



US DEPARTMENT OF VETERANS AFFAIRS **OFFICE OF INSPECTOR GENERAL**

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of the Peer Review Process at the VA Caribbean Healthcare System in San Juan, Puerto Rico

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Executive Summary

The VA Office of Inspector General (OIG) initiated a healthcare inspection on September 2, 2025, in response to anonymous allegations received regarding the integrity of the peer review process at the VA Caribbean Healthcare System (facility) in San Juan, Puerto Rico. The OIG conducted an unannounced site visit from December 2–4, 2025, followed by virtual interviews through January 21, 2026.

The OIG determined the facility met Veterans Health Administration (VHA) Directive 1190(1), *Peer Review for Quality Management*, requirements for peer review process management including alignment with committee structure, documentation of initial and final levels of care, recommendations for education and quality improvement, and required quarterly reporting to the clinical executive committee.¹ The OIG found that peer review committee members assigned final levels of care based on a majority vote. Additionally, members described having discussions to forget the patient outcome and focus on the episode of care under review in an effort to avoid hindsight or outcome bias. However, the OIG identified that the peer review committee made decisions regarding completing institutional disclosures, which is not part of the committee's quality management process, that should have been made by facility leaders. The OIG made one recommendation to the Facility Director to address this issue.

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 findings and recommendation and provided an acceptable action plan to ensure all discussion related to the disclosure of adverse events is removed from Peer Review Committee proceedings (see appendixes A and B). The OIG will follow up on the planned actions until they are completed.

A handwritten signature in black ink, appearing to read "David C. Krulak".

DAVID C. KRULAK, MD, MPH, MBA
Assistant Inspector General
for Healthcare Inspections

¹ VHA Directive 1190(1), *Peer Review for Quality Management*, November 21, 2018, amended July 19, 2024.

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Abbreviations

AI	artificial intelligence
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) initiated a healthcare inspection on September 2, 2025, in response to allegations forwarded from the Office of Accountability and Whistleblower Protection regarding the peer review process at the VA Caribbean Healthcare System (facility) in San Juan, Puerto Rico. The OIG conducted an unannounced site visit December 2 through 4, 2025, and additional interviews virtually through January 21, 2026.

Background

The facility, part of Veterans Integrated Service Network (VISN) 8, is classified as a level 1a, high-complexity facility serving Puerto Rico and the United States Virgin Islands, which provides a full range of patient care services including primary care, mental health, surgical, and intensive care.¹ From October 1, 2024, through September 30, 2025, the facility provided services to 60,494 patients. The facility is affiliated with four accredited medical schools in Puerto Rico; University of Puerto Rico, Universidad Central del Caribe, Ponce School of Medicine, and San Juan Bautista Medical School.

Peer Review for Quality Management

Veterans Health Administration (VHA) Directive 1190(1), *Peer Review for Quality Management*, states peer review is a confidential and nonpunitive process that evaluates a provider's "decisions and actions" during a specific episode of care.² The assessment determines "how similarly qualified clinicians would have managed the patient's care under the same or similar circumstances."³ VHA facilities include peer review as part of their quality management program. The goal of peer review is to promote learning and improve patient care without assigning blame or fault. To maintain program integrity, the process must be consistent, credible, and impartial.⁴

The need for a peer review is determined using criteria outlined in VHA Directive 1190(1). Examples of clinical events meeting criteria are death following surgery, death within 24 hours

¹ VHA Office of Productivity, Efficiency and Staffing, "VHA Facility Complexity Model," December 15, 2017, categorizes medical facilities by complexity level based on patient population, clinical services offered, educational and research missions, and operational cost. Complexity levels include 1a, 1b, 1c, 2, and 3, with level 1a being the most complex and level 3 being the least complex.

² VHA Directive 1190(1) *Peer Review for Quality Management*, November 21, 2018, amended July 19, 2024.

³ VHA Directive 1190(1).

⁴ VHA Directive 1190(1).

of admission, and inpatient suicides. A peer with relevant expertise conducts the initial peer review.⁵

VHA’s peer review process is summarized through five steps (see figure 1).

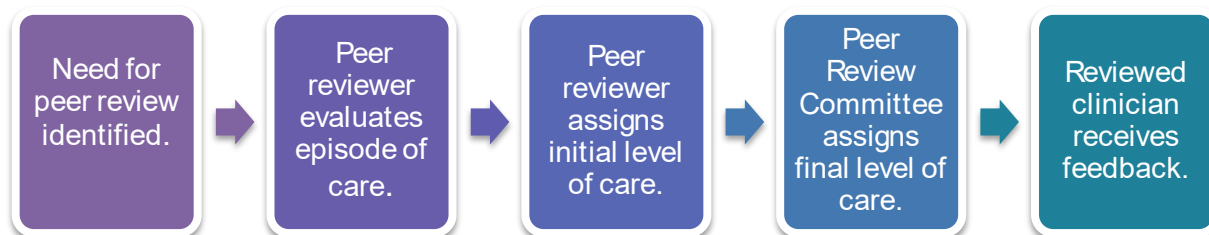


Figure 1. VHA Peer Review for Quality Management Process.

Source: OIG analysis of VA Talent Management System Risk Management Peer Review Training.

There are three levels of care that can be assigned to a peer review to specify to what degree the standard of care was met for a specific episode of care.

- Level 1 – “most experienced and competent clinicians would have managed the case [care] in a similar manner.”
- Level 2 – “most experienced and competent clinicians might have managed the case [care] differently but remains within the standard of care.”
- Level 3 – “most experienced and competent clinicians would have managed the case [care] differently.”⁶

If an initial level of care of 2 or 3 is assigned, the peer-reviewed clinician is offered an opportunity to provide input to the facility peer review committee. The peer review committee then reviews the case, discusses the findings, and decides on the final level of care.⁷

Institutional Disclosure

VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, defines an institutional disclosure as a process by which facility leaders, along with clinicians, inform the patient or representative that an adverse event has occurred that resulted in, or is expected to result in, death or a serious injury.⁸ Additionally, VHA Directive 1190(1) states that “[d]ecisions regarding

⁵ VHA Directive 1190(1).

⁶ VHA Directive 1190(1).

⁷ VHA Directive 1190(1).

⁸ VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

institutional disclosure are made by facility leadership and are not part of the Peer Review for Quality Management process.”⁹

Allegations

The Office of Accountability and Whistleblower Protection received an anonymous allegation questioning the integrity of the facility’s peer review process and referred it to the OIG on August 4, 2025. Specific allegations included:

- The Chief of Staff improperly influences and manipulates the final determination of level of care.
- Hindsight and outcome bias exist in peer review case evaluation.
- Facility providers are changing their practice for fear of the punitive use of peer review.

On September 2, 2025, the OIG initiated a healthcare inspection to evaluate these allegations and to review the program’s adherence to VHA Directive 1190(1), *Peer Review for Quality Management*.¹⁰

Scope and Methodology

The OIG initiated the inspection September 2, 2025, and conducted an unannounced site visit December 2–4, 2025, with additional virtual interviews from December 11, 2025, through January 21, 2026.

The OIG interviewed a VISN 8 Quality Management Specialist; facility executive leaders including the Facility Director, Chief of Staff, and Associate Director of Patient Care Services; the peer review coordinator; and members of the peer review committee including chiefs of emergency medicine, surgery, endocrinology, and internal medicine; the section chief of general surgery; a former chief nurse of mental health; a social worker; and a hospitalist.

The OIG reviewed VHA and facility policies related to the peer review process; organizational charts; medical staff bylaws; facility peer review and clinical executive committee charters; peer review training documents; peer review and clinical executive committee meeting minutes from fiscal year 2025 (October 1, 2024, through September 30, 2025).

The OIG developed questionnaires to solicit voluntary feedback from facility staff regarding their experience with the peer review process. Questionnaires were distributed in December 2025 to a total of 422 facility staff, who were either peer reviewed (218) or participated as peer reviewers (208) from October 1, 2023, through September 30, 2025. The response rate for both

⁹ VHA Directive 1190(1).

¹⁰ VHA Directive 1190(1).

questionnaires was 30 percent. Data specific to a select topic are reported, however, due to the low response rate among both groups, the data were deemed insufficient for meaningful analysis.

The inspection team’s analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency’s standards.¹¹ During the preparation of this report, the inspection team used peer-reviewed, standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, questionnaire responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and take full responsibility for the content of the publication. All references are for original source material, not artificial intelligence (AI)-generated content. Office of Healthcare Inspection teams do not use AI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget (OMB) Memorandum M-25-21, “Accelerating Federal Use of AI through Innovation, Governance, and Public Trust.”¹²

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.

¹¹ Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation*, December 2020.

¹² Executive Office of the President, Office of Management and Budget, “Accelerating Federal Use of AI through Innovation, Governance, and Public Trust,” Memorandum for the Heads of Executive Departments and Agencies, M-25-21: § 4(a), April 3, 2025.

Inspection Results

1. Adherence to VHA Directive

The OIG determined the facility met VHA Directive 1190(1) requirements for managing peer reviews. However, the OIG found peer review committee actions regarding determining the need for an institutional disclosure did not align with the directive.

According to VHA Directive 1190(1), a facility director must establish a multidisciplinary peer review committee chaired by the Chief of Staff. The peer review committee must include the Associate Director of Patient Care Services, be multidisciplinary with the inclusion of ad hoc members when appropriate, and have a majority of voting members present to meet quorum. Peer review committee meeting minutes should reflect peer review case discussions that may include the initial level of care assigned and the final level of care determination for cases reviewed by the committee. The peer review committee must also submit quarterly reports to the medical (clinical) executive committee or equivalent and set criteria for analyzing aggregate data trends.¹³

The OIG reviewed the facility charter and determined a peer review committee was established with the Chief of Staff serving as the designated chair.¹⁴ Voting was in compliance with VHA Directive 1190(1) regarding voting members, quorum, and the method used for voting.¹⁵ Through interviews and a review of the facility charter, the OIG learned that once a quorum is met, the peer review committee uses a majority vote, conducted electronically through Microsoft Teams, to assign the final level of care.

The OIG reviewed peer review committee meeting minutes for fiscal year 2025 and found detailed discussions with clear documentation of the initial peer review level and the final level of care the peer review committee assigned. In accordance with VHA Directive 1190(1), the following were documented in peer review committee meeting minutes

- Clinician input opportunities for level 2 or higher;
- Cases deferred when a qualified peer was unavailable to present;
- Independent evaluations of individual clinicians when multiple providers were involved in care and external peer reviews;

¹³ VHA Directive 1190(1).

¹⁴ VA Caribbean Healthcare System Charter 23-48, *Peer Review Committee (PRC)*, February 13, 2023.

¹⁵ VHA Directive 1190(1); System Charter 23-48.

- VHA contractor audits, as part of the interrater reliability process, with findings discussed within the peer review committee.¹⁶

The OIG reviewed minutes from the facility’s clinical executive committee related to the peer review committee’s quarterly reports for fiscal year 2025. The OIG found 100 percent compliance with VHA Directive 1190(1) requirements, including reporting the number of completed peer reviews, levels of care assigned and changed, number of clinicians who elected to submit written comments following review of their work, and timeliness of steps in the process.¹⁷

The OIG also reviewed the VISN 8 fiscal year 2025 Quality Patient Safety site visit report, which did not issue any findings of noncompliance and complimented the facility’s peer review committee meeting minutes for detailed documentation, including notation of completed actions.

Institutional Disclosure

Peer reviews and institutional disclosures are separate processes that serve different purposes. The purpose of peer review is to determine (in a nonpunitive manner) whether a provider has deviated from accepted standards and, if so, how such deviations can be avoided in the future. The purpose of an institutional disclosure is to inform a patient or representative of adverse events “directly associated” with VA medical care that result in death or serious bodily injury or might result in death or serious bodily injury in the future.

The OIG reviewed peer review committee meeting minutes and found documentation of discussions about the appropriateness of institutional disclosures during case evaluations. The peer review committee also made decisions on whether to conduct an institutional disclosure based on case evaluations. In communications with the OIG, both the Chief of Staff and the facility peer review coordinator reported that when the peer review committee decides an institutional disclosure is warranted, a facility’s quality management staff coordinates next steps. Further, when the peer review committee determines that an institutional disclosure is not appropriate, the Chief of Staff reported that no further discussion or review regarding an institutional disclosure occurs.

The OIG determined that, for cases brought to the peer review committee, facility leaders deferred the decision to initiate an institutional disclosure to the committee. This practice does not comply with VHA Directive 1190(1), which specifies that facility leaders, including the Chief of Staff, are responsible for making decisions regarding institutional disclosures.

¹⁶ VHA Directive 1190(1).

¹⁷ VHA Directive 1190(1).

2. Process Integrity

VHA Directive 1190(1), *Peer Review for Quality Management*, states that the peer review process is to be “balanced” with the primary focus on “whether the clinical decisions and actions of a clinician during a specific clinical encounter met the standard of care.”¹⁸

Chief of Staff Influence

The OIG did not substantiate that the Chief of Staff improperly influenced or manipulated the final determination of levels of care.

The OIG reviewed peer review committee meeting minutes for fiscal year 2025 and found documentation showing the peer review committee assigned the final level of care with detailed rationale. The OIG identified one case as an example in which peer review committee members selected a different level of care than the Chief of Staff and determined the final level of care by majority vote.

Bias in Case Reviews

The OIG is unable to determine whether peer reviewers’ bias affected the level of care assigned. However, peer review committee members reported recognizing the potential influence of hindsight and outcome bias and intentionally considering these issues during discussions.

Hindsight bias is “the tendency, after an event has occurred, to overestimate the extent to which the outcome could have been foreseen.” Outcome bias is “the tendency to judge the quality of a decision based on the information about the outcome of that decision.”¹⁹ Hindsight and outcome bias may occur and affect a peer review when the reviewer knows what ultimately happened to a patient, which can influence a reviewer’s interpretation of clinical decisions.²⁰ When a patient experiences a bad outcome, peer reviewers may attribute fault to a clinician, even when the clinician’s actions were reasonable based on the information available at the time of care. Conversely, peer reviewers may excuse suboptimal care in the absence of a bad outcome. In either situation, knowledge of a patient’s outcome could potentially distort the determined level of care and compromise the ability to identify areas for improvement.²¹

¹⁸ VHA Directive 1190(1).

¹⁹ American Psychological Association, “hindsight bias,” accessed October 9, 2025, <https://dictionary.apa.org/hindsight-bias>; Vincent Berthet, “The Impact of Cognitive Biases on Professionals’ Decision-Making: A Review of Four Occupational Areas,” *Frontiers in Psychology* 12 (January 3, 2022), <https://doi.org/10.3389/fpsyg.2021.802439>.

²⁰ Husam Bader et al., “Clinical peer Review; A mandatory process with potential inherent bias in desperate need of reform,” *Journal of Community Hospital Internal Medicine Perspectives* 11 (November 15, 2021): 817-820, <https://doi.org/10.1080/20009666.2021.1965704>.

²¹ Bader et al., “Clinical peer Review; A mandatory process with potential inherent bias in desperate need of reform.”

The thought process of a reviewer in a decision can only possibly be known through conversation with the individual. As the OIG's assessment was based on a review of documentation, the OIG is unable to know a peer reviewer's thought process and therefore cannot determine whether hindsight or outcome bias affected the initial level of care assigned.

In interviews, peer review committee members disclosed an awareness of the possibility of hindsight and outcome bias. They told the OIG that when hindsight or outcome bias occurs during discussions, the conversation is redirected to forget the patient's outcome and focus on the episode of care under review. Further, committee members also stated they frequently provided verbal reminders that the final level of care should be based on an episode of care and not the patient outcome.

Review of Practice Changes and Peer Review

The OIG found some individual providers reported changing their clinical practice because they believed peer review might be punitive. However, the OIG was unable to substantiate that punitive actions were taken as a result of peer review.

The OIG team distributed a questionnaire to solicit voluntary feedback from 218 facility staff who had been peer reviewed and received 65 (29.8 percent) responses. While the 29.8 percent response rate limits generalizability and represents only the views of those who responded to the questionnaire, the information provided offers insight into facility staff's peer review experience. Replies indicated 21 of those who responded believed the peer review process was punitive. Of those 21 respondents, 13 reported changing their clinical practice for fear of being peer reviewed. Most reported changes involved practicing defensive medicine, including ordering extra or repeat tests, avoiding complex patients, and placing referrals. *Defensive medicine* is a term used, in part, to describe providing medical care with the focus on avoiding litigation and may not benefit the patient.²² Defensive medicine prioritizes the perceived needs of a provider instead of delivering patient-centered care. Providers practicing defensive medicine may expose patients to unnecessary testing while also incurring higher financial costs for their care.

The OIG reviewed fiscal year 2025 peer review committee meeting minutes and found recommendations were focused on education and opportunities to improve the quality of care and did not include disciplinary actions. In interviews, staff did not identify any specific incidents of punitive action resulting from peer review.

²² Gianfranco Pischredda, Ludovico Marin? and Katia Corsi, "Defensive medicine through the lens of the managerial perspective: a literature review," *BMC Health Services Research* 23, no. 1104 (October 17, 2023), <https://link.springer.com/article/10.1186/s12913-023-10089-3>.

Conclusion

The OIG determined the facility's peer review process adhered to requirements set forth in VHA Directive 1190(1), and the facility implemented processes that were consistent, credible, and impartial throughout. However, the OIG found that the peer review committee's involvement with institutional disclosures exceeded their quality management role. The OIG did not substantiate that the Chief of Staff improperly influenced or manipulated final level of care determinations or that punitive actions were taken as a result of peer review. Furthermore, the OIG was unable to determine whether hindsight or outcome bias affected assigned level of care determinations for peer reviews.

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.

Recommendation

The VA Caribbean Healthcare System Director ensures that facility leaders make decisions regarding the need for institutional disclosures independent of the peer review process in alignment with VHA Directive 1190 (1), *Peer Review for Quality Management*.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 11, 2026

From: Acting Director, VA Sunshine Healthcare Network (10N8)

Subj: VA OIG Draft Report—Review of the Peer Review Process at the VA Caribbean Healthcare System in San Juan, Puerto Rico

To: Director, Office of Healthcare Inspections (54HL05)
Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review the OIG Draft Report, Review of the Peer Review Process at VA Caribbean Healthcare System in San Juan, Puerto Rico. I reviewed the action plan provided by VA Caribbean Healthcare System and concur with the response.

2. Should you need further information, please contact the Veterans Integrated Service Network 8 Quality Management Officer.

(Original signed by:)

David Dunning, MPA

[OIG comment: The OIG received the above memorandum from VHA on May 12, 2026.]

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 12, 2026

From: Executive Director, Department of Veterans Affairs (VA) Caribbean Healthcare System (672)

Subj: VA OIG Draft Report—Review of the Peer Review Process at VA Caribbean Healthcare System in San Juan, Puerto Rico

To: Acting Director, VA Sunshine Healthcare Network (10N8)

1. We appreciate the opportunity to review and comment on the OIG draft report—Review of the Peer Review Process at VA Caribbean Healthcare System in San Juan, Puerto Rico. The VA Caribbean Healthcare System concurs with the recommendation and will take corrective action.
2. I have reviewed the documentation and concur with the response as submitted.
3. Should you need further information, please contact the Chief of Quality Management & Patient Safety.

(Original signed by:)

Antonio Sánchez, MD, MHSA, FAPA, FACHE

[OIG comment: The OIG received the above memorandum from VHA on May 12, 2026.]

Facility Director Response

Recommendation

The VA Caribbean Healthcare System Director ensures that facility leaders make decisions regarding the need for institutional disclosures independent of the peer review process in alignment with VHA Directive 1190 (1), *Peer Review for Quality Management*.

Concur

Nonconcur

Target date for completion: November 2026

Director Comments

The VA Caribbean Healthcare System Chief of Staff, in collaboration with the Associate Director for Patient Care Services, will ensure all discussion related to the disclosure of adverse events, as defined by VHA Directive 1004.08, Disclosure of Adverse Events to Patients, is removed from Peer Review Committee proceedings. To validate sustainment, the facility Quality Manager will review and monitor Peer Review Committee minutes for six consecutive months, documenting adherence and confirming 100 percent compliance through ongoing oversight.

OIG Contact and Staff Acknowledgments

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