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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Assessment of Cytopathology Processing at the Oklahoma City VA Medical Center in Oklahoma

Healthcare Inspection | **25-00814-62** | **February 19, 2026**

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Oklahoma City VA Medical Center (facility) in Oklahoma in response to an allegation that patients awaiting a possible cancer diagnosis were experiencing delays in receiving pathology testing results. The OIG identified five patients associated with nine potentially delayed specimens within the facility's Pathology and Laboratory Medicine Service (P&LMS) cytopathology subspecialty.[1]

On December 4, 2024, the OIG opened a healthcare inspection, and conducted a site visit February 11 through 13, 2025, to further evaluate delays with the nine identified cytopathology specimens. The OIG conducted additional interviews virtually through April 22, 2025, and reviewed documentation through September 4, 2025. During the inspection, the OIG identified additional concerns with corrective action documentation when quality metrics were unmet, delays with the chief of P&LMS's specimen processing times, and reporting of laboratory and patient safety events.

Assessment of Cytopathology Processing

The OIG substantiated delays with four of the nine identified specimens associated with four of the five patients. The OIG found P&LMS quality staff did not conduct further quality of care reviews when delays were identified.

The Veterans Health Administration (VHA) Directive 1106 Guidance, *Pathology and Laboratory Medicine Service*, outlines that VHA monitors timeliness through turnaround time (TAT), which is calculated from the date the specimen is received in the laboratory to the time a pathologist signs the report in the electronic health record (EHR).[2] The OIG completed an EHR review of the nine specimens and identified four specimens with potential delays, including TAT of 11 working days for a lung specimen, 30 days for a gland specimen, 8 days for a spine biopsy, and two months for a thyroid biopsy sent to an outside laboratory for additional testing. The

[1] Cytopathology, also known as cytology, is a specific branch of pathology. The cytopathology process begins when a healthcare provider collects a specimen of body fluid or tissue from a patient. A technician prepares slides of the specimen; a cytotechnologist screens the slides; and a pathologist reads and interprets the slides, makes a diagnosis, and completes a final report for the referring healthcare provider. Within this report, the OIG uses the term cytopathology when referencing the examination of cells from bodily tissues or fluids to determine a diagnosis. Cleveland Clinic, "Cytology (Cytopathology)," accessed March 26, 2025, https://my.clevelandclinic.org/health/diagnostics/21714-cytology; Pathology supports the diagnosis of disease using laboratory testing. Pathologists are physicians who look at blood and other body fluids to examine specimens under a microscope to make a diagnosis. Johns Hopkins Medicine, "Clinical Pathology Overview," accessed March 28, 2025, https://johnshopkinshealthcare.staywellsolutionsonline.com/Search/85,P00955.

[2] VHA Directive 1106 Guidance, *Pathology and Laboratory Medicine Service*, January 24, 2024, guidance updated May 9, 2024.

chief of P&LMS, who had been the pathologist assigned to each of the four specimens, acknowledged the delays and opined that competing administrative duties were a contributing factor.

The OIG requested facility P&LMS quality staff also conduct an EHR review of the nine specimens for delays in patient care and for patient harm. A P&LMS quality staff member concluded the same four specimens identified by the OIG "possibly took longer than they should have." However, the reviewer did not analyze for risk or patient harm.

Documentation of Routine Turnaround Time Corrective Actions

Facility policy Pathology and Laboratory Medicine Service LabAdmin.0030, *Annual Quality Assurance/ Quality Improvement Metrics* requires a two-working day TAT, as suggested by VHA, for routine non-gynecological cytopathology reports when testing is performed on-site.[3] Facility P&LMS quality staff are responsible for analyzing outliers in quality metrics, determining process improvements, and establishing monitoring methods.[4] All P&LMS quality management activities, including when quality monitors exceed thresholds, must be documented for corrective action, and quality management plans must be monitored and evaluated for effectiveness.[5]

The OIG found facility cytopathology staff did not meet a benchmark set by the chief of P&LMS for 8 of 12 months in calendar year 2024. Additionally, facility cytopathology statistics reports did not document specific actions for improvement or a method to monitor effectiveness of corrective actions.

The OIG is concerned that without documentation of corrective actions, facility leaders' ability to monitor progress and target future quality improvement actions is limited.

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[3] VHA Directive 1106 Guidance; Pathology and Laboratory Medicine Service LabAdmin.0721 version 3, *Annual Quality Assurance/ Quality Improvement Metrics*, October 4, 2023. This procedure was in effect for a portion of the period of events discussed in this report. It was replaced by Pathology and Laboratory Medicine Service LabAdmin.0721 version 4, *Annual Quality Assurance/ Quality Improvement Metrics*, March 26, 2025. The 2025 procedure has the same or similar language to the 2023 procedure related to routine non-gynecological cytopathology specimen TAT expectations.

[4] Pathology and Laboratory Medicine Service LabAdmin.0012 version 3.0, *General Quality Management Program*, September 14, 2023. This procedure was in effect for a portion of the period of events discussed in this report. It was replaced by Pathology and Laboratory Medicine Service LabAdmin.0012 version 4.0, *General Quality Management Program*, January 8, 2025. The 2025 procedure has the same or similar language to the 2023 procedure related to facility P&LMS quality staff responsibilities.

[5] VHA Directive 1106 Guidance. VHA requires an Anatomic Pathology "Quality Monitor plan that is consistent with VA, accreditation agency and CLIA requirements." VHA laboratories must use the Quality Essentials (QSE) model defined by Clinical Laboratory Standards Institute or the facility's established laboratory PLM QM plan; Pathology and Laboratory Medicine Service LabAdmin.0012 version 3.0; Pathology and Laboratory Medicine Service LabAdmin.0012 version 4.0. The 2025 procedure has the same or similar language to the 2023 procedure related to quality management actions.

Review of Chief of P&LMS Turnaround Time

According to VHA Directive 1106 Guidance, timely completion and accuracy of reports should be a part of each pathologist's ongoing professional practice evaluation.[6]

After an April 2025 audit requested by the Veterans Integrated Service Network Chief Medical Officer of the facility's P&LMS program, the OIG reviewed the two most recent ongoing professional practice evaluations for facility pathologists who processed cytopathology tests. The OIG found the chief of P&LMS met TAT expectations for only 25 percent of tests from January through June 2024 and 0 percent of tests from July through December 2024, potentially presenting risks to patient safety. In June 2025, the OIG learned that facility leaders initiated actions to address the chief of P&LMS's performance concerns. The OIG concluded that facility leaders followed VHA guidance, however, did not review non-cytopathology cases completed by the chief of P&LMS to assess patient risk.

Review of Reporting of Laboratory and Patient Safety Events

The OIG found that facility P&LMS staff lacked an understanding of laboratory event reporting requirements for variance events and patient safety event reporting in the Joint Patient Safety Reporting (JPSR) system.[7]

Facility policy states laboratory staff are to "detect and report errors, incidents and variance events" on the internal P&LMS SharePoint site, with P&LMS quality staff members responsible for tracking trends in variance reporting, and the facility chief of P&LMS approving corrective actions.[8] The OIG reviewed cytopathology P&LMS variance reports from October 2023 through January 2025, identifying 21 variance events, but no cytopathology variance events were logged after August 2024. The OIG found no documented evidence of implementation of corrective actions to address the lack of reporting concerns. The absence of expected variance reports may impact P&LMS leaders' ability to identify and monitor trends.

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[6] VHA Directive 1106 Guidance; VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. Ongoing professional practice evaluation is "the ongoing monitoring of privileged LIPs [licensed independent providers] to identify clinical practice trends that may impact the quality and safety of care."

[7] VHA National Center for Patient Safety, *JPSR Guidebook*, December 2023. The Joint Patient Safety Reporting system is VHA's "patient safety event reporting system and database."; VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024. "A patient safety event is an event, incident or condition, directly associated with care or services provided to a patient, that could have resulted or did result in unintentional harm." "Patient safety events include but are not limited to adverse events and close calls."; Facility Policy Pathology and Laboratory Medicine Service LabAdmin.0030, *Mislabel & Problem Specimen Variance Policy*, October 30, 2024. A variance event is a specimen problem, including mislabeling or processing errors, that occurs at any stage of laboratory testing.

[8] Pathology and Laboratory Medicine Service LabAdmin.0030.

VHA and facility policy require staff to report variance events in the JPSR system when a patient safety concern is identified.[9] The OIG requested cytopathology processing JPSR records from October 1, 2023, through January 29, 2025, and received one JPSR record. Given the patient safety concerns identified in this review, the OIG would have expected multiple patient safety reports in the JPSR system. During interviews, P&LMS staff reported limited understanding of JPSR report requirements despite compliance with required annual training.

The OIG made five recommendations to the Facility Director related to a review of patient harm for the four patients identified in this report, documentation and monitoring of routine non-gynecological turnaround times, completing a comprehensive review of the quality of care provided by the chief of P&LMS, variance event reporting processes, and patient safety event reporting processes.

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

VA Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided an acceptable action plan (see appendixes A and B). The OIG will follow up on the planned actions until they are completed.

The system director concurred with the OIG's five recommendations and shared plans and actions taken to review the quality of care for the four patients, improve documentation and monitoring of TAT metrics, address the chief's performance, and educate staff on variance and patient safety event reporting processes.

JULIE KROVIAK, MD
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in the role of Acting Assistant Inspector General,
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[9] VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO) memorandum to Veterans Integrated Service Network Directors, "Requirements for Mislabeled Laboratory Specimen Reporting in the Joint Patient Safety Reporting System for Veterans Health Administration," November 29, 2024; Pathology and Laboratory Medicine Service LabAdmin.0030.

Contents

Abbreviations

EHR	electronic health record
JPSR	Joint Patient Safety Reporting
OIG	Office of Inspector General
P&LMS	Pathology and Laboratory Medicine Service
TAT	turnaround time
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) initiated a healthcare inspection on December 4, 2024, and conducted a site visit February 11 through 13, 2025, in response to allegations of cytopathology processing delays in the Pathology and Laboratory Medicine Service (P&LMS) at the Oklahoma City VA Medical Center (facility) in Oklahoma.[1] The OIG conducted additional interviews virtually through April 22, 2025, and reviewed documentation through September 4, 2025.

Background

The facility is part of Veterans Integrated Service Network (VISN) 19, the VA Rocky Mountain Network, and operates "15 outpatient clinics, in addition to 4 outpatient clinic partnerships." The facility provides primary, tertiary, and long-term healthcare services, including medicine, surgery, psychiatry, extended care, and rehabilitation. From October 1, 2022, through September 30, 2023, the facility served 76,556 unique patients. The Veterans Health Administration (VHA) classifies the facility as a level 1b, high complexity facility.[2]

Pathology

Pathology supports the diagnosis of disease using laboratory testing of blood and other body fluids, tissues, and individual cells. A pathologist looks at blood, urine, and other body fluid specimens under a microscope to make a diagnosis.[3] Pathologists are physicians that may specialize in a specific branch of pathology, including cytopathology.[4]

Cytotechnologists are certified laboratory staff responsible for providing preliminary interpretation of specimens and collaborating with pathologists to "diagnose benign and infectious processes, precancerous lesions, and malignant diseases."[5]

The cytopathology process begins when a healthcare provider collects a specimen of body fluid or tissue from a patient. A technician prepares slides of the specimen for analysis, and a

[1] Cleveland Clinic, "Cytology (Cytopathology)," accessed March 26, 2025, https://my.clevelandclinic.org/health/diagnostics/21714-cytology. Cytopathology involves the diagnosis of or screening for disease by examination of cells from body fluid or tissue.

[2] VHA Office of Productivity, Efficiency, & Staffing (OPES), "Facility Complexity Model Fact Sheet," October 1, 2023. The Facility Complexity Model categorizes VHA facilities at levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex and level 3 being the least complex. A level 1b facility has "medium-high volume, high-risk patients, many complex clinical programs, and medium-large research and teaching programs."

[3] Johns Hopkins Medicine, "Clinical Pathology Overview," accessed March 28, 2025, https://johnshopkinshealthcare.staywellsolutionsonline.com/Search/85,P00955.

[4] Cleveland Clinic, "Cytology (Cytopathology)."

[5] VA, *National Standard of Practice: Cytotechnologist*, March 2024.

cytotechnologist screens the slides, identifying any cellular abnormalities. Finally, a pathologist reads and interprets the slides, makes a diagnosis, and completes a final report for the referring healthcare provider.[6]

Allegation and Concerns

During an OIG healthcare facility inspection in August 2024, the OIG learned of an allegation regarding delays in pathology testing for patients awaiting a possible cancer diagnosis.[7] A complainant provided a list of 18 patient names for review. The OIG completed a preliminary review of the patients' electronic health records (EHRs) and found potential delays. Upon review, the OIG identified five patients associated with nine potentially delayed specimens.[8] On December 4, 2024, the OIG opened a healthcare inspection to further evaluate delays with the nine identified cytopathology specimens. During the inspection, the OIG identified additional concerns with corrective action documentation when quality metrics were unmet, delays with the chief of P&LMS's specimen processing times, and reporting of laboratory and patient safety events.

Scope and Methodology

The OIG initiated the inspection on December 4, 2024, and conducted a site visit from February 11 through 13, 2025. The OIG conducted additional interviews virtually through April 22, 2025, and reviewed documentation through September 4, 2025.

The OIG interviewed the VHA P&LMS National Enforcement Office quality and compliance agent, facility leaders, and relevant facility staff and performed observational rounds in the Anatomic Pathology Laboratory on February 12, 2025. The OIG viewed the cytopathology specimen collection and technician preparation areas and spoke to select P&LMS staff members regarding cytotechnology specimen processing, from collection and preparation to final review and completion. The OIG reviewed the EHRs of the five patients, resulting in nine specimens, identified for this review.

The OIG reviewed applicable VHA directives and handbooks, facility policies related to cytopathology and patient safety, facility committee meeting minutes, quality and management review documents, results of external site visits, and other relevant documents.

[6] Cleveland Clinic, "Cytology (Cytopathology)."

[7] VA OIG, *Healthcare Facility Inspection of the VA Oklahoma City Healthcare System in Oklahoma*, Report No. 24-00596-129, May 28, 2025.

[8] All nine potential processing delays occurred within the facility's P&LMS cytopathology subspecialty.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

1. Assessment of Cytopathology Processing

The OIG substantiated that cytopathology processing delays occurred in four of the nine specimens. In a separate review of the nine specimens requested by the OIG, a facility P&LMS quality staff member identified that delays in cytopathology processing may have occurred with the same four specimens. However, the reviewer did not analyze for risk and potential patient harm as expected.

The facility's Pathology and Laboratory Medicine Procedure No. LabCyto 1226 policy states, "Timely and accurate cytology reports are essential for quality patient care and determining the course of care for each patient."[9] Further, VHA Directive 1106 Guidance, *Pathology and Laboratory Medicine Service*, outlines that VHA monitors timeliness through turnaround time (TAT), which is calculated from the date the specimen is received in the laboratory to the time a pathologist signs the report in the EHR.[10]

[9] Pathology and Laboratory Medicine Procedure No. LabCyto 1226, *Turnaround Time*, May 24, 2018; Cleveland Clinic, "Cytology (Cytopathology)." Cytopathology is also known as cytology. For purposes of this report, the OIG uses the term cytopathology when referencing the examination of cells from bodily tissues or fluids to determine a diagnosis.

[10] VHA Directive 1106 Guidance, *Pathology and Laboratory Medicine Service*, January 24, 2024, guidance updated May 9, 2024.

The OIG completed an EHR review of the five patients associated with nine cytopathology specimens and identified potential delays with four specimens associated with four different patients. The OIG discovered

- the first patient's specimen, a lung bronchoalveolar lavage, took 11 working days for cytopathology staff to process the report despite the specimen being primarily blood, leading to an inconclusive test result;[11]
- the second patient's biopsy specimen of a parotid gland mass took 30 working days to process, with no initial report available to the ordering provider;
- the third patient's specimen, a thoracic spine vertebrae biopsy, took eight working days for the final report to be released; and
- the fourth patient's specimen, a thyroid nodule biopsy, needed additional testing at an outside laboratory; however, the specimen was not sent out until two months after the initial report.

The OIG requested facility P&LMS quality staff also conduct an EHR review of the nine specimens for delays in patient care and for patient harm. A P&LMS quality staff member completed the review and concluded four cases, consistent with the specimens identified by the OIG, "possibly took longer than they should have." The P&LMS quality staff member reported the perception that the pathologist in each of the reports contributed to the delay, "but I can not tell with absolute certainty." The OIG and the P&LMS quality staff member identified that the chief of P&LMS had been the pathologist assigned to each of the four specimens. During an interview, the chief of P&LMS acknowledged the delays, and could not specifically recall the reasons for the delays in clinical care but opined that competing administrative duties were a contributing factor. In an interview, the P&LMS quality staff member stated the review of the nine specimens did not include whether the delays affected patient care or caused patient harm.

The OIG is concerned that the P&LMS quality staff member and chief of P&LMS did not conduct further quality of care reviews when the delays were identified. A comprehensive review of the processing delays would allow facility leaders to evaluate risk and patient harm.

[11] The complexity determination of a cytology specimen is made by the pathologist at the time of review. The first patient's specimen (11 days) was considered routine and the other three were considered complex; Cleveland Clinic, "Interstitial Lung Disease," accessed June 18, 2025, https://my.clevelandclinic.org/departments/respiratory/depts/interstitial-lung-disease#glossary-of-terms-tab. Bronchoalveolar alveolar lavage is performed using a scope to look at the lung airways. During lavage, water from the scope washes an area of the lung to remove cells and proteins for evaluation and diagnosis, such as infection and cancer.

Documentation of Routine Turnaround Time Corrective Actions

The OIG found the chief of P&LMS and the P&LMS quality staff member did not document corrective actions and improvement plans when routine non-gynecological cytopathology TAT metrics were not met as required by VHA Directive 1106 Guidance.

VHA requires facility laboratories to establish and monitor expected TAT for routine cytopathology reports.[12] Facility policy Pathology and Laboratory Medicine Service LabAdmin.0030, *Annual Quality Assurance/ Quality Improvement Metrics* requires a two-working day TAT, as suggested by VHA, for routine non-gynecological cytopathology reports when testing is performed on-site.[13] Further, the facility chief of P&LMS must oversee all pathology-related quality reviews.[14] Facility P&LMS quality staff are responsible for analyzing outliers in quality metrics, determining process improvements, and establishing monitoring methods.[15] All P&LMS quality management activities, including when quality monitors exceed thresholds, must be documented for corrective action, and quality management plans must be monitored and evaluated for effectiveness.[16]

Through document review, the OIG learned that as part of the facility's "Cytology Continuous Improvement Plan," laboratory staff are expected to measure, assess, and continuously improve on several quality monitors, including a two-day TAT for routine non-gynecological cytopathology reports.[17] To assess for delays in cytopathology processing times, the OIG reviewed cytopathology TAT statistics reports for calendar year 2024. The facility chief of P&LMS had set a benchmark to complete 90 percent of routine non-gynecological

[12] VHA Directive 1106 Guidance.

[13] VHA Directive 1106 Guidance; Pathology and Laboratory Medicine Service LabAdmin.0721 version 3, *Annual Quality Assurance/ Quality Improvement Metrics*, October 4, 2023. This procedure was in effect for a portion of the period of events discussed in this report. It was replaced by Pathology and Laboratory Medicine Service LabAdmin.0721 version 4, *Annual Quality Assurance/ Quality Improvement Metrics*, March 26, 2025. The 2025 procedure has the same or similar language to the 2023 procedure related to routine non-gynecological cytopathology specimen TAT expectations.

[14] VHA Directive 1106 Guidance.

[15] Pathology and Laboratory Medicine Service LabAdmin.0012 version 3.0, *General Quality Management Program*, September 14, 2023. This procedure was in effect for a portion of the period of events discussed in this report. It was replaced by Pathology and Laboratory Medicine Service LabAdmin.0012 version 4.0, *General Quality Management Program*, January 8, 2025. The 2025 procedure has the same or similar language to the 2023 procedure related to facility P&LMS quality staff responsibilities.

[16] VHA Directive 1106 Guidance. VHA requires an Anatomic Pathology "Quality Monitor plan that is consistent with VA, accreditation agency and CLIA requirements." VHA laboratories must use the Quality Essentials (QSE) model defined by Clinical Laboratory Standards Institute or the facility's established laboratory PLM QM plan; Pathology and Laboratory Medicine Service LabAdmin.0012 version 3.0; Pathology and Laboratory Medicine Service LabAdmin.0012 version 4.0. The 2025 procedure has the same or similar language to the 2023 procedure related to quality management actions.

[17] Pathology and Laboratory Medicine Service CY1533, *Cytology Continuous Quality Improvement Plan*, February 9, 2024. The Cytology Laboratory's Continuous Quality Improvement (CQI) plan is an extension of OKC VAHCS Laboratory's Quality Management (QM) plan.

cytopathology reports within two business days.[18] The OIG learned that facility cytopathology staff did not meet this metric for 8 of 12 months in calendar year 2024. (See figure 1.)

Cytopathology Turnaround Time	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Routine Non-Gynecological Reports	✗ 86%	✓ 92%	✗ 82%	✓ 92%	✗ 87%	✗ 83%	✗ 82%	✗ 68%	✗ 63%	✓ 93%	✗ 77%	✓ 95%

Figure 1. *Facility cytopathology two-day TAT metrics for calendar year 2024.*
Source: OIG analysis of the Facility 2024 Annual Statistics Summary Report.
Note: The facility's target is to complete routine non-gynecological reports within two days at least 90 percent of the time.

Through document review, the OIG discovered that while comments in the reports indicated actions would be taken to improve the TAT, the comments did not identify who would be responsible or describe specific actions. For example, comments from May 2024 statistics stated "Non-GYN [non-gynecological] Cytology target not met. Will continue to monitor," and in August 2024, after only meeting 68 percent of the target, comments included "will be inquiring about ways to improve NonGYN TAT"; however, statistics fell further the following month.

The OIG interviewed the chief of P&LMS and a P&LMS quality staff member to discern what actions were taken when the target was not met and how the actions were documented. The chief of P&LMS reported meeting regularly with P&LMS quality staff to review statistics, trend data, and verbally discuss corrective actions. The chief of P&LMS stated "the statistics are addressed, the action plan is not necessarily formally addressed, no." The P&LMS quality staff member also related that corrective actions were only documented as brief comments in the cytopathology statistics monthly report and that there was no formal documented action plan or method for monitoring effectiveness. The OIG would have expected documented evidence of improvement action plans when targets were not met, including monitoring the effectiveness of any implemented actions, according to VHA Directive 1106.[19]

During interviews with the OIG, P&LMS leaders reported that, although not documented, actions had been implemented to improve two-day TAT metrics for routine non-gynecological cytopathology specimens that included:

- hiring an additional pathologist in October 2024;

[18] The chief of P&LMS reviewed and approved the benchmark as part of annual quality assurance and improvement metrics. Pathology and Laboratory Medicine Service LabAdmin.0721 version 3; Pathology and Laboratory Medicine Service LabAdmin.0721 version 4.

[19] VHA Directive 1106; Pathology and Laboratory Medicine Service LabAdmin.0012 version 3.0; Pathology and Laboratory Medicine Service LabAdmin.0012 version 4.0.

- changing the pathologist assignment rotation from weekly to daily so cases would not accumulate, and pathologists could complete workload more timely; and
- increasing how often administrative staff printed a list that provided pathologists with incomplete specimen reports from "on demand" to daily.

Based on the improvement actions reported by P&LMS leaders, the OIG expanded the review of cytopathology processing times to include January through March 2025. Through document review, the OIG found the facility exceeded the target benchmark to complete 90 percent of routine non-gynecological cytopathology reports within two business days every month, reaching 93 percent in January, 96 percent in February, and 99 percent in March 2025. The OIG acknowledges the improvement of cytopathology TAT metrics in calendar year 2025; however, the OIG cannot determine if the additional staff, daily rotation, or printed lists contributed to the improved statistics as P&LMS staff did not document corrective actions or monitor changes for improvements.

The OIG concluded that the chief of P&LMS and the P&LMS quality staff member did not document corrective actions and improvement plans as required when routine non-gynecological TAT metrics were not met. The OIG is concerned that without documentation of corrective actions when changes that improve quality metrics are implemented, facility leaders' ability to identify the issues that directly contributed to improved TAT statistics, and to target future actions for continued improvement, is limited.

Review of Chief of P&LMS Turnaround Time

The OIG found the chief of P&LMS's cytopathology results were consistently outside the expected two-day TAT for routine non-gynecological cytopathology specimens.

VHA Directive 1106 Guidance sets the expectation that timely completion and accuracy of reports should be a part of each pathologist's ongoing professional practice evaluation.[20] The facility's ongoing professional practice evaluation for pathologists includes a patient care measure of completing 90 percent of non-gynecological routine reports within two days.

In an interview with a VISN pathology and laboratory administrative officer, the OIG learned of concerns with the facility chief of P&LMS's TAT for processing cytopathology results. The VISN pathology and laboratory administrative officer reported that in April 2025, due to "concerns down there" the VISN Chief Medical Officer requested an audit of the facility's P&LMS program. The VISN pathology and laboratory administrative officer related that, during the audit, it was discovered that the chief of P&LMS did not meet two-day TAT expectations for

[20] VHA Directive 1106 Guidance; VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. Ongoing professional practice evaluation is "the ongoing monitoring of privileged LIPs [licensed independent providers] to identify clinical practice trends that may impact the quality and safety of care."

any routine non-gynecological specimens reviewed on the most recent ongoing professional practice evaluation.[21]

Based on this information, the OIG conducted a review of select pathologists' two most recent ongoing professional practice evaluations. Specifically, the OIG focused the review on pathologists at the facility who processed cytopathology tests. The OIG found that the chief of P&LMS was an outlier among the pathologists in terms of meeting the two-day TAT expectations (see table 1).

Table 1. Non-GYN Cytopathology Two-Day TAT

Pathologist	Jan–Jun 2024	Jul–Dec 2024
Chief of P&LMS	25% (9/36)	0% (0/58)
Section Chief of Anatomical Pathology	83% (137/165)	86% (56/65)
Pathologist A	93% (118/127)	81% (171/211)
Pathologist B	98% (172/176)	98% (216/221)

Source: OIG analysis of facility ongoing professional practice evaluation documentation.
Note: The facility's target is 90 percent or greater.

Although multiple pathologists did not meet the greater than 90 percent target, the OIG is particularly concerned with the chief of P&LMS's TAT processing, potentially presenting risks to patient safety. The OIG noted that the deputy chief of staff recommended a focused professional practice evaluation for cause for the chief of P&LMS following the July through December 2024 ongoing professional practice evaluation results.[22] However, the OIG learned that an focused professional practice evaluation for cause was not completed. During an interview, the chief of P&LMS acknowledged being unable to meet TAT expectations due to conflicts with administrative duties.

In June 2025, the OIG learned that facility leaders initiated actions to address the chief of P&LMS's performance concerns. The OIG concluded that facility leaders did not review non-cytopathology cases completed by the chief of P&LMS to assess patient risk. The OIG is concerned about potential delays with non-cytopathology cases and subsequent patient impact.

[21] VHA Directive 1106 Guidance. Ongoing professional practice evaluations are completed every six months.

[22] VHA Directive 1100.21(1). A focused professional practice evaluation for cause "is a time-limited period during which the clinical service chief assesses the health care LIP's performance to determine if any action should be taken on the LIP's privileges after a clinical concern has been triggered."

2. Review of Reporting of Laboratory and Patient Safety Events

The OIG found that facility P&LMS staff lacked an understanding of laboratory event reporting requirements for variance events and patient safety event reporting in the Joint Patient Safety Reporting (JPSR) system.[23]

VHA Directive 1106 Guidance requires laboratories to have a "written procedure for investigating and resolving any labeling error, suboptimal specimens, or specimen discrepancies in anatomic pathology."[24] Facility policy Pathology and Laboratory Medicine Service LabAdmin.0030 states laboratory staff are to "detect and report errors, incidents and variance events" using an electronic form on the internal P&LMS SharePoint site.[25] Additionally, the P&LMS quality staff members are responsible for tracking trends in variance reporting, and the facility chief of P&LMS reviews and approves any corrective actions.[26]

During interviews, P&LMS staff reported a lack of awareness, limited involvement, and inconsistent understanding regarding when to enter a variance event. For example, when asked by the OIG how to report a mislabeling concern, a P&LMS staff member stated this would be reported to the supervisor, and entering variance reports is a responsibility of the quality assurance staff. A P&LMS quality staff member reported providing initial training regarding variance event reporting to P&LMS staff two to three years ago and stated, " I think most of the … people know how to do it, have done it at least one time, but I have not retrained."

The chief of P&LMS stated during interviews with the OIG that variance reports were discussed monthly at the P&LMS service meeting and identified trends were addressed weekly with P&LMS quality staff. The OIG reviewed cytopathology P&LMS variance reports from October 2023 through January 2025, which identified 21 variance events documented by a single author; no cytopathology variance events were logged after the author left employment at the facility in September 2024. The OIG found no documented evidence in P&LMS service meetings of implementation of corrective actions to address the lack of reporting concerns.

During interviews, the OIG alerted the chief of P&LMS and a quality staff member that variance events had not been reported since August 2024 and both staff acknowledged they would have

[23] VHA National Center for Patient Safety, *JPSR Guidebook*, December 2023. The Joint Patient Safety Reporting system is VHA's "patient safety event reporting system and database."; VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024. "A patient safety event is an event, incident or condition, directly associated with care or services provided to a patient, that could have resulted or did result in unintentional harm." "Patient safety events include but are not limited to adverse events and close calls."; Pathology and Laboratory Medicine Service LabAdmin.0030, *Mislabel & Problem Specimen Variance Policy*, October 30, 2024. A variance event is a specimen problem, including mislabeling or processing errors, that occurs at any stage of laboratory testing.

[24] VHA Directive 1106 Guidance.

[25] Pathology and Laboratory Medicine Service LabAdmin.0030.

[26] Pathology and Laboratory Medicine Service LabAdmin.0030.

expected subsequent variance reporting. The chief of P&LMS reported the vacant cytopathology supervisor position contributed to a lack of oversight of P&LMS staff event reporting. Due to the lack of documentation, the OIG could not assess whether incidents occurred during this time frame that should have been reported as variance events. The OIG determined that the absence of expected variance reports may impact P&LMS leaders' ability to identify and monitor trends in variance events.

VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, indicates that when an event or incident could be a patient safety event, staff have an ethical duty to follow VHA procedures for reporting the event in the JPSR system.[27] The VHA memorandum "Requirements for Mislabeled Laboratory Specimen Reporting in the Joint Patient Safety Reporting System for Veterans Health Administration" and facility policy Pathology and Laboratory Medicine Service LabAdmin.0030 require staff to report variance events in the JPSR system when a patient safety concern is identified.[28]

To further evaluate P&LMS patient safety reporting, the OIG requested JPSR records related to cytopathology processing from October 1, 2023, through January 29, 2025, to determine whether patient safety concerns were reported, and a facility staff member provided one JPSR record for a cytopathology specimen. Given the patient safety concerns identified by P&LMS staff regarding cytopathology specimen delays, the OIG would have expected multiple reports of patient safety events in the JPSR system, particularly for the four patients identified in this review.

During interviews with the OIG, some P&LMS staff reported no knowledge of the JPSR system, while others acknowledged not reporting close calls as patient safety events if immediately addressed. When questioned by the OIG about training completion for reporting patient safety events, a patient safety and quality staff member reported that staff were aware of the reporting requirements and received JPSR training at new employee orientation and annually through the electronic VA training system. The OIG determined, through document review, that interviewed P&LMS staff completed annual JPSR training; therefore, the OIG would have expected staff to be knowledgeable on entering patient safety reports into the system.

The OIG concluded that despite completing the required JPSR training, P&LMS staff did not follow reporting processes and did not enter patient safety events in the JPSR system when indicated. The OIG is concerned that the lack of reporting patient safety events diminishes the ability of facility leaders, quality management staff, and the patient safety manager to identify and remediate unsafe conditions or track events to determine whether further quality of care

[27] VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

[28] VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO) memorandum to Veterans Integrated Service Network Directors, "Requirements for Mislabeled Laboratory Specimen Reporting in the Joint Patient Safety Reporting System for Veterans Health Administration," November 29, 2024; Pathology and Laboratory Medicine Service LabAdmin.0030.

reviews or interventions are warranted. The OIG is also concerned that an inconsistent understanding and awareness of responsibility to report events among P&LMS staff could contribute to a lack of reporting of variance events as patient safety events.

Conclusion

The OIG substantiated that cytopathology processing delays occurred in four of the nine specimens reviewed. In a separate review requested by the OIG, a facility P&LMS quality staff member identified that delays in cytopathology processing may have occurred with the same four specimens but did not assess for risk and potential patient harm. The OIG is concerned that because the P&LMS quality staff member and the chief of P&LMS did not conduct further quality of care reviews when the delays were identified, opportunities to better evaluate risk and patient harm were limited.

The OIG discovered that facility cytopathology staff did not meet the routine non-gynecological cytopathology TAT metrics for several months in calendar year 2024, and corrective actions were not documented when the metrics were not met. Without documentation of corrective actions when changes that improve quality metrics are implemented, facility leaders' ability to identify issues that directly contributed to improved TAT statistics, and to target future actions for continued improvement, is limited.

The OIG found the chief of P&LMS cytopathology results were consistently outside of the expected two-working day TAT for routine non-gynecological cytopathology specimens, and facility leaders took action to address performance concerns.

The OIG determined that facility P&LMS staff lacked an understanding of laboratory event reporting requirements for variance events and patient safety event reporting in the JPSR system. An inconsistent understanding and awareness of responsibility to report events could contribute to a lack of reporting and diminish the ability to remediate unsafe conditions or track events to determine whether further quality of care reviews or interventions are warranted.

VHA concurred with the OIG's five recommendations. The system director shared plans and actions taken to review the quality of care for the four patients, improve documentation and monitoring of TAT metrics, address the chief's performance, and educate staff on variance and patient safety event reporting processes.

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

Recommendations 1–5

1. The Oklahoma City VA Health Care System Director, with Pathology and Laboratory Medicine Service leaders, conducts a comprehensive review of the quality of care for the four patients identified in this report, including determinations of cytopathology processing delays and assessment of patient harm, and takes action as warranted.

2. The Oklahoma City VA Health Care System Director ensures that routine non-gynecological turnaround time corrective actions are documented and monitored for effectiveness, as required by the Veterans Health Administration.

3. The Oklahoma City VA Health Care System Director conducts a comprehensive review of the quality of care provided by the Chief of Pathology and Laboratory Medicine Service, identifies deficiencies, and takes action as warranted.

4. The Oklahoma City VA Health Care System Director reviews the Pathology and Laboratory Medicine Service event reporting requirements for variance events and ensures completion according to facility policy and Veterans Health Administration requirements.

5. The Oklahoma City VA Health Care System Director, in conjunction with the National Center for Patient Safety, evaluates patient safety event reporting processes within the Pathology and Laboratory Medicine Service, and ensures completion according to Veterans Health Administration requirements.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: January 6, 2026

From: Director, VA Rocky Mountain Network (10N19)

Subj: Healthcare Inspection—Assessment of Cytopathology Processing at the Oklahoma City VA Medical Center in Oklahoma

To: Director, Office of Healthcare Inspections (54HL02)
Chief Integrity and Compliance Officer (10OIC)

1. We are committed to implementing high reliability principles and practices which create a culture and environment that are physically and psychologically safe for Veterans, caregivers and staff. We appreciate the opportunity to review and comment on the Office of Inspector General (OIG) report, Assessment of Cytopathology Processing at the Oklahoma City VA Medical Center in Oklahoma.

2. Based upon a thorough review of the report by VISN 19 Leadership, I concur with the recommendations and submitted action plans of the Oklahoma City VA Medical Center. These recommendations will be used to strengthen our processes and improve the care that is provided to our Veterans.

3. I would like to thank the Office of Inspector General for their thorough review and if there are any questions regarding responses or additional information required, please contact the Veterans Integrated Services Network 19 Quality Management Officer.

(*Original signed by:*)

Sunaina Kumar-Giebel, MHA

[OIG comment: The OIG received the above memorandum from VHA on November 19, 2025 and updated version on January 7, 2026 .]

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: January 5, 2026

From: Director, Oklahoma City VA Health Care System (00/635)

Subj: Healthcare Inspection—Assessment of Cytopathology Processing at the Oklahoma City VA Medical Center in Oklahoma

To: Director, VA Rocky Mountain Network (10N19)

1. We appreciate the opportunity to review and comment on the OIG draft report— Assessment of Cytopathology Processing at the Oklahoma City VA Medical Center in Oklahoma. The Oklahoma City VA Health Care System concurs with the recommendations provided in the report. We are committed to taking the necessary corrective actions and hereby request the closure of recommendation 3.

2. I have reviewed the documentation and concur with the responses as submitted.

3. Should you need further information, please contact the Chief, Office of Quality, Safety, and Value.

(*Original signed by*:)

Wade Vlosich

[OIG comment: The OIG received the above memorandum from VHA on November 19, 2025 and updated version on January 7, 2026.]

Facility Director Response

Recommendation 1

The Oklahoma City VA Health Care System Director, with Pathology and Laboratory Medicine Service leaders, conducts a comprehensive review of the quality of care for the four patients identified in this report, including determinations of cytopathology processing delays and assessment of patient harm, and takes action as warranted.

_X_ Concur

____Nonconcur

Target date for completion: October 2025

Director Comments

Oklahoma City VA Health Care System leaders had a comprehensive review completed of the quality of care for the four patients identified in this report at time of the on-site visit. However, documentation of the review cannot be located. A second review was completed on October 10, 2025, and documented. The review indicates there was no patient harm resulting from the processing delays.

OIG Comments

The OIG considers this recommendation open to allow time for the submission of documentation of the comprehensive review to support closure to include documentation regarding the efforts to locate the outcome of the first comprehensive review.

Recommendation 2

The Oklahoma City VA Health Care System Director ensures that routine non-gynecological turnaround time corrective actions are documented and monitored for effectiveness, as required by the Veterans Health Administration.

_X_ Concur

____Nonconcur

Target date for completion: March 2026

Director Comments

Turnaround times for both gynecological and non-gynecological specimens are monitored monthly and reported to the monthly Pathology and Laboratory Medicine and Quality Management Service meeting. Oklahoma City VA Health Care System Pathology and Laboratory Medicine leadership will ensure action plans are documented in the monthly

Pathology and Laboratory Medicine and Quality Management Service meeting minutes for months when the 90% benchmark is not met.

Recommendation 3

The Oklahoma City VA Health Care System Director conducts a comprehensive review of the quality of care provided by the Chief of Pathology and Laboratory Medicine Service, identifies deficiencies, and takes action as warranted.

_X_ Concur

____Nonconcur

Target date for completion: August 2025

Director Comments

The actions requested by this recommendation are complete. The Chief of Pathology and Laboratory Medicine Service no longer works at the Oklahoma City VA Health Care System. Requesting closure based on the supporting documentation provided. Documentation of separation was provided to the Office of Inspector General on August 12, 2025.

OIG Comments

The OIG considers this recommendation open regarding the comprehensive review of the quality of care provided by the Chief of Pathology and Laboratory Medicine Service to allow time for the submission of documentation of the comprehensive review to support closure.

Recommendation 4

The Oklahoma City VA Health Care System Director reviews the Pathology and Laboratory Medicine Service event reporting requirements for variance events and ensures completion according to facility policy and Veterans Health Administration requirements.

_X_ Concur

____Nonconcur

Target date for completion: November 2025

Director Comments

Oklahoma City VA Health Care System Pathology and Laboratory Medicine Service leadership will review the Standard Operator Procedure (SOP), “LabAdmin.0030, Mislabel and Problem Specimen Variance Policy,” to ensure the SOP is appropriate. One hundred percent of Pathology and Laboratory Medicine Service staff will be re-educated on the requirements for reporting variance events.

OIG Comments

The OIG considers this recommendation open to allow time for the submission of documentation of the standard operator procedure (SOP) and the re-education of Pathology and Laboratory Medicine Service staff to support closure.

Recommendation 5

The Oklahoma City VA Health Care System Director, in conjunction with the National Center for Patient Safety, evaluates patient safety event reporting processes within the Pathology and Laboratory Medicine Service, and ensures completion according to Veterans Health Administration requirements.

_X_ Concur

____Nonconcur

Target date for completion: April 2026

Director Comments

Oklahoma City VA Health Care System provided focused patient safety event reporting training to the Pathology and Laboratory Medicine Service when the initial concerns were identified, prior to the OIG site visit. The event included: individualized one-on-one education to all members of the service during patient safety rounding and focused on identifying reporting barriers. Staff were directed to single button access of the reporting system through the facility internet home page. Staff who voiced refusal to report patient safety events subsequently left the Health Care System. To further augment facility education practices the facility Patient Safety Manager contacted the National Center for Patient Safety via email inquiring about additional training opportunities and best practices to potentially implement with the Pathology and Laboratory Medicine Service to ensure completion of patient safety event reporting when applicable. Focused rounding in Pathology and Laboratory Medicine Service by the Patient Safety Manager will continue for another 6 months. Review will include applicable patient safety event reporting, ease of access to reporting systems, and discussion of best practices. Report will be sent to the Quality Management Chief via monthly email communication.

OIG Contact and Staff Acknowledgments

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