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VETERANS HEALTH ADMINISTRATION

Review of Clinical Contact Centers to Assess Leadership and Oversight

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Executive Summary

In May 2020, the Veterans Health Administration (VHA) began the VA Health Connect modernization initiative to transform individual medical facilities' call centers into regionally managed units called clinical contact centers. These units are meant to expand veterans' access to care and services, better address a patient's reason for contacting VA the first time they call (known as first-contact resolution), and provide an improved experience for veterans.[1] The centers were required to integrate operations and provide veterans 24-hour access to four core services by December 31, 2021: primary care scheduling, pharmacy support, clinical triage, and virtual provider care.[2] VHA also established two key performance standards:[3]

- **Call abandonment rate.** No more than 5 percent of calls should go unanswered (that is, at least 95 percent of calls should be answered before a caller hangs up).
- **Timeliness.** At least 80 percent of primary care scheduling and pharmacy calls should be answered within 30 seconds (clinical triage should answer calls within 120 seconds).[4]

Organizationally, clinical contact center staff are managed by one of VHA's 18 Veterans Integrated Service Networks (VISNs); staff must answer any call and help veterans regardless of what medical facility a veteran is attempting to call within a regional network.[5] For this report, centers that successfully operate in this manner are considered *integrated*. Medical facilities and their outpatient clinics are required to route incoming calls for the core services to their VISN's clinical contact center.[6] VHA spent more than $197 million to upgrade the centers' telephone and clinical technology systems and spends over $3.9 million annually on software licenses that allow staff to easily schedule veterans' appointments or refill prescriptions across a network.

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[1] First-contact resolution helps connect veterans with services in a timely manner.

[2] In June 2020 and March 2021, the assistant under secretary for health for operations issued two memoranda to the VISN directors outlining the goals for the VA Health Connect initiative: "Veterans Integrated Service Network Clinical Contact Center Modernization," memorandum to VISN directors, June 15, 2020, and "Veterans Integrated Service Network Clinical Contact Center Expectations and Next Steps (VIEWS #04320748)," memorandum to VISN directors, amended March 11, 2021. In May 2022, the assistant under secretary for health for operations issued a directive outlining requirements for clinical contact centers: VHA Directive 1006.04(2), *Clinical Contact Centers*, last amended November 9, 2023. VHA formally refers to virtual provider care as "virtual clinic visits."

[3] *Veterans Health Administration* (*VHA) Clinical Contact Center Modernization Data and Metrics Guidance*, January 14, 2021 (not publicly accessible).

[4] For clinical triage's timeliness standard, 80 percent of calls should be answered within 120 seconds. VHA and industry standards formally refer to timeliness standards as "service level" standards.

[5] VHA divides the United States into 18 regional networks, or VISNs, that provide administrative and clinical oversight for the region's local facilities. For more information and a map detailing these geographic areas, see https://www.va.gov/HEALTH/visns.asp.

[6] VHA Directive 1006.04(2), *Clinical Contact Centers*.

The VA Office of Inspector General (OIG) conducted this review from October 2024 through July 2025, with a focus on operations during fiscal year (FY) 2024, to assess how well the VISNs established the four core services within their clinical contact centers and how much progress the primary care scheduling service made in meeting VHA performance standards and targets. The OIG focused on the clinical contact centers' scheduling and administration service because that operation directly affects veterans' ability to access primary care at all the network's medical facilities as well as virtual care at the contact centers.

The OIG reviewed criteria from VHA policy related to VA Health Connect implementation requirements, staffing, scheduling practices, and performance standards and interviewed officials from VHA's Office of Integrated Veteran Care (IVC). The review team analyzed 17 clinical contact centers' call and staffing data to determine the nature and extent of implementation and scheduling performance issues from October 1, 2023, through September 30, 2024 (FY 2024). The team also analyzed centers' action plans that were developed to meet FY 2024 scheduling performance standards.

Based on the OIG's review, the acting under secretary for health said VHA plans to improve the oversight of its clinical contact centers. For example, VISNs will be required to submit documentation of their progress toward fully integrating clinical contact center core services. IVC is also developing standard operating procedures for local phone queues at clinical contact centers and will add scheduler performance metrics to the FY 2026 VISN performance goals. The acting under secretary concurred or concurred in principle with the OIG's recommendations. The OIG agreed to close recommendation 4 based on actions VHA has already taken. The OIG found the action plans for all other recommendations acceptable and will monitor progress and close each recommendation when adequate documentation demonstrates sufficient implementation.

What the Review Found

VHA is currently taking action to consolidate and modernize its call centers, with the goal of a unified, veteran-centric service model. However, national data on scheduling, pharmacy, and clinical triage services showed, of these services, only clinical triage met VHA's call abandonment and timeliness standards in FY 2024.[7] Clinical triage was slightly below the 5 percent call abandonment standard, while pharmacy services were at an estimated 6 percent of calls abandoned and scheduling services were at an estimated 11 percent of calls abandoned. Neither scheduling nor pharmacy service met the timeliness standard, although clinical triage service met this standard with 82 percent of calls answered within 120 seconds.

[7] Virtual provider care was not included in the review team's analysis because this service does not directly receive calls. FY 2024 began October 1, 2023, and ended September 30, 2024.

While most clinical contact centers had all four services set up for telephone system and data consolidation at the VISN level by September 2022, most did not fully integrate their operations.[8] Nationwide, clinical contact center performance may be affected because most centers did not fully integrate their operations and some centers did not provide 24-hour pharmacy or scheduling services in FY 2024. Additionally, some medical facilities did not route some incoming calls to their regional contact center as required.[9] The review team also found that centers did not adequately oversee schedulers' performance to make sure veterans' calls were answered in accordance with VHA's performance standards.

Clinical Contact Centers Did Not Meet Scheduling & Pharmacy Performance Standards in FY 2024

Looking at all call center data, the review team found that primary care scheduling and pharmacy support services did not meet VHA's 5 percent standard for the call abandonment rate in FY 2024; however, clinical triage services met both standards.[10] Clinical triage was slightly below the 5 percent call abandonment standard, while pharmacy services were at an estimated 6 percent of calls abandoned and scheduling services were at an estimated 11 percent of calls abandoned. Neither the scheduling nor pharmacy services met the timeliness standard, although clinical triage was able to meet this standard with about 82 percent of calls answered within 120 seconds.

Most Clinical Contact Centers Did Not Integrate Medical Facilities' Call Activities

VHA policy requires a VISN integration model for the core services to best resolve a patient's issue during their first call, and the model should reduce the number of staff needed to answer calls VISN-wide.[11] But of the 17 clinical contact centers included in this review, the OIG found that 12 (71 percent) had not integrated their operations for scheduling services, pharmacy services, or both—and staff primarily answered calls only for their assigned medical facility.

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[8] A fully integrated clinical contact center manages data and staff at the VISN level, standardizes processes, and provides 24-hour services. VISN 4 and VISN 12 had three of four services operational by September 2022 and launched the remaining service by April 2024. Of the 18 VISNs, the OIG team did not review VISN 7 because it had not consolidated its facility telephone system and call data to the VISN level until March 2024; therefore it was not in the scope of the review. Further, the OIG issued a report with recommendations to assist the VISN 7 clinical contact center once it became operational. 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. See appendix A for a summary of the team's findings across all 17 VISNs reviewed.

[9] VHA Directive 1006.04(2).

[10] Virtual provider care was not included in the review team's analysis because this service does not directly receive calls. FY 2024 began October 1, 2023, and ended September 30, 2024.

[11] VHA Directive 1006.04(2). Clinical contact center staff are required to be managed at the VISN level rather than at the medical facility level.

Integrated centers use a standard appointment scheduling process to schedule veterans in any facility across a VISN, while nonintegrated centers assign staff to specific facilities and they can schedule appointments only for their assigned facility. As a practice, staff at these nonintegrated centers are not expected to handle calls for other facilities in their VISN, which may increase veterans' call wait times and delay first-contact resolution and veterans' access to care. Most VISN directors and clinical contact center directors state that a barrier to full integration with pharmacy and scheduling services is the lack of agreement at some facilities to standardize either pharmacy practices or scheduling practices and to use an updated clinical technology system.

According to VA's recommended staffing model, integrating services and managing staff at the VISN level reduces the number of staff required at clinical contact centers. Based on this model, the review team estimated that the 12 clinical contact centers whose scheduling and pharmacy services were not integrated would need 200 fewer staff if they integrated these services, which would reduce staffing costs by about $17.3 million.[12]

Some Centers Did Not Provide Veterans 24-Hour Access to Scheduling or Pharmacy Services

The review team found that all 17 clinical contact centers reviewed provided 24-hour coverage for clinical triage in FY 2024, but three centers did not provide 24-hour access to scheduling, as required by VHA policy.[13] Although 24-hour pharmacy coverage is not required, only two of the 17 clinical contact centers did not provide after-hour pharmacy services; the acting assistant under secretary for health for IVC, the program office that oversees the clinical contact centers, agreed that there could be other opportunities to extend after-hours pharmacy care to veterans.

In FY 2024, the three VISNs with clinical contact centers that did not provide 24-hour scheduling answered only about 11 percent of the estimated 83,200 calls they received outside business hours.[14] The centers' directors said they stopped providing 24-hour coverage due to low staffing and low call volume after hours or to focus on meeting performance standards during business hours. IVC officials told the review team they were aware these centers were providing inadequate coverage and met with the clinical contact center leaders to discuss their action plans to address this issue. As of July 2025, these three centers were not providing 24-hour scheduling service for veterans.

Veterans who called after hours to the two clinical contact centers that did not provide 24-hour pharmacy services could use an automated system to refill prescriptions; otherwise, all pharmacy

[12] See appendix B for more on the review team's methodology, and see appendix C for a discussion of monetary benefits.

[13] VHA Directive 1006.04(2).

[14] For the purposes of this report, the review team considered business hours to be 7:00 a.m. to 6:00 p.m. Monday through Friday (based on the clinical contact centers' FY 2024 call volume).

calls were automatically disconnected after a brief message saying the pharmacy was closed. In FY 2024, about 55,900 after-hours pharmacy calls were not answered at these two centers.

Some Facilities Answered Calls That Should Have Been Handled by the Clinical Contact Centers

Twenty-four medical facilities within 12 VISNs did not route scheduling and outpatient clinic calls to their clinical contact centers and instead used facility staff to handle calls for 157 local phone queues.[15] Although there may be reasons for local queues, answering the calls waiting in these queues took facility staff's time away from answering internal phone lines and doing other assigned duties such as checking patients in for appointments. Facility staff did not answer about 222,000 of 2.3 million calls in FY 2024, resulting in an abandonment rate of about 10 percent (double the standard). Most center directors were unaware these medical facilities were operating local queues; as of June 2025, some queues had been deactivated and transferred to the clinical contact center, while other queues remained locally operated for various reasons.

Strengthened Oversight of How Schedulers Handle Time and Availability Would Improve Performance

Scheduling directly affects veterans' ability to access primary care at their VISN's medical facilities. In examining scheduling in FY 2024, the review team found that only three of the 17 clinical contact centers reviewed met the call abandonment rate and timeliness performance standards. The other 14 centers had an average abandonment rate of about 13 percent (8 percentage points over the standard) and answered on average only about 57 percent of their calls within 30 seconds (23 percentage points below the standard).

The centers said they focused on meeting the abandonment rate and timeliness standards, which were included in IVC's annual performance standards. But access to scheduling and administration services at the centers also depends on the availability of schedulers to answer calls. Most centers did not focus on schedulers' handle time—that is, the time spent on a call plus after-call work, such as updating a veteran's electronic health record—nor did they focus on the amount of time schedulers were unavailable to take calls. Handle time and availability, therefore, affected abandonment rates and timeliness.

In FY 2024, all schedulers were expected to maintain an average handle time of no more than eight minutes.[16] But clinical contact centers may not always be adequately monitoring schedulers' handle times. The review team found that at the three clinical contact centers that

[15] VHA Directive 1006.04(2).

[16] When the clinical contact centers were established in 2021, each center was required to set its own handle-time target. By April 2023, IVC set eight minutes as the handle-time target for all clinical contact centers. IVC updated the guidance on April 9, 2025, removing the eight-minute target because it believed centers should establish this measure at the VISN level.

met both performance standards, only about 9 percent of schedulers had an average handle time greater than the eight-minute target. By contrast, at the 14 centers that did not meet the performance standards, about 28 percent of schedulers exceeded the eight-minute target. In particular, 82 schedulers (about 12 percent) had average handle times of 15 minutes to 36 minutes.

Most supervisors at the 14 clinical contact centers that did not meet performance standards did not closely monitor handle time, and most leaders did not include this target in the schedulers' performance plans in FY 2024. Supervisors and schedulers said handle time varied by call and they did not want to limit the amount of time helping veterans. Others were simply unaware of VHA's handle-time target. Meanwhile, at the centers that met both performance standards, supervisors used various methods—such as training—to help schedulers lower consistently higher handle times.

Regarding availability, VHA policy generally requires schedulers across all the clinical contact centers' services to be available at least 70 percent of their workday to serve veterans, or to not exceed 30 percent of total time unavailable.[17] Across all centers, the number of schedulers unavailable more than 30 percent of their workdays varied from zero to over 30.[18] At the centers that met VHA's performance standards, only one of the 564 schedulers exceeded 30 percent unavailability. Meanwhile, at the centers that did not meet VHA's performance standards, about 5 percent (122 of 2,359 schedulers) exceeded that target. These 122 schedulers accounted for about 19,900 hours of excessive unavailability—equivalent to more than nine full-time schedulers working an entire year without handling a single call.[19] Had the schedulers been available in this time, they would have been able to answer up to an additional estimated 177,800 calls from veterans.[20] The review team determined management and oversight practices were inconsistent across the VISNs, and centers that actively reviewed availability and included it in scheduler performance plans were generally more likely to meet performance standards than centers that did not. Differences in performance expectations across VISNs may also be attributed to IVC releasing contradictory expectations for schedulers' performance in August 2022—which allowed schedulers to receive a successful evaluation if they demonstrated an 18–35 percent unavailability even though existing guidance set a target of 30 percent unavailability.

[17] *VHA Clinical Contact Center Modernization Data and Metrics Guidance*.

[18] Four centers had zero schedulers unavailable for more than 30 percent of their workday.

[19] The review team calculated excessive unavailability by analyzing the ready status of schedulers at each VISN, identifying schedulers who were in a "not ready" status for more than 30 percent of their total time logged into the phone system, and calculating the difference between their actual time in "not ready" status and 30 percent of their total time logged into the phone system. The review team included schedulers that took calls for at least 30 days during FY 2024.

[20] Since schedulers took an average of six minutes and 42 seconds to handle calls, they should have been able to handle about 177,800 calls in the estimated 19,900 hours of excessive unavailability.

IVC Recently Implemented a Waiver Process

In FY 2024, IVC relied on the clinical contact centers' action plans to determine whether centers were complying with VA Health Connect requirements. In response to a national waiver policy, IVC implemented a waiver process in December 2024 for centers to request a temporary exemption from compliance, such as not integrating operations or not providing 24-hour services.[21] IVC's updated waiver policy does not specify the type of information or data that should be included as part of the waiver applications nor does it require VHA's chief operating officer, who oversees the VISNs, to periodically review waivers. As of April 2025, IVC had rejected three centers' waiver applications because the applications lacked sufficient data and evidence demonstrating the need for a waiver.

What the OIG Recommended

The OIG made nine recommendations to the under secretary for health: (1) require VISN directors to fully integrate core services; (2) require medical facility directors to coordinate with IVC and the clinical contact centers on any local phone queue for services the clinical contact center provides; (3) direct clinical contact center leaders to determine if schedulers are arbitrarily ending calls in the telephone system to reduce the number of calls routed to them; (4) require IVC to review guidance and address inconsistencies about schedulers' availability; (5) direct clinical contact center leaders to routinely evaluate and address schedulers' handle time and availability; (6) direct IVC to include schedulers' handle time and availability as part of VA Health Connect's annual performance standards; (7) make sure IVC and the chief operating officer reallocate scheduling staff as needed so all centers provide core services and meet required performance plans; (8) direct IVC to formalize and clarify internal waiver guidance and include examples of the specific evidence needed; and (9) ensure the assistant under secretary for health for IVC and the chief operating officer periodically review waiver submissions and the planned actions to comply with VA Health Connect requirements.[22]

VA Management Comments and OIG Response

The acting under secretary for health concurred with recommendations 1 through 6 as well as 8 and 9; concurred in principle with recommendation 7; and provided an action plan for each recommendation. The full text of the acting under secretary's comments appears in appendix D.

The OIG agreed to close recommendation 4 based on the actions taken. The OIG found the action plans for all other recommendations acceptable and will monitor progress and close each

[21] IVC said it implemented this waiver process because VHA released a national policy for waivers in March 2024. VHA Directive 1023, *Waivers to VHA National Policy*, March 5, 2024.

[22] The recommendations addressed to the under secretary for health are directed to anyone in an acting status or performing the delegable duties of the position.

recommendation when adequate documentation demonstrates sufficient implementation steps have been taken.

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Contents

Abbreviations

FY	fiscal year
GAO	Government Accountability Office
IVC	Office of Integrated Veteran Care
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

Historically, individual medical facilities in the Veterans Health Administration (VHA) operated call centers during business hours based on local business models to provide services to veterans. VHA is taking action to consolidate and modernize its call centers, with the goal of a unified, veteran centric service model. In May 2020, VHA began the VA Health Connect initiative to transform individual facilities' call centers into regional units called clinical contact centers. The goal was to standardize facility call center operations nationwide and provide veterans access to services 24 hours a day.[23] The clinical contact centers are managed by VA's 18 regional Veterans Integrated Service Networks (VISNs) and are intended to effectively and efficiently assist callers, reduce patient wait times and delays in care, and promptly direct veterans to the medical care they need.[24] The initiative had an implementation deadline of December 31, 2021, for the clinical contact centers to establish four core services available to veterans VISN-wide.[25] Each center is required to

- schedule primary care visits and respond to general inquiries;
- provide veterans with pharmacy services, including renewing and refilling medications;
- provide clinical triage where patients can talk to a registered nurse about symptoms and concerns and receive recommendations for healthcare needs; and
- refer veterans for virtual provider care that allows patients to conveniently talk with clinicians by phone, video, or chat to discuss healthcare needs.[26]

[23] 38 U.S.C. § 7301(b). "The primary function of the [Veterans Health] Administration is to provide a complete medical and hospital service for the medical care and treatment of veterans, as provided in this title and in regulations prescribed by the Secretary pursuant to this title." In June 2020 and March 2021, the assistant under secretary for health for operations issued two memoranda to the VISN directors outlining the goals for the VA Health Connect initiative: "Veterans Integrated Service Network Clinical Contact Center Modernization," memorandum to VISN directors, June 15, 2020, and "Veterans Integrated Service Network Clinical Contact Center Expectations and Next Steps (VIEWS #04320748)," memorandum to VISN directors, amended March 11, 2021. In May 2022, the assistant under secretary for health for operations issued a directive outlining requirements for clinical contact centers: VHA Directive 1006.04(2), *Clinical Contact Centers*, last amended November 9, 2023.

[24] VHA divides the United States into 18 regional networks, or VISNs, which provide administrative and clinical oversight for the region's local facilities. For more information and a map detailing these geographic areas, see https://www.va.gov/HEALTH/visns.asp.

[25] Assistant under secretary for health for operations, "Veterans Integrated Service Network Clinical Contact Center Expectations and Next Steps (VIEWS #04320748)," memorandum to VISN directors, amended March 11, 2021.

[26] VHA Directive 1006.04(2). VHA formally refers to virtual provider care as "virtual clinic visits."

The VA Office of Inspector General (OIG) conducted this review to assess how well the VISNs established the four core services in their clinical contact centers and how much progress the primary care scheduling services made in meeting VHA performance standards and targets.

Clinical Contact Center Operations

Clinical contact centers should operate at the VISN level to expand veterans' access to care and services, maximize first-contact resolution, and provide an improved veteran experience. When a veteran calls the local VA medical facility or outpatient clinic (or the VISN clinical contact center toll-free number), an automated system then answers the call and presents the caller with several options. The system then routes the call to one of three required core services (except virtual care, which requires an appointment) at the center.[27] Center staff then answer incoming calls to provide first-contact resolution, which means the clinical contact centers should address a patient's reason for contacting VA during the initial call, which helps to connect veterans with services in a timely manner. Figure 1 shows how veterans can select services during a call.

[27] VHA Directive 1006.04(2). For schedulers to schedule virtual care appointments, clinical triage staff routed calls from clinical triage service to the scheduling service.

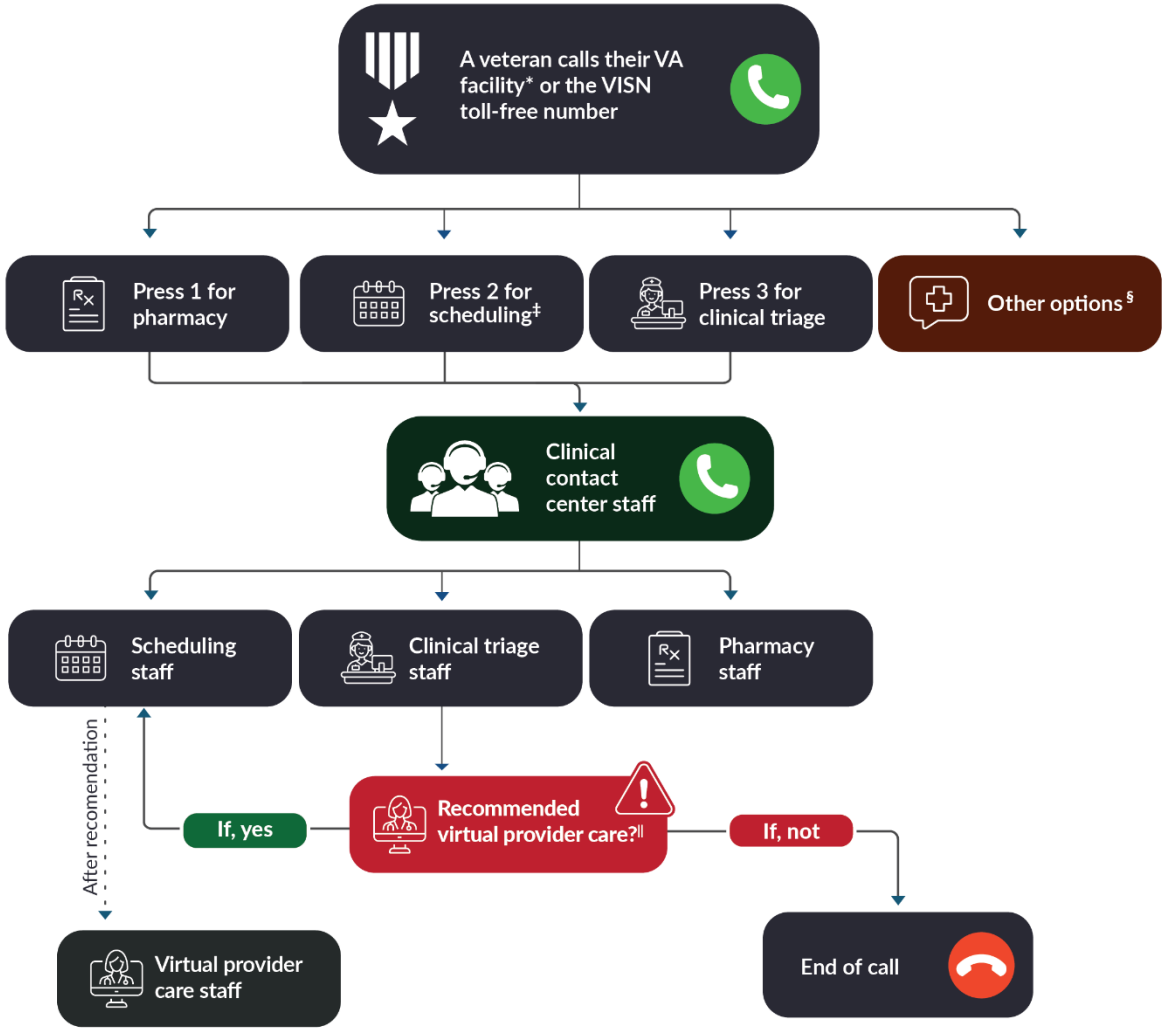

Figure 1. *Veterans' access to clinical contact center services.*

Source: Clinical Contact Center Office of Information and Technology Playbook and VA Health Connect Guidebook.

** VA facilities include outpatient clinics.*

‡ Primary care scheduling and administration service.

§ Other options include speaking to a facility operator. Facility operators assist with connecting veterans to other staff or departments at a VA medical facility.

|| Clinical triage staff may also transfer or recommend a veteran to emergency services.

VHA initially spent almost $2 million to upgrade its telephone infrastructure at each clinical contact center so they could answer calls from any VISN facility; annually, VHA spends another

$2.6 million for the telephone infrastructure licenses.[28] VHA also spent over $195 million to use a scheduling management application, which enables center staff to schedule appointments or refill prescriptions across a VISN.[29] In fiscal year (FY) 2024, VHA spent another $1.3 million for licenses to use this application.

To determine staffing levels at each center, VISNs use the Erlang-C calculator (referred to in this report as the staffing model).[30] The staffing model considers variables such as the number of incoming calls in a given time, the amount of "shrinkage" (such as time off, breaks, meetings attended by center staff), the target average answer speed, and the target call abandonment rate (that is, the percentage of incoming calls that are not answered).[31] Clinical contact center staff work from medical facilities or remotely but are organizationally managed under their respective VISN.[32] In FY 2024 (the OIG's review period), clinical contact center staff worked primarily remotely, with a few exceptions at certain facilities.[33]

Organizationally, clinical contact center staff must be managed at the VISN level and provide support across their regional network. For the purposes of this report, clinical contact center staff who answer any call and help veterans regardless of what facility a veteran is trying to call are working in an *integrated center*. VISNs with integrated centers use the scheduling management application so staff can easily access veterans' information as well as information from any facility within that VISN. Furthermore, integrated centers maintain a standard appointment scheduling process that enables staff to easily schedule veterans in any facility across the VISN, as required by

[28] The upgraded telephone infrastructure, which includes hardware and software components, combines computing, networking, storage, software, and automation capabilities into a single system that allows for management across VISNs. VHA paid $450 per clinical contact center employee for annual technology licenses. VHA reported the centers had over 5,800 staff with technology licenses during FY 2024, at a cost of $2.6 million. Between this $2.6 million for technology licenses and the $1.3 million for licenses to use the scheduling and prescription filling application, VHA spent a total of about $3.9 million on software licenses in FY 2024 ($2.6 million plus $1.3 million). With the upgraded telephone infrastructure and scheduling management application, VHA spent a total of about $197 million ($2 million plus $195 million).

[29] The Customer Relationship Management application is intended to modernize the clinical contact centers' scheduling operations. The primary goal is to consolidate existing facility business practices under one umbrella, allowing staff to easily obtain veterans' information across the country. *Salesforce Veterans Affairs Health Connect Customer Relationship Management*, August 23, 2022.

[30] *VA Health Connect Guidebook*, release No. 9, November 2023.

[31] Variables used in the Erlang-C calculator include number of incoming calls, length of time call center operates per day, target handle time, target answer time and the respective percentage of calls answered in that target time, maximum occupancy of staff, shrinkage, average patience (the expected time a caller will wait before hanging up), working hours per week, and reporting interval. *VA Health Connect Guidebook*.

[32] *VA Health Connect Guidebook*.

[33] The review period was October 1, 2023, to September 30, 2024, or FY 2024. In accordance with the "Return to In-Person Work" executive order (Federal Register No. 2025-01907), signed January 20, 2025, all employees under the executive branch of the federal government needed to return to in-person work as soon as possible. This executive order allowed for exemptions by department and agency heads; the Office of Integrated Veteran Care (IVC) asked for a waiver on March 13, 2025, and on May 23, 2025, the Office of the Chief Operating Officer approved the return-to-in-person-work exemption for clinical contact centers.

VHA policy.[34] By contrast, a *nonintegrated center* assigns staff to specific facilities, and they can schedule appointments only for their assigned facility.

Performance Standards and Targets

VHA's Office of Integrated Veteran Care (IVC) has performance standards and targets to ensure efficient operations at all VISN clinical contact centers.[35] IVC has policies that centers should follow to fully implement the VA Health Connect initiative in addition to integration, such as 24-hour coverage.[36] Centers are also encouraged to partner with other VISNs to provide the required 24-hour coverage.[37] Table 1 lists the primary standards and targets and their operational definitions outlined in VHA's guidance.[38]

Table 1. Performance Standards and Targets for Clinical Contact Centers

Performance category	Operational definition	Metric*
Standard: Call abandonment rate	Percentage of calls terminated by the caller before being answered	5% or less per year
Standard: Timeliness	Percentage of calls answered within the average speed-of-answer goal (30 seconds or less for schedulers and pharmacists or 120 seconds or less for clinical triage service)	80% or higher per year
Target: Agent availability	Percentage of time staff should be available to answer calls	70%
Target: Handle time‡	Average time staff spend on a single call, comprising time on the phone, hold time, and after-call work§	8 minutes for scheduling

Source: VHA Clinical Contact Center Modernization Data and Metrics Guidance.

* *These standards do not apply to virtual care because that service does not receive calls.*

‡ *Each clinical contact center was required to establish its own handle-time metric until April 2023, when IVC set handle-time metrics for the three services that receive calls (primary care scheduling, pharmacy support, and clinical triage). While each service had a set handle-time metric in FY 2024, for the purposes of this review the team focused on the eight-minute handle-time metric for scheduling.*

§ *After-call work includes documenting and summarizing the call in VA's electronic health record system and forwarding the record to the caller's primary care physician.*

[34] VHA Directive 1006.04(2).

[35] *Veterans Health Administration (VHA) Clinical Contact Center Modernization Data and Metrics Guidance*, January 14, 2021 (not publicly accessible). IVC is discussed in the "VHA Governance Structure and Responsibilities" section.

[36] VHA Directive 1006.04(2).

[37] VHA Directive 1006.04(2).

[38] According to IVC, most of the standards are based on industry call center standards.

For the purposes of this report, the team defines the national abandonment rate and timeliness requirements as performance *standards*, and handle time and availability are considered *targets* because they affect the performance standards but are not specifically required.

Performance Improvement Process

As of March 2025, clinical contact centers continued to implement VA Health Connect requirements. IVC has established multiple mechanisms to help VISNs and centers improve compliance with policies and performance, including initiative requirements and an annual performance improvement process.

Each fiscal year IVC develops annual performance plans by selecting specific policy requirements, performance standards, and targets for clinical contact centers to meet that fiscal year.[39] For the annual performance plans, centers should either meet expectations or improve their performance by a certain percentage that fiscal year.[40] For example, clinical contact centers are expected to achieve the abandonment rate and timeliness metrics or improve their performance on those metrics by at least 10 percent over their previous year's performance.[41] At the end of the fiscal year, each clinical contact center is required to attest to IVC whether it met VA Health Connect requirements and annual performance plans.[42] Centers that did not meet the initiative requirements or meet or improve metrics in the performance categories must provide an action plan for the areas of noncompliance and submit an updated six-month status to IVC.[43]

For FY 2023, the performance plans included VISN integration, 24-hour coverage, and the performance standards (abandonment rate and timeliness) and included staff availability as a target. For FY 2024, IVC focused on the abandonment rate and timeliness performance standards but did not specifically include integration, 24-hour coverage policy requirements, or the staff

[39] IVC formally refers to the performance plan as "Performance Objectives."

[40] The fiscal year performance plans have nine areas, including achieving key metrics, conducting call recording reviews, coaching, and having one quality management employee assigned to each center. The team focused on the requirements only in the key metrics section due to their effect on the clinical contact centers' operations and the provision of timely access to veterans.

[41] VHA and the call center industry formally refer to the timeliness standards as "service level" standards.

[42] VHA Directive 1006.04(2).

[43] IVC, *FY 2024 VISN Clinical Contact Center Attestation* (not publicly accessible).

availability target.[44] According to an IVC official, that was because VISNs still had to attest to compliance with these three initiative requirements.[45]

IVC holds an annual meeting with clinical contact center leaders at noncompliant VISNs so officials can discuss the action plans and the steps to achieve compliance and improve performance. In FY 2024, IVC met with each center's leaders regularly (and as needed) to discuss performance data, compliance with VHA policies, action plans, and strategies to improve performance. IVC also held weekly meetings with clinical contact center staff to discuss clinical contact center operations, distributed weekly newsletters to keep center staff up-to-date, and held recurring "lunch and learn" meetings on various topics, including reviewing performance and associated data, to help the clinical contact centers.

FY 2024 Performance for the VA Health Connect Initiative

IVC reported that in FY 2024, clinical contact centers improved performance over FY 2023 by answering about two million more calls, lowering call abandonment rates by 2 percentage points, and reducing the average answer time by 26 seconds. Figure 2 breaks down VHA's reported data and shows how VA Health Connect improved in FY 2024.

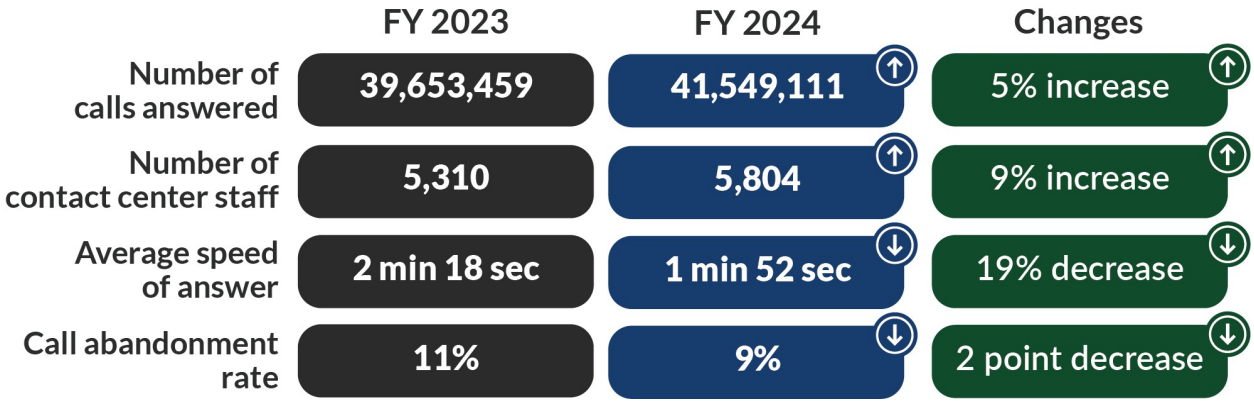

Figure 2. *VA Health Connect data for FYs 2023 and 2024.*

Source: IVC reported analysis of FY 2023 and FY 2024 VA Health Connect data.

[44] For FY 2025, IVC continued its focus on the call abandonment rate and service timeliness standards as well as determining whether clinical contact centers met the metrics or improved their performance by 10 percent over the previous year. VA Health Connect FY 2024 and FY 2025 VISN performance plans (not publicly accessible); VHA Directive 1090, *Telephone Access for Clinical Care*, September 20, 2023; VA Health Connect FY 2023 and FY 2024 VISN performance plans (not publicly accessible).

[45] An official said IVC removed these initiative requirements because it wanted more emphasis on quality control management and as noted there was a designated process for clinical contact centers to attest to compliance for integration and 24-hour coverage.

VHA's call data showed that in FY 2024, the 17 clinical contact centers reviewed received about 45 million calls.[46] Of the core services, scheduling received the most calls at about 24.4 million (54 percent), followed by pharmacy with around 13.7 million (30 percent), and clinical triage with about 6.9 million (15 percent). Figure 3 shows the distribution of FY 2024 calls for the three core services that directly receive calls: primary care scheduling, pharmacy support, and clinical triage.[47]

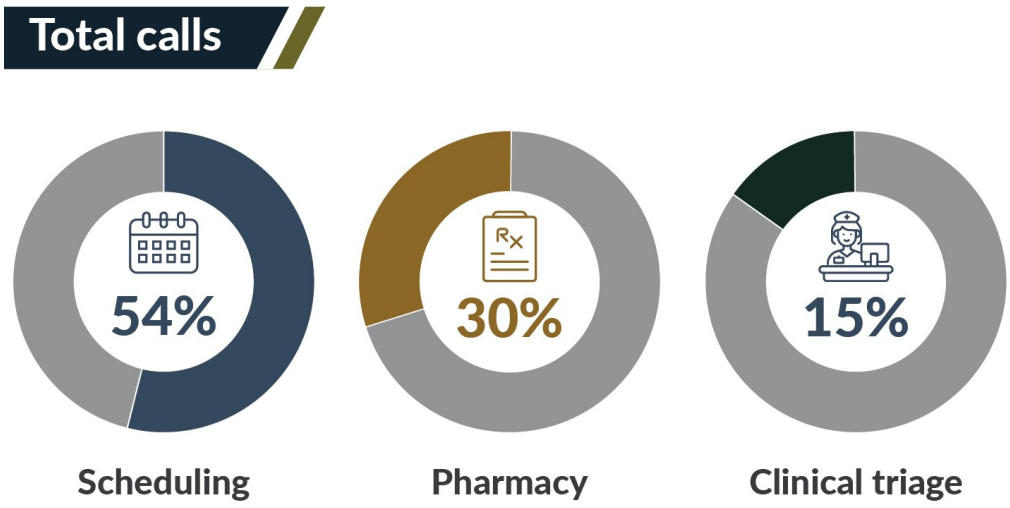

Figure 3. *Number of calls received in FY 2024 for scheduling, pharmacy, and clinical triage services.*

Source: VA OIG analysis of Cisco Unified Intelligence Center system data in FY 2024.

Note: Percentages in the figure are rounded.

VHA Governance Structure and Responsibilities

The deputy under secretary for health is responsible for leading VHA's clinical policies and programs. Figure 4 provides an overview of VHA's governance structure and relevant relationships related to clinical contact centers.

[46] The review team reviewed 17 VISNs that were operational at the start of FY 2024 (October 1, 2023); VISN 7 was excluded from the scope because its clinical contact center was not in operation until March 2024, and the OIG issued a report with recommendations to assist VISN 7 clinical contact center once it became operational. 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.

[47] As described previously with figure 1, the virtual provider care service does not directly receive calls.

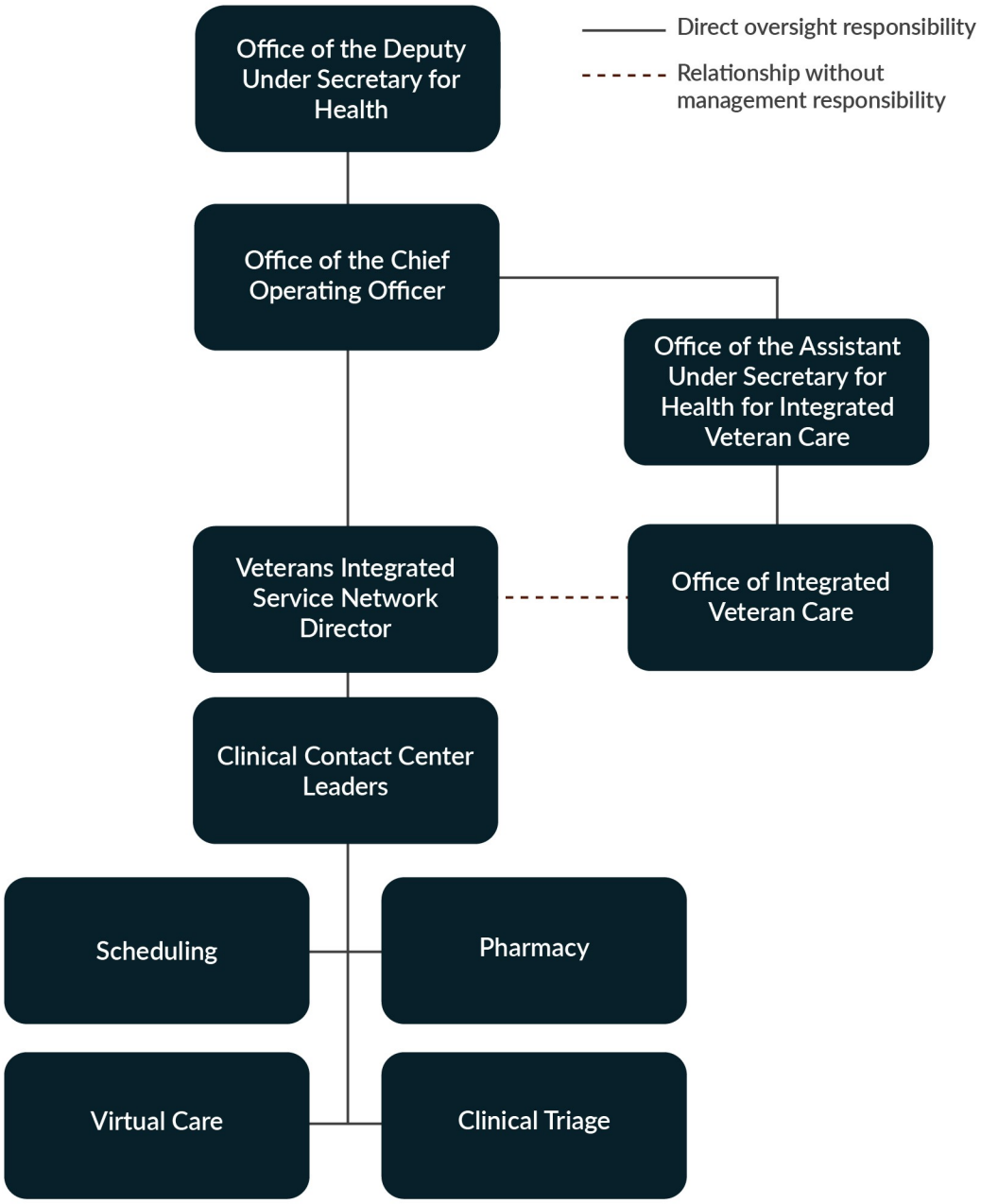

Figure 4. *VHA entities associated with clinical contact centers, as of July 2023.*
Source: VA OIG analysis.

Under the deputy under secretary for health, the chief operating officer is responsible for overseeing planning, managing finances and operations, and implementing priorities for VHA. The chief operating officer's office oversees clinical contact center requirements and helps VISN

directors resolve implementation and compliance challenges at the medical facilities in their networks.[48]

Office of the Assistant Under Secretary for Health for Integrated Veteran Care

This office reports to the chief operating officer and supports IVC in implementing VA Health Connect requirements. It provides oversight and guidance to help IVC in meeting the requirements.

Office of Integrated Veteran Care

This office oversees functions related to access both within VHA and through community partners. IVC's Integrated Access directorate is responsible for developing processes and practices that provide veterans with access to timely and appropriate health care—for both VHA (direct care and virtual care) and community care. The transformative care modalities office in the Integrated Access directorate planned, implemented, and oversees the VA Health Connect initiative. This includes providing guidance to senior VHA and VISN leaders who supervise the centers.

Veterans Integrated Service Network Director

Each VISN director is responsible for establishing and operating a regional clinical contact center and ensuring all VISN medical facilities comply with applicable policies. This includes staffing the clinical contact center and delivering 24-hour services via a toll-free number.

Clinical Contact Center Leaders

Each clinical contact center is led by a director, an executive director, a chief for each core service, and supervisors. Directors are responsible for their center's operations. This includes employing VISN clinical and administrative staff who answer and manage incoming calls for the core services. Directors are also responsible for ensuring centers are adequately staffed. Clinical contact center leaders are required to evaluate performance data and identify opportunities for improvement.[49]

Supervisors oversee the center's daily operations, review performance reports, and ensure staff are trained to address a veteran's reasons for calling the center. Specific duties may depend on the core service:

[48] VHA Directive 1006.04(2). In July 2023, VHA's updated organizational chart showed that the chief operating officer oversees the VISNs and IVC.

[49] VA Health Connect, *Quality Management Framework*, September 2024.

- **Scheduling** staff (referred to as schedulers) make, reschedule, and cancel primary care appointments and provide information and 24-hour support regarding VA services. The administrative scheduling service directly impacts veterans' ability to receive care, and it is often the first and only touchpoint for veterans calling a clinical contact center.
- **Pharmacy** staff renew and refill medications and address questions and concerns related to medications. Pharmacy staff also determine the most effective way to fulfill a veteran's medication requirements. The pharmacy service is staffed by pharmacists, clinical pharmacist practitioners, and pharmacy technicians.
- **Clinical triage** staff evaluate patient symptoms and concerns and analyze the next course of action. Based on clinical need and availability, registered nurses can transfer or refer patients to emergency services, other clinical contact center services, or facility staff.
- **Virtual provider care** staff—physicians, nurse practitioners, and physician assistants—diagnose and treat veterans by phone, video, or chat. If a clinical triage call recommends a virtual appointment, the veteran must make an appointment with scheduling. Virtual appointments usually occur within 24 hours of a veteran's referral by clinical triage.

Results and Recommendations

Finding: VISNs Did Not Fully Implement, Integrate, and Improve Clinical Contact Centers' Performance to Efficiently Answer Veterans' Calls

The review team found that primary care scheduling and pharmacy support services did not meet VHA's 5 percent metric for the call abandonment rate standard or meet the 80 percent timeliness standard in FY 2024.[50] However, clinical triage met both the call abandonment rate and timeliness standards in FY 2024. Further, as of September 2024, most VISN directors had not made sure their clinical contact centers had fully implemented the VA Health Connect initiative as VHA had required them to do by December 31, 2021.[51] Specifically, most centers did not operate VISN-wide integrated scheduling or pharmacy services. In addition, three centers did not provide 24-hour scheduling services as required. The two centers that did not provide 24-hour pharmacy services also did not employ strategies to ensure after-hours callers received some sort of assistance as the other 15 centers did.[52] Medical facilities across 12 of the 17 VISNs reviewed also did not route local calls to clinical contact centers for scheduling services or outpatient clinic questions, as required. These issues occurred because IVC worked primarily with the clinical contact center leaders during implementation and did not routinely work with VHA's chief operating officer to require that centers implement the VA Health Connect initiative. During implementation, clinical contact center leaders disclosed during interviews that the chief operating officer did not consistently require VISN directors to fully implement the initiative by the deadline. Additionally, based on the staffing model VHA uses, the OIG estimated that $17.3 million in employment-related costs could have been used for other purposes if clinical contact centers had fully integrated scheduling and pharmacy services to efficiently answer calls VISN-wide.[53]

Furthermore, 14 of the 17 clinical contact centers reviewed did not meet call abandonment and timeliness performance standards in FY 2024. Some VISN clinical contact center leaders said they need more schedulers to meet these standards, but the review team found that centers were

[50] Virtual provider care was not included in the review because it does not directly receive calls.

[51] VHA Directive 1006.04(2).

[52] VHA Directive 1006.04(3). IVC officials said a 24-hour pharmacy service is not required, and this information was communicated to center leaders in presentations beginning around March 2023. In June 2025, IVC amended its directive to reflect this changed requirement; while 24-hour coverage is required, pharmacy and virtual provider care services are only required during clinical contact center-defined core hours or based on identified need.

[53] The OIG team used VA's recommended staffing methodology to identify the number of schedulers and pharmacy technicians each VISN would have needed if they had been integrated in FY 2024, which was subtracted from each VISN's actual number of schedulers and pharmacy technicians in FY 2024. These differences were then converted to dollar amounts by multiplying them by the estimated annual cost of a scheduler or pharmacy technician, respectively. See appendix B for further details and appendix C for further discussion of monetary benefits.

generally adequately staffed and, instead, other operations issues contributed to inefficiencies, such as lengthy handle times and excessive unavailability of some schedulers. Because the centers did not meet performance standards to answer veterans' calls quickly, veterans did not receive consistent services and may have experienced delays in accessing care.

The finding is based on the following determinations:

- Clinical contact centers did not meet performance standards in FY 2024.
- Most VISNs did not fully implement the VA Health Connect initiative.
- Clinical contact centers need to significantly improve scheduling to meet VHA performance standards.
- IVC recently implemented a waiver process.

What the OIG Did

The OIG, which conducted its work from October 2024 through July 2025, reviewed criteria from VHA policy related to VA Health Connect implementation requirements, staffing, scheduling practices, and performance standards and interviewed IVC officials. The review team analyzed 17 clinical contact centers' call and staffing data to determine the nature and extent of implementation and scheduling performance issues from October 1, 2023, through September 30, 2024 (FY 2024). The team also analyzed centers' action plans that were developed to meet FY 2024 scheduling performance standards.

The OIG focused on the performance of clinical contact centers' scheduling and administration service because that operation directly affects veterans' ability to access primary care at all the network's medical facilities as well as virtual care at the contact centers. The review team excluded VISN 7 from the scope because its clinical contact center was not operational at the beginning of FY 2024.[54]

The review team judgmentally selected three clinical contact centers operating under diverse circumstances—the VA New England Healthcare System (VISN 1), the VA Capitol Health Care Network (VISN 5), and the South Central VA Health Care Network (VISN 16)—for site visits to compare a clinical contact center that integrated operations and met scheduling performance standards; a center that integrated operations and did not meet those standards; and a center that

[54] The OIG made recommendations to assist the VISN 7 clinical contact center after it became operational. VA OIG, *Atlanta Call Center Staffing and Operational Challenges Provide Lessons for the New VISN 7 Clinical Contact Center*.

did not integrate or meet standards.[55] Figure 5 details whether the selected centers were integrated and whether each center met performance standards for FY 2024.

VISN	Integrated operations?	Call abandonment rate	Timeliness: Percentage of calls answered within 30 seconds	Met scheduling performance standards?
1	✓	5%	80%	✓
5	✓	26%	24%	✗
16	✗	16%	61%	✗

✓ YES ✗ NO

Figure 5. *Selected VISN clinical contact centers and their FY 2024 performance outcomes.*

Source: VA OIG analysis of Cisco Unified Intelligence Center system data in FY 2024.

Note: VISNs 5 and 16 also did not meet the annual performance standards of improving their abandonment rate and timeliness performance by 10 percent from the previous fiscal year. See appendix A for more information.

At each site visit, the team assessed the clinical contact center's operations and management practices, reviewed applicable documentation, and interviewed VISN directors, center leaders, and other staff. The team observed schedulers answering incoming calls to better understand how they handle calls. The team also contacted the other 14 clinical contact centers under review to discuss identified implementation and scheduling performance issues. See appendix B for more details on the review's scope and methodology.

Clinical Contact Centers Did Not Meet Scheduling and Pharmacy Performance Standards in FY 2024

Looking at all call center data, the review team found that primary care scheduling and pharmacy support services did not meet VHA's 5 percent standard for the call abandonment rate in FY 2024.[56] As shown in figure 6, the clinical triage service met the standard; the pharmacy

[55] VISN 1 comprises eight facilities: Bedford, Boston, and Leeds in Massachusetts; West Haven, Connecticut; Manchester, New Hampshire; Augusta, Maine; Providence, Rhode Island; and White River Junction, Vermont. VISN 5 comprises six facilities: Baltimore, Maryland; Beckley, Clarksburg, Martinsburg, and Huntington in West Virginia; and Washington, DC. VISN 16 comprises eight facilities: Alexandria, Shreveport, and New Orleans in Louisiana; Little Rock and Fayetteville in Arkansas; Jackson and Biloxi in Mississippi; and Houston, Texas.

[56] Virtual provider care was not included in the review because it does not directly receive calls.

service was close as well (about 6 percent). The scheduling service had a much higher abandonment rate at around 11 percent, more than double the standard.

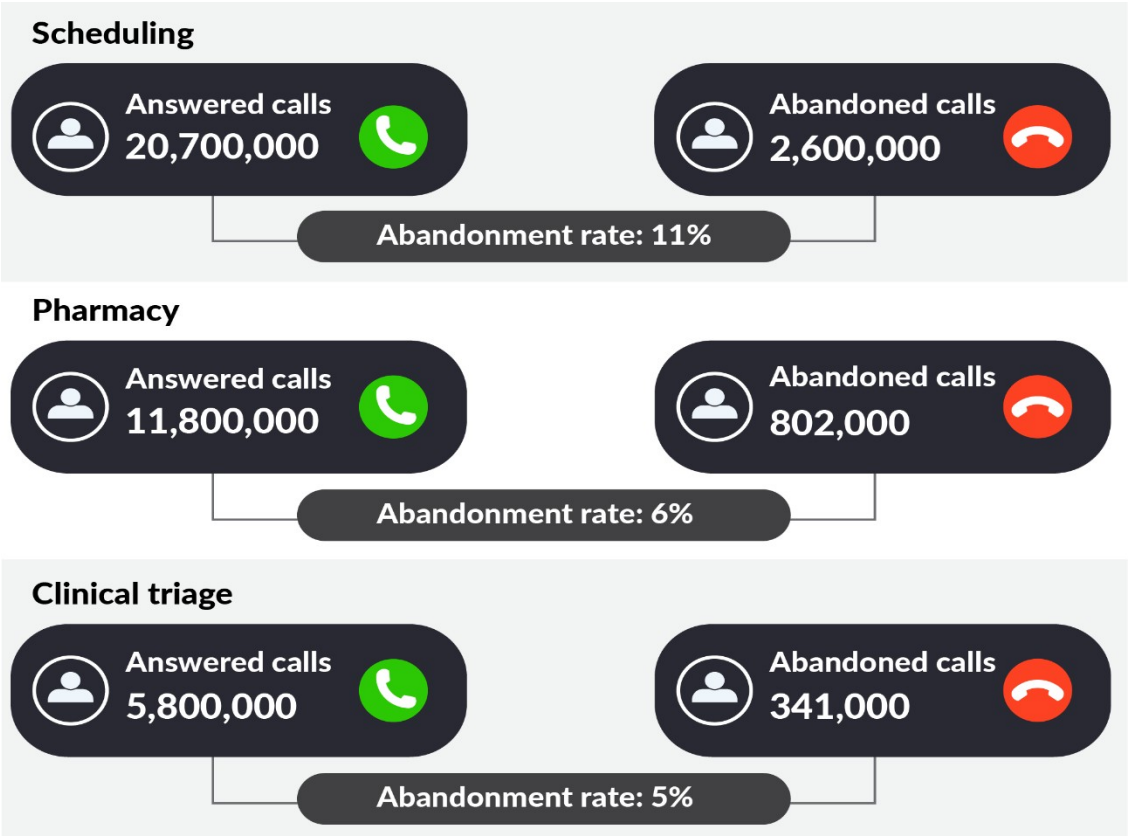

Figure 6. *Overview of calls received during business hours in FY 2024, by service.*
Source: VA OIG analysis of Cisco Unified Intelligence Center system data during FY 2024.
Note: The review team considered business hours to be 7:00 a.m. to 6:00 p.m. Monday through Friday. The answered and abandoned calls are rounded and therefore do not yield the rounded percentages shown.

Furthermore, neither the scheduling nor pharmacy services reviewed met the 80 percent timeliness standard as shown in figure 7, whereas the clinical triage was able to meet the standard at 82 percent.[57]

[57] VA Health Connect, *Data Definitions for the VA Health Connect Dashboard*, April 18, 2023.

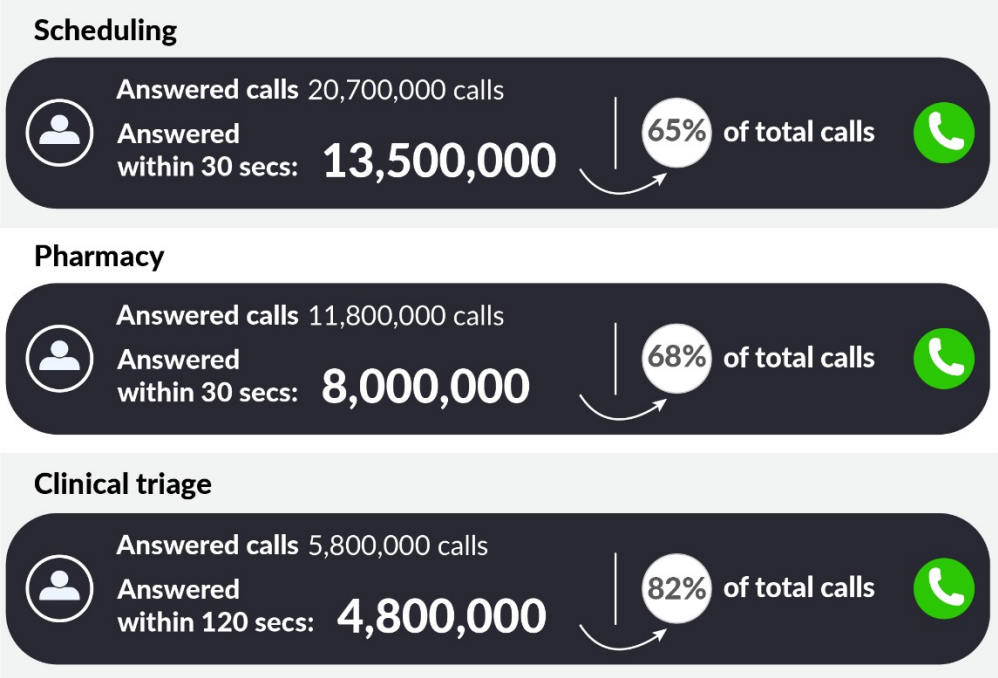

Figure 7. *Overview of calls answered within the timeliness standard during business hours in FY 2024, by service.*

Source: VA OIG analysis of Cisco Unified Intelligence Center system data during FY 2024.

Note: The review team considered business hours to be 7:00 a.m. to 6:00 p.m. Monday through Friday. Information for the answered calls and the calls answered within 30 and 120 seconds was rounded and therefore does not yield the percentages shown. The percentages are also rounded. The review team took into consideration clinical triage calls answered by schedulers. Schedulers in this service are required to answer calls within 30 seconds.

Scheduling and pharmacy services not meeting both performance standards in FY 2024 may be related to VISNs not fully integrating their scheduling or pharmacy services or providing 24-hour coverage, as discussed in the following sections.

Most VISNs Did Not Fully Implement the VA Health Connect Initiative

Although VHA standardized some clinical contact center operations across VISNs, many VISNs and their medical facilities did not make the full operational changes required by the VA Health Connect initiative to optimize veterans' access to care.[58] This lack of full implementation may have contributed to VA Health Connect services not meeting the standards for call abandonment rate and timeliness in FY 2024.

[58] VHA Directive 1006.04(2).

The OIG found that

- 12 of the 17 centers reviewed did not integrate the scheduling or pharmacy call workload for their facilities, and staff at some of these centers primarily answered calls only for their assigned facility;
- four of 17 centers did not offer 24-hour scheduling or pharmacy coverage; and
- 24 medical facilities in 12 VISNs did not follow guidance requiring them to route scheduling and outpatient clinic calls to their respective VISN centers and instead continued to have facility staff handle these calls.

Many Clinical Contact Centers Did Not Integrate Medical Facilities' Call Activities

To best ensure the clinical contact centers address a patient's reason for contacting VA during the initial call (that is, first-contact resolution), VHA's policy for the clinical contact centers required VISNs to integrate core services by December 31, 2021.[59] As described earlier, an integrated center manages its staff at the VISN level and needs fewer staff to help veterans across a VISN regardless of what facility a veteran calls. By contrast, a nonintegrated center has staff assigned to specific facilities, and they can answer calls only for their facility, which requires more staff.

The review team found that most of the 17 reviewed clinical contact centers had the core services (primary care scheduling, pharmacy support, clinical triage, and virtual provider care) operational by September 2022.[60] But 12 of the 17 centers (about 71 percent) did not *integrate* their medical facilities' scheduling service, pharmacy service, or both as of September 30, 2024.[61] Of those 12, five centers managed staff at the facility level rather than the VISN level; at the remaining seven, the staff were managed at the VISN level but their operations were not integrated.[62] In a distinct departure from the integrated model, staff at these 12 clinical contact centers were not expected to handle calls for other facilities in their VISN. This increased the risk that veterans experienced longer call wait times—delaying first-contact resolution and veterans' access to care. Figure 8 shows the 12 clinical contact centers that the

[59] VHA Directive 1006.04(2).

[60] VHA Directive 1006.04(2). According to IVC, VISN 4 and VISN 12 had three of four services operational by September 2022 and launched the remaining service by April 2024. IVC also reported that VISN 7 did not have most services online until March 2024.

[61] The clinical contact center policy does not specify what constitutes a fully integrated center. In collaboration with IVC, the review team set an integration benchmark of staff answering calls VISN-wide for scheduling and pharmacy at 60 percent of the time or more. The team found that clinical triage services were integrated based on discussions with center staff and documentation that showed nurses were answering calls VISN-wide.

[62] During site visits and follow-ups, five VISNs disclosed that their staff at the medical facilities were handling calls and were managed at the facility level rather than the VISN.

review team found were not using the integrated approach for scheduling and pharmacy services. Specifically, eight centers integrated neither service, three integrated pharmacy but not scheduling operations, and one center integrated scheduling but not pharmacy service.

Figure 8. *VISN clinical contact services not fully integrated as of September 30, 2024.*

Source: VA OIG analysis of Cisco Unified Intelligence Center system data and VA Health Connect dashboards data in FY 2024.

Note: A map detailing each VISN and its regional area of oversight is available on VHA's VISN web page at https://www.va.gov/HEALTH/visns.asp.

** Pharmacy services at these VISNs are handled by other VA departments.*

IVC officials acknowledged that sometime before November 2023, most VISNs' clinical contact centers were not integrated, so they updated their policy that month to require that the centers fully integrate. IVC does not directly oversee VISNs, but IVC has met with the VISN directors at least once a year to highlight the benefits of integrating, such as the cost savings VA would achieve by reducing staff. IVC told the review team that the assistant under secretary for health for integrated veteran care shared some challenges with attaining full clinical contact center operations across all VISNs with the VHA chief operating officer who was in that position at that time. But IVC could not provide evidence to the review team confirming these issues were discussed with the chief operating officer.[63]

Pharmacy Systems Are Outdated at Some Centers

Most clinical contact center leaders acknowledged the VISNs and medical facilities were unable to standardize their business processes, creating barriers to integration. As of August 2025, the centers had not started using the new scheduling management application. Clinical contact center supervisors and the national pharmacy program manager acknowledged that staff were still using an outdated healthcare records system for pharmacy services. The outdated system required staff to pull up multiple screens, whereas the new application would allow access to each facility's pharmacy system on just one screen. IVC told the review team it was aware of these challenges

[63] The review team could not discuss the integration issue with this assistant under secretary for health for integrated veteran care because she had left VA as of February 2025.

and was updating the application at every center so staff could provide pharmacy support VISN-wide.

Lack of Integration Can Hinder Efficiencies in Scheduling

As noted, all VISNs installed the scheduling management application. However, challenges over standardized business processes persisted between the VISNs and the medical facilities, meaning schedulers at some centers still answered only their own calls and made appointments only for their providers. Because of this, during site visits, call center staff at the nonintegrated centers disclosed that they did not consistently use the application, affecting call efficiency and delaying veterans' access to care.

For example, in the nonintegrated VISN 16 clinical contact center, staff were managed at the facility level and spent most of their time answering calls made to their facilities. The center's chief nursing officer reported that the lack of standardization caused by not using the updated scheduling management application made scheduling primary care appointments across the VISN cumbersome. As a case in point, 11 schedulers were assigned to the New Orleans VA Medical Center and generally answered calls only for that facility during business hours. They received other facilities' calls only when callers had been on hold for at least 30 minutes or when there were at least 75 callers waiting in the other facilities' phone queues. If callers had wanted to schedule primary care appointments at facilities in VISN 16 other than New Orleans, these schedulers sent notes to the veterans' primary care teams at the other facilities so they could call the veterans back. This process was not only inefficient, but it also likely delayed veterans' access to care.

In contrast, VISN 1 is one of five regions that operated an integrated clinical contact center where staff—regardless of facility affiliation—answer calls and provide VISN-wide assistance to veterans.[64] The review team's FY 2024 data analysis for VISN 1 showed that about 159 schedulers per day answered calls across the VISN. According to the center's director, a few years before the VA Health Connect initiative, VISN 1 started using an integrated approach to consolidate calls into facility-level call centers instead of directing calls to individual facility services (like primary care clinics or dermatology), and the VISN observed that this consolidation improved efficiency. When VHA launched the VA Health Connect initiative, the VISN 1 director recognized the benefits of further consolidation and started integrating all VISN 1 facility-level call centers into one clinical contact center.

[64] Clinical contact center data for VISNs 1,5, 6, 15, and 21 showed that these centers' core services were integrated in FY 2024.

VISNs That Did Not Integrate Clinical Contact Center Operations Missed Opportunities to Reduce Staffing Needs and Costs

According to the recommended staffing model, integrated clinical contact centers need fewer staff, reducing operating costs. For example, VISN 16, which was not integrated, had 121 schedulers to address incoming calls for all its facilities' queues, compared to needing 101 schedulers pursuant to VHA's recommended staffing model—a difference of 20 schedulers. The review team estimated that the 11 VISNs that did not integrate scheduling services would have needed about 180 fewer schedulers to meet performance standards if they had integrated. For scheduling alone, VHA could save about $15 million per year in reduced staffing costs if VISNs fully integrated that service at their clinical contact centers.[65]

Using a similar methodology, the review team estimated that the nine VISNs that did not integrate pharmacy services (as shown previously in figure 8) could operate with 23 fewer staff and reduce annual salary costs by about $2.2 million if they integrated and used the staffing model recommended by VHA. In summary, the 12 centers without integrated pharmacy or scheduling services could eliminate 200 staff and cut annual salary costs by about $17.3 million by fully integrating both services.[66] The OIG's first recommendation is for the chief operating officer to require VISN directors to fully integrate services as required at all clinical contact centers.

Some Clinical Contact Centers Did Not Provide Veterans 24-Hour Access to Scheduling or Pharmacy Services

VHA policy requires clinical contact centers to provide veterans with 24-hour access to scheduling and clinical triage.[67] During FY 2024, the 17 clinical contact centers reviewed received about 4.3 million calls outside business hours.[68] The review team's data analysis found that all 17 clinical contact centers provided 24-hour coverage for clinical triage, but three centers did not provide 24-hour access to scheduling services. Further, although not required, two centers did not provide 24-hour pharmacy service or employ strategies like the other 15 centers

[65] The review team estimated the potential cost savings for each VISN by subtracting the number of schedulers VA's staffing model identified the VISN would have needed if it were integrated from the VISN's actual staffing. This difference was then multiplied by the estimated annual cost of a scheduler. Further explanation is provided in appendix B. The review team did not include VISNs 20, 21, 22, and 23 because these clinical contact centers were understaffed in FY 2024, according to the staffing model.

[66] The estimated savings for scheduling and pharmacy services are rounded and do not precisely total $17.3 million, which is also rounded. See appendix B for more information about the scope and methodology.

[67] VHA Directive 1006.04(3). IVC officials said a 24-hour pharmacy service is not required, and this information was communicated to center leaders in presentations beginning around March 2023. In June 2025, IVC amended its directive to reflect this changed requirement; while 24-hour coverage is required, pharmacy and virtual provider care services are only required during clinical contact center-defined core hours or based on identified need.

[68] For the purposes of this report, the review team considered business hours were from 7:00 a.m. to 6:00 p.m. Monday through Friday (based on the clinical contact centers' FY 2024 call volume).

to make sure callers received some sort of assistance when calling after hours. The four centers were the following (VISN 17 did not provide services in either category):

- VISN 5, VISN 6, and VISN 17 did not provide 24-hour scheduling services.
- VISN 17 and VISN 21 did not provide 24-hour pharmacy services.

Specifically, VISN 5 did not provide scheduling services on weekends or overnight on Monday through Friday (from 8:00 p.m. to 6:00 a.m.), while VISN 6 and VISN 17 did not provide scheduling services on weekends or from 5:00 p.m. to 6:00 a.m. Monday through Friday.[69] Figure 9 summarizes the number of calls received and not answered outside business hours for these two services across the four clinical contact centers.[70]

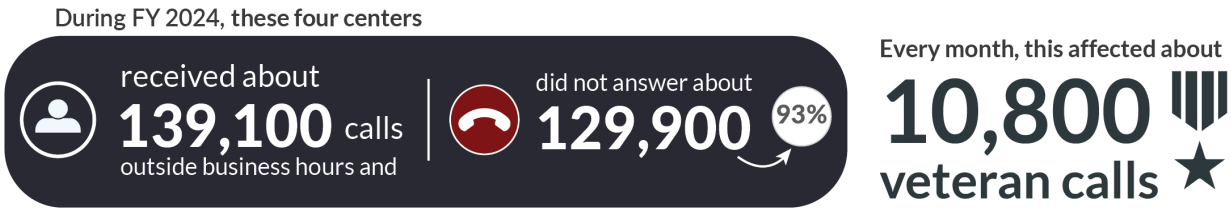

Figure 9. *Summary of four clinical contact centers that did not provide 24-hour scheduling or pharmacy services.*

Source: VA OIG analysis of Cisco Unified Intelligence Center system data in FY 2024.

Note: VISN 5 did not provide 24-hour scheduling services from October 2023 to March 2024. While these services started in March, they ended by June 2024 due to a staffing shortage.

24-Hour Scheduling Access

Regarding primary care scheduling, the VISN 5, VISN 6, and VISN 17 clinical contact centers received about 83,200 veteran calls outside business hours in FY 2024 and answered only about 9,200 (about 11 percent).[71] Based on FY 2024 data, the review team estimated that a lack of 24-hour scheduling coverage at these centers could have affected access to primary care for an average of about 6,200 veteran calls per month.

The clinical contact center directors at VISNs 5, 6, and 17 said their centers stopped providing 24-hour scheduling for reasons such as a lack of staffing, low after-hours call volumes, or to

[69] VISN 5 provides weekend coverage from 7:00 a.m. to 5:30 p.m. Between 5:30 p.m. and 7:00 a.m. (which is outside business hours), callers are met with a recording advising them to call back during business hours.

[70] A site visit to VISN 5 and follow-up with VISNs 6, 17, and 21 confirmed that they were not providing coverage outside business hours for scheduling or pharmacy services. The OIG did not include virtual provider care in this review because VHA policy requires 24 hours to schedule an appointment, which can be completed during business hours. In June 2025 IVC amended its directive to state while 24-hour coverage is required, virtual provider services and virtual pharmacy services are only required during clinical contact center-defined core hours or based on identified need.

[71] In FY 2024, VISN 5 provided 24-hour access to primary care scheduling for three months, from March 2024 to June 2024.

focus on meeting performance standards during business hours. The IVC acting director told the review team that IVC was aware that these centers were not providing 24-hour scheduling in FY 2024 and discussed their action plans with clinical contact center leaders. Despite IVC working with clinical contact center leaders to address this issue, as of July 2025, these centers were not providing 24-hour scheduling coverage to assist veterans as required by policy.

24-Hour Pharmacy Access

Meanwhile for pharmacy services, 15 of the 17 clinical contact centers reviewed provided 24-hour pharmacy services in FY 2024 (88 percent), although they used various means to do so.[72] For example, in VISN 5 after-hours pharmacy calls were answered by clinical triage staff if veterans had medication concerns, or veterans could use an automated system to request prescription refills. VISNs 12, 15, and 23 partnered with VISN 10's center to provide pharmacy services after hours and on weekends and holidays.

Although not required, two clinical contact centers—in VISN 17 and VISN 21—did not provide 24-hour pharmacy coverage in FY 2024 and did not have a required written plan to otherwise support pharmacy services outside business hours.[73] VISN 17's center provided pharmacy coverage only from 8:00 a.m. to 4:30 p.m. Monday through Friday, and VISN 21's did so only from 7:30 a.m. to 7:00 p.m. Monday through Friday. Veterans calling outside these hours at both centers could use an automated system to refill prescriptions; otherwise, all calls routed to the pharmacy queues were automatically disconnected after a brief message saying the pharmacy was closed. During FY 2024, these two centers received about 55,900 calls for pharmacy services when services were not offered (about 4,700 calls per month), so these veterans could not have their medication questions or concerns addressed in a timely manner. Employing strategies like the other clinical contact centers could help more veterans get their issues addressed the first time they call VA. The acting assistant under secretary for health for IVC agreed that other opportunities could exist to extend after-hours pharmacy care to veterans. The clinical contact center directors for VISN 17 and VISN 21 both reported that their centers unsuccessfully attempted to partner with other VISNs to provide 24-hour pharmacy coverage.

At Some Medical Facilities, Staff Answered Calls That Should Have Been Handled by the Clinical Contact Centers

All medical facilities' and outpatient clinics' pharmacy needs, appointment requests for appropriate services, and general inquiries should be routed directly to the clinical contact center

[72] *VA Health Connect Guidebook*. Seven of these centers provided 24-hour pharmacy services directly, and eight used other means to provide the coverage. VHA policy allows contact centers to have a written plan to provide pharmacy coverage outside business hours.

[73] VHA, *VA Health Connect: Pharmacy Staffing Recommendation for Off-Core Coverage*, September 8, 2022.

as a veteran's first point of contact, according to VHA policy.[74] The OIG acknowledges that facilities need to have some local phone queues to provide direct access to a service, but VISNs and facility directors also need to ensure these do not duplicate efforts with the clinical contact centers. During FY 2024, the review team learned that 24 facilities across 12 VISNs still operated 157 local phone queues—with 1,043 facility staff answering over two million calls for general primary care and outpatient clinic questions.[75] These 157 queues had a call abandonment rate of about 10 percent (about 222,000 calls), double the 5 percent standard. This increased VHA's risk that veterans experienced delays in care.[76] Furthermore, having facility staff answering these calls takes their time away from doing other assigned duties, such as checking patients in for appointments.

Eight of the 12 clinical contact center directors were unaware that medical facilities in their VISN were operating these local queues in FY 2024. The team followed up with the center directors to determine the disposition of the queues, and as of June 2025, some queues had been deactivated and transferred to the clinical contact center, while other queues remained in operation locally for various reasons, such as facilitating transfers to primary care. Of note, the VISN 10 and VISN 15 center directors said they did not plan to transition some local queues to their centers because they believed those calls were best handled by local facility staff.[77] An IVC official disclosed that staffing needs at clinical contact centers would need to be considered when facilities transfer these calls from local queues to the centers.

The OIG's second recommendation is for VA to require that medical facilities coordinate with IVC and their respective VISN clinical contact center before setting up or maintaining a local phone queue for a service the center provides.

Clinical Contact Centers Need to Significantly Improve Scheduling to Meet VHA Performance Standards

As discussed above, clinical contact centers were expected to either meet two national performance standards in FY 2024—call abandonment rate and timeliness—or improve their

[74] VHA Directive 1006.04(2).

[75] Some of the 2.3 million calls may not have been related to services provided by clinical contact centers, but the OIG had no way to identify the volume of unrelated calls. For example, some queues handled primary care, which would normally route to a center, as well as specialty care scheduling, which should be handled at the facility level.

[76] VHA Directive 1090 requires VISNs and medical facilities to collect performance metrics and follow standards that ensure patients have the same access regardless of geographical location. IVC confirmed that local call centers are required to use the same abandonment rate and timeliness performance standards. Facility staff answered about two million of the 2.3 million calls received.

[77] Specifically, there was no plan to integrate the local phone queues for one VISN 10 medical facility in Saginaw, Michigan, or for the outpatient clinics for VISN 15. The VISN 10 clinical contact center director stated that the decision to not fully transition some local queues to the center was made by both medical facility directors, as it was believed those calls were best handled by local facility staff.

performance in these two areas by at least 10 percent compared to FY 2023.[78] According to the OIG team's review of the centers' scheduling performance data,

- three centers met both VHA performance standards (VISNs 1, 4, and 10);
- two centers met one VHA performance standard and improved on the other standard by at least 10 percent;
- six centers met neither performance standard but improved at least 10 percent on one of the standards compared to FY 2023; and
- six centers neither met both performance standards nor improved either standard by at least 10 percent compared to FY 2023.

In all, 14 of the 17 centers reviewed did not meet both performance standards at the end of FY 2024, although some did improve by 10 percent compared to the prior year. These 14 centers had an average call abandonment rate of 13 percent (8 percentage points over the standard) and answered on average only 57 percent of their calls within 30 seconds (23 percentage points below the standard). Appendix A provides more detail on all 17 centers' call abandonment rates and scheduling timeliness data.

Some conditions that contributed to the clinical contact centers' performance problems were not addressed in the centers' action plans. Generally, the action plans of those centers that did not meet both performance standards proposed adding staff when feasible and strengthening monitoring to improve performance, but many plans did not address operations issues—like the time spent on a call plus after-call work (handle time) or the amount of time schedulers were unavailable to take calls (availability)—to increase efficiency.

The review team found that many schedulers at the clinical contact centers did not meet VHA handle-time and availability targets, which are intended to promote effective and efficient operations.[79] For instance, the centers focused on meeting the abandonment rate and timeliness standards in IVC's annual performance plan—not on metrics like handle-time and availability targets, which were not part of IVC's FY 2024 performance plan but are included in guidance.[80] When schedulers miss handle-time and availability targets, the call abandonment rate and the timeliness of answering calls can be affected. IVC monitored the abandonment rate and timeliness performance standards but relied on the centers to monitor schedulers' handle time and availability. Centers should act to improve performance when those targets are not met.

[78] The FY 2024 call abandonment rate standard was no more than 5 percent per year. The timeliness standard was at least 80 percent per year. *VHA Clinical Contact Center Modernization Data and Metrics Guidance*.

[79] *VHA Clinical Contact Center Modernization Data and Metrics Guidance*.

[80] VA Health Connect VISN performance plans for FY 2024.

Strengthened Oversight Could Improve Handle Times and Increase the Number of Calls Schedulers Answer

Access to primary care scheduling at the clinical contact centers depends on the availability of schedulers to answer calls. VA Health Connect policy includes a handle-time target to ensure schedulers efficiently answer an optimal number of calls, which in turn should make the schedulers more available to improve the timeliness of answered calls and reduce the number of abandoned calls. As of April 2023, all schedulers were expected to maintain an average handle time of eight minutes.[81] Handle time comprises the time schedulers need to answer a call (referred to as talk time), hold time, and any needed work afterward (referred to as after-call work), which might include documentation of the call or appointment details in VA's electronic health record system. Incoming calls to centers should be automatically routed to any scheduler logged into the telephone system in ready mode. Calls should not be routed to schedulers again until the call and after-call work are completed, at which time schedulers should manually put themselves back in ready mode in the telephone system.

However, clinical contact centers did not adequately monitor schedulers' handle times. The review team found that at the 14 centers that did not meet the performance standards, 657 of 2,371 schedulers (about 28 percent) exceeded the eight-minute target. Among those, 82 schedulers (about 12 percent) had average handle times of 15 minutes to 36 minutes. By contrast, only 48 of 564 schedulers (about 9 percent) had an average handle time greater than the eight-minute target at the three centers that met both performance standards (VISNs 1, 4, and 10). Table 2 shows the correlation between high handle times and high average talk time and after-call work time for the schedulers that exceeded the target at the 14 clinical contact centers that did not meet performance standards.

[81] When the clinical contact centers were established in 2021, VHA had not established a handle time target and expected each center to monitor handle time. By April 2023, IVC set eight minutes as the handle-time target for all contact centers. IVC updated the guidance on April 2025, removing the eight-minute target because IVC officials believed clinical contact centers should establish handle-time targets at the VISN level.

Table 2. Handle Time for Schedulers that Exceeded the Target at 14 Centers That Did Not Meet Performance Standards*

Number of schedulers	Handle time	Average talk time (minutes:seconds)	Average after-call work (minutes:seconds)
575	8–15 minutes	4:50	4:14
53	15–20 minutes	8:13	8:15
21	20–25 minutes	12:36	9:24
8	more than 25 minutes	14:15	13:32

Source: VA OIG analysis of Cisco Unified Intelligence Center system data in FY 2024.

** The 14 centers were in VISNs 2, 5, 6, 8, 9, 12, 15, 16, 17, 19, 20, 21, 22, and 23.*

During site visits with the clinical contact centers, the review team noted that some centers did not effectively address schedulers' high talk time. After interviews with these supervisors, the review team noted that supervisors had not implemented strategies to improve schedulers' high handle time, such as retraining or pairing schedulers who had high handle times with more efficient schedulers. Supervisors and schedulers reported that handle time varied by call and said they did not want to limit the amount of time spent with a veteran. Other supervisors and schedulers were unaware a handle-time target existed. One supervisor said some veterans who call enjoy talking, and the schedulers entertain their conversations even when the scheduler has addressed the reason for calling. A scheduler described herself as a listener and said if a veteran wants to talk, she will not rush the call regardless of the time it takes. This approach affected the scheduler's average handle time, which was about 10 minutes in FY 2024. The OIG recognizes the worthy approach of giving a veteran full space to talk, but many schedulers appear to have developed an ability to conclude a call with the veteran feeling they were heard.

The review team observed during its visits that the length of calls and the amount of work needed to address calls varied, but some schedulers completed after-call work more efficiently than others. The more efficient schedulers generally did not wait until they finished a call to start the after-call work. Even when schedulers received more complicated calls, the more efficient schedulers started the after-call work while they were still on the phone. The team observed these schedulers generally completed after-call work in less than five minutes and promptly placed themselves in ready mode again to take other calls.

At most of the clinical contact centers that did not meet performance standards, supervisors did not closely monitor handle time—either talk time or after-call work time—and leaders had not included handle-time targets in schedulers' performance plans for FY 2024. VISN 5 was among those centers not effectively monitoring their schedulers' handle times. VISN 5 center leaders provided no target for handle time, but they did include after-call work time in schedulers' performance plans with a goal of five minutes or less and they used a timer in the telephone system to help achieve this goal. IVC does not require centers to use a timer, but centers can set a limit to the time schedulers take for after-call work before the telephone system automatically

places the scheduler back in ready mode to receive calls. The team found that VISN 5's approach was ineffective, though, because multiple schedulers appeared to consistently take the same amount of time to complete their after-call work. For example, one scheduler ended after-call work for 92 of 178 calls (about 52 percent) exactly at the four-minute mark during a one-week period. Based on this, the OIG's third recommendation is for IVC to assess if some schedulers are arbitrarily ending calls in the telephone system to remain in after-call work status longer than needed to reduce the number of calls routed to them. The team also found VISN 16's not using a timer ineffective, since schedulers could manually control when they placed themselves back in ready mode to take another call after they completed work on a prior call, and there was no limit on the amount of time they could spend in after-call status.

The VISN 5 and VISN 16 center supervisors and the VISN 16 director were aware of their schedulers' high handle times (including after-call work) and generally acknowledged they did not have effective means to address these issues. IVC told the review team it did not include handle time in the clinical contact centers' annual performance standards because officials expected center leaders would monitor that target and address issues as needed.

In contrast, at the three clinical contact centers that met both performance standards (VISNs 1, 4, and 10), handle time was not included as a metric in scheduler's performance plans, but these centers' scheduling chiefs directed supervisors to monitor handle time to identify trends and address any issues. VISN 1 center supervisors said they advised schedulers to strive to complete calls in six minutes or less rather than IVC's eight-minute target. At this center, schedulers' average handle time was six minutes, 18 seconds in FY 2024. According to the VISN 1, 4, and 10 clinical contact centers' supervisors, various methods helped schedulers attain consistently lower handle times—such as retraining, shadowing a high-performing scheduler, reaching out to schedulers via Microsoft Teams during calls over eight minutes and asking why the call was going on so long or offering assistance, and having one-on-one conversations to promote reduced talk time and after-call work.

To Improve Performance, Schedulers Should Increase the Time They Are Available to Answer Calls

VHA policy generally requires schedulers to be available at least 70 percent of their workday to serve veterans; the remainder of the workday—such as lunch, breaks, and meetings—is considered time unavailable.[82] To meet IVC's national availability target of 70 percent, schedulers who work a typical eight-and-a-half-hour day (including lunch and breaks) need to be

[82] *VHA Clinical Contact Center Modernization Data and Metrics Guidance*.

available to take calls for an average of about six hours.[83] Schedulers should make themselves available by changing their status in the phone system to "ready," which prompts the telephone system to automatically route calls to them. When schedulers take breaks or are otherwise unavailable to accept calls, they should change their status in the phone system to "not ready," which prevents the telephone system from routing calls to them. The system prompts schedulers to select the reason they are not ready to take calls; options include breaks or meals, meetings, duties as assigned, or phone failure.

In FY 2024, most clinical contact centers had schedulers who did not meet the 70 percent target and were therefore unavailable to take calls for more than 30 percent of their workdays. This level of unavailability restricted the centers' efficiency and limited schedulers' ability to answer more calls, thereby increasing caller wait times and call abandonment. At the three centers that met both the FY 2024 abandonment rate and timeliness performance standards (VISNs 1, 4, and 10), only one of the 564 schedulers had excessive unavailability. In contrast, at centers that did not meet VHA's performance standards, 122 of the 2,359 schedulers, or 5 percent, had excessive unavailability.[84] The number of schedulers with excessive unavailability ranged from one to 34 schedulers depending on the center. This range suggests that some operations issues were not consistent between centers; some appeared to struggle more than others with availability. However, several with low unavailability (of 3 percent or less) still did not meet performance standards, suggesting their performance was attributable to other issues, such as staff with high handle time. Figure 10 shows each VISN's number of schedulers over the 30 percent unavailability limit and the percentage of VISN schedulers they represent.

[83] To calculate the number of hours schedulers should be available to take calls based on the 70 percent standard, the review team multiplied the 70 percent by a typical workday of eight and a half hours (0.70 × 8.5 hours = 5.95 hours, which is six hours when rounded to the nearest hour). This target allows schedulers about two and a half hours of each typical workday to be unavailable for lunch, breaks, meetings, potential phone failure, or other duties.

[84] Though VISN 5 and VISN 15 did not meet VHA's performance standards, neither clinical contact center employed any schedulers who were unavailable for more than 30 percent of their workdays.

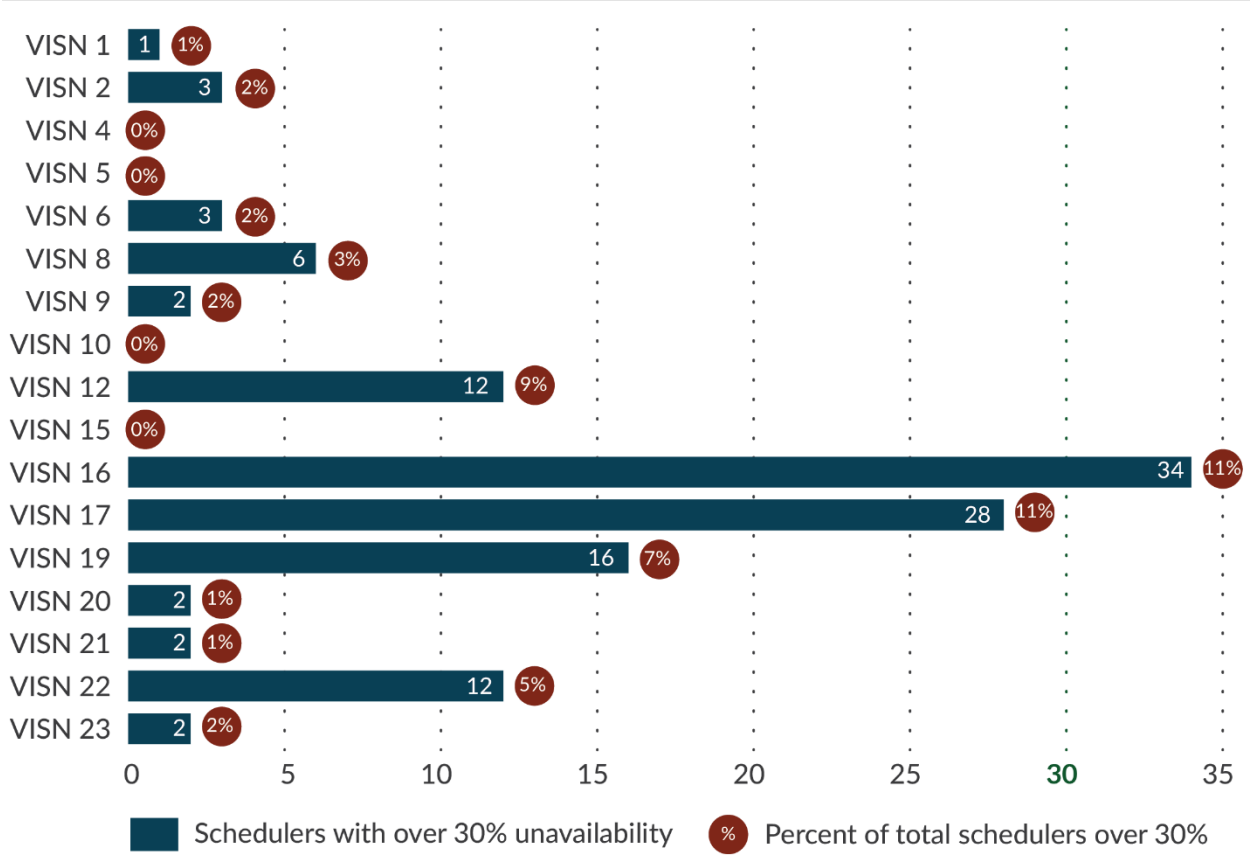

Figure 10. *Number of schedulers unavailable for more than 30 percent of their workday, by VISN.*

Source: VA OIG analysis of Cisco Unified Intelligence Center system data in FY 2024.

Note: A map detailing each VISN and its regional area of oversight is available on VHA's VISN web page at https://www.va.gov/HEALTH/visns.asp.

The review team determined that the 122 schedulers across the 14 VISNs that did not meet both performance standards accounted for about 19,900 hours of excessive unavailability—equivalent to more than nine full-time schedulers working an entire year without handling a single call.[85] Had these schedulers been more available in FY 2024, they might have answered an extra 177,800 calls, potentially reducing the number of abandoned calls nationwide in FY 2024 from 2.6 million to just over 2.4 million.[86]

[85] The review team calculated excessive unavailability by analyzing the ready status of schedulers at each VISN, identifying schedulers who were in a "not ready" status for more than 30 percent of their total time logged into the phone system, and calculating the difference between their actual time in "not ready" status and 30 percent of their total time logged into the phone system. The review team included schedulers that took calls for at least 30 days during FY 2024.

[86] Since schedulers took an average of six minutes and 42 seconds to handle calls during FY 2024, they should have been able to handle about 177,800 calls, had they been in ready status during the 19,900 hours of excessive unavailability.

Figure 11 details the reasons (and percentages) for unavailability for the schedulers who did not meet the availability target, based on their time in the "not ready" status. This sheds light on the responsibilities these schedulers reported having that reduced their availability to answer veterans' calls.

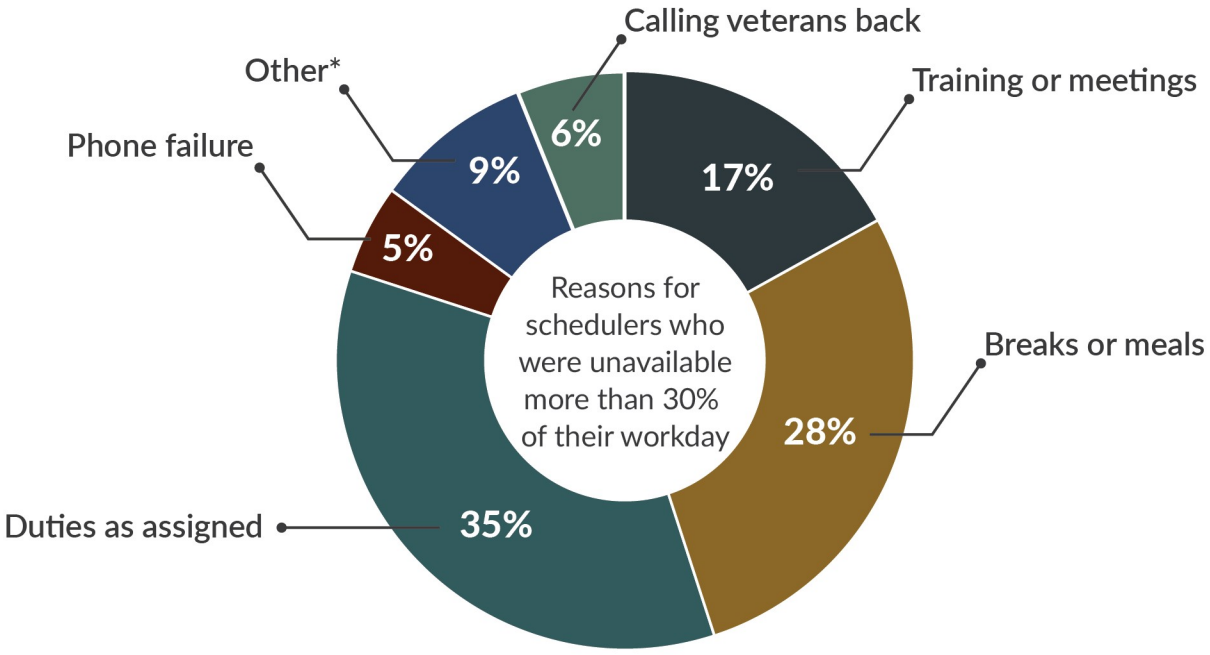

Figure 11. *Percentage of time schedulers in "not ready" status for more than 30 percent of their workday in FY 2024, by reason for unavailability.*

Source: VA OIG analysis of Cisco Unified Intelligence Center system data in FY 2024.

** Other reasons include schedulers logging into the phone system, schedulers ending their shift, supervisors initiating unavailability, and schedulers responding to health chats.*

The most common reason schedulers set their status as unavailable was "Duties as Assigned," which accounted for about 35 percent of the total time unavailable in FY 2024. However, the OIG team found that the time attributed to each reason was not evenly distributed among these schedulers; the majority was mostly attributed to schedulers at one or only a few centers. For example, of the total duties-as-assigned hours, more than 65 percent were at VISN 16's and VISN 17's centers. The review team determined that both centers had disproportionately high "not ready" time because they were not integrated and because schedulers were supervised at the facility level, and the local facility leaders had priorities beyond the clinical contact centers' mission. In another example, though calling veterans back accounted for about 6 percent of these schedulers' unavailability, more than 75 percent of that was attributed to schedulers from

VISN 19.[87] By analyzing time unavailable and through conversations with various center leaders, the review team determined that schedulers at nonintegrated centers were assigned additional tasks unrelated to answering calls, which reduced the centers' chances of meeting its performance standards.

Schedulers self-report the reasons for their status; therefore, the OIG team could not independently verify the time schedulers truly spent in each "not ready" category. Supervisors generally monitored schedulers in real time to ensure they were in the appropriate status. The review team determined that management and oversight practices were inconsistent across VISNs, and clinical contact centers that actively reviewed scheduler availability were generally more likely to have met performance standards than centers that did not. As scheduling supervisors noted, including availability in schedulers' performance plans or through real-time supervision is vital to ensure schedulers' efficiency.

VISN 1, for example, included availability in its schedulers' performance plans—rating schedulers as fully successful if they were available 70 percent of their total time and exceptional if they were available 80 percent or their total time. Only one of VISN 1's 159 schedulers did not meet the availability target, potentially contributing to the clinical contact center's success in meeting both the abandonment rate and timeliness standards.[88] In contrast, VISN 16 had no such requirement or corresponding monitoring in place, and 34 of its center's 304 schedulers (11 percent) did not meet the availability target, and schedulers averaged being unavailable for about 42 percent of the workday.

Differences in schedulers' performance expectations across VISNs may be attributed to IVC releasing conflicting guidance for clinical contact center leaders to use in evaluating schedulers' performance. In 2021, IVC's guidance required schedulers to spend at least 70 percent of their day available to answer calls.[89] In 2022, IVC released new guidance that allowed schedulers to receive a successful evaluation with between 18 and 35 percent unavailability (as shown in table 3)—contradicting the earlier guidance that set schedulers' unavailability target at 30 percent. According to IVC officials, this guidance is reviewed and updated quarterly to reflect their ongoing efforts to adapt performance standards to operational needs. During this review, three clinical contact centers noted they had set expectations in accordance with IVC's 2022 performance plan guidance, potentially allowing schedulers to be rated as successful even when they were unavailable between 30 and 35 percent of the time.[90]

[87] According to VISN 19, these schedulers were not integrated or assigned to the VISN clinical contact center and as of August 2025, duties as assigned, such as calling veterans back instead of answering calls, were discontinued after these schedulers were assigned to the VISN 19 center.

[88] The other two VISNs that met both the performance standards, VISN 4 and VISN 10, did not have any schedulers who did not meet the availability target, contributing to their success in meeting the standards.

[89] *VHA Clinical Contact Center Modernization Data and Metrics Guidance*.

[90] *VHA Clinical Contact Center Modernization Data and Metrics Guidance*.

Table 3. Performance Plan Guidance for Scheduler Availability by IVC

Achievement level	Metric
Exceptional	Monthly average time unavailable 18% or less of workday
Fully successful	Monthly average time unavailable over 18% to 35% of workday
Not successful	Monthly average time unavailable more than 35% of workday

Source: VA Health Connect Recommended e-Performance Plan*, August 5, 2022.*

According to IVC, the 2022 guidance and its thresholds for each metric were selected by a diverse workgroup of supervisors, human resources staff, and clinical contact center leaders. IVC said it was unaware the performance plan guidance contradicted the 30 percent unavailability target. The OIG's fourth recommendation is for IVC to review and address inconsistencies in its availability guidance.

Clinical Contact Center Supervisors Did Not Address Known Performance Issues Among Schedulers

Of the three clinical contact centers the review team visited, two that did not meet standards had supervisors who did not actively address schedulers' performance issues. In contrast, the supervisors at the center that met the standards were involved in making sure schedulers answered calls efficiently.

Supervisors at VISN 5 and VISN 16—the two visited centers that did not meet the standards—focused more on daily operational concerns. Several supervisors said they relied heavily on quality management reports (from quality team staff), which focused on customer service and scheduling appointments, to oversee their schedulers' performance.[91] They also monitored clinical contact center dashboards, which provide real-time call data throughout the day, and they reviewed performance reports for each of their schedulers, which included metrics such as abandonment rate, handle time, total calls handled, and availability to take calls. However, the team found that these supervisors were inconsistent in how often they reviewed the performance reports. Some said they reviewed the reports monthly, while others said they reviewed the reports only a few times a year. Even when supervisors identified performance problems in these reports, they did not know how to correct the issues and, as noted previously, some leaders did not include targets such as handle time and availability in schedulers' performance plans.

At VISN 1, however, the clinical contact center supervisors consistently reviewed daily, weekly, and monthly performance reports and provided schedulers with their performance results weekly,

[91] Clinical contact centers have quality management staff who listen to calls to evaluate them and provide training.

addressing any issues schedulers encountered as needed. These supervisors said they met daily with their leaders as well as daily with schedulers to discuss performance data and share information. On Mondays (the busiest day), VISN 1 supervisors even answered calls themselves to lessen wait times and reduce the rate of abandoned calls. Additionally, center supervisors did the quality reviews and listened to schedulers' calls, enabling lower-level supervisors to address quality and performance issues such as how to efficiently answer calls. The team concluded these factors helped VISN 1 meet its FY 2024 performance standards.

The OIG's fifth recommendation directs clinical contact center leaders to routinely evaluate and, if needed, address schedulers' handle and availability time when it exceeds targets to improve performance and reduce inefficiencies.

Action Plans Focused on Hiring More Schedulers Rather Than Addressing Operational Challenges

For the 14 clinical contact centers that did not meet the FY 2024 performance standards, the OIG team reviewed the action plans of the 12 that neither met both standards nor improved their performance from FY 2023.[92] These action plans often emphasized a need to hire more schedulers to increase call capacity or a need to integrate scheduling operations so any scheduler can answer calls from all facilities in the VISN. But many action plans did not address schedulers' performance, handle time, or availability, which—based on the OIG's analysis for this review—could have helped the centers meet VHA performance standards. Some 29 percent of schedulers at the 12 centers exceeded the handle-time target, and 6 percent did not meet the availability target. The team found that only three of the 12 plans included actions to improve schedulers' availability, and none addressed the need to reduce handle time.[93] The OIG's sixth recommendation is to include schedulers' handle time and availability in the annual performance improvement process to make sure clinical contact centers address these areas.

Notably, four clinical contact centers were focused on hiring more schedulers and administrative staff or integrating schedulers at the center in their action plans, although these centers were already overstaffed according to VHA's staffing model. For example, VISN 19's center was overstaffed by 14 schedulers on average according to the staffing model, yet center leaders' action plan called for hiring more schedulers, not for taking steps to improve handle time or availability despite 30 percent of schedulers not meeting the handle-time target and 7 percent of

[92] VISN 2 and VISN 8 also did not meet the call abandonment rate and timeliness standards in IVC's FY 2024 performance plan, but according to IVC officials, these VISNs were not required to submit action plans because they met those performance standards in FY 2023.

[93] VISNs 6, 21, and 22 included actions to improve scheduler availability in their action plans, intending to improve their respective 2 percent, 1 percent, and 5 percent of schedulers who were unavailable for more than 30 percent of their total workday. The VISN 21 clinical contact center did not include handle time in its action plan because during the OIG's review period, it had a handle time of just under six minutes, beating the eight-minute target.

schedulers not meeting the availability target. Figure 12 shows the results of the review team's analysis of scheduler staffing and action plans for the 12 centers that submitted action plans to improve their FY 2024 performance.

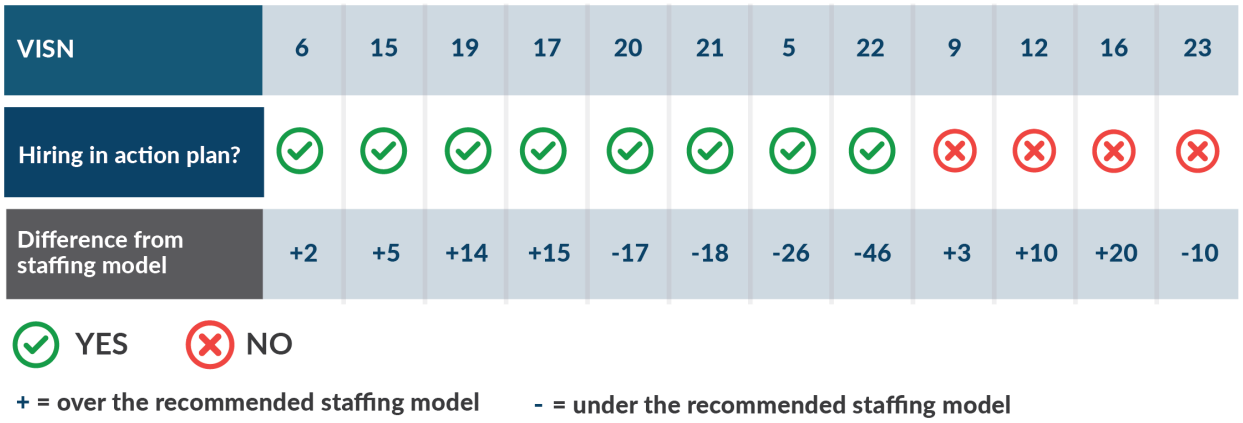

Figure 12. *Clinical contact center staffing compared to staffing model and action plan hiring information.*
Source: OIG analysis of Cisco Unified Intelligence Center system data and submitted action plans.
Note: A map detailing the VISNs and their geographic areas of oversight is available on VHA's VISN web page at https://www.va.gov/HEALTH/visns.asp.

Three of the four VISNs that did not include hiring in their action plans had more than enough schedulers at their centers to answer calls; VISNs 9, 12, and 16 had anywhere from three to 20 more schedulers than the staffing model indicated they needed. The other, VISN 23, was understaffed in FY 2024 but did not include hiring in its action plan. The VISN 23 clinical contact center director asserted that the center did not meet its metrics because of inadequate staffing and budgetary constraints that prevented hiring the appropriate number of schedulers.

The OIG concluded that all 12 centers that submitted action plans to improve their FY 2024 performance need to give more attention to addressing both schedulers' performance and operational inefficiencies. This problem appears especially important at those centers that reported they need more schedulers even though they were overstaffed or that reported they were understaffed based on the staffing model yet did not include hiring schedulers in their action plans. The OIG's seventh recommendation is to evaluate existing staffing and, if necessary, reallocate staff so all clinical contact centers provide services and meet required performance standards for scheduling.[94]

[94] The review team analyzed staffing for the five VISNs that did not have action plans—in other words, the VISNs that met both performance standards or improved their FY 2023 performance by 10 percent—and noted that four were significantly overstaffed, by an average of more than 31 schedulers according to the staffing model.

IVC Recently Implemented a Waiver Process

In FY 2024, IVC relied on the clinical contact centers' action plans to determine whether centers were complying with VA Health Connect requirements. In December 2024, IVC implemented a local waiver process, in response to a national waiver policy issued in March 2024, for the centers to request a temporary reprieve from compliance with VA Health Connect requirements—such as not integrating operations or not providing 24-hour services.[95]

The review team obtained and reviewed waiver requests for the clinical contact centers to determine whether IVC had approved waivers that applied to the issues identified in this report. As of April 2025, three clinical contact centers had submitted waiver requests. VISN 2 requested to not integrate its operations, VISN 12 requested to route scheduling calls to the triage service after business hours, and VISN 5 requested not to provide scheduling services after business hours. IVC rejected all requests because of insufficient data and evidence demonstrating the need for a waiver.

Waiver submissions should include supporting data, information on the clinical impact as well as action plans meant to achieve compliance with VHA policy.[96] IVC's updated waiver policy does not specify the type of information or data that should be included as part of the waiver process, nor does it require that the chief operating officer, who oversees the VISNs, periodically review these waivers. The OIG's eighth recommendation is to clarify waiver guidance and include examples of the specific evidence that would be required for a clinical contact center not to provide 24-hour services—such as exploring the use of other strategies like routing calls to another service or partnering with another center to provide around-the-clock coverage. The OIG's ninth recommendation is to ensure the chief operating officer periodically reviews these waiver submissions and the planned actions to comply with implementation requirements.

Conclusion

VHA should make sure all clinical contact centers are fully integrated to provide veterans with 24-hour access and a better chance at having their issue addressed the first time they call. To do so, centers should share resources VISN-wide, ensure adequate resources to handle call volume, or seek other means—such as partnering with other VISNs—to provide 24-hour coverage and meet performance standards. Additionally, VISNs must consolidate redundant phone queues in medical facilities and outpatient clinics and route these calls to the regional centers so local facility staff are not burdened answering calls that should be routed to the centers. These issues occurred because, as of this review, there was no indication IVC worked with VHA's chief operating officer to make sure integrated centers were fully implemented nationwide. VISN directors also did not fulfill their responsibility to implement the VA Health Connect initiative

[95] VHA Directive 1023, *Waivers to VHA National Policy*, March 5, 2024.

[96] VA Health Connect Internal Policy Waiver Process, November 19, 2024 (not publicly accessible).

and work with their medical facilities to develop cohesive, integrated systems at the VISN level. As a result, the OIG estimated that VA could have used about $17.3 million in salary costs for other purposes if 12 of the 17 centers had fully integrated their scheduling and pharmacy services to efficiently answer calls, as they were required to do.

Furthermore, most clinical contact centers did not meet the call abandonment rate and scheduling timeliness performance standards in FY 2024, despite some centers showing improvement over the previous year. Center directors focused on adding staff to meet performance standards, but the OIG found that most centers were either adequately staffed or overstaffed based on the staffing model. If center directors better addressed operational issues—such as lengthy handle times and scheduler unavailability—and maximized their use of existing staff, VHA's clinical contact centers could be more efficient, better meet the 24-hour coverage requirement for veterans' calls, and prevent delays in veterans' care.

Recommendations 1–9

The OIG made nine recommendations to the under secretary for health:[97]

1. Require the chief operating officer to direct the Veterans Integrated Service Network directors to fully integrate the core services in accordance with policy to improve operational efficiencies and access for veterans.
2. Establish a process requiring medical facility directors to coordinate with the Office of Integrated Veteran Care and the clinical contact centers before setting up or maintaining a local phone queue for services the clinical contact center provides.
3. Require the Office of Integrated Veteran Care to direct the clinical contact center leaders to determine if schedulers are arbitrarily ending calls in the telephone system to remain in after-call work status longer than needed to reduce the number of calls routed to them.
4. Require the Office of Integrated Veteran Care to review and address inconsistencies in guidance on schedulers' availability.
5. Direct clinical contact center leaders to routinely evaluate and, if needed, address schedulers' handle time and availability time to improve performance and reduce inefficiencies.
6. Direct the Office of Integrated Veteran Care to include schedulers' handle time and availability time as part of VA Health Connect's annual performance plans to make sure clinical contact centers monitor and address these areas.

[97] The recommendations addressed to the under secretary for health are directed to anyone in an acting status or performing the delegable duties of the position.

7. Make sure the Office of Integrated Veteran Care and chief operating officer evaluate VA Health Connect staffing for scheduling and, if necessary, reallocate staff so all clinical contact centers provide core services and meet required performance standards for scheduling.
8. Direct the Office of Integrated Veteran Care to formalize and clarify internal waiver guidance and include examples of the specific evidence that would be required for a clinical contact center not to provide 24-hour services—such as exploring the use of other strategies like routing calls to another service or partnering with other centers to provide coverage.
9. Ensure the assistant under secretary for health for the Office of Integrated Veteran Care and chief operating officer periodically review the clinical contact center waiver submissions and the planned actions to comply with VA Health Connect requirements.

VA Management Comments

VHA is planning action to improve the oversight of its clinical contact centers. For example, VISNs will be required to submit documentation of their progress toward fully integrating clinical contact center core services, IVC is also developing standard operating procedures for local phone queues at clinical contact centers and will add scheduler performance metrics to the FY 2026 VISN performance goals.

VA's acting under secretary for health concurred with recommendations 1 through 6 as well as 8 and 9; the acting under secretary for health concurred in principle with recommendation 7. He provided an action plan for each recommendation and requested closure for recommendation 4. Appendix D includes the full text of the acting under secretary's comments.

For recommendation 1, IVC updated its annual formal attestation process to require review by the chief operating officer. During the first and third quarter of each fiscal year, all VISNs will be required to submit attestation forms, and in some cases action plans, to the chief operating officer documenting their progress toward fully integrating clinical contact center core services.

For recommendation 2, IVC is creating guidance for VISNs to use when developing standard operating procedures for local phone queues at clinical contact centers. This guidance is expected to be incorporated into VISN-level performance plans for FY 2026.

For recommendation 3, IVC will implement a continuous process improvement program focused on average handle time and identifying and reducing prolonged after-call work. Once this new program produces data, IVC will provide additional guidance to VISNs to help mitigate the issue of schedulers unnecessarily extending after-call status.

For recommendation 4, IVC reviewed and updated guidance on the 70 percent scheduler availability target. IVC published the new guidance on the VA Health Connect SharePoint in

April 2025. The acting under secretary requested closure of this recommendation based on these actions.

To address recommendation 5, IVC will add scheduler performance metrics to VISN performance goals beginning in FY 2026. IVC will also provide guidance to VISNs on monitoring scheduler metrics after results of the continuous process improvement program, noted in the response to recommendation 3, are released. IVC is updating the performance plans of schedulers to align these recommendations.

For recommendation 6, IVC will integrate handle time and availability in schedulers' performance plans beginning in FY 2026. IVC is also in the process of updating the schedulers' performance plans, and corrective action plans will be developed and implemented to make sure schedulers adhere to these performance standards.

For recommendation 7, which the acting under secretary concurred with in principle, IVC will collaborate with the VISNs to evaluate staffing. Based on the results, IVC and the chief operating officer "will explore the feasibility of reallocating schedulers." IVC also will include evaluation results in the annual VISN attestation process (discussed in response to recommendation 1) and discuss results with VISN leaders.

For recommendation 8, IVC is updating its internal waiver guidance and will collaborate with the Office of Integrity and Compliance to make sure guidance aligns with policies and standards.

For recommendation 9, IVC will continue to implement an annual formal attestation process and make sure all attestation forms and action plans are submitted twice per fiscal year to the chief operating officer and the assistant under secretary for health for IVC.

OIG Response

The acting under secretary for health provided acceptable planned corrective actions for the nine recommendations. The OIG closed recommendation 4 as implemented based on documentation provided. The OIG found the action plans for all other recommendations acceptable and will continue to evaluate VHA's actions and will close the remaining recommendations when VHA provides complete documentation and sufficient evidence addressing the intent of the recommendations and the issues identified.

Appendix A: Background

For the 17 clinical contact centers reviewed, figure A.1 summarizes call abandonment rates, timeliness, and fiscal year (FY) 2024 performance for scheduling services.

VISN	Abandonment rate	Timeliness % answered within 30 seconds	Met both standards*	Met one standard‡	Met annual performance goal§
1	5%	80%	✓	−	✓
2	6%	77%	✗	✗	✓
4	3%	88%	✓	−	✓
5	26%	24%	✗	✗	✗
6	15%	50%	✗	✗	✗
8	6%	86%	✗	✓	✓
9	10%	66%	✗	✗	✓
10	2%	94%	✓	−	✓
12	6%	71%	✗	✗	✓
15	7%	70%	✗	✗	✓
16	16%	61%	✗	✗	✗
17	5%	74%	✗	✓	✓
19	19%	52%	✗	✗	✗
20	19%	35%	✗	✗	✗
21	14%	57%	✗	✗	✗
22	13%	45%	✗	✗	✓
23	22%	31%	✗	✗	✓

✓ Yes ✗ No − Not applicable

Figure A.1. *VISN clinical contact center FY 2024 performance.*

Source: VA OIG analysis of Cisco Unified Intelligence Center system data in FY 2024.

Note: VISN means Veterans Integrated Service Network. A map detailing the VISNs and their geographic areas of oversight is available on VHA's VISN web page at first-contact resolution; Office of Integrated Veteran Care; handle time; integration model.

** The clinical contact center had a call abandonment rate of 5 percent or less and answered at least 80 percent of calls within an average of 30 seconds.*

‡ The clinical contact center met one performance standard and may or may not have improved by at least 10 percent in the other performance standard.

§ The VISNs with a green check mark in this column met both standards; met one standard and improved over the previous year's performance by 10 percent in the other standard; or met neither standard but improved over the previous year's performance in both standards.

Appendix B: Scope and Methodology

Scope

The VA Office of Inspector General (OIG) review team conducted its work from October 2024 through July 2025 to assess the establishment of clinical contact centers and their progress in meeting Veterans Health Administration (VHA) performance standards and targets for primary care scheduling service.[98] The review team focused on fiscal year (FY) 2024—October 1, 2023, to September 30, 2024—and reviewed 17 of 18 clinical contact centers' operations for the core services.[99] To assess performance standards for the scheduling and administrative service, the team analyzed the 24.4 million calls schedulers received.

Methodology

The review team identified and reviewed applicable VHA policies and guidance, and the team interviewed Office of Integrated Veteran Care (IVC) officials to understand the implementation and oversight of clinical contact center operations and performance standards.

The review team worked with the OIG's Office of Data and Analytics to establish a universe of the 17 clinical contact centers that were in operation throughout FY 2024 and to review VHA's national call data for the centers' FY 2024 scheduling, pharmacy, and clinical triage operations and performance data. This included scheduling services' call abandonment rates, timeliness, staffing levels, recommended staffing levels based on the required staffing model, and schedulers' handle time and availability. The team also analyzed centers' available action plans, which were designed to meet FY 2024 scheduling performance standards.

The review team further analyzed the 17 clinical contact centers' scheduling, pharmacy, and clinical triage data to determine whether they were providing 24-hour coverage and whether staff were integrated to answer calls across the regional Veterans Integrated Service Network (VISN).[100] The review team assessed medical facilities' phone queue call data to determine whether appropriate calls were routed to the contact centers or whether medical facility staff were also answering scheduling, pharmacy, and clinical triage calls in efforts duplicative of the contact centers. The team analyzed this data to determine the nature and extent of operational and scheduling performance issues at the centers.

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[98] The OIG focused on the performance of the Veterans Integrated Service Network (VISN) clinical contact centers' scheduling and administration service because that operation directly affects veterans' ability to access primary care at all the network's medical facilities as well as virtual care at the contact centers.

[99] VISN 7 was not in the scope of this review because it was not operational until March FY 2024.

[100] VHA divides the United States into 18 regional networks, or VISNs, which provide administrative and clinical oversight for the region's local facilities. For more information and a map detailing these geographic areas, see https://www.va.gov/HEALTH/visns.asp.

Given IVC's two nationwide performance standards for FY 2024 regarding call abandonment rate and service-level timeliness, the review team divided the 17 centers into two groups: one group that met the performance standards and the other group that did not. The review team then judgmentally selected three clinical contact centers: two that did not meet the performance standards, and one center that did. To examine how and whether these clinical contact centers fully implemented the VA Health Connect initiative and to assess the processes and controls they had to meet scheduling performance standards, the team visited the following sites from November 2024 through January 2025:

- The VA New England Healthcare System (VISN 1), which met scheduling performance standards
- The VA Capital Health Care Network (VISN 5), which did not meet scheduling performance standards
- The South Central VA Health Care Network (VISN 16), which did not meet scheduling performance standards

Other considerations for selecting these VISNs included their integration of call operations, staffing levels, schedulers' handle time, and schedulers' availability time. The team interviewed and obtained documentation from clinical contact center leaders, supervisors, quality management staff, and center staff to understand the establishment of the center operations, the status of implementation, and any challenges and processes to meet scheduling performance standards. The team also listened to incoming scheduling calls at the centers to understand how staff handle calls. During these site visits, the team confirmed issues identified through VHA's call data and better understood why some issues occurred.

The team also followed up with the remaining 14 clinical contact centers to confirm implementation and scheduling performance issues identified, such as not providing 24-hour coverage or schedulers exceeding the handle time. Additionally, the team obtained implementation information and reviewed scheduling processes and controls to understand why some centers fully implemented their operations and had a low number of schedulers that exceeded the handle time or availability targets, while other centers did not.

To estimate the number of staff and associated salary cost with the integrated center model, the review team used the recommended staffing model (Erlang-C calculator). The team calculated the average number of staff each clinical contact center would have needed if it had been integrated based on the following factors: its actual call volume from FY 2024, handle time from April 1 through September 30, 2023; timeliness standard of 80 percent; average speed of answer of 30 seconds; and a 30 percent shrinkage rate (such as time off, breaks, meetings attended by center staff). The review team identified the average number of staff needed for each hour during core hours and subsequently calculated the average number of staff that would be needed across an average working day. The review team also calculated the average number of staff that

actually worked for each hour during core hours and subsequently calculated the average number of staff that actually worked across an average day. The review team then calculated the difference in average staffing because of integration by subtracting the needed staff for integrated clinical contact centers from the actual average staffing.

The team then multiplied this number by the average annual cost of a clinical contact center scheduler: $85,000.[101] Table B.1 shows the average number of schedulers needed for an integration model based on the recommended staffing model (Erlang-C calculator) compared to the average schedulers working—as well as the cost associated with not using the integrated model for scheduling.

Table B.1. Better-Use-of-Funds Calculation for Clinical Contact Centers if Primary Care Scheduling Had Been Integrated

VISN	Average number of integrated schedulers	Average number of schedulers working	Difference	Average scheduler salary cost	Total
2	36	47	11	$85,000	$935,000
4	76	115	39	$85,000	$3,315,000
8	63	100	37	$85,000	$3,145,000
9	51	54	3	$85,000	$255,000
10	54	92	38	$85,000	$3,230,000
16	101	121	20	$85,000	$1,700,000
17	111	126	15	$85,000	$1,275,000
19	70	84	14	$85,000	$1,190,000
20	77	60	-17	$85,000	N/A*
22	157	111	-46	$85,000	N/A*
23	60	50	-10	$85,000	N/A*
Total	**—**	**—**	**—**	**—**	**$15,045,000**

Source: VA OIG analysis of Cisco Unified Intelligence Center system data in FY 2024.

** "N/A" means "not applicable." Clinical contact centers that appear to require more schedulers with integration were excluded from the calculation. These centers were significantly understaffed in FY 2024 and, therefore, require more schedulers regardless of integration.*

The review team used this same methodology for the pharmacy service, calculating the difference in cost between the average staffing if a clinical contact center had been integrated

[101] The annual cost of $85,000 per scheduler was generated using methodology provided by the Office of Integrated Veteran Care's (IVC) project manager. IVC had used this same methodology, using an estimate of a $50,000 salary for contact center schedulers and an overhead rate of 1.7 to account for translated costs (the overhead rate includes elements such as benefits, taxes, health insurance, recruitment, bonuses, and seat costs).

and actual average staffing, and multiplying this by the annual average cost of center pharmacy staff: $96,900.[102] Table B.2 shows the number of pharmacy staff needed for an integration model based on the recommended staffing model (Erlang-C calculator) compared to the average staff working—as well as the cost associated with not using the integrated model for pharmacy.

Table B.2. Better-Use-of-Funds Calculation for Clinical Contact Centers if Pharmacy Services Had Been Integrated

VISN	Average number of integrated staff	Number of average staff working	Difference	Average pharmacy staff salary cost	Total
8	61	69	8	$96,900	$775,200
9	42	24	-18	$96,900	N/A*
10	78	78	0	$96,900	N/A*
12	35	35	0	$96,900	N/A*
16	33	38	5	$96,900	$484,500
17	27	35	8	$96,900	$775,200
19	36	30	-6	$96,900	N/A*
20	48	36	-12	$96,900	N/A*
23	27	29	2	$96,900	$193,800
Total	—	—	—	—	**$2,228,700**

Source: VA OIG analysis of Cisco Unified Intelligence Center system data and salary cost in FY 2024.

** "N/A" means "not applicable." Clinical contact centers that appear to require more staff with integration were excluded from the calculation. These centers were understaffed in FY 2024 and therefore require more staff regardless of integration.*

Internal Controls

The review team determined that performing an internal control step was not necessary unless internal control deficiencies were noted during the review. During the review, the team exercised diligence in identifying internal control deficiencies and noted that clinical contact center leaders and facility leaders should increase their designed internal control activities to identify and address operational inefficiencies.[103] The team's assessment identified four principles with a

[102] The annual cost of $96,900 per staff was generated using methodology provided by IVC's project manager. IVC had used this same methodology, using an estimate of a $57,000 salary for staff and an overhead rate of 1.7 to account for translated costs.

[103] Government Accountability Office (GAO), *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

significant risk of affecting the sufficiency and appropriateness of evidence, as shown in table B.3.

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

Component	Principle	Deficiency identified by this report that may affect the sufficiency and appropriateness of evidence
Control Environment	2. Exercise Oversight Responsibility	Most clinical contact centers did not integrate their operations for scheduling and pharmacy and staff primarily answered calls only for their own facility.
Control Environment	5. Enforce Accountability	Regional directors were not directed to take steps to fully integrate services to improve operational efficiencies.
Control Activities	10. Design Control Activities	IVC did not require medical facilities to coordinate before setting up or maintaining a local phone queue for services the clinical contact center provides.
Monitoring	16. Perform Monitoring Activities	Clinical contact centers did not evaluate schedulers' handle time and availability time to improve performance and reduce inefficiencies.

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 review team relied on computer-processed data obtained from the Cisco Unified Intelligence Center system for FY 2024. To determine the reliability of this data, the team performed tests to identify any errors, including missing data attributes, calculation errors, duplicate records, alphabetic or numeric characters in incorrect fields, or illogical relationship among data elements.[104]

[104] GAO, *Assessing Data Reliability*, GAO-20-283G, December 2019.

For data validation, the team compared the call data to VHA's call data, reviewed relevant documentation when available, and confirmed clinical contact center staffing, handle time, and availability data for accuracy with the centers during site visits and follow-up inquiries.

Though the review team noted that the data included calls that were not directly related to the program office's specific standards or targets (for example, some calls in primary care scheduling queues were intended for specialty clinics or other purposes), these calls do not affect the data's reliability to support the review objectives and conclusions. Clinical contact centers anticipate some incoming calls may be outside their scope and require more support beyond schedulers. Since these calls may affect scheduler and center performance, the review team decided they should be included in the data analysis to properly assess workload and efficiency.

The review team did not identify any data issues, and the team concluded that the Cisco Unified Intelligence Center 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*.

Appendix C: Monetary Benefits in Accordance with Inspector General Act Amendments

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs[105]
2	VHA did not ensure most Veterans Integrated Service Networks' clinical contact centers have fully integrated scheduling or pharmacy services to share resources VISN-wide as required and, therefore, is not achieving economies of scale.	$17,273,700	$0
	Total	**$17,273,700**	**$0**

[105] The OIG questions costs when VA action or inaction (such as spending or failure to fully compensate eligible beneficiaries) is determined by the OIG to violate a provision of law, regulation, contract, grant, cooperative agreement, or other agreement; when costs are not supported by adequate documentation; or when they are expended for purposes that are unnecessary or unreasonable under governing authorities. Within questioned costs, the OIG must, as required by section 405 of the IG Act, report unsupported costs. Unsupported costs are those determined by the OIG to lack adequate documentation at the time of the audit. The review team did not identify any questioned costs.

Appendix D: VA Management Comments, Acting Under Secretary for Health

Department of Veterans Affairs Memorandum

Date: August 27, 2025

From: Acting Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Clinical Contact Centers Need Stronger Veterans Integrated Service Network (VISN) Leadership and Oversight to Realize Staff Efficiencies and Cost Savings (VIEWS 13518477)

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

1. Thank you for the opportunity to review and comment on OIG's draft report on Clinical Contact Centers Need Stronger VISN Leadership and Oversight to Realize Staff Efficiencies and Cost Savings. The Veterans Health Administration (VHA) concurs with recommendations 1 through 6, 8 and 9; and concurs in principle with recommendation 7 made to the Under Secretary for Health. The action plan is included as an attachment.

2. VHA is leading the Clinical Contact Center Modernization initiative through VA Health Connect, offering four core services (clinical triage, scheduling and administration, virtual clinic visits and pharmacy services) to approximately nine million Veterans. The Modernization initiative currently under way has facilitated care delivery across the enterprise, providing seamless virtual care under the principle of "The Right Care, Right Now".

3. VA Health Connect is a single, real-time system for reporting data nationwide, making it easier to gauge overall operations and by integrating various technology tools to enhance efficiency. More than 4,000 Registered Nurses, Medical Support Assistants, and medical providers actively use the platform, and in fiscal (FY) 2024, the call centers handled about 41.5 million calls and is on track to manage 50 million calls in FY 2025.

The OIG removed point of contact information prior to publication.

(Original signed by)

Steven L. Lieberman, M.D., MBA, FACHE

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

Clinical Contact Centers Need Stronger VISN Leadership and Oversight to Realize Staff Efficiencies and Cost Savings

2025-00228-AE-0013

Recommendation 1: Require the chief operating officer to direct the Veterans Integrated Service Network directors to fully integrate the core services in accordance with policy to improve operational efficiencies and access for veterans.

VHA Comments: Concur.

VHA's Chief Operating Officer (COO) will direct all Veteran Integrated Service Network (VISN) Network Directors (NDs) to fully integrate clinical contact center core services. To support this recommendation, Integrated Veteran Care (IVC) has updated its annual formal attestation process to include VHA COO review. This process requires all VISNs to submit attestation forms and action plans (the latter for those who are non-compliant with VHA Directive 1006.04(3)) to the VHA COO during first (Q1) and third (Q3) quarters of each fiscal year

Status: In Progress **Target Completion Date:** October 2026

Recommendation 2: Establish a process requiring medical facility directors to coordinate with the Office of Integrated Veteran Care and the clinical contact centers before setting up or maintaining a local phone queue for services the clinical contact center provides.

VHA Comments: Concur

VHA's Chief Operating Officer (COO) will direct all Veteran Integrated Service Network (VISN) Network Directors (NDs) to coordinate local phone queue for services the clinical contact center provides with IVC before setting up or maintaining them. To support VISN leadership in accomplishing this recommendation, IVC is creating guidance for VISNs to use when developing their own VISN level Standard Operating Procedures (SOPs) regarding the auditing of phone queues at the VISN, facility, and Community Based Outpatient Clinic (CBOC) levels. This guidance will be incorporated into the FY26 VISN-level Performance Goals, with a planned release in Q1FY26.

Status: In Progress **Target Completion Date:** December 2026

Recommendation 3: Require the Office of Integrated Veteran Care to direct the clinical contact center leaders to determine if schedulers are arbitrarily ending calls in the telephone system to remain in after-call work status longer than needed to reduce the number of calls routed to them.

VHA Comments: Concur

VHA recognizes the importance of directing clinical contact center leaders to determine if schedulers are, in fact, arbitrarily ending calls in the telephone system to prolong their after-call work status. To address this, IVC will implement a continuous process improvement (CPI) program as part of the High Reliability Organization (HRO) workgroup, focused on average handle time, including after-call work status. These measures aim to identify and reduce prolonged and inconsistent after-call work times.

By December 2025, IVC will have the information from the CPI program to inform guidance to help mitigate the issue of, schedulers unnecessarily extending after-call status, thereby increasing operational efficiency, decreasing Veteran wait times, and improving the quality of care provided to Veterans for their scheduling needs. IVC anticipates the recommended guidance to be implemented by VISNs by October 2026.

Status: In Progress **Target Completion Date:** October 2026

Recommendation 4: Require the Office of Integrated Veteran Care to review and address inconsistencies in guidance on schedulers' availability.

VHA Comments: Concur

VHA recognizes the importance of providing consistent guidance to the field. In reaction to VA's Office of Inspector General (OIG) review team preliminary findings shared with the program office, IVC performed a review and updated outdated guidance on scheduler availability to reflect the 70 percent availability target. The outdated guidance was achieved and replaced with new, consistent guidelines as documented in the VA Health Connect Dashboards Data Definitions document. The updated VA Health Connect Dashboards Data Definitions document was published on the VA Health Connect SharePoint on April 9, 2025. Evidence documenting the updates and archival has been submitted to OIG as a separate attachment for review.

VHA considers this recommendation complete and implemented.

Status: Completed **Target Completion Date:** August 2025

Recommendation 5: Direct clinical contact center leaders to routinely evaluate and, if needed, address schedulers' handle time and availability time to improve performance and reduce inefficiencies.

VHA Comments: Concur

VHA agrees importance of directing clinical contact center leaders to regularly assess and, if necessary, improve schedulers' handle time and availability to boost performance and reduce inefficiencies. VHA's Chief Operating Officer (COO) will direct all Veteran Integrated Service Network (VISN) Network Directors (NDs) to direct clinical contact center leaders in meeting this recommendation. To support VISN leadership in accomplishing this recommendation, IVC will incorporate scheduler performance metrics into the FY26 VISN performance goals, which will be released Q1 FY26.

As part of our Continuous Process Improvement (CPI) project, referenced in the action plan for Recommendation 3, IVC will revise supervisory guidance materials depending on the results of the CPI project. These revisions will encompass best practices for real-time monitoring of scheduling staff and methodologies for tracking and trending staff data to identify areas for potential improvement. Additionally, corrective action plans will be formulated and implemented when necessary to ensure schedulers meet performance standards.

IVC is currently in the process of updating the Advanced Medical Support Assistant (AMSA) performance plan to align with these recommendations. It should be noted that while the program office will provide oversight and guidance, the enforcement of these requirements resides at the VISN level.

The target completion date for this recommendation has been set for December 2026, based on the time required by VISNs to report their progress following the end of the fiscal year.

This plan aims to improve the efficiency and effectiveness of scheduling operations, thereby reducing inefficiencies and improving overall performance.

Status: In-Progress **Target Completion Date:** December 2026

Recommendation 6: Include schedulers' handle time and availability time as part of VA Health Connect's annual performance plans to make sure clinical contact centers monitor and address these areas.

VHA Comments: Concur

VHA recognizes the importance of including schedulers' handle time and availability time as part of VA Health Connect's annual performance plans. VHA's Chief Operating Officer (COO) will direct all Veteran Integrated Service Network (VISN) Network Directors (NDs) to direct clinical contact center leaders in meeting this recommendation. To support VISN leadership in accomplishing this recommendation, IVC will integrate these metrics into the FY26 VISN performance goals, set to be released in Q1 FY26. As referenced in the Recommendation 5 action plan, IVC will revise supervisory guidance materials under our Continuous Process Improvement (CPI) project (originally mentioned in the action plan response to Recommendation 3) depending on the results of the CPI project. These revisions will include best practices for real-time monitoring of scheduling staff and methodologies for tracking and analyzing staff data to pinpoint opportunities for improvement.

Furthermore, corrective action plans will be developed and implemented for scheduling staff as needed to ensure adherence to performance standards. Concurrently, IVC is updating the Advanced Medical Support Assistant (AMSA) performance plan to reflect these changes. It is important to note that while the program office can provide oversight and guidance, enforcement resides at the VISN level.

The target completion date of December 2026 considers the time required for VISNs to report their progress following the conclusion of the fiscal year.

Status: In-Progress **Target Completion Date:** December 2026

Recommendation 7: Make sure the Office of Integrated Veteran Care and chief operating officer evaluate VA Health Connect staffing for scheduling and, if necessary, reallocate staff so all clinical contact centers provide core services and meet required performance standards for scheduling.

VHA Comments: Concur in Principle

VHA concurs in principle with the recommendation to evaluate VA Health Connect staffing for scheduling and reallocating staff if necessary to meet core services and required performance standards. To address this recommendation, IVC will partner with the Veteran Integrated Service Networks (VISNs) to conduct an evaluation of scheduling staffing. Based on this evaluation, IVC and the VHA Chief Operating Officer (COO) will explore the feasibility of reallocating schedulers.

IVC will incorporate this evaluation into the annual VA Health Connect attestation process and discuss the results with VISN and Network Directors (NDs) during their end-of-year retrospective compliance meeting. VISNs will be required to develop action plans and provide mid-year updates. The COO will provide VISN leadership with operational data from VA Health Connect to assist with staffing allocation.

Staff performance and analysis tools have been provided to the VISNs, along with training sessions conducted to aid in staff modeling. Each site must consider its unique circumstances, such as community

sharing agreements, Veteran demographics, and natural disaster considerations that can significantly impact staffing needs.

It is essential that each site retains autonomy over its Full-Time Equivalent (FTE) positions to manage specific needs effectively. Flexibility in staffing is crucial for the successful operation of our facilities. Each site is best positioned to determine and adjust its staffing requirements to meet both operational and scheduling performance standards.

Status: In progress **Target Completion Date:** January 2027

Recommendation 8: Direct the Office of Integrated Veteran Care to formalize and clarify internal waiver guidance and include examples of the specific evidence that would be required for a clinical contact center to not provide 24-hour services—such as exploring the use of other strategies like routing calls to another service or partnering with other centers to provide coverage.

VHA Comments: Concur

VHA acknowledges the importance of formalizing and clarifying internal waiver guidance. IVC is actively working on improving and refining the internal policy waiver process. IVC will collaborate with the Office of Integrity and Compliance to ensure alignment with existing policies and standards. IVC aims to publish the revised waiver process by the third quarter of FY2026.

Status: In-Progress **Target Completion Date:** March 2026

Recommendation 9: Ensure the assistant under secretary for health for the Office of Integrated Veteran Care and chief operating officer periodically review the clinical contact center waiver submissions and the planned actions to comply with VA Health Connect requirements.

VHA Comments: Concur

VHA concurs with the importance of periodic reviews of clinical contact center waiver submissions and the corresponding actions to comply with VA Health Connect requirements by IVC Assistant Under Secretary for Health (AUSH) and the VHA Chief Operating Officer (COO). In response to this recommendation, IVC will continue implementation of the annual formal attestation process. This process ensures that all VISN-level attestation forms and action plans are submitted to the VHA COO and IVC AUSH on a biannual basis for oversight and awareness. To promote transparency and accountability, these documents will be shared in the first (Q1) and third (Q3) quarters of each fiscal year, highlighting the compliance status with VHA Directive 1006.04(3) across the VISNs.

IVC's structured and periodic review process seeks to strengthen monitoring and enhance the overall quality of care provided to Veterans.

Status: In-Progress **Target Completion Date:** June 2026

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

OIG Contact and Staff Acknowledgments

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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

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