards for timely access and first-call resolution, the OIG team first reviewed VHA criteria related to phone access for specialty care. The team also interviewed VHA's Specialty Care Program Office and Office of Integrated Veteran Care leaders—the program offices with oversight of medical specialty care and general access to care, respectively, at the time of this review. Other specialty care services may be under different program offices. The team selected a statistical sample of 15 facilities of the 132 with specialty care services from April 2024 through March 2025—which was the most recent data available at the time of analysis. For this sample, the team analyzed data on specialty care clinic appointment volumes and complaints from VA's patient advocate system. The team identified complaints related to unanswered calls using a broad, free text search that encompassed all clinical services at the 132 medical facilities. Of the 15 facilities, the team identified the six specialty care services with the highest complaints in VA's patient advocate system. Based on the ratio of patient complaints to specialty appointments, the team grouped the sample into 11 higher-complaint facilities and four lower-complaint facilities. By selecting from both categories, the team could assess whether

there were common impediments for higher-complaint facilities and identify lessons learned from lower-complaint facilities. The team visited facilities marked by an asterisk in the lists that follow.

The 11 higher-complaint facilities are ranked here by highest complaint ratio to lowest:

- Montgomery, Alabama
- Richmond, Virginia
- Washington, DC*
- Charleston, South Carolina
- West Haven, Connecticut
- Ann Arbor, Michigan
- Miami, Florida*
- Fresno, California
- Gainesville, Florida
- White River Junction, Vermont
- Albuquerque, New Mexico

The four lower-complaint facilities are listed by the lowest complaint ratio to fourth lowest:

- Palo Alto, California*
- Orlando, Florida
- Milwaukee, Wisconsin
- Las Vegas, Nevada

From November 2025 through February 2026, the team contacted all 15 facilities to learn about call operations and patient access issues at the clinics offering the six specialty care services identified: audiology, dental, mental health, optometry, podiatry, and radiology. The team visited three of the facilities, as noted above, to assess how these specialty care clinics managed incoming calls and addressed patient complaints about unanswered calls to clinics.

The team analyzed over 8,200 complaints about unanswered calls across the 15 facilities; the six specialty care services the team focused on were associated with 2,300 of those complaints. The team also reviewed data for 2.9 million call attempts and tested over 200 phone numbers (detailed in the section that follows) in November and December 2025.

Additional discussions were held with leaders from three program offices—VHA's Specialty Care Program Office, VHA's Office of Integrated Veteran Care, and OIT—throughout the project to discuss the results and potential causes of identified concerns. These leaders generally agreed with the preliminary results and recommendations during these briefings. See appendix A for more detail on the review's scope and methodology.

Accuracy of Contact Information for Specialty Care Clinics

Pursuant to 38 C.F.R. § 0.603 and VA's I CARE customer service principles, staff are expected to prioritize veterans' needs and ensure seamless access to health care. Access includes enabling veterans to contact or connect with clinics via phone. However, the OIG found that veterans could not always reach the selected specialty care clinics at the 15 reviewed facilities by phone because of inaccurate telephone numbers.

The OIG team called 219 phone numbers listed in either facility internal directories, which operators use to transfer veterans to specific clinics, or listed on facility websites (171 from the 11 higher-complaint-facilities and 48 from the four lower-complaint facilities). Of the 219 numbers tested, 78 (36 percent) were inaccurate (with 73 of the 78 inaccurate numbers coming from higher-complaint facilities). When calling the inaccurate numbers, the team either reached a different clinic, was automatically disconnected, or received an automated message stating the number was not in service. Veterans calling these numbers or operators transferring calls to these numbers could experience the same issue, preventing seamless access to the specialty care clinics.

As shown in table 1, the OIG's review of clinic call data from August 2024 through July 2025 for the six specialty care services found that of the over 2.9 million calls received, about 573,000 (about 20 percent) were to the 78 inaccurate phone numbers. Most of the inaccurate numbers were listed in the directories that operators use to transfer veterans to specific clinics.

Table 1. Veterans' Call Attempts to Inaccurate Phone Numbers for Specialty Care (by descending order of percentage of call attempts to inaccurate numbers)

Specialty care clinic type	Number of accurate phone numbers	Number of inaccurate phone numbers	Number and percentage of veterans' call attempts to the inaccurate phone numbers	Total call attempts by veterans
Mental health	26	19	364,000 (47%)	772,000
Radiology	52	24	93,500 (16%)	594,000
Optometry	17	12	71,200 (13%)	535,000
Audiology	15	11	26,300 (9%)	300,000
Podiatry	15	8	12,300 (3%)	383,000

Specialty care clinic type	Number of accurate phone numbers	Number of inaccurate phone numbers	Number and percentage of veterans' call attempts to the inaccurate phone numbers	Total call attempts by veterans
Dental	16	4	5,800 (2%)	346,000
Total	**141**	**78**	**573,000 (20%)**	**2,900,000**

Source: VA OIG testing of specialty care clinic phone numbers in November and December 2025 and analysis of Cisco Finesse call data from August 2024 through July 2025.

Note: Numbers in the table are rounded.

Of note, 63 percent of the inaccurate numbers and call attempts collectively occurred in the mental health (47 percent) and radiology clinics (16 percent). Both types of clinics serve high-risk patients who may require swift access and treatment for critical conditions. The OIG team identified several issues veterans reported in their complaints about being unable to reach these two clinical services by phone. According to complaints in the patient advocate system, some veterans waited on hold with the radiology clinic for up to 30 minutes or experienced continuous ringing for about 10 minutes before being disconnected. In one complaint, a veteran reported he needed to undergo "serious tests" but was given three different phone numbers for the radiology clinic by VA staff; all were incorrect, and he was unable to be transferred by the operator, who also lacked the correct number. Additionally, several other patient complaints indicated that veterans attempted to call the mental health clinic to schedule appointments, but the line would ring multiple times before automatically disconnecting.

Veterans at 13 of the 15 facilities reviewed also reported through the patient advocate system they could not reach staff by phone to schedule or change appointments, forcing them to drive to facilities in person. For example, a veteran reported difficulty reaching dental clinic staff despite several days of repeated phone call attempts. As a result, the veteran drove nearly 50 miles to the facility solely to schedule an appointment.

The OIG team observed this firsthand on multiple occasions while on-site at facilities in Miami, Florida, and Washington, DC, where the team heard veterans tell VA staff about their experiences. For example, in Washington, DC, the OIG team observed a veteran in the audiology clinic telling scheduling staff that after multiple unanswered phone calls, he decided to drive to the facility to make an appointment. Similarly, at the Miami facility, the OIG observed a veteran scheduling an appointment at the audiology clinic and telling staff he would need to visit the podiatry clinic in person to schedule an appointment there as well.

Facility Operators' Internal Directories

Of the 78 inaccurate numbers the OIG team identified from its sample of facilities, 67 were listed only on facility operators' internal directories.[12] The OIG team learned that VHA has no national policy requiring routine reviews or updates of its facility directories. Without mandated reviews, facilities relied on local procedures or practices to update directories, which often did not require regular accuracy checks or clearly assign responsibility for ongoing corrections.

Staff at three of the four selected facilities that had fewer complaints about phone access to specialty clinics said they sent updates as needed to their public affairs offices, which managed the directory centrally for each facility. One of these facilities also provided staff with a guide on who to contact and how to submit updates.

Leaders at nine of the 11 selected facilities with higher numbers of complaints told the OIG team that staff knew who to contact for updates. However, at one of those facilities (in Washington, DC), clinic staff, administrators, and managers the OIG interviewed said they did not know how to update directory information. At another facility (in Miami), staff maintained two separate directories: one updated by the facility librarian and another used by operators. But the operators' directory was not widely known nor integrated into the update process, resulting in outdated contact information. Half the phone numbers for the six clinics at the Miami facility were inaccurate, and all were in the operators' directory.

Facility Websites

The OIG team found that facilities did not always check phone numbers on their websites for specialty care clinics when performing the annual website review required by VHA Directive 6102.[13] Of note, inaccurate phone numbers on websites appeared only in the 11 higher-complaint facilities.

Six higher-complaint facilities in the OIG's review were associated with nine inaccurate specialty care clinic phone numbers listed on public websites. Leaders at three of these facilities said they lacked a formal way to update their websites, while the other three said a process was in place. However, the OIG found four of the nine incorrect numbers were at three facilities claiming to have a process.

During interviews at site visits to Washington, DC, and Miami, some clinic staff reported updating phone numbers by working with their public affairs office, while others were unsure whether any process existed. As was the case with internal directories at the facility in Washington, DC, clinic staff, managers, and administrators there said they did not know how to

[12] Another nine of the incorrect numbers were listed only on facility websites, and two were listed on both directories and websites.

[13] VHA Directive 6102, *Internet and Intranet Service*, August 5, 2019.

update website information. At the Miami facility, the public affairs office said clinics were responsible for notifying them of updates, but public affairs staff did not proactively request updates during annual website reviews, which may have contributed to inaccurate information remaining online.

By contrast, none of the four lower-complaint facilities had incorrect contact information on their websites. As a best practice, three of these facilities provided only the single main facility number, thus avoiding individual clinic numbers that might change and reducing the risk of errors. The other lower-complaint facility, in Palo Alto, listed individual clinic phone numbers on its website but had established strong processes to update the numbers as needed. Clinic staff from that facility told the OIG team they understood how to communicate updates and said the public affairs office conducted monthly website reviews and emailed specialty care clinics annually to confirm or update information.

The OIG team provided the 15 facilities reviewed with the 78 incorrect numbers, and the facilities indicated they would be corrected. As of April 2026, 11 of these facilities reported 43 of the numbers were corrected, such as by updating directories so veterans are not transferred to incorrect lines or by alerting public affairs staff to update an incorrect extension on a public web page. Further, a VISN reported that one facility stated in December 2025 it assigned specific staff to manage directory updates, set up quarterly accuracy checks, and share these changes during the facility's operational huddle.

Interactive Phone Systems

As noted, VHA Directive 1090 requires facilities to use interactive systems that guide veterans to the right clinic and resolve needs on the first call, for all service lines providing clinical care. This directive and its related VHA memo also require standardized menus with options for clinical services and require regular reviews to improve access and reduce delays.[14] The OIG found, however, that 11 of the 15 facilities did not have interactive systems that routed veterans directly to staff who could resolve their needs on the first call. Ineffective systems often were due to facilities not reviewing the interactive system prompts as required, not knowing they could add specialty care options, or not knowing they were required to review the systems periodically.

At eight of the 11 higher-complaint facilities, calls were generally routed to general scheduling queues or operators. Further, none of these eight facilities had interactive systems that could schedule at least five of the six specialty care services. The patient advocate system at these reviewed facilities showed veterans were frustrated with these interactive systems and did not

[14] Assistant under secretary for health for the Office of Integrated Veteran Care, "INFORMATIONAL: Veterans Integrated Service Network (VISN) Interactive Voice Response (IVR) Standardization and Coordination with VA Health Connect Clinical Contact Centers (VIEWS #10924531)," memorandum.

receive seamless assistance. For example, at the Miami facility, the interactive system did not include secondary prompts for specialty care clinics. Veterans who pressed "3" for scheduling reached staff who could not schedule appointments for mental health, audiology, dental, optometry, and radiology. Instead, these veterans were transferred to operators or to clinic numbers, and when clinics did not answer, calls looped back to operators or required veterans to call again. Scheduling staff often sent messages to clinic administrative staff to follow up, but it was unclear whether the clinic staff did so. This breakdown caused confusion about how to reach clinic staff, delays in accessing care, and frustration for veterans.

VHA Directive 1090 requires facility and regional staff to collaborate in reviewing and maintaining the interactive system. In addition, as noted earlier, VHA Directive 1231(4) requires clinical and administrative staff to work as a team to improve phone access, resolve issues quickly, and reduce delays in care. The OIG found that one facility's administrative chief did not appear to work with regional or clinic staff to review the automated system's effectiveness or ensure first-call resolution. That facility's administrative chief was also unaware of this issue because she had not reviewed patient complaints for trends or patterns, nor discussed phone access issues with facility administrative managers or clinic chiefs.

By contrast, three of the four lower-complaint facilities had interactive systems that could schedule at least five of the six specialty care services. These facilities used secondary prompts to connect veterans directly to those specialty care clinics, which improved first-call resolution, reduced transfers, and sped up scheduling and reaching staff for other reasons related to care management. For example, the interactive system at the facility in Milwaukee, Wisconsin, allowed veterans who pressed "2" for scheduling to choose which of the specialty care clinics to be routed to; this minimized transfers, improved efficiency, and reduced operators routing calls back and forth between clinics. Further, the OIG noted that proactive oversight and collaboration among leaders, administrative staff, and OIT staff at the Milwaukee facility helped the facility maintain compliance with VHA standards and improve performance for calls to specialty care clinics. These steps included information technology support to maintain the interactive system, updates to the system's routing and menu options, and annual reviews.

In response to the OIG review, as of May 2026, five facilities had updated their interactive systems, in addition to the four facilities that were already compliant. The other six facilities were still updating their interactive systems but had not completed the work. These facilities generally indicated updates were planned or in progress, but no verifiable interactive system functionality was available at the time of the OIG's review.

Specialty Care Clinic Phone Management Practices

Ineffective phone management practices at all 15 facilities reviewed (and for 54 of the 89 specialty care clinics reviewed) risked delaying or impeding veterans' access to care by not resolving their needs during the first call. Of the 141 phone numbers the OIG determined were

functional (of the 219 tested), 92 (65 percent) were answered by the correct clinic during testing, but the remaining 49 (35 percent) either continuously rang without a response or went directly to voicemail. All the calls that rang continuously were at the higher-complaint facilities, as shown in figure 2.

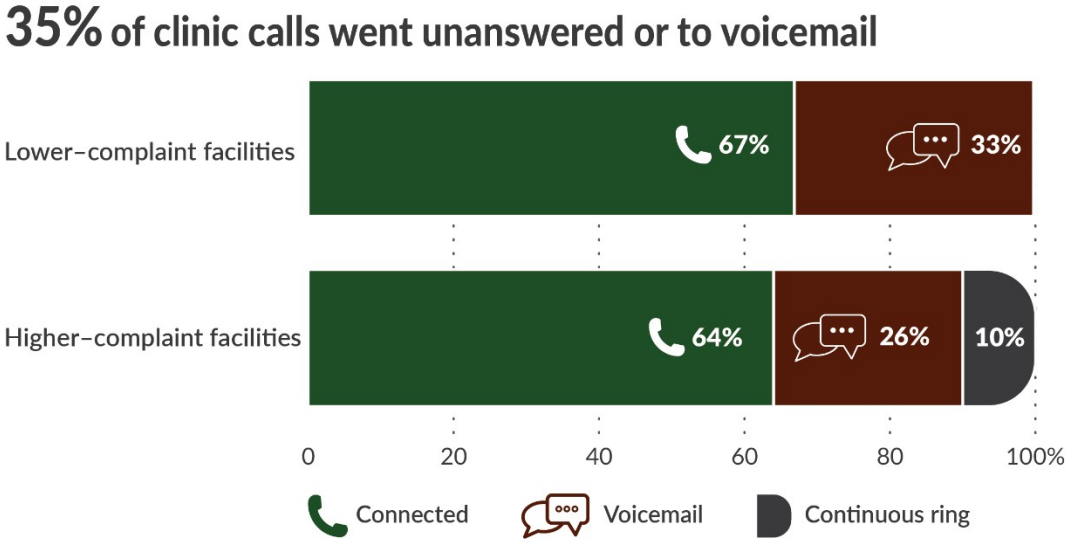

Figure 2. *Distribution of calls for lower- and higher-complaint sampled facilities.*
Source: VA OIG testing results for the specialty care clinics reviewed in November and December 2025.

Phone Configurations

Call issues occurred in part because of the way the specialty care clinics configured their phone systems. Facilities can use specialty care clinic shared lines, queues, or other methods to answer calls if they meet VHA standards. Whatever the configuration, facility leaders should have access to call performance data to monitor ongoing compliance with VHA Directive 1090.

The OIG found that as of January 2026, 13 of the 15 reviewed facilities had phone configurations using shared lines and individual extensions for some clinics, which are not trackable. As a result, those facilities did not collect data on the number of calls answered, the time it took to answer calls, and the number of calls abandoned at 54 of the 89 clinics. This left leaders at those facilities without essential call performance data to determine whether those standards were being met.

As shown in table 2, more than 1.3 million of the 2.9 million veteran call attempts from the OIG sample went untracked during the 12-month review period ending July 31, 2025. Of the untracked calls at the 54 clinics (in 13 facilities), about 468,000 were to radiology clinics, and

about 125,000 were to mental health clinics.[15] These two specialty care clinics, which serve patients at high risk of adverse health outcomes, faced significant challenges tracking call data. The OIG discussed with the VA Deputy Secretary and the under secretary for health in February 2026 how challenges with tracking call data affect VHA's ability to make sure veterans have swift access to specialty care, particularly for patients at high risk of adverse health outcomes such as veterans attempting to contact radiology or mental health clinics. For example, in March 2025, a veteran's spouse reported difficulty scheduling a critical radiology appointment for her husband who required evaluation for possible advanced cancer that may have spread. She reported making multiple phone calls that went to voicemail, with no follow-up within the promised 24 hours.

Table 2. Call Tracking for Six Specialty Care Services from the OIG Sample Facilities*

Specialty care clinic type	Veteran call attempts not tracked	Total veteran call attempts	Percentage of calls not tracked
Radiology	468,000	594,000	79%
Dental	229,000	346,000	66%
Audiology	184,000	300,000	61%
Podiatry	169,000	383,000	44%
Optometry	146,000	536,000	27%
Mental health	125,000	772,000	16%
Total	**1,300,000**	**2,900,000**	**45%**

Source: VA OIG analysis of Cisco call data from August 2024 through July 2025.

** "Veteran call attempts not tracked" are from the 13 facilities using shared lines and individual extensions for some clinics, which are not trackable. "Total veteran call attempts" are from the 15 facilities reviewed.*

Note: Veteran call attempt counts are rounded.

Meanwhile, 35 of the 89 specialty care clinics the OIG team reviewed (in the 15 facilities in the sample) reported having call queues that could track call performance metrics and share trends with facility leaders. The OIG team analyzed Cisco Finesse data provided by OIT and found that some of the 35 clinics did not store or collect data in this system, making it unavailable for OIG analysis. According to OIT officials, medical facilities did not store call data because there was no requirement to retain it for a set period, and their systems routinely overwrote old data with new data. However, the team identified 30 specialty care queues across the 35 clinics with usable

[15] VA OIG, *VHA Facilities' Collection and Oversight of Specialty Care Call Data*, Report No. 25-03621-68, February 19, 2026. Following the issuance of this preliminary advisory memorandum, the OIG verified in March 2026 an increase in clinics without trackable call data. There were 49 clinics with untrackable data reported in the memorandum, which increased to 54 (of 89) based on updated information provided by an OIT staff member.

data maintained by the facilities for the review, noting that some queues may have handled calls for multiple specialty clinics. Among these queues, abandonment rate and average speed of answer data were readily available and showed

- 21 (70 percent) met the abandonment rate standard (that is, fewer than 5 percent of calls went unanswered) and,
- on average, calls were answered within the 30-second speed-of-answer standard.

Though the OIG could not confirm that every queue answered calls for the six specialty services in the review, the results suggest that specialty care clinics with centralized queues are likely to meet performance standards. When clinics establish centralized queues, staff are assigned to focus solely on managing the queue and handling incoming calls. In contrast, clinics without centralized queues often rely on staff who split their attention between calls and other assigned duties. During a visit to the Washington, DC, facility, the OIG team observed staff at a specialty care clinic who let calls go unanswered because they were engaged in other duties, such as checking in patients for appointments. Clinics without centralized queues and designated staff may face greater challenges in managing calls efficiently.

As of January 2026, six facilities in the sample (Milwaukee; Montgomery; Orlando; Palo Alto; Richmond; and Washington, DC) reported to the OIG team that they planned to transition 19 specialty care clinics to queueing systems in fiscal year 2026 (which ends September 30, 2026). The review team confirmed that as of May 2026, 12 of these 19 clinics had established queues.

Voicemail Management

VHA Directive 1006.04(3) prohibits the use of voicemail for patient calls in primary care. The directive does not address or restrict voicemail use in specialty care clinics, and no other VHA policy prohibits it. Program officials confirmed that facilities are permitted to use voicemail for specialty care clinics.[16] However, VA lacks a national policy that outlines expectations for these clinics' use of voicemail. OIT also reported it did not have a way to easily track the number of voicemails specialty care clinics receive.

How clinics use and respond to voicemail affects seamless access to care for veterans as well as first-call resolution. Veterans' complaints documented in the patient advocate system often assert that calls go to voicemail, messages are not returned, and full voicemail boxes prevent them from leaving messages. Several facilities acknowledged these problems, and the OIG team directly experienced instances of calls going to voicemail while testing numbers during visits to facilities in Palo Alto and Washington, DC.

[16] VHA Directive 1006.04(3), *Clinical Contact Centers*, amended June 16, 2025.

Of the 15 facilities reviewed, 12 had at least one specialty care clinic that routed unanswered calls to voicemail. About 530,000 of the over 2.9 million call attempts (18 percent) for the six specialty care services at these facilities went to voicemail during the 12-month review period ending July 31, 2025.[17] Mental health, radiology, and dental clinics accounted for more than 70 percent of calls that went to voicemail.

Three lower-complaint facilities had clear expectations for staff to check and return voicemail within at least 24 hours. Three higher-complaint facilities also had their own voicemail policies. These three averaged about a third fewer patient complaints about voicemail during the review period than the six higher-complaint facilities without such processes.

The lack of both national policy and tracked voicemail data for specialty care clinics increased the risk of veterans' voicemails not being returned at all or not being returned in time to address their needs. In February 2026, in response to this review, OIT developed and launched a national dashboard that specialty care clinics can use to obtain voicemail data, making it easier for these clinics to view the number of voicemails received and retrieved. While this is a step in the right direction, without national guidance, facilities may not consistently follow up with voicemails within established time frames.

Oversight and Call Management Requirements

The OIG identified widespread gaps in compliance with VA oversight policies, which hindered the effective monitoring of specialty care call performance. Leaders from VHA's Specialty Care Program Office and the Office of Integrated Veteran Care—the program offices with oversight at the time of this review for medical specialty care and general access to care, respectively—told the OIG they misunderstood the scope of VHA Directive 1090 requirements for facilities to track phone metrics. Specifically, leaders from the Office of Integrated Veteran Care believed these requirements applied only to regional clinical contact centers, which focus on scheduling primary care and facility call centers because these centers were set up using queues with performance data from Cisco Finesse. This was because specialty care was not directly mentioned in the directive, and the program office had been focusing on clinical contact centers. However, after reviewing language in the directive that it "applies to all service lines providing clinical care," officials confirmed that these requirements applied to specialty care. The Specialty Care Program Office senior medical officer acknowledged this lack of awareness could mean facilities were also unaware of the requirements, which would limit monitoring.

The OIG briefed leaders in VHA and OIT in January 2026 and issued a preliminary results advisory memorandum in February 2026, informing these offices that 13 of the 15 facilities the

[17] During a site visit to the Washington, DC, facility, staff confirmed the use of voicemails for specialty care clinics, but the volume of voicemail data were not included in this analysis because the facility was on the Avaya phone system, through which the data were not available at the time of the review.

OIG team reviewed lacked required call performance data for specialty care.[18] In response to OIG briefings and initial findings, VA implemented several early corrective actions including facility-level efforts to update inaccurate phone numbers on websites and internal directories and adjust interactive automated prompts to add specialty care options. Facilities also had plans to add call queueing systems in fiscal year 2026 (ending September 30, 2026) instead of sending unanswered calls to voicemail. Also in February 2026, OIT developed and launched a national dashboard that provides facilities with the number of voicemails received and retrieved to improve oversight of specialty care voicemails.

As of May 2026, neither Directive 1090 nor Directive 1231(4) clearly assigned responsibility for monitoring call data, stated the frequency of reviews, or required action plans to address identified deficiencies. The absence of these details limits opportunities for meaningful corrective action and improvement in phone access for veterans. Leaders from both program offices said they relied on facilities to manage their own phone systems for specialty care clinics and agreed that the directives should be more comprehensive and clearer in assigning monitoring responsibility for call data.

At the facility level, the OIG found that, like the program office, most leaders were aware of the directive but were unaware that call performance standards applied to specialty care clinics because this was either not communicated clearly to them through the regional networks or they believed the directive only applied to call centers configured with queues to collect performance call data. As a result, some facilities did not collect required call performance metrics for specialty care clinics, which precluded leaders' ability to assess and continuously improve veterans' phone access.

The OIG team noted that all four facilities in the team's review that had received fewer complaints had their own established processes to monitor call performance for specialty care clinics. These included conducting anonymous caller audits, engaging process-improvement work groups, analyzing patient complaint trends, and holding regular discussions about call performance with regional network leaders. For example, at the Palo Alto facility, most specialty care clinic managers relied on monthly complaint trends from the patient advocate system to identify and address underlying issues. This approach, combined with quick coordination to resolve complaints, resulted in only eight complaints about phone calls during the 12-month review period.

In contrast, five of the 11 higher-complaint facilities in the team's review did not have local processes to monitor call performance for these clinics. For example, facility managers in Washington, DC, did not monitor whether calls were answered. At the Miami facility, managers tracked unanswered calls but lacked metrics for answered calls on timeliness and first-call

[18] VA OIG, *VHA Facilities' Collection and Oversight of Specialty Care Call Data*.

resolution. In addition to limited monitoring of call data, neither facility used complaint trends from the patient advocate system to identify issues, nor did they share complaints about phone calls with specialty care clinic leaders. In response to this report, some VISNs and facilities have reported implementing improvement efforts: for example, one VISN reported the Washington, DC, facility established a committee that reports to facility leaders and oversees phone operations and call performance.

Conclusion

The OIG determined that veterans' ability to access specialty care clinics by phone is hindered by inaccurate contact information for reaching clinics, ineffective interactive call-routing systems, and poor call management practices that resulted in unanswered calls and unmonitored voicemails. These issues are compounded by the lack of reliable call performance data (such as how quickly calls are taken) and oversight of first-call resolution. Leaders lack the information needed to identify gaps and take effective corrective action. However, some facilities demonstrated success in addressing callers' needs through maintenance of accurate directories, centralized queues, and structured voicemail procedures. These best practices are not instituted by all VA facilities or consistently implemented proactively. Without national guidance and monitoring, veterans seeking specialty care remain at risk of delays in accessing care, uncertainty about when they will receive care, and frustration when attempting to schedule and manage care, particularly for high-risk health conditions associated with radiology services and mental health treatment. The following recommendations are intended to continue VA's improvement for veterans and their families to prevent delays, uncertainty about when they will receive care, and frustration when attempting to schedule or manage specialty care by phone.

Recommendations 1–5

The OIG made five recommendations to the under secretary for health—who should work with OIT, as appropriate—to do the following:

1. Create a process for facilities to regularly update and verify specialty care clinics' phone numbers listed in internal facility directories and on websites.
2. Annually evaluate and verify that automated interactive phone systems route veterans directly to the correct specialty care clinic and assess whether the phone systems support first-call resolution.
3. Reconfigure specialty care clinics' phone lines to be able to collect required call performance data and assess whether centralized queues enhance the efficiency of phone management.
4. Provide guidance to specialty care clinics on how they should manage and respond to voicemails, including for routine reviews of voicemail data.

5. Provide guidance that assigns both the responsibility for and the frequency of routine monitoring of call performance data and analyses of complaint data trends from the patient advocate system to identify and address veterans' phone access issues for specialty care clinics.

VA Management Comments

In June 2026, the under secretary for health concurred with recommendations 1 and 2 and concurred in principle with recommendations 3 through 5. The under secretary submitted responsive corrective action plans to address each recommendation. These actions include creating an enterprise process for routinely updating specialty care phone numbers, establishing an annual review to ensure automated phone systems route veteran calls correctly, and conducting a joint VHA–OIT assessment to identify which specialty care phone lines to collect data from to assess call performance. VHA will also evaluate the systemwide role of voicemail to develop practical guidance that supports timely responses and will assess how call-performance data and patient advocate complaint trends can be integrated to identify veterans' access issues. All recommendations are targeted for completion in May 2027.

OIG Response

The OIG will monitor VHA's corrective actions and will close the recommendations once VHA provides sufficient evidence that it has strengthened its oversight processes and addressed the risks identified in this report. The full text of the under secretary for health's comments can be found in appendix B.

Appendix A: Scope and Methodology

Scope

The VA Office of Inspector General (OIG) conducted its work from November 2025 through May 2026. The review focused on a sample of incoming specialty care calls and patient complaints in the patient advocate system from August 1, 2024, through July 31, 2025 (the review period), at 132 facilities that provided specialty care.

Methodology

The OIG team identified and reviewed applicable VHA policies and guidance and interviewed VHA officials, including those from the Office of Integrated Veteran Care, to understand their roles and responsibilities in ensuring established performance standards were followed for calls to specialty care services.

To select the sample of facilities, the OIG statistically identified 132 facilities listed in the patient advocate system and that also provided specialty care from April 2024 through March 2025, which was the most recent data available at the time of analysis.[19] During that period, these facilities received about 33,000 patient complaints about unanswered calls, which the team obtained and reviewed from the patient advocate system. To identify the total number of patient complaints related to unanswered calls, the OIG conducted a broad free-text search using keywords such as unanswered, no response, and voicemail. This search encompassed all services, and was not restricted to specialty services for the 132 facilities.

To select a sample for detailed review, the team implemented a hybrid approach of statistical sampling and targeted (judgmental) selections. First, OIG statisticians calculated each facility's patient complaint ratio—the number of patient complaints per 10,000 completed specialty care appointments. They then selected facilities to ensure sampling and review of a wide range of complaint ratios. Five facilities had much higher complaint ratios, so were automatically included in the sample (categorized as "certainty,") and 10 facilities were selected to divide further by using a stratified, probability-proportional-to-size sampling approach:

- The 10 facilities were stratified into four quartiles (each representing a separate category) based on complaint ratios (from low to high).
- In each quartile, facilities were sampled with probability proportional to the square of each facility's number of appointments. From these quartiles,

[19] The OIG excluded the Atlanta facility because its specialty care clinic call operations were already assessed in a prior hotline review, and a report with recommendations was issued: VA OIG, *Atlanta Call Center Staffing and Operational Challenges Provide Lessons for the New VISN 7 Clinical Contact Center*, January 30, 2025. As of February 2026, the OIG agreed to close three of the four recommendations in that report.

statisticians chose two facilities for each of the two quartiles with lower ratios (quartiles 1 and 2) and three facilities each from the two quartiles with higher ratios (quartiles 3 and 4).

Table A.1 details the number of patient complaints and specialty appointments, the complaint ratio, and the complaint categories for the 15 facilities in the OIG's sample.

Table A.1. Classification of Selected Medical Facilities in OIG Sample (by the highest to lowest patient complaints per specialty care appointments)

Medical facility and location	Patient complaints*	Specialty care appointments completed	Patient complaints per 10,000 specialty care appointments	Complaint category
Central Alabama VA Medical Center–Montgomery (Alabama)	662	200,509	33	Certainty
Richmond VA Medical Center (Virginia)	1,582	493,883	32	Certainty
Washington VA Medical Center (District of Columbia)	1,220	428,091	28.5	Certainty
Ralph H. Johnson Department of Veterans Affairs Medical Center (Charleston, South Carolina)	1,134	490,333	23.1	Certainty
West Haven VA Medical Center (Connecticut)	883	406,274	21.7	Certainty
Lieutenant Colonel Charles S. Kettles VA Medical Center (Ann Arbor, Michigan)	558	369,585	15.1	Quartile 4
Fresno VA Medical Center (California)	310	223,393	13.9	Quartile 4
Bruce W. Carter Department of Veterans Affairs Medical Center (Miami, Florida)	509	457,250	11.1	Quartile 4
Malcom Randall Department of Veterans Affairs Medical Center (Gainesville, Florida)	744	806,255	9.2	Quartile 3
White River Junction VA Medical Center (Vermont) ‡	132	156,589	8.4	Quartile 3
Raymond G. Murphy Department of Veterans Affairs Medical Center (Albuquerque, New Mexico)	221	275,099	8	Quartile 3

Medical facility and location	Patient complaints*	Specialty care appointments completed	Patient complaints per 10,000 specialty care appointments	Complaint category
Clement J. Zablocki Veterans' Administration Medical Center (Milwaukee, Wisconsin)	239	441,378	5.4	Quartile 2
North Las Vegas VA Medical Center (Nevada)	253	502,356	5	Quartile 2
Orlando VA Medical Center (Florida)	278	813,916	3.4	Quartile 1
Palo Alto VA Medical Center (California)	54	393,963	1.4	Quartile 1

Source: VA OIG analysis of specialty care appointments and patient complaints from April 2024 through March 2025 using the most recent data available at the time of analysis from VA's Corporate Data Warehouse.

** Patient complaints are for all types of services and are not restricted to just specialty care.*

‡ The OIG team excluded dental services at the White River Junction VA Medical Center from the review because the facility does not offer this service; all dental services are handled by community care providers.

The OIG team also analyzed patient complaints for these 15 facilities to identify the top six specialty care services with over 250 reported complaints about not answering phones, as shown in table A.2.

Table A.2. Specialty Care Clinics with the Highest Complaints About Responsiveness, August 2024–July 2025

Specialty care type	VA care provided	Patient complaints
Dental	Comprises preventive, restorative, and surgical dental care	570
Radiology	Covers diagnostic imaging, computerized tomography, magnetic resonance imaging, ultrasound, and nuclear medicine procedures	401
Optometry	Includes eye exams, prescription glasses, low vision rehabilitation, and ocular disease management	385
Audiology	Comprises hearing evaluations, hearing aids, tinnitus management, and rehabilitative services at VA facilities	379
Podiatry	Involves foot and ankle care, including preventive, diagnostic, and surgical services	314

Specialty care type	VA care provided	Patient complaints
Mental health	Comprises inpatient and outpatient services to include individual and family services for conditions such as posttraumatic stress disorder, military sexual trauma, and depression	268

Source: VHA Directives 1121 and 1160.01; VHA Handbooks 11301.01(1), 1105.02, 1121.01; and 1122.01; and the OIG team's analysis of specialty appointments and patient complaints using data from the Corporate Data Warehouse.

After selecting the 15 medical facilities and the six specialty services, the OIG team analyzed data available from August 2024 through July 2025. The team examined call data from Cisco Finesse queues, when available, to assess whether facilities met performance standards for abandonment rates and timeliness. For facilities without established specialty care phone queues, the team worked with the OIG's Office of Data Analytics to obtain limited call data from VA's Corporate Data Warehouse, primarily using the TeleMate platform for the six specialty care services.

The team also verified contact information for 89 specialty care clinics across the 15 facilities reviewed. Using internal phone directories and website listings, the team called 219 numbers for the reviewed specialty care services in October and November 2025 to test their accuracy. Additionally, in January and February 2026, the team called each facility's main phone number to determine whether its interactive automated system directly connected callers to clinics in support of first-call resolution for the reviewed specialty care services.

To more fully assess whether medical facilities had established processes and effective oversight to meet performance standards for specialty care service calls, the team also visited three medical facilities, judgmentally chosen from the 15 facilities selected for review:

- Washington VA Medical Center (DC)
- Bruce W. Carter Department of Veterans Affairs Medical Center (Miami, Florida)
- Palo Alto VA Medical Center (California)

These three represented different regional Veterans Integrated Service Networks and had varying patient complaint ratios. During these visits, the team interviewed staff to understand existing policies and procedures and assessed operations to identify factors affecting responsiveness to specialty care calls for the six clinics. The team also followed up with the other 12 facilities from November 2025 through February 2026 to learn about call operations, policies, procedures, and patient access issues at specialty care clinics.

Internal Controls

The team assessed internal controls to determine whether they were significant to the review objective. This included consideration of the five internal control components: control environment, risk assessment, control activities, information and communication, and monitoring.[20] In addition, the team reviewed the principles of internal controls as associated with the objective and identified three components and four principles as significant.[21] The team identified internal control deficiencies during this review and proposed recommendations to address those listed in table A.3.

Table A.3. VA OIG Analysis of Internal Control Components and Principles Identified as Significant

Component	Principle	Deficiency identified by this review
Control environment	2. Exercise oversight responsibility	Most facilities reviewed did not perform oversight of specialty care call performance to identify phone access issues and initiate improvements when applicable.
	3. Establish structure, responsibility, and authority	VHA program officials, regional leaders, and some medical facility leaders interviewed were unaware of a requirement to monitor specialty care call metrics in established guidance. Additionally, some facilities did not establish processes to ensure directories and public phone numbers were correct and routinely reviewed for accuracy.
Control activities	10. Design control activities	Some facilities did not have phone systems that could track specialty care call performance; therefore, those facilities could not monitor their own data.
Monitoring	17. Evaluate issues and remediate deficiencies	VHA guidance did not clearly assign responsibility either for monitoring specialty care call performance or for addressing identified phone access issues. VHA guidance also did not establish to whom metrics should be reported, nor how often.

Source: VA OIG analysis of internal control components and principles. The principles listed are consistent with the Government Accountability Office's Standards for Internal Control in the Federal Government.

Data Reliability

The OIG team relied on computer-processed data obtained from the Cisco Finesse system, patient advocate system, TeleMate system, and Avaya phone system from August 2024 through July 2025. To determine the reliability of these data, the team performed tests to identify any

[20] Government Accountability Office, *Standards for Internal Control in the Federal Government*, GAO-25-107721, May 2025.

[21] Because the review was limited to the internal control components and underlying principles identified, it may not have disclosed all internal control deficiencies that could have existed at the time of this review.

errors, including missing data attributes, calculation errors, duplicate records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements.[22]

To validate call data, the team compared system call data to facility records when available, reviewed relevant documentation when obtainable, called phone numbers provided by the facilities to verify contact information, and reviewed the interactive system. The OIG team validated the contact information facilities provided by calling these numbers and providing facilities the results to confirm. The OIG team noted as part of the finding that call data were limited for specific phone configurations, and the team could not validate the limited call data from TeleMate and Avaya because facilities were not collecting this information. However, the OIG's recommendation 3 is meant to ensure facilities capture these data.

For patient advocate information, the OIG team provided patient complaint information to the reviewed facilities to confirm accuracy. The team did not identify any data issues and concluded that the Cisco Finesse, patient advocate, TeleMate, and Avaya data were sufficient and reliable to support the review's objective and conclusions.

Government Standards

The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation* (December 2020).

[22] Government Accountability Office, *Assessing Data Reliability*, GAO-20-283G, December 2019.

Appendix B: VA Management Comments, Under Secretary for Health

Department of Veterans Affairs Memorandum

Date: June 9, 2026

From: Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Report, Medical Facilities Management of Specialty Calls (VIEWS 14743128).

To: Assistant Inspector General for Audits and Evaluations (52)

1. Thank you for the opportunity to review and comment on OIG's report on Medical Facilities Management of Specialty Calls. Attached is the Veterans Health Administration's (VHA) action plan.
2. VHA greatly values the OIG's assistance in ensuring that all stakeholders are unified in supporting VHA's vision of providing all Veterans with access to the highest quality care. Your collaboration is instrumental in helping us achieve our commitment to excellence in health care services for Veterans.

The OIG removed point of contact information prior to publication.

(Original signed by)

John J. Bartrum, JD, MBA

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA) Action Plan

OIG Draft Report – Review of Medical Facilities' Management of Specialty Care Calls (OIG Project Number 2025-03621-AE-0143)

Recommendation 1: Create a process for facilities to regularly update and verify specialty care clinics' phone numbers listed in internal facility directories and on websites.

VHA Comments: Concur. Veterans Health Administration (VHA) will establish a high-level enterprise process for facilities to routinely update and verify specialty care clinic phone numbers in internal directories and on public-facing websites. VHA will confirm the national policy that governs contact information management and will coordinate with the responsible program office to ensure the guidance remains current and clearly defines expectations.

Using this policy, VHA will develop a flexible standard operating procedure (SOP) that outlines the standard process for facilities to validate and report updates while remaining adaptable during the reorganization. VHA will begin this work by conducting an enterprise-wide information refresh to collect accurate specialty care contact information from all facilities. VHA will also work with Public Affairs and the relevant operational and technical offices to determine how facilities will gather, verify, and submit updated information for inclusion in national systems. This structure strengthens and sustains routine, enterprise-wide verification of specialty care contact data.

Status: In Progress Target Completion Date: May 2027

Recommendation 2: Annually evaluate and verify that automated interactive phone systems route veterans directly to the correct specialty care clinic and assess whether the phone systems support first-call resolution.

VHA Comments: Concur. VHA will establish an enterprise process to annually evaluate and verify that automated interactive phone systems route Veterans to the correct specialty care clinic and support first-call resolution. VHA will convene a cross-functional workgroup to assess current practices and identify actions needed to ensure consistency across facilities, recognizing that medical centers maintain ownership of their Interactive Voice Response (IVR) systems. This workgroup will review existing standards and determine whether updates are necessary to address specialty care routing, sub-options, and related communication and education requirements. The team will also confirm the overarching policy and identify the appropriate program office to maintain the associated SOP as organizational roles evolve. VHA will establish a recurring annual evaluation and self-inspection process for facilities and will use available tools to monitor IVR performance and identify system changes. This approach strengthens routing accuracy, improves the Veteran experience, and supports consistent oversight across the enterprise.

Status: In Progress Target Completion Date: May 2027

Recommendation 3: Reconfigure specialty care clinics' phone lines to be able to collect required call performance data and assess whether centralized queues enhance the efficiency of phone management.

VHA Comments: Concur in principle. VHA concurs in principle because additional enterprise-level assessment is needed to fully understand current capabilities, operational variability, and the feasibility of standardizing specialty care phone line configurations across all medical centers. VHA and the Office of

Information and Technology (OIT) will conduct an enterprise assessment to understand how facilities currently use existing capabilities to collect call performance data and to determine the operational feasibility of reconfiguring specialty care phone lines across the system. The technical platform to support enhanced data collection already exists at all medical centers, so VHA will evaluate how facilities apply these capabilities, identify gaps, and ensure that any changes do not create unintended negative impacts on operations.

As part of this assessment, VHA will identify which specialty care lines require reconfiguration and will prioritize them based on call -demand data, performance metrics, and resource availability. This approach allows VHA to focus efforts on the most critical specialty areas first while recognizing enterprise--wide resource limitations. VHA will also consider the capacity limits of the current platform during joint VHA and OIT planning and will factor those limits into decisions about new queue designs. As VHA evaluates future cloud-based- platforms, it will assess how those solutions could support greater scalability.

VHA will review current configurations, confirm the relevant policy framework, and determine which national program office will maintain related guidance as organizational structures evolve. For potential centralized queue structures, VHA will work with the field to assess feasibility by identifying best practices, evaluating operational impacts, and testing approaches through controlled scope and scale efforts before considering broader adoption. This phased, data driven process will help VHA validate feasibility, maintain operational stability, and support the workforce throughout implementation.

Status: In Progress Target Completion Date: May 2027

Recommendation 4: Provide guidance to specialty care clinics on how they should manage and respond to voicemails, including for routine reviews of voicemail data.

VHA Comments: Concur in Principle. VHA concurs in principle because additional assessment is necessary to determine the appropriate enterprise role of voicemail in specialty care clinics and to ensure any guidance developed supports timely responses to veterans without creating unintended operational burdens for facilities. VHA will review and assess the role of voicemail in specialty care clinics to determine what guidance supports timely and consistent voicemail management. This assessment will evaluate how facilities currently use voicemail, identify available tools and capabilities within existing platforms, and determine whether VHA can establish enterprise expectations without creating unintended negative impacts on clinic operations. VHA will engage with the field to understand local practices, challenges, and resource considerations. Using this information, VHA will identify potential best practices, evaluate their applicability across diverse operating environments, and, when appropriate, test approaches through scope-and-scale efforts before considering broader implementation. This process will allow VHA to develop practical, balanced guidance that supports responsiveness to veterans while aligning with facility workflows and existing systems.

Status: In Progress Target Completion Date: May 2027

Recommendation 5: Provide guidance that assigns both the responsibility for and the frequency of routine monitoring of call performance data and analyses of complaint data trends from the patient advocate system to identify and address veterans' phone access issues for specialty care clinics.

VHA Comments: Concur in Principle. VHA concurs in principle because additional assessment is required to determine the appropriate system-wide approach for specialty care clinics and to ensure that any guidance developed supports timely responses to veterans without adversely affecting clinical operations. VHA will use the findings and decisions from Recommendation 3 to guide its approach for

monitoring call performance data. VHA will review information collected through patient advocate systems to determine whether complaint trends can align with call performance data to identify specialty care phone access issues. OIT will conduct a high level review of current processes to determine the optimal approach for transitioning call performance data to a centralized platform that supports enterprise level data integration and analysis. This approach will allow VHA to develop dashboards and other analytic tools that provide comprehensive insight into call data trends. VHA and OIT will assess current practices, available tools, and operational considerations that may affect the ability to integrate data sources. Using the results of this assessment, VHA will determine what guidance to issue regarding responsibility, monitoring frequency, and the appropriate use of patient advocate data in routine oversight. This method enables VHA to set expectations that are feasible, operationally sound, and aligned with system capabilities.

Status: In Progress Target Completion Date: May 2027

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

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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

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