US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

VHA Facilities' Collection and Oversight of Specialty Care Call Data

Preliminary Result Advisory Memorandum | **25-03621-68** | **February 19, 2026**

OUR MISSION

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

CONNECT WITH US

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

PRIVACY NOTICE

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

QUALITY STANDARDS

The Office of Inspector General (OIG) has released this preliminary result advisory memorandum to provide information on matters of concern that the OIG has gathered as part of its oversight mission. The OIG is conducting the review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation*.

February 12, 2026[1]

PRELIMINARY RESULT ADVISORY MEMORANDUM

TO: Honorable Paul R. Lawrence, Ph.D, Deputy Secretary of Veterans Affairs, performing the delegable duties of the Assistant Secretary for Information and Technology and Chief Information Officer (005); Honorable John J. Bartrum, MBA, J.D, Veterans Affairs Under Secretary for Health, Veterans Health Administration (10)

FROM: Larry Reinkemeyer, Assistant Inspector General, Office of Audits and Evaluations (52), VA Office of Inspector General

SUBJECT: VHA Facilities' Collection and Oversight of Specialty Care Call Data

The VA Office of Inspector General (OIG) is issuing this preliminary result advisory memorandum to inform the Veterans Health Administration (VHA) and Office of Information and Technology of significant issues affecting veterans' access to specialty care at VA medical facilities, particularly for high-risk patients seeking radiology or mental health services. As a result of the issues identified, veterans may face delays and scheduling challenges in receiving care.

In November 2025, the OIG launched a national review to determine whether leaders at VA medical facilities ensure staff answer veterans' telephone calls for specialty care within established performance standards to make sure veterans have ready access to care and to reduce delays in care. The OIG found that 13 of the 15 medical facilities in the team's sample review did not have key data—such as the number of abandoned (calls where the caller hung up before anyone answered) and answered calls and average call wait times—making it difficult to determine whether veterans reached specialty care clinics quickly and easily. The OIG is disseminating these findings to ensure all VHA medical facilities are aware of and can proactively start collecting and overseeing specialty care call data.

VA's I CARE Core Values and Characteristics require VA to provide veterans with seamless access to health care.[2] In addition, VHA Directive 1090 states that medical facilities and the regional Veterans Integrated Service Networks (VISNs) that provide administrative and clinical

[1] This memorandum was sent to VHA on February 12, 2026.

[2] VA's Core Values, Characteristics, and Customer Service Principles require VA programs to provide exceptional customer service that includes smooth and easy access to health care; 38 C.F.R. Part 0, *Values, Standards of Ethical Conduct, and Related Responsibilities*, May 20, 2019.

oversight for facilities, must collect and analyze call performance metrics on an ongoing basis.[3] Metrics tracked include call volume, average speed of answer, and whether at least 80 percent of calls are answered within the timeliness standard of 30 seconds and 5 percent or fewer calls are unanswered (that is, abandoned).

The OIG examined call operations for 90 clinics across six specialties—audiology, dental, mental health, optometry, podiatry, and radiology—at 15 statistically selected facilities (out of 132 facilities).[4] These clinics were selected because VA patient complaints reported in VA's patient advocate system from August 2024 through July 2025 frequently involved reports that calls for these specialties went unanswered.[5]

As of January 2026, the OIG found that 13 of the 15 reviewed medical facilities did not have critical call data for nearly one million of the 2.1 million veteran call attempts over the 12-month period ending July 31, 2025.[6] Specifically:

- Leaders at those 13 facilities had no oversight of call performance for 49 of their 78 clinics, leaving nearly one million veteran call attempts untracked. The 49 clinics use individual or shared phone lines, which are not trackable using a telephone system. This leaves the responsibility with individual clinics and facilities to manage calls and ensure veterans can access care. By contrast, the other 29 clinics located within the 13 facilities were configured as queues (that route incoming calls by placing callers "in line" so their inquiries can be addressed in a specific order), which record call performance data in the telephone system.
- Radiology and mental health clinics, which serve patients who are at high risk of adverse health outcomes, faced significant challenges. Out of the nearly one million untracked calls at the 49 clinics, at least 338,000 were to radiology clinics and 109,000 to mental health clinics—putting veterans who may need timely and critical care at risk.
- Veterans trying to access care at these clinics reported that they faced delays, uncertainty, and frustration. For example, in March 2025, a veteran's spouse

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

[4] The 132 facilities were identified in the patient advocate system as having unanswered calls and providing specialty care from August 2024 through July 2025. The OIG excluded the Atlanta facility because its specialty clinic call operations were already assessed in a prior hotline review, and a report with recommendations was issued: VA OIG, *Atlanta Call Center Staffing and Operational Challenges Provide Lessons for the New VISN 7 Clinical Contact Center*, Report No. 23-01609-14, January 30, 2025. As of February 2026, the OIG has concurred with closing three of the four recommendations, while implementation of the Atlanta facility's evaluation of call data for mental health and specialty care remains in progress.

[5] Veterans can share feedback with VA in several ways, including in-person, telephone, email, and mail; no matter how the feedback is submitted, it goes into a patient advocate system, called Patient Advocate Tracking System Replacement tool, where a patient advocate reviews it and sends it to the right medical facility service for resolution.

[6] The call volume data excludes the Washington DC facility due to unavailability at the time of issuance.

reported difficulty scheduling a critical radiology appointment for her husband who required evaluation for cancer that may have spread. She reported making multiple phone calls that went to voicemail, with no follow-up within the promised 24 hours.

- Veterans at the 13 reviewed facilities also reported through VA's patient advocate system they could not reach staff by phone to schedule or change appointments, forcing them to drive to facilities in person. The OIG observed this firsthand during site visits at VA facilities in Miami, Florida, and Washington, DC, where veterans told VA staff about their experiences while the team was present.

The OIG communicated its preliminary findings to VHA in January 2026, and a VA Office of Information and Technology official confirmed that VA lacks a system to capture call performance data for specialty clinics that use individual or shared phone lines. However, at that time, across the facilities, only 19 of the 49 specialty clinics reported that they planned to reconfigure to start collecting and monitoring call data through queues. Of the 13 facilities, seven did not have plans to reconfigure any of their remaining specialty clinics.

Because phone access is a primary way veterans schedule specialty care appointments, the absence of data needed to track call performance may impact VHA's awareness of delays in veterans' timely access to care, especially for high-risk patients needing mental health or radiology services. Further, absent data may prevent leaders from identifying problems or taking corrective action to ensure timely, seamless care.

The OIG's national review of medical facilities' management of specialty clinic calls is ongoing, and a comprehensive analysis of this finding and others will be included in the final report.

LARRY M. REINKEMEYER
Assistant Inspector General
for Audits and Evaluations

OIG Contact and Staff Acknowledgments

Contact	For more information about this management advisory memorandum, please contact the Office of Inspector General at (202) 461–4720.
Team	Jennifer L. McDonald, Director Jake Barber Daniel Malik Jennifer Marcos Corina Riba
Other Contributors	Clifton Baker Kendal Ferguson Andrew Waghorn Rachelle Wang-Cendejas Bill Warhop

Preliminary Result Advisory Memorandum Distribution

VA Distribution

Office of the Secretary
Office of Accountability and Whistleblower Protection
Office of Congressional and Legislative Affairs
Office of General Counsel
Office of Information and Technology
Office of Public and Intergovernmental Affairs
Veterans Health Administration

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget

OIG reports and memoranda are available at www.vaoig.gov.