

National Practitioner Data Bank

2000 Annual Report



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Requests for copies of this report and information on the National Practitioner Data Bank should be directed to the Data Bank Customer Service Center, **1-800-767-6732**. This report and other information is also available on the Internet at www.npdb-hipdb.com.

NATIONAL PRACTITIONER DATA BANK

2000 ANNUAL REPORT

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EXECUTIVE SUMMARY

The National Practitioner Data Bank (NPDB) has maintained records of licensure, clinical privileges, professional society membership, and Drug Enforcement Agency (DEA) actions taken against health care practitioners and malpractice payments made for their benefit since September 1, 1990. Since 1997 the NPDB also has kept reports of exclusions from participation in the Medicare and Medicaid programs. This report shows NPDB activities and accomplishments during 2000 by describing operational improvements and presenting program statistics. Also, NPDB guidelines are reviewed, and issues impacting reporting trends are discussed.

Operational Improvements

The NPDB continued improving its policies and operations in 2000, including:

- ! Discontinuation of QPRAC Reporting and Querying Software and Transition to Integrated Querying and Reporting Service (IQRS) on the Internet
- ! IQRS and NPDB-Healthcare Integrity and Protection Data Bank (HIPDB) Web Site Updated and Improved
- ! Development and Implementation of Interface Control Document Transfer Program
- ! Formation of IQRS Users Review Panel
- ! Completion of Optimal Report Coding Study

- ! Implementation of Project to Identify and Eliminate Duplicate and Duplicative Reports from NPDB
- ! Third Generation NPDB Operations Contract Awarded to SRA
- ! Imposition of Sanctions Under the NPDB's Confidentiality Provisions
- ! Comparison of NPDB Malpractice Payment Reporting to National Association of Insurance Commissioners (NAIC) Reporting
- ! Comparison of Public Citizen's *Questionable Doctors* Listings to NPDB
- ! Implementation of Practitioner Remediation and Enhancement Partnership Program
- ! Completion of Data Collection for Customer Satisfaction Survey of NPDB Users
- ! Continuation of NPDB Educational and Promotional Efforts

Reports

By December 31, 2000, the end of its 124th month of operations, the NPDB contained reports on 264,065 reportable actions, malpractice payments, and Medicare/Medicaid exclusions involving 164,320 individual practitioners. Of the 164,320 practitioners reported to the NPDB, 69.7 percent were physicians (including M.D. and D.O. residents and interns), 14.1 percent were dentists (including dental residents), 6.2 percent were nurses and nursing-related practitioners, and 10 percent were other health care practitioners. About two-thirds of physicians with reports (65.4 percent) had only one report in the NPDB, 85 percent had two or fewer reports, 97.4 percent had five or fewer, and 99.6 percent had 10 or fewer. Notably, few physicians had both Medical Malpractice Payment Reports and Reportable Action Reports. Only 6.2 percent had at least one report of both types.

Approximately 53.0 percent of all reports received during 2000 concerned malpractice payments, although cumulatively malpractice payments comprised 72.7 percent of all reports. The lower percentage of Malpractice Payment Reports for 2000 reflects a large number of Medicare/Medicaid Exclusion Reports received during 2000 in conjunction with the opening of the HIPDB. These reports were also placed in the NPDB. During 2000, physicians were responsible for 80.3 percent of all Malpractice Payment Reports. Dentists were responsible for 12.2 percent, and all other health care practitioners were responsible for the remaining 7.5 percent. These figures are similar to the percentages from previous years.

Cumulatively, the median malpractice payment for physicians was \$99,500 (\$105,708 adjusting for inflation to standardize payments made in prior years to 2000 dollars) and the mean malpractice payment for physicians was \$202,301 (approximately \$225,600 adjusting for inflation).¹ Both the mean and the median payments for 2000 were higher than the cumulative figures. During 2000, as in previous years, obstetrics-related cases, which represented approximately 8.3 percent of all physician Malpractice Payment Reports, had the highest median and mean payment amounts (\$225,000 and \$417,181 respectively). The median obstetrics-related payment for physicians was \$25,000 more than 1999, and the mean was \$55,329 more than in 1999. Incidents relating to equipment/product failures (0.19 percent of all reports) had the lowest mean and second lowest median payments during 2000 (\$73,821 and \$45,000 respectively). For all medical malpractice payments made during 2000, the mean delay between an incident that led to a payment and the payment itself was 4.48 years. This is about three and a half days longer than in 1999. The 2000 mean physician payment delay varied markedly between the States, as in previous years, and ranged from 2.99 years in Minnesota to 6.28 years in New York.

Reportable actions (licensure, clinical privileges, professional society membership, and DEA actions) represent 18.1 percent of all reports received from September 1, 1990 through December 31, 2000 and 15.5 percent (5,703 of 36,763) of all reports received by the NPDB during 2000. The 5,703 reportable action reports received during 2000 are 9.9 percent more than the number of reportable actions submitted to the NPDB during 1999, reversing a decline of 2.9 percent from 1998 to 1999. The number of licensure action reports received increased 12 percent and the professional society membership action reports increased 66.7 percent, from 18 in 1999 to 30 in 2000. During 2000, licensure actions comprised 80.5 percent of all reportable actions and clinical privileges reports comprised 18.9 percent.

HRSA continues to be concerned about the low level of clinical privileges actions reported by hospitals and other clinical privileges reporters such as health maintenance organizations. This concern reflects general agreement at a 1996 HRSA-sponsored conference on the issue of hospital clinical privileges reporting that the level of reporting is unreasonably low. Nationally over the history of the NPDB, there are 3.9 times more licensure reports than clinical privileges reports. Moreover, 52.5 percent of the hospitals currently in "active" registered status with the NPDB have *never* submitted a clinical privileges report. Clinical privileges reporting seems to be concentrated in a few facilities even in States which have comparatively high overall clinical privileging reporting levels.

A number of other reporting issues are discussed in this Annual Report. These issues include reporting of malpractice payments made for the benefit of resident physicians and nurses and the use of the "corporate shield" to avoid reporting malpractice payments.

¹Generally for malpractice payment data the median is a better indicator of the "average" or typical payment than is the mean since the means are skewed by a few very large payments.

Queries

From September 1, 1990 through December 31, 2000, the NPDB responded to over 22.6 million inquiries (“queries”) from authorized organizations such as hospitals, managed care organizations (HMOs, PPOs, and group practices), State licensing boards, professional societies, and individual practitioners seeking to review their own records. During 2000, entity query volume increased 2.2 percent, from 3,222,348 queries in 1999 to 3,292,157 queries in 2000. Although the number of mandatory hospital queries increased by 12.9 percent from 1996 to 2000, the increase in the number of voluntary queries (queries by all registered entities other than hospitals) has been larger. From 1996 to 2000 there was a 22.7 percent increase in voluntary queries, from 1,771,440 to 2,173,329. During 2000, 66.0 percent of queries were submitted by voluntary queriers; cumulatively from September 1, 1990 through December 31, 2000 well over half (57.2 percent) of the queries were submitted by voluntary queriers. Of the voluntary queriers, managed care organizations are the most active. Although they represent 19.2 percent of all entities that have queried the NPDB through December 31, 2000, they had made 46.3 percent of all queries cumulatively. These organizations made 54 percent of all queries during 2000.

Matches

When a query is submitted concerning a practitioner who has one or more reports in the NPDB, a “match” is made, and the querier is sent copies of the reports. As reports naming additional practitioners are submitted to the NPDB and as more queries are made, both the number and rate of matches increases. During 2000 a total of 416,827 matches were made on entity queries; thus, 12.7 percent of all entity queries resulted in a match. Cumulatively 2,286,539 matches have been made on entity queries; the match rate from the opening of the NPDB through the end of 2000 is 10.2 percent.

Disputes and Secretarial Reviews

A practitioner about whom a report has been filed may dispute either the accuracy of the report or the fact that the report should have been filed. If the disagreement is not resolved between the practitioner and the reporter, the practitioner may ultimately request a review of the report by the Secretary of Health and Human Services. At the end of 2000, 4.7 percent (1,755) of all licensure reports, 15.6 percent (1,495) of all clinical privileges reports, and 4.1 percent (7,811) of all Malpractice Payment Reports in the NPDB were in dispute. Only a few practitioners who dispute reports also request Secretarial Review. There were 120 requests for Secretarial Review during 2000. Reportable actions represent 58.3 percent of all 2000 requests for Secretarial Review and 61 percent of all requests cumulatively for Secretarial Review. This is in sharp contrast to the 15.5 percent of all reports represented by reportable actions in 2000 and the 18.1 percent cumulatively. Of the 120 requests for Secretarial Review received during the year, 48 cases were resolved by the Secretary before the end of the year. Of these, 2.1 percent were resolved in favor of the practitioner or the entity voluntarily changed the report in a way that was acceptable to the practitioner. Cumulatively, 12.2 percent of 1,284 resolved requests for Secretarial Review have been decided in favor of the practitioner or changed by the reporting entity in a way which satisfies the practitioner.

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INTRODUCTION: THE NPDB PROGRAM

The National Practitioner Data Bank (NPDB) was established to implement the Health Care Quality Improvement Act of 1986, Title IV of P.L. 99-660, as amended (the HCQIA). Enacted November 14, 1986, the Act authorized the Secretary of Health and Human Services to establish a national data bank ensuring that unethical or incompetent physicians, dentists, and other types of health care practitioners do not compromise health care quality. It was intended to restrict the ability of unethical or incompetent practitioners to move from State to State without disclosure or discovery of previously damaging or incompetent performance.

The HCQIA also includes provisions encouraging the use of peer review. Peer review bodies and their members are granted immunity from private damages if their review actions are conducted in good faith and in accordance with established standards. However, entities found not to be in compliance with NPDB reporting requirements may lose immunity for three years.

Administration and Operation of the NPDB Program

The Division of Quality Assurance (DQA) of the Bureau of Health Professions (BHP), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (DHHS), is responsible for administering and managing the NPDB program. The NPDB itself is operated by a contractor, SRA International, Inc. (SRA), which began doing so in June 1995.²

²SRA replaced Unisys Corporation, which had operated the NPDB from its opening on September 1, 1990.

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SRA has created the Integrated Querying and Reporting Service (IQRS), an Internet reporting and querying system for the NPDB and the Healthcare Integrity and Protection Data Bank (HIPDB). Circle Solutions, Inc. is a subcontractor to SRA for operation of the NPDB Customer Service Center.

An Executive Committee advises SRA on operation and policy matters. The committee includes representatives from various health professions, national health organizations, State professional licensing bodies, malpractice insurers, and the public. It usually meets three times a year with both SRA and DQA personnel.

The Role of the NPDB

The NPDB is a central repository of information about: (1) malpractice payments made for the benefit of physicians, dentists, and other health care practitioners; (2) licensure actions taken by State medical boards and State boards of dentistry against physicians and dentists; (3) professional review actions primarily taken against physicians and dentists by hospitals and other health care entities, including health maintenance organizations, group practices, and professional societies; (4) actions taken by the Drug Enforcement Agency (DEA), and (5) Medicare/Medicaid exclusions.⁴ Information is collected from private and government entities, including the Armed Forces, located in the 50 States and all other areas under U.S. jurisdiction.⁵

NPDB information is made available upon request to registered entities eligible to query (State licensing boards, professional societies, and other health care entities that conduct peer review, including HMOs, PPOs, group practices, etc.) or required to query (hospitals). These entities query about practitioners who currently have or are requesting licensure, clinical privileges, or professional

³SRA replaced Unisys Corporation, which had operated the NPDB from its opening on September 1, 1990.

⁴Hospitals and other health care entities also *may* voluntarily report professional review (clinical privileges) actions taken against licensed health care practitioners other than physicians and dentists.

⁵In addition to the 50 States, the District of Columbia, and Armed Forces installations throughout the world, entities eligible to report and query are located in Puerto Rico, the Virgin Islands, American Samoa, the Federated States of Micronesia, Guam, the Northern Mariana Islands, and Palau.

society membership. The NPDB's information alerts querying entities of possible problems in a practitioner's past so they may further review a practitioner's background as needed. The NPDB augments and verifies, not replaces, other sources of information. It is a flagging system only, not a system designed to collect and disclose full records of reported incidents or actions. *It also is important to note the NPDB does not have information on reportable actions taken or malpractice payments made before September 1, 1990, the date it opened.* As reports accumulate over time, the NPDB's information becomes more valuable.

How the NPDB Protects the Public

Although the Act does not allow release of practitioner-specific NPDB information to the public, the public does benefit from it. Licensing authorities and peer reviewers get information needed to identify possibly incompetent or unprofessional physicians, dentists, and other health care practitioners. They can use this information to make better licensing and credentialing decisions that protect the public. In addition, to help the public better understand medical malpractice and disciplinary issues, the NPDB responds to individual requests for statistical information, conducts research, publishes articles, and presents educational programs. A Public Use File containing selected information from each NPDB report also is available.⁶ This file can be used to analyze statistical information. For example, researchers could use the file to compare malpractice payments made for the benefit of physicians to those made for physician assistants in terms of numbers and dollar amounts of payments, and types of incidents leading to payments. Similarly, health care entities could use the file to identify problem areas in the delivery of services so they could target quality improvement actions toward them.

How the NPDB Obtains Information

The NPDB receives three types of information: (1) reports on "adverse" actions, (2) reports on malpractice payments, and (3) Medicare/Medicaid Exclusion Reports.

Adverse Action Reports *must* be submitted to the NPDB in several circumstances.

⁶Information identifying individual practitioners, patients, or reporting entities other than State Licensing Boards is not released to the public in either the Public Use File or in statistical reports. The Public Use File may be obtained from the National Technical Information Service. For information call 703-605-6000 or visit on the Internet www.ntis.gov/fcpc/cpn8158.htm. For a detailed listing of the variables and values for each variable in the Public Use File, visit www.npdb-hipdb.org/docs/publicuse.htm.

- ! When a State medical board or State board of dentistry takes certain *licensure disciplinary actions*, such as revocation, suspension, or restriction of a license, for reasons related to a practitioner's professional competence or conduct, a report must be sent to the NPDB. Revisions to previously reported actions also must be reported.
- ! A clinical privileges report must be filed with the NPDB when (1) a hospital, HMO, or other health care entity takes certain *professional review actions* that adversely affect for more than 30 days the clinical privileges of a physician or dentist with a staff appointment or clinical privileges, or when (2) a physician or dentist voluntarily surrenders or restricts his or her clinical privileges while being investigated for possible professional incompetence or improper conduct or in return for an entity stopping an investigation. Revisions to previously reported actions also must be reported. Clinical privileges adverse actions also *may* be reported for health care practitioners other than physicians and dentists, but it is not required.
- ! When a professional society takes a *professional review action* adversely affecting a physician's or a dentist's membership, that action must be reported. Revisions to previously reported actions also must be reported. Such actions also *may* be reported for health care practitioners other than physicians or dentists.
- ! When the DEA revokes the DEA registration ("number") of a practitioner, a report is filed.

Medical Malpractice Payment Reports *must* be submitted to the NPDB when an insurance company or self-insured entity (but not a self-insured individual⁷) makes a payment of any amount for the benefit of a physician, dentist, or other licensed health care practitioner in settlement of, or satisfaction of, a judgment or malpractice action or claim.

The DHHS's exclusion of a practitioner from Medicare or Medicaid reimbursement is reported to the NPDB, published in the Federal Register, and posted on the Internet. Placing the information in the NPDB makes it conveniently available to queriers, who do not have to search the *Federal Register* or the Internet to find out if a practitioner has been excluded from participation in these programs. Queriers receive exclusion information along with other reports when they query the NPDB.

⁷Self-insured practitioners originally reported their malpractice payments. However, on August 27, 1993, the U.S. Court of Appeals for the D.C. Circuit reversed the December 12, 1991, Federal District Court ruling in *American Dental Association, et al., v. Donna E. Shalala*, No. 92-5038, and held that self-insured individuals were not "entities" under the HCQIA and did not have to report payments made from personal funds. All such reports have been removed from the NPDB.

Requesting Information from the NPDB

Hospitals, certain health care entities, State licensure boards, and professional societies may request information from (“query”) the NPDB. Hospitals are *required* to routinely query the NPDB. Malpractice insurers cannot query the NPDB.⁸

A hospital *must* query the NPDB:

- ! When it considers a physician, dentist, or other health care practitioner for a medical staff appointment or for clinical privileges; and
- ! At least once every two years concerning any physician, dentist, or other health care practitioner who is on its medical staff or has clinical privileges at the hospital.

A hospital *may* query at any time during professional review activity.

Other eligible entities *may* request information from the NPDB.

- ! Boards of medical or dental examiners or other State licensing boards may query at any time.
- ! Health care entities such as HMOs, preferred provider organizations, and group practices may query when (1) entering an employment or affiliation arrangement with a physician, dentist, or other health care practitioner; (2) considering an applicant for medical staff appointment or clinical privileges; (3) or conducting peer review activity. To be eligible, such entities must both provide health care services and have a formal peer review process for the purpose of furthering health care quality.
- ! Professional societies may query when screening membership applicants or in support of peer review activities.

The NPDB also may be queried in two other circumstances.

- ! Physicians, dentists, or other health care practitioners may “self-query” the NPDB about themselves at any time. Practitioners may not query to obtain records of other practitioners.

⁸Self-insured health care entities may query for peer review but not for “insurance” purposes.

- ! An attorney for a plaintiff in a malpractice action against a hospital may query and receive information from the NPDB about a specific practitioner in limited circumstances. In cases where plaintiffs represent themselves, they may obtain information for themselves. This is possible when independently obtained evidence submitted to DHHS discloses that the hospital did not make a required query to the NPDB on the practitioner. If it is demonstrated the hospital failed to query as required, the attorney or plaintiff will be provided with information the hospital would have received had it queried.

Querying Fees

As mandated by law, user fees, not taxpayer funds, are used to operate the NPDB. The NPDB fee structure is designed to ensure the NPDB is self-supporting. All queriers must pay a fee for each practitioner about whom information is requested. The base entity query fee is \$4 per name for queries submitted via IQRS and paid for electronically. Self-queries, which are more expensive to process because they require some manual intervention, cost \$10 each. All query fees must be paid by credit card at the time of query submission or through prior arrangement for automatic electronic funds transfer.

Confidentiality of NPDB Information

Under the terms of the HCQIA, NPDB information that permits identification of particular practitioners, entities, or patients is confidential. The DHHS has designated the NPDB as a confidential "System of Records" under the Privacy Act of 1974. Authorized queriers who receive NPDB information must use it solely for the purposes for which it was provided. Any person violating the confidentiality of NPDB information is subject to a civil money penalty of up to \$11,000 for each violation.

The Act does *not* let the NPDB disclose information on specific practitioners to medical malpractice insurers or the public. Federal statutes provide criminal penalties, including fines and imprisonment, for individuals who knowingly and willfully query the NPDB under false pretenses or who fraudulently gain access to NPDB information. There are similar criminal penalties for individuals who knowingly and willfully report to the NPDB under false pretenses.

Accuracy of NPDB Information

Reports to the NPDB are entered *exactly* as received from reporters. To ensure accuracy, each practitioner reported to the NPDB is notified a report has been made and is provided a copy of it. Since March 1994, the NPDB has allowed practitioners to submit a statement expressing their views of the circumstances surrounding any Malpractice Payment Report or Adverse Action Report concerning them. The practitioner's statement is disclosed along with the report. If a practitioner decides to dispute the report's accuracy in addition to or instead of filing a statement, the practitioner is requested to notify the NPDB that the report is being disputed. The report in question is then noted as under dispute when released in response to queries. The practitioner also must attempt to work with the reporting entity to reach agreement on revision or avoidance of a disputed report. If a practitioner's concerns are not resolved by the reporting entity, the practitioner may ask the Secretary of Health and Human Services to review the disputed information. The Secretary then makes the final determination whether a report should remain unchanged, be modified, or be voided and removed from the NPDB.

Federal Participation in the NPDB

Federal agencies and health care entities participate in the NPDB program. Section 432(b) of the Act prescribes that the Secretary shall seek to establish a Memorandum of Understanding (MOU) with the Secretary of Defense and with the Secretary of Veterans Affairs to apply provisions of the Act to hospitals, other facilities, and health care providers under their jurisdictions. Section 432(c) prescribes that the Secretary also shall seek to enter into an MOU with the Administrator of the DEA (Department of Justice) concerning the reporting of information on physicians and other practitioners whose registration to dispense controlled substances has been suspended or revoked under section 304 of the Controlled Substances Act.

The Secretary signed an MOU with the Department of Defense (DOD) September 21, 1987, with the DEA November 4, 1988, and with the Department of Veterans Affairs (DVA) November 19, 1990. In addition, MOUs with the U.S. Coast Guard (Department of Transportation) and with the Bureau of Prisons (Department of Justice) were signed June 6, 1994 and August 21, 1994, respectively. Policies under which the Public Health Service participates in the NPDB were implemented November 9, 1989 and October 15, 1990.

Under an agreement between HRSA, the Health Care Financing Administration (HCFA), and the Office of Inspector General (OIG), Medicaid and Medicare exclusions were placed in the NPDB in March 1997 and have been updated periodically. Reinstatement reports were added in October 1997. The initial reports included all exclusions in effect as of the March 1997 submission date to the NPDB regardless of when the penalty was imposed.

2000 NPDB IMPROVEMENTS AND PROSPECTS FOR THE FUTURE

The tenth full year of operation of the NPDB was marked by the following activities by the NPDB and DHHS. These improvements have already or will in the future improve service to NPDB customers: The NPDB continued improving its policies and operations in 2000, including:

- ! Discontinuation of QPRAC Reporting and Querying Software and Transition to Integrated Querying and Reporting Service (IQRS) on the Internet
- ! IQRS and NPDB-HIPDB Web Site Updated and Improved
- ! Development and Implementation of Interface Control Document Transfer Program
- ! Formation of IQRS Users Review Panel
- ! Completion of Optimal Report Coding Study
- ! Implementation of Project to Eliminate Duplicate and Duplicative Reports from NPDB
- ! Third Generation NPDB Operations Contract Awarded to SRA
- ! Imposition of Sanctions Under the NPDB's Confidentiality Provisions
- ! Comparison of NPDB Malpractice Payment Reporting to National Association of Insurance Commissioners (NAIC) Reporting
- ! Comparison of Public Citizen's *20,125 Questionable Doctors Disciplined by State and Federal Governments* Books to NPDB
- ! Implementation of Practitioner Remediation and Enhancement Partnership Program
- ! Completion of Data Collection for Customer Satisfaction Survey of NPDB Users
- ! Continuation of NPDB Educational and Promotional Efforts

Discontinuation of QPRAC Reporting and Querying Software and Transition to Integrated Querying and Reporting Service (IQRS) on the Internet

The NPDB-HIPDB transitioned completely from QPRAC, the previous software-based querying and reporting system, to an online, Internet-based system, the IQRS. The NPDB helped users make the final transition to IQRS through information on the web page, newsletters, broadcast messages, Customer Service Center assistance, brochures, and a special outreach program to assist third party software enhancers. QPRAC users exported their existing QPRAC practitioner databases into the IQRS, using a QPRAC 4.01 export utility that allowed them to copy practitioner records they created with QPRAC into the IQRS subject database. A fact sheet helped users do this, along with training from DQA.

The IQRS was designed to improve report timeliness, reduce input errors, and reduce operating costs. Under the IQRS, NPDB and HIPDB reporting are combined into one system, with a set of rules determining how reports are accepted into each data bank. Based upon the information reported, the IQRS routes reporting transactions to the appropriate Data Bank(s). Therefore, the IQRS reduces the reporting burden by allowing eligible entities to submit a single report to both the NPDB and HIPDB. Querying is similarly facilitated and eligible queriers can submit a single query to both the NPDB and HIPDB.

IQRS users must have Internet access and a web browser. Users also need a plug-in or stand-alone program that reads files in Portable Document Format (PDF), such as Adobe Acrobat Reader 4.0. The NPDB-HIPDB code operates on a secure Internet server, providing a secure environment for querying, reporting, data storage, and retrieval. The IQRS employs the latest information security advances.

IQRS and NPDB-HIPDB Web Site Updated and Improved

The IQRS was improved as the Data Banks continued to advance technologically. Most prominent are plans for an NPDB Interactive Training Program on the NPDB-HIPDB web site to test users' knowledge of the NPDB and the reportability of actions to it. It will be designed to assist users with applying NPDB policy to everyday situations. The NPDB Interactive Training Program will be modeled on the HIPDB's program, which became operational in 2000.

Other improvements in 2000 made the IQRS web site easier to use. The site's "look and feel" changed to make IQRS more visually appealing. Navigation of the web site was improved to reduce scrolling and allow users to move expediently to areas of interest to help them complete their work faster and more easily. The IQRS on-line help screens were updated and improved, with additional text providing more detailed explanations and instructions. A "What's New" information page was added to the IQRS welcome page.

The capabilities of the IQRS were also enhanced. Users can now also submit batch queries and save draft reports for later completion. The IQRS provided output products in parsable format to better support high-volume queriers and third-party software. Another new IQRS capability was batch downloading, which consolidates multiple query responses into a single file, when the number of queries submitted is 11 or more. The wording of subject notification documents also was improved. Future improvements include better password protections, upgrading the Oracle software database, and improving the self-query process to enable better use of the Internet and provide faster potential turn-around times.

Development and Implementation of Interface Control Document Transfer Program

The Interface Control Document (ICD) Transfer Program, or ITP, helps high-volume queriers who generate queries automatically from custom (third party) software or other special purpose software obtain information more easily from the NPDB-HIPDB. They can submit queries electronically by sending ICD files to the NPDB-HIPDB, rather than through the IQRS. An ICD specifies the data elements (variables), data types, acceptable values and codes, organization, and format for submitting queries to the NPDB-HIPDB in an electronic transaction file and for interpreting (i.e. parsing) responses received from the NPDB-HIPDB.

The ITP is the program that transmits ICD query submission files and receives query responses from the NPDB-HIPDB. Through ITP, queriers can receive responses in parsable text format. The ITP is the only recognized method of ICD submission. The data is transmitted over an Internet Secure Socket Layer (SSL) connection for security. This ITP program can be executed as a stand-alone program, or it can be executed under control of another program. The ITP requires the Java 2 Runtime Environment, available as a free download from Sun Microsystem's Java web site.

Formation of IQRS Users Review Panel

The Integrated Reporting and Querying Service Users Review Panel (IQRS URP) was created this year and met in July and November. This group of IQRS developers, government officials and users meet twice a year in a feedback session that lets users take part in building the system. The primary mission of the IQRS URP is to discuss issues regarding the IQRS; identify new IQRS requirements; review current IQRS querying and reporting issues; and address NPDB-HIPDB operational related issues. In design review sessions, users' feedback on proposed IQRS changes helps developers improve the IQRS. Users also discuss their ideas about past, current and future IQRS performance. Their issues and suggestions often result in problems being solved and operations being improved.

Completion of Optimal Report Coding Study

The final report of a study by the Center for Health Policy Studies of Columbia, Maryland on optimal coding schemes for NPDB Adverse Action and Malpractice Payment codes was completed in September 2000. The study examined how reporting to the NPDB could be improved, especially as it relates to coding of the reasons for the malpractice payment or the type of, and reason for, the adverse action taken. A significant fraction of reports of malpractice payments and adverse actions are reported with "Not Otherwise Classified" (NOC) reason codes. The study examined how the use of NOC, "Other," and categories without specific reasons can be reduced. Two committees on Adverse Action Reporting and Malpractice Payment Reporting, composed of NPDB users and experts, made several suggestions for improving reporting codes, such as contacting NOC reporters and providing guidance, collecting standard narrative data in data fields in addition to the narrative text, and changes in offense and specialty codes. These changes are being reviewed by DQA for implementation.

Implementation of Project to Identify and Eliminate Duplicate and Duplicative Reports from NPDB

The NPDB contractor, SRA, Inc., is working on improving the NPDB by eliminating identical reports, linking related reports, and cleaning up data. To that end, SRA has developed software to identify duplicate and duplicative reports. For the project, SRA is identifying and correcting duplicate or essentially identical reports and identifying and correcting duplicative reports, which are different reports that should be in the NPDB only once. To improve the information the NPDB provides, SRA, Inc. is identifying and linking related reports, which are correctly filed reports about the same event. SRA is also using the NPDB research data file to identify abnormal data, so it can identify data errors and correct them with reporters' cooperation. This effort should improve the NPDB by making reports more accurate and eliminating errors.

Third Generation NPDB Operations Contract Awarded to SRA

The new "Third Generation" contract for the operation, maintenance, and enhancement of the NPDB and HIPDB was awarded to SRA, of Fairfax, Va., on December 20, 2000. The old contract expires June 30, 2001. The contract is a performance-based firm fixed-price agreement for six years. The contract includes high performance standards for the contractor and a small bonus incentive if SRA exceeds them. The contract was awarded through the Department of Transportation's GWAC, or governmentwide acquisitions contract. This contract will control costs and establish performance indicators and incentives that should improve customer service, accuracy and timeliness.

Imposition of Sanctions Under the NPDB's Confidentiality Provisions

Queries into the NPDB are restricted by statute to hospitals, other health care entities, State licensing boards, and professional societies. Credentialing Verification Organizations, physician recruitment firms, and physician placement services are not eligible to access information in the NPDB under their own authority. These organizations and other organizations that do not meet the statute's specific query eligibility criteria may only interact with the NPDB as Authorized Agents. Authorized Agents may only query the NPDB with the authorization of an eligible entity (i.e., the eligible entity must designate the Authorized Agent to act on its behalf by completing the Authorized Agent Designation form) for specifically designated and limited purposes.

Potential violations of the NPDB's confidentiality provisions are referred to the OIG for further investigation and possible enforcement action.

In Spring 2000, a physician placement service paid a fine and entered into a settlement with the OIG, DHHS to resolve its civil monetary penalty liability for violations of provisions on confidentiality in the use of information contained in the NPDB. The OIG is authorized to impose a civil money penalty of up to \$11,000 against each responsible individual, entity, or organization for *each* improper disclosure, use, or access to information from the NPDB. This is the second time the OIG has used the HCQIA Civil Money Penalty authority to issue a fine against an entity that was accused of violating the NPDB's confidentiality provisions.

Comparison of NPDB Malpractice Payment Reporting to National Association of Insurance Commissioners (NAIC) Reporting

A comparison of NPDB Malpractice Payment Reporting to information gathered by the NAIC was begun during 2000. The goals of the comparison are to examine the level of compliance with NPDB Malpractice Payment Reporting requirements and to identify specific under-reporting insurers and obtain required reports. Individual payments are reported to the NPDB by law, but the number of payments made and total amount paid are reported voluntarily to the NAIC in "Annual Statements." The NAIC has no information about individual payments. More than 80 companies were contacted about their 1998 reporting and 224 overdue reports have been received. The next steps of the project include comparing 1997 reports and obtaining 1999 and 2000 NAIC data.

Comparison of Public Citizen's 20,125 Questionable Doctors Disciplined by State and Federal Governments Books to NPDB

DQA compared NPDB licensure reports to actions listed in Public Citizen's *20,125 Questionable Doctors* books. A sample of eligible listings from each State was taken from the *Questionable Doctors* books and were matched with NPDB information based on name, State, date, action taken and reason for action. Findings showed 82 percent of licensure actions reported to Public Citizen were reported to the NPDB, with States ranging from 100 percent (Mississippi and North Dakota) to 32 percent (New Mexico). A comprehensive comparison will be conducted and DQA will work with States to improve reporting.

Implementation of Practitioner Remediation and Enhancement Partnership Program

DQA launched a new program to foster mutual trust and positive working relationships between hospitals and State Medical Boards. The Practitioner Remediation and Enhancement Partnership (PREP) program seeks to encourage a more positive approach by health care organizations toward reporting adverse actions to State professional licensing authorities, and by extension, to the NPDB. PREP promotes reporting to the NPDB as ethical, socially responsible conduct, rather than "reporting colleagues to the cops." The program also provides a means whereby practitioners who are not candidates for "serious" board action can improve their practice, and care to patients can be improved. These means, interventions to upgrade the skills and knowledge of practitioners who are considered deficient, are proactive, preventative actions that will hopefully prevent medical errors from occurring. Boards and hospitals participating in the program are expected to manage and set up their individual intervention programs.

The Citizen Advocacy Center, working with DQA, is seeking funding for the project for boards. Its staff will assist, advise, and help coordinate projects in various States. DQA staff and the CAC held a conference November 30 - December 1, 2000, with 16 boards participating. This two-day meeting provided an overview of the PREP program and offered the opportunity for participating State Boards of Medicine and Nursing, boards considering participation, and national organizations, to offer their perspective on the project. For more information, see the program's web site at www.4patientsafety.net.

Completion of Data Collection for Customer Satisfaction Survey of NPDB Users

DQA sponsored a survey of NPDB users and non-users by the University of Illinois at Chicago, Northwestern University, and the University of Tennessee Health Science Center. The survey's primary purpose was to assess satisfaction of current NPDB users with the reporting and querying processes, identify methods for improving these processes, and assess user perception of

the usefulness of the NPDB information in licensing and credentialing decisions. Additional questions were fielded to potential HIPDB users (who are currently NPDB users) to assess projected use of the HIPDB and determine how the HIPDB can best meet user needs. A separate survey of NPDB non-users was conducted to determine why these institutions did not use the NPDB, and how they believed that the processes of the NPDB could be improved. Response rates were 69.8 percent for the user survey and 83.3 percent for the non-user survey. The final draft of the report will be available in 2001.

Continuation of NPDB Educational and Promotional Efforts

DQA had several initiatives to educate users and potential users about the NPDB's policies and to promote the use of the NPDB. A fact sheet detailing 10 myths about the NPDB was created to educate people about the NPDB. It covers such areas of concern as the Federal Torts Claim Act (FTCA), accessibility to information on the data bank, and the ability of subjects to enter information in their own defense. During March, the DQA staff talked to Community Health Centers to develop an education program for practitioners. DQA also helped train representatives of managed care organizations at a National Committee for Quality Assurance (NCQA) conference, assisting them with complying with NCQA's Standards for Accreditation, including compliance with NPDB requirements. They also promoted the NCQA's use of the NPDB for quality assurance efforts.

Extensive outreach and presentations to medical organizations for both practitioners and providers helped make the NPDB more understandable to entities and potential subjects of reports and promoted its use in quality assurance efforts. To aid in this outreach, a marketing plan to educate potential users, reporters and quierers about the data bank was developed. Information and articles encouraging use of the NPDB were also posted on the Internet, published in newsletters, and sent out to potential users through brochures.

Lastly, the NPDB *Guidebook*, a critical source of information to NPDB users, is being updated to reflect operational and policy changes. Because of the changeover from QPRAC to the IQRS, as well as policy modifications, some sections of the *Guidebook* have become out of date. Instead of section by section, the *Guidebook* is now being revised in its entirety all at once. The *Guidebook* interprets the regulations and provides users with guidelines on how to report and query to the NPDB. The last version of the *Guidebook* was completed in May 1996, but certain chapters were updated in 1999. The *Guidebook* will include updated addresses (including URLs) for all State Medical and Dental Boards.

NPDB OPERATIONS: REPORTING SUMMARY

This section primarily summarizes descriptive statistics concerning all reports during calendar year 2000. For comparative purposes, information is provided for each of the most recent five years (1996 through 2000) as well as cumulatively from the opening of the NPDB on September 1, 1990 through December 31, 2000.

Tables 1 through 3 present data on practitioners reported and reports received by the NPDB through December 31, 2000 by report type.⁹ Table 1 shows the number of practitioners, by type, with reports in the NPDB, the number of reports in the NPDB for each type of practitioner, and the ratio of reports per practitioner with reports. There are more physicians with reports than any other type of practitioner. Physicians have an average of 1.70 reports per each reported physician, and dentists, the second largest group of practitioners reported, have an average of 1.59 reports for each reported dentist. Comparison between physicians and dentists and other types of practitioners, however, is misleading since reporting of licensure, clinical privileges, and professional society membership actions is required only for physicians and dentists.

Tables 2 through 5 provide information by type of report (medical malpractice payments and “adverse actions” involving licensure, clinical privileges, professional society membership, or the DEA actions, as well as Medicare/Medicaid exclusions.) It should be noted that some “adverse action” reports are not “adverse” to the practitioner involved and concern reinstatements, reductions of penalties, or reversals of previous actions.¹⁰ Therefore, the term “reportable actions” is used unless non-adverse actions are excluded. Table 2 shows the number and percent distribution of reports received by type of report. Table 4 shows Malpractice Payment Reports by practitioner type, and Table 5 shows reportable actions and Medicare/Medicaid exclusions by practitioner type.

⁹All report statistics in this document concern disclosable reports C reports which would be disclosed in response to a query C in the NPDB as of December 31, 2000. This does not directly measure the workload of the NPDB in processing reports. It excludes, for example, incomplete reports submitted but rejected and reports that were received but later voided. In the case of modified reports, the report as modified is included in the statistics for the year the original report was submitted, not the year the modification was submitted. This is a change from the way modified reports were counted in NPDB Annual Reports for 1998 and previously. Statistics for 1999 and earlier years may also differ slightly from those reported in previous Annual Reports because reports voided during 2000 are no longer included in counts.

¹⁰Of the 37,664 reported licensure actions in the NPDB, 3,359 reports or 9 percent were for licenses reinstated or restored. Of the 9,593 reported clinical privileges actions, 664 reports or 6.9 percent concerned reductions, reinstatements, or reversals of previous actions. Of the 353 reported professional society membership actions, 13 reports or 3.7 percent were reinstatements or reversals of previous actions. None of the 294 reported DEA Reports were considered non-adverse. Of the 24,223 Exclusion Reports, 2,659 or 11 percent are reinstatements.

MEDICAL MALPRACTICE PAYMENT REPORTS ANALYSIS

This section primarily discusses descriptive statistics concerning 2000 Malpractice Payment Reports. For comparative purposes, information is provided for each of the most recent five years (1996 through 2000) as well as cumulatively from the opening of the NPDB on September 1, 1990 through December 31, 2000.

Medical Malpractice Payments

Data from Table 2, as illustrated in Figure 1, show that, for each year, Malpractice Payment Reports represent the greatest proportion of reports contained in the NPDB. Cumulative data show that at the end of 2000, 72.7 percent of all the NPDB's reports concerned malpractice payments. During 2000 itself, the NPDB received 19,493 such reports (53.0 percent of all reports received). Exclusion Reports were first placed in the NPDB in 1997. Reports that year included practitioners excluded in previous years and not yet reinstated, thus 1997 reporting statistics are not comparable to those of previous or later years. Exclusion reporting was also atypical in 2000, as explained below. If Exclusion Reports are excluded, then malpractice payments constitute 78.3 percent of 1997 reports, 76.8 percent of 1998 reports, 78.6 percent of 1999 reports, and 77.4 percent of 2000 reports.

Table 3 shows the percent change by report type from year to year. State licensure action reporting in 2000 increased over 1999 and was at its highest level since 1998. The 2000 Exclusion Reports increased greatly over 1999, reflecting both an increase in exclusions and reporting to the newly opened HIPDB of exclusions not previously reported. These HIPDB reports were also placed in the NPDB. The apparent large decrease in Exclusion Reports for 1998 and 1999 as compared to 1997 reflects the fact that the count for 1997 includes both 1997 exclusions and exclusions in earlier years for practitioners who had not been reinstated. Thus the 1998 and 1999 exclusion counts, which include only actions reported during the respective years, are not comparable to the count for 1997.

Table 4 shows Malpractice Payment Reports for all types of practitioners¹¹ during the most recent five years and cumulatively. Although only physicians and dentists must be

¹¹Allopathic physicians; allopathic interns and residents; osteopathic physicians; and osteopathic physician interns and residents are all considered physicians for statistical purposes. Dentists and dentist residents are considered dentists for statistical purposes. For statistical purposes, the "other" category includes all remaining practitioner types which may be reported to the NPDB: pharmacists; pharmacists (nuclear); pharmacy assistants; registered (professional) nurses; nurse anesthetists; nurse midwives; nurse practitioners; licensed practical or vocational nurses; nurses aides; home health aides (homemakers); psychiatric technicians; dieticians; nutritionists; emt, basic; emt, cardiac/critical care; emt, intermediate; emt, paramedic; social workers, clinical; podiatrists; clinical psychologists; audiologists; art/recreation

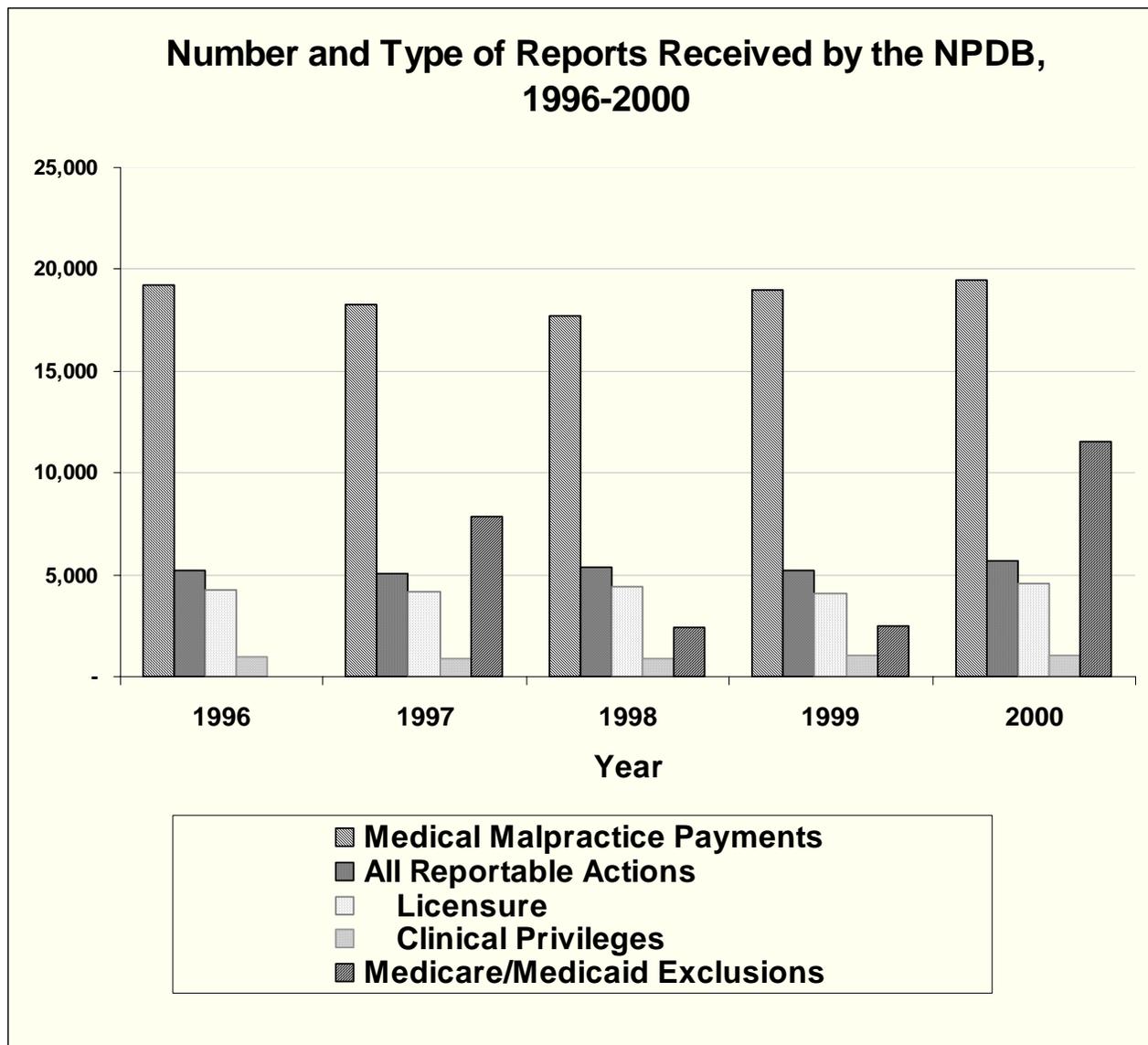


Figure 1

reported to the NPDB if a reportable action is taken against them, all health care practitioners

therapists; massage therapists; occupational therapists; occupational therapy assistants; physical therapists; physical therapy assistants; rehabilitation therapists; speech/language pathologists; medical technologists; nuclear medicine technologists; cytotechnologists; radiation therapy technologists; radiologic technologists; acupuncturists; athletic trainers; chiropractors; dental assistants; dental hygienists; denturists; homeopaths; medical assistants; mental health counselors; midwives, lay (non-nurse); naturopaths; ophthalmologists; opticians; optometrists; orthotics/prosthetics fitters; physician assistants; physician assistants, osteopathic; perfusionists; podiatric assistants; professional counselors; professional counselors (alcohol); professional counselors (family/marriage); professional counselors (substance abuse); respiratory therapists; respiratory therapy technicians; and any other type of health care practitioner which is licensed in one or more States.

must be reported to the NPDB if a malpractice payment is made for their benefit. Cumulatively, physicians were responsible for 149,211 (77.8 percent) of the NPDB's Malpractice Payment Reports while dentists were responsible for 27,094 reports (14.1 percent), and all other types of practitioners were responsible for 15,541 reports (8.1 percent). The number of malpractice payments reported in 2000 (19,493) increased by 2.5 percent over the number reported during 1999 (19,020). During 2000, physicians were responsible for 15,622 Malpractice Payment Reports (80.3 percent of all Malpractice Payment Reports received during the year). The number of physician malpractice payments reported increased 3.3 percent from 1999 to 2000. Dentists were responsible for 2,366 Malpractice Payment Reports (12.2 percent). "Other practitioners" were responsible for 1,458 Malpractice Payment Reports (7.5 percent).

Malpractice Payment Reporting Issues

Two aspects of Malpractice Payment Reporting are of particular interest to reporters, queriers, practitioners, and policy makers. First, the "corporate shield" issue reflects possible under-reporting of malpractice payments. The second, reporting physicians in residency programs, concerns the appropriateness of reporting malpractice payments made for the benefit of physicians in training who are supposed to be acting only under the direction and supervision of attending physicians.

"Corporate Shield"

Malpractice Payment Reporting may be affected by use of the "corporate shield." Attorneys have worked out settlements in which the name of a health care organization (e.g., a hospital or group practice) is substituted for the name of the practitioner, who would otherwise be reported to the NPDB. This is most common when the health care organization is responsible for the malpractice coverage of the practitioner. Under current NPDB regulations, if a practitioner is named in the claim but not in the settlement, no report must be filed with the NPDB unless the practitioner is excluded from the settlement as a condition of the settlement.

The extent of use of the "corporate shield" cannot be measured with available data. The "corporate shield" masks the extent of substandard care as measured by individual malpractice payments reported to the NPDB. It also reduces the NPDB's usefulness as a flagging system. Proposals to change regulations to resolve the "corporate shield" problem were discussed by the NPDB Executive Committee during its 2000 meetings, and they are being reviewed by HRSA.

Malpractice Payment Reporting by Federal Agencies

The DOD and the DVA report through Memoranda of Understanding with the Department of Health and Human Services. The DOD reports malpractice payments to the NPDB only if the Surgeon General of the affected military department (Air Force, Army, or Navy) concludes on the basis of three criteria that the payment should be reported. Analysis of DOD reports indicates the Surgeons General of the three military departments apply these criteria differently. DVA uses a similar process when deciding whether to report malpractice payments.

Malpractice Payments for Physicians in Residency Programs

The reporting of malpractice payments made for the benefit of residents is an issue that continued to be of interest during 2000 as it was in earlier years.¹² Some argue that since residents act under the direction of attending physicians, as long as they are acting within the bounds of their residency program, residents by definition are not responsible for the care provided. Therefore, regardless of whether or not they are named in a claim for which a malpractice payment is ultimately made, they should not be reported to the NPDB. The HCQIA, however, makes no exceptions for malpractice payments made for the benefit of residents. Payments for residents must be reported to the NPDB. At the end of 2000 a total of 1,342 physicians had Malpractice Payment Reports listing them as allopathic or osteopathic interns or residents at the time of the incident which led to the payment. Of these 1,342 physicians, 1,186 were allopathic residents and 166 were osteopathic residents. The NPDB contained a total of 1,887 intern or resident-related Malpractice Payment Reports for these practitioners (1,598 for allopathic interns or residents and 289 for osteopathic interns or residents). A total of 1,188 of the reported interns and residents had only one Malpractice Payment Report as an intern or resident; 55 had two such reports; one had nine reports; one had 21 reports; and one had 45 Malpractice Payment Reports for incidents while an intern or resident. Later in their career or even while they were in a residency program, these practitioners also may have had other Malpractice Payment Reports that did not identify them as interns or residents.

State Reporting Rates: Malpractice Payments

Table 6 shows the number of Malpractice Payment Reports for physicians and dentists from September 1, 1990 through December 31, 2000 by State (generally the State in which the practitioner maintained his or her practice at the time the incident took place).

¹²Fischer, J.E. and Oshel, R.E. The National Practitioner Data Bank: What You Need to Know. *Bulletin of the American College of Surgeons*. June 1998, 83:2; 24-26. Fischer, J.E. The NPDB and Surgical Residents. *Bulletin of the American College of Surgeons*. April 1996. 81:4; 22-25. Ebert, P.A. As I See It. *Bulletin of the American College of Surgeons*. July 1996. 81:7; 4-5. See also reply by Chen, V. and Oshel, R. Letters, *Bulletin of the American College of Surgeons*, January 1997. 82:1; 67-68.

Table 6 also includes the “adjusted” number of payments, which excludes malpractice payments made by State patient compensation funds and similar State funds. Nine States¹³ have or had such funds, and most fund payments pertain to practitioners practicing in these States. Usually when payments are made by these funds, two reports are filed with the NPDB (one from the primary insurer and one from the fund) whenever a total malpractice settlement or award exceeds a maximum set by the State for the practitioners’ primary malpractice carrier. These funds sometimes make payments for practitioners reported to the NPDB as working in other States. Payments by the funds are excluded from the “adjusted” column so malpractice incidents are not counted twice. *Although the “adjusted” is the best available indicator of the number of distinct malpractice incidents which result in payments, it is an imperfect measure.* Some State funds are the primary insurer and only payer for some claims. Since these payments cannot be readily identified, they are excluded from the “adjusted” column even though they are the only report in the NPDB for the incident. The “adjusted” column also does not take into account insurers of last resort which in most cases provide primary coverage but in other cases provide secondary coverage for payments over primary policy limits and report these over-limits payments.¹⁴

In addition to presenting by State the cumulative number of payments and the adjusted number of payments for both physicians and dentists, Table 6 shows the ratio of payments for dentists to payments for physicians. Nationally, using the adjusted numbers, there is about one dental payment for every five physician payments. In Utah, however, there has been one dentist payment for every 2.6 physician payments. In California there is one dental payment for about every 2.9 physician payments. In Mississippi, West Virginia, and Wyoming there is less than one dental payment for every 10 physician payments. It should be noted that in States with relatively few physicians or dentists, the number of payments sometimes are heavily impacted by large numbers of reports for a single practitioner, which can skew comparisons between States. For example, the high ratio of dental payments to physician payments in Utah is largely the result of a very large number of payments made for one dentist during 1994.

Tables 7 and 8 present the annual number and adjusted number (as described above) of Malpractice Payment Reports for physicians and dentists, respectively, by State for each of the last five calendar years. As noted above, the number of payments in any given year in a State may be impacted by unusual circumstances such as the settlement of a large number of claims against a single practitioner. State payment counts may also be substantially impacted by other reporting

¹³Florida, Indiana, Kansas, Louisiana, Nebraska, New Mexico, Pennsylvania, South Carolina, and Wisconsin.

¹⁴Kansas is an example of a state in which the fund is the primary carrier in some cases; the Kansas fund is the primary carrier for payments for practitioners at the University of Kansas Medical Center. New York is an example of a state with an insurer of last resort which sometimes provides over-limits coverage but usually is a practitioner’s primary insurer.

artifacts such as a reporter submitting a substantial number of delinquent reports at the same time. Indiana reporting, for example, was impacted by receipt of delinquent reports during 1996 and 1997.

It especially should be noted that the number of payments in any given State is affected by the specific provisions of the malpractice statutes in each State. Statutory provisions may make it easier or more difficult for plaintiffs to sue for malpractice and obtain a payment. There are differences from State to State in the statute of limitations provisions governing when plaintiffs may sue. There also are differences in the burden of proof. In addition, some States limit payments for non-economic damages (e.g., pain and suffering). These limits may reduce the number of claims filed by reducing the total potential recovery and the financial incentive for plaintiffs and their attorneys to file suit, particularly for children or retirees who are unlikely to lose earned income because of malpractice incidents. Sometimes changes in malpractice statutes may be responsible for changes in the number of payments within a State observed from year to year. Changes in State statutes, however, are unlikely to explain differences in payment trends observed for physicians and dentists within the same State. For example, the number of physician malpractice payments in New York has steadily increased over the past five years while the number of dentist payments has varied up and down over the period but was only slightly larger in 1999 than it was in 1996. There was a bigger increase in 2000.

State Differences in Payment Amounts for Physicians

State variations in mean and median malpractice payment amounts also are of interest. We examined all physician Malpractice Payment Reports received by the NPDB between its opening and December 31, 2000. The results are shown in Table 9. Note that these numbers are not adjusted for the impact of State patient compensation and similar funds, which have the effect of lowering the observed mean and median payment. Because mean payments can be substantially impacted by a single large payment or a few such payments, a State's median payment is normally a better indicator of typical malpractice payment amounts.¹⁵ The cumulative median for the NPDB was \$99,500. The median physician payment in 2000 was \$125,000. The highest 2000 medians were found in Maine, Illinois, Massachusetts, Alabama, and Connecticut, all of which had a median payment of \$200,000 or more. The lowest 2000 median was found in California at \$55,000. Indiana, Kentucky and Vermont all had median payments of \$75,000.¹⁶

¹⁵The median payment is the amount where half the payments are above and half are below. For example, if the payments were \$25,000, \$50,000 and \$225,000, the median payment would be \$50,000.

¹⁶The California median payment for physicians is artificially impacted by a State law which is commonly believed to require reporting to the State only of malpractice payments of \$30,000 or more. During 2000, 95 (6.7 percent) of California physician's 1,408 malpractice payments were for \$29,999. Payments for \$29,999 are extremely rare in other States. Another 68 California payments were for exactly \$30,000, which is immediately below the actual reporting threshold. When these payments are combined with the \$29,999 payments, fully 11.6 percent of California physician malpractice payments are within \$2.00 of the State reporting threshold.

The cumulative mean physician malpractice payment for the NPDB was \$202,301. Adjusted for inflation, assuming 2000 dollars for all payments, the mean payment was \$225,612. The mean payment during 2000 was \$248,947. During 2000 mean payments ranged from lows of \$118,501 in Michigan and \$142,637 in California to highs of \$584,338 in the District of Columbia and \$457,855 in Illinois. Note that the ranking of States by median payment amounts does not take into account the fact that two separately reported payments may be made for some malpractice claims in States with patient compensation funds and other similar payers. The median (and mean) payment amounts for these States would be higher if a single report were filed showing the total payment for the claim from all payers.

State Differences in Payment Delays for Physicians

There also are substantial differences between the States in how long it takes to receive a malpractice payment after an incident occurs (“payment delay”). For all physician Malpractice Payment Reports received from the opening of the NPDB through December 31, 2000, the mean delay between incident and payment was 4.83 years. For 2000 payments, the mean delay was 4.66 years. Thus during 2000, payments were made on average about two months quicker than the average for all payments. On average, during 2000, payments were made most quickly in Minnesota (2.99 years). Payments were slowest in New York (6.28 years). Average payment delays continued to decrease in 2000. The average physician payment came about 21 days sooner than in 1999.

Variations in Payment Amounts and Payment Delays for Different Types of Cases

Different types of malpractice cases are likely to have different payment amounts and varying payment delays. As shown in Table 10, which includes only payments for physicians, the NPDB categorizes malpractice events into ten broad categories. During 2000, incidents relating to equipment and product problems had the second lowest median and lowest mean payments (\$45,000 and \$73,821, respectively). The lowest median and the second lowest mean payment amounts for physicians were for miscellaneous incidents (\$30,000 and \$121,478 respectively). However, there were only 29 equipment and product reports and only 170 miscellaneous reports. Together these categories represent only 1.3 percent of all physician malpractice payments in 2000. As in previous years, obstetrics-related cases (1,291 reports, 8.3 percent of all physician Malpractice Payment Reports) had by far the highest median and mean payments (\$225,000 and \$417,181 respectively).

The mean payment delay is shown in Table 11, which includes payments for all types of practitioners for each type of case. The 1,344 obstetrics-related payments in 2000 (6.9 percent of all 2000 payments) had the longest mean delay between incident and payment (5.78 years), followed by 259 payments (1.3 percent) for monitoring cases (4.99 years). The shortest average delay for

2000 payments was for equipment and product related cases (3.39 years). There were 57 such cases for all types of practitioners, representing 0.3 percent of all 2000 malpractice payments.

Malpractice Payments for Nurses

As reflected in requests for information made to DQA, there has been increasing interest in nurse malpractice payments. The NPDB classifies registered nurses into four categories: Nurse Anesthetists, Nurse Midwives, Nurse Practitioners, and Registered Nurses not otherwise classified, referred to in the tables as Registered Nurses. Malpractice payments for nurses are relatively rare. As shown in Table 12, all types of Registered Nurses have been responsible for 3,202 malpractice payments (1.7 percent of all payments) over the history of the NPDB. Slightly less than two-thirds of the payments for nurses were made for non-specialized Registered Nurses. Nurse Anesthetists were responsible for 22.9 percent of nurse payments. Nurse Midwives were responsible for 7.5 percent, and Nurse Practitioners were responsible for 4.7 percent of all nurse payments. Monitoring, treatment, and medication problems are responsible for the majority of payments for non-specialized nurses, but obstetrics and surgery-related problems are also responsible for significant numbers of payments for these nurses. As would be expected, anesthesia-related problems are responsible for 84.8 percent of the 735 payments for Nurse Anesthetists. Similarly, obstetrics-related problems are responsible for 80.1 percent of the 241 Nurse Midwife payments. Diagnosis-related problems are responsible for 41.7 percent of the 151 payments for Nurse Practitioners. Treatment-related problems are responsible for another 24.5 percent of payments for these nurses.

As shown in Table 13, the median and mean payment for all types of nurses in 2000 was \$82,700 and \$269,090, respectively. The median is \$42,300 less than the median physician payment but the mean is \$20,143 larger than the mean physician payment in 2000. Similarly, the inflation-adjusted cumulative median nurse payment \$77,752 is \$27,956 less than the \$105,708 inflation-adjusted cumulative median payment for physicians and the inflation-adjusted cumulative mean nurse payment of \$258,726 is \$33,118 larger than the cumulative mean physician payment.

Table 14 shows the cumulative nurse malpractice payment rate by State. An adjusted number is provided to account for payments made by State compensation and similar funds, but the adjusted payments account for only 1.6 percent of nurse payments. Vermont had only one nurse Malpractice Payment Report in the NPDB while New Jersey had the most, 392. The ratio of nurse payments to physician payments may be calculated by referring to Table 6 column 2 for the adjusted number of physician reports and Table 14 column 2 for the adjusted number of nurse reports. The ratio of nurse payments to physician payments (using adjusted figures) for Vermont (with only one nurse payment) is obviously the lowest in the nation, but six States have fewer than one nurse payment for every 100 physician payments. In contrast, the ratio for New Mexico, which is the highest in the nation, is 7.6 nurse payments for every 100 physician payments. Four other States also have ratios of more than 6 nurse payments for every 100 physician payments. Since the same

malpractice statutes apply within a State for both physicians and nurses, this suggests that there may be substantial differences in nurses and physicians' safety of practice in different States.¹⁷

Malpractice Payments for Physician Assistants

DQA has also had many requests for information on malpractice payments for Physician Assistants. As shown in Table 15, there are relatively few such payments. Physician Assistants have been responsible for only 452 malpractice payments since the opening of the NPDB (0.2 percent of all payments). Both cumulatively and during 2000, diagnosis-related problems were responsible for well over half of all Physician Assistant malpractice payments (52.7 percent cumulatively and 53.4 percent in 2000). Treatment-related payments were the second largest category both cumulatively and in 2000 (27.4 percent and 24.7 percent, respectively). Excepting one obstetrics-related payment and six monitoring-related payments, payments in the diagnosis category were responsible for the largest median payment (\$72,500).

REPORTABLE ACTION AND MEDICARE/MEDICAID EXCLUSION REPORTS ANALYSIS

This section primarily presents descriptive statistics concerning 2000 reportable actions and Medicare/Medicaid exclusions. For comparative purposes, information is provided for each of the most recent five years (1996 through 2000) as well as cumulatively from the opening of the NPDB on September 1, 1990 through December 31, 2000.

Licensure, clinical privileges, professional society membership disciplinary actions, actions taken by the DEA concerning authorization to prescribe controlled substances, and revisions to such actions must be reported to the NPDB if they are taken against physicians and dentists. As shown in Table 2, reportable actions represent 15.5 percent of all reports received by the NPDB during 2000 and, cumulatively, 18.1 percent of all reports in the NPDB. The number of reportable action reports received increased by 515 reports to a total of 5,703 (a 9.9 percent increase) from 1999 to 2000 (Table 3). This followed a 2.9 percent decrease in reportable actions from 1998 to 1999. The 5,703 reportable action reports received during 2000 were the largest number of such reports received in any single year to date.

¹⁷Other explanations may also be applicable; possible differences in the ratio of nurses to physicians in practice in the States may play a particularly important role. We have not explored these possible differences.

During 2000, licensure actions made up 80.5 percent of all reportable actions and 12.5 percent of all NPDB reports (including malpractice payments and Medicare/Medicaid exclusions). As shown in Table 2, licensure actions continue to represent the majority of reportable actions (cumulatively 78.6 percent of all reportable actions). Licensure reports increased by 12.0 percent in 2000 compared to 1999. Licensure reports for physicians increased by 10.9 percent in 2000. Licensure reports for dentists, in contrast, increased by 21.7 percent. Licensure reports for physicians constituted 77 percent of all licensure reports in 2000.

The number of clinical privileges actions also increased from 1999 to 2000. There were 1,006 such reports in 1999 and 1,080 in 2000, an increase of 7.4 percent. Physician clinical privileges reports increased by 9.5 percent and voluntarily submitted clinical privileges reports for non-physician/non-dentists decreased by 22.7 percent to a total of 58. Clinical privileges actions represented 18.9 percent of all 2000 reportable action reports and 2.9 percent of all 2000 NPDB reports.

Professional society membership actions (only 30 reported) made up 1 percent of all reportable actions during 2000. No DEA reports were received during 2000. The number of reported professional society and DEA actions has remained almost negligible throughout the NPDB's history. From September 1990 to December 2000, the two combined represented only 1.4 percent of reportable action reports and .2 percent of all NPDB reports. The greatest number of professional society membership actions and DEA actions submitted in one year was 100 in 1994.

Table 5 presents information on all types of reportable actions and on Exclusion Reports by type of practitioner, type of report, and year. Physicians are responsible for the largest number of all reportable actions during 2000 and earlier years. During 2000, physicians were responsible for 77 percent of licensure actions, 92.4 percent of clinical privileges actions, and 93.3 percent of professional society membership actions. In contrast, physicians were responsible for only 20 percent of the Medicaid/Medicare exclusion actions added to the NPDB during 2000.

Over the past few years physicians on a per practitioner basis were more likely to be reported than were dentists. However, in 2000 physicians, who represent about 81.5 percent of the nation's total physician-dentist work force, were responsible for only 77.1 percent of licensure reports for the work force. They were, however, responsible for 97.7 percent of all clinical privileges reports for physicians and dentists. This result is expected, however, since dentists frequently do not hold clinical privileges at a health care entity and thus could not be reported for a clinical privileges action.

Dentists, who comprise approximately 18.5 percent of the nation's total physician-dentist work force, during 2000 were responsible for 22.9 percent of physician and dentist licensure actions,

2.3 percent of clinical privileges actions,¹⁸ no professional society membership actions, no DEA actions, and 22.6 percent of Exclusion Reports for physicians and dentists. The number of dental licensure reports has generally grown slightly each year, and 2000 represents the greatest number of dental licensure actions submitted to the NPDB in a single year (1,048 reports).

Voluntary reporting of reportable actions against “other practitioners” was not a significant source of reportable action reports to the NPDB during 2000. Only 69 reportable action reports were voluntarily submitted for “other practitioners.” Only two professional society membership actions are contained in the NPDB for practitioners other than physicians or dentists. However, “other practitioners” accounted for the majority of Exclusion Reports (74.2 percent of 11,401 reports) added to the NPDB during 2000.

Actions Reporting Issue: Under-Reporting of Clinical Privileges Actions

There is general agreement that the level of clinical privileges reporting shown in Tables 2 and 3 is unreasonably low. This could reflect either an actual low number of actions taken (perhaps because hospitals substituted non-reportable actions for reportable actions) or failure to file reports concerning reportable actions taken, or both. In October 1996, the Northwestern University Institute for Health Services Research and Policy Studies, under contract with HRSA, held a conference on clinical privileges reporting by hospitals. Participants included executives from the American Medical Association; the American Osteopathic Association; the American Hospital Association; the Joint Commission on Accreditation of Health Care Organizations; the HCFA; the DHHS OIG; DQA, BHP, HRSA, DHHS (which manages the operations of the NPDB program); the Federation of State Medical Boards; Public Citizen Health Research Group; Citizen Advocacy Center; individual State hospital associations; individual hospitals; and hospital attorneys. The participants reached consensus that “the number of reports in the NPDB on adverse actions against clinical privileges is unreasonably low, compared with what would be expected if hospitals pursued disciplinary actions aggressively and reported all such actions.”¹⁹ There was also agreement that research was needed to better understand the perceived under-reporting so appropriate steps could be taken to improve reporting. The NPDB and DQA have been conducting research on the issue and working with relevant organizations to try to ensure that reportable actions should be reported actually are reported. The 25.4 percent increase in clinical privileges reporting from 1998 to 2000 may reflect the results of this effort. However, even with the observed increased reporting, the number of clinical privileges actions reported remains unreasonably low.

¹⁸This small percentage reflects the fact that relatively few dentists work in hospitals.

¹⁹Institute for Health Services Research and Policy Studies, Northwestern University. HRSA Roundtable Conference Report.

Tables 16 and 17 shed additional light on the low level of reporting of clinical privileges actions by hospitals. Table 16 lists for each State the number of non-Federal hospitals with “active” NPDB registrations and the number and percent of these hospitals that have *never* reported to the NPDB. These percentages range from 20 percent in Delaware to 83.3 percent in South Dakota. Nationally, as of December 31, 2000, 52.5 percent of non-Federal hospitals registered with the NPDB and in “active” status had *never* reported a clinical privileges action to the NPDB. Analysis in a previous year has shown that clinical privileges reporting seems to be concentrated in a few facilities even in States which have comparatively high over-all clinical privileges reporting levels. This pattern may reflect a willingness (or unwillingness) to take reportable clinical privileges actions more than it reflects a concentration of problem physicians in only a few hospitals.

Table 17 compares licensure reporting and clinical privileges reporting for physicians by State. The ratio of adverse clinical privileges reports (excluding reinstatements, etc.) to adverse licensure reports (again excluding reinstatements, etc.) ranges from a low of one adverse clinical privileges report for every 5.5 adverse licensure reports in Mississippi to a high of one adverse clinical privileges report in Nebraska for every 0.73 adverse licensure reports (i.e., more adverse clinical privileges reports than adverse licensure reports). While these ratios reflect variations in the reporting of both licensure actions and clinical privileges actions, the extreme variation from State to State is instructive. It seems extremely likely that the extent of the observed differences reflect variations in willingness to take actions rather than such a substantial difference in the conduct or competence of the physicians practicing in the various States.

Adverse Licensure Reports for Physicians and Dentists Practicing In-State

Table 18 presents information on the cumulative number of licensure reports for physicians and dentists by State. For both types of practitioners, data are presented for the total number of licensure reports, the number of licensure reports which are adverse (i.e., are not reinstatements, etc.), and the number of adverse licensure reports for in-State practitioners. Physicians and dentists are often licensed in more than one State. If one State takes a licensure action, other States often take a parallel action because of the first State’s action. Typically the practitioner is actively practicing in the first State which takes action; actions taken by the other States in which the practitioner is licensed prevent the practitioner from moving back to those States and resuming practice, but these actions do not reflect the extent of actions taken by the boards in relation to problems occurring in their States.

For physicians, 90 percent of all licensure actions reported to the NPDB have been adverse in nature. For dentists, about 94 percent have been adverse. In Nevada and New Mexico 100 percent of the reported physician licensure actions have been adverse. This contrasts with South Carolina, in which only 75 percent of the physician licensure actions have been adverse.

We also examined the proportion of all physician licensure actions that are adverse and affect in-State physicians. Nationally 74 percent of licensure actions are both adverse and pertain to in-State physicians. The low was 40 percent in the District of Columbia and the high was 93 percent in Oregon.

For dentists, about 94 percent of all licensure actions reported to the NPDB have been adverse in nature. In seventeen States 100 percent of the reported dentist licensure actions have been adverse. The low was Illinois for which only 70 percent of the dental licensure actions were adverse.

We also examined the proportion of all dentist licensure actions that are adverse and affect in-State dentists. Nationally 93 percent of licensure actions are both adverse and pertain to in-State dentists. The lows were 50 percent in Vermont and 66 percent in Iowa. In seven States all dental licensure actions were adverse and pertained to in-State dentists.

RELATIONSHIP BETWEEN REPORT TYPES AND MULTIPLE REPORTS ANALYSIS

Data on both malpractice payments and reportable actions can be examined to discover patterns and relationships. Below, we examine the relationship between Malpractice Payment and Reportable Action Reports. We also look at information regarding physicians with multiple reports in the NPDB.

Relationship Between Malpractice Payments and Reportable Actions

Physicians with high numbers of Malpractice Payment Reports tend to have at least some Adverse Action Reports and vice versa. Tables 19 and 20 show this data. For example, as shown in Table 19, although 95 percent of the 71,865 physicians with only one Malpractice Payment Report in the NPDB have no reportable action reports, only 41.6 percent of the 221 physicians with ten or more Malpractice Payment Reports have no reportable action reports. Generally, as a physician's number of Malpractice Payment Reports increases, the likelihood that the physician has action reports also increases. Similarly, as shown in Table 20, there is a tendency for a smaller proportion of physicians to have no Malpractice Payment Reports as their number of reportable action reports increases. However, the trend reverses for physicians with eight or more reportable action reports. One explanation may be that physicians with large numbers of reportable action reports leave the profession and no longer have the opportunity to commit malpractice.

Physicians with Multiple Reports in the NPDB

A related area of interest is the number and percentage of practitioners with multiple Malpractice Payment or Reportable Action Reports in the NPDB. As seen in Table 1, at the end of

2000, a total of 164,320 individual practitioners had disclosable reports in the NPDB. Of these, 114,522 (69.7 percent) were physicians. Most physicians (65.4 percent) with reports in the NPDB had only one report, but the mean number of reports per physician was 1.7. Physicians with exactly two reports made up 19.6 percent of the total. About 97.4 percent had five or fewer reports and 99.6 percent of physicians with reports had ten or fewer reports. Only 420 (0.4 percent of physicians with reports) had more than 10 reports. Of the 114,522 physicians with reports, 94,015 (82.1 percent) had only Malpractice Payment Reports; 7,286 (6.4 percent) had only licensure reports; 2,256 (2.0 percent) had only clinical privileges reports; and 1,323 (1.2 percent) had only MMERs. The remainder had Drug and Enforcement or Professional Society reports. Notably, only 4,787 (4.2 percent) had at least one Malpractice Payment Report and at least one licensure report, and only 2,515 (2.2 percent) had at least one Malpractice Payment Report and at least one clinical privileges report. Only 1,087 (1 percent) had Malpractice Payment, licensure, and clinical privileges reports. Only 211 (.18 percent) had at least one Malpractice Payment, licensure action, clinical privileges action, and Exclusion Report at the end of 2000.

Approximately 28.3 percent of the 100,241 physicians with at least one Malpractice Payment Report had two or more reports. These 28,376 physicians had 77,386 Malpractice Payment Reports in the NPDB, representing 51.8 percent of the 149,251 Malpractice Payment Reports in the NPDB.

REGISTERED ENTITIES ANALYSIS

This section primarily presents descriptive statistics concerning 2000 registered entities. For comparative purposes, information is provided cumulatively from the opening of the NPDB on September 1, 1990 through December 31, 2000.

All reporting and querying to the NPDB (except for practitioner self-querying) is performed by registered entities that certify that they meet the eligibility requirements of the HCQIA of 1986. Table 21 provides information on 15,580 registered entities that have reported or queried at least once since the opening of the NPDB and those active as of December 31, 2000. Some entities have (or had in the past) multiple registration numbers either simultaneously or sequentially, so the numbers shown in Table 21 do not necessarily reflect the actual number of individual entities which have reported to or queried the NPDB. Hospitals make up the largest category of registered entities. At the end of 2000 hospitals accounted for 5,879 (53.5 percent) of the NPDB's active registered entities. Hospitals made up 48.2 percent of the entities which had ever registered with the NPDB. HMOs, PPOs, and Group Practices accounted for 1,425 active registrations (13 percent) at the end of 2000. Other Health Care Entities held 3,166 active registrations (28.8 percent). The 298 malpractice insurers with active registrations accounted for only 2.7 percent of all active registrations. Other categories accounted for even smaller percentages of the NPDB's active registrations at the end of 2000.

QUERIES ANALYSIS

This section primarily discusses queries during 2000. For comparative purposes, information is provided for each of the most recent five years (1996 through 2000) as well as cumulatively from the opening of the NPDB on September 1, 1990 through December 31, 2000.

Query data are presented in Table 22. A total of 3,292,157 entity requests for the disclosure of information (queries) were processed by the NPDB during 2000. This is an average of over six queries every minute, 24 hours a day, 365 days a year, or one query about every 10 seconds. The number of queries in 2000 increased 2.2 percent from the 3,222,348 queries processed during 1999. It is also almost 4.1 times as many queries as the 809,844 queries processed during the NPDB's first full year of operation, 1991. Cumulatively, the NPDB had processed 22,312,102 entity queries by the end of 2000.

Practitioner self-queries also are shown in Table 22. Practitioners who want to verify their record (or lack of a record) in the NPDB can query on their own record at any time. Some State boards, which could query the NPDB, instead require practitioners to submit self-query results with license applications. During 2000, the NPDB processed 33,296 self-query requests. This was a decrease of 19.6 percent from the number of self-queries processed during 1999 and is a decrease of 36.7 percent from the record 52,603 self-queries processed during 1997. Only 2,764 (8.3 percent) of the self-query requests during 2000 were matched with reports in the NPDB. Cumulatively from the opening of the NPDB, 339,415 self-queries have been processed; 26,896 (7.9 percent) of these queries were matched with reports in the NPDB.

The NPDB classifies entity queries as "required" and "voluntary." Hospitals are required to query for all new applicants for privileges or staff appointment and once every two years concerning their privileged staff. Hospitals voluntarily may query for other peer review activities, but for analysis purposes we assume that all hospital queries are required. Figure 2 shows querying volumes for the last 10 years. Hospitals made most of the queries to the NPDB in its first few years of operation. Although the number of hospital queries increased by 51.1 percent from the 740,262 in 1991 (the NPDB's first full year of operation), to 1,118,828 queries in 2000, the growth in the number of voluntary queries has been much greater. These queries increased from 65,269 in 1991 to 2,173,329 in 2000, an increase of over 3,300 percent. Voluntary queries represented 66 percent of all entity queries during 2000 (Table 23).

The distribution of queries by querier type is shown in Table 23. Of the voluntary queriers, managed care organizations (defined for this purpose as entities registered as HMOs PPOs and Group Practices) are the most active. Although they represent 16.5 percent of all querying entities during 2000 and 19.2 percent of all entities that have ever queried the NPDB, they made 54 percent of all queries during 2000 and have been responsible for 46.3 percent of queries ever submitted to the NPDB. Other health care entities (i.e., non-hospitals and non-managed care organizations) made

Growth in Queries by Querier Type, 1990 - 2000

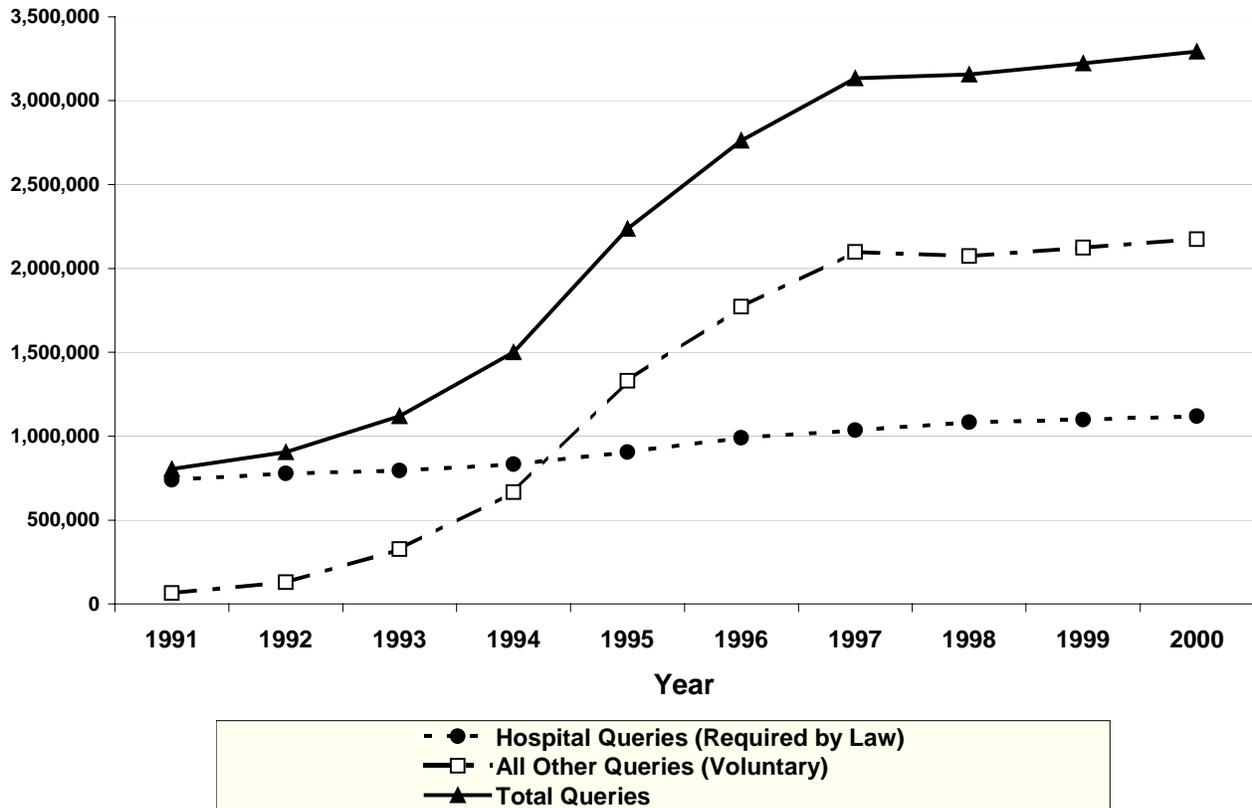


Figure 2

11.3 percent of the queries in 2000 and 10.1 percent cumulatively. State licensing boards made 0.4 percent of queries both during 2000 and cumulatively.²⁰ Professional societies were responsible for 0.3 percent of all queries both during 2000 and cumulatively.

Queriers request information on many types of practitioners. Table 24 shows by practitioner type the number of queries submitted during a sample period in October and November 2000. Allopathic physicians are the subject of by far the most queries during this period; more than 71 percent of queries submitted concerned allopathic physicians, interns and residents. The second

²⁰The low volume of State board queries may be explained by the fact that entities are required to provide State Boards copies of reports when they are sent to the NPDB so the boards do not need to query to obtain reports for in-State practitioners and by the fact that some boards require practitioners to submit self-query results with applications for licensure.

largest category, dentists, accounted for only 4.4 percent of all queries. Osteopathic physicians, interns and residents accounted for 4.11 percent, clinical psychologists accounted for 2.68 percent, clinical social workers accounted for 2.59 percent, optometrists accounted for 1.94 percent, podiatrists accounted for 1.88 percent, chiropractors accounted for 1.65 percent, non-specialized registered nurses accounted for 1.64 percent, nurse practitioners accounted for 1.16 percent, and physical therapists and physician assistants accounted for 1.07 percent each.

Matches

When an entity submits a query on a practitioner, a “match” occurs when that individual is found to have a report in the NPDB. As shown in Table 22, the 416,827 entity queries matched during 2000 represents a match rate of 12.7 percent. Although the match rate has steadily risen since the opening of the NPDB, we hypothesize that it will plateau once the NPDB has been in operation the same length of time as the average practitioner practices, all other factors (such as malpractice payment rates for older and younger physicians) being equal. About 87.3 percent of entity queries submitted receive a “no-match” response from the NPDB, meaning that the practitioner in question does not have a report in the NPDB. This does not mean, however, that there was no value in receiving these responses. During 1995 the OIG completed an evaluation of the utility of the NPDB and found that 77 percent of the hospitals and 96 percent of the managed care organizations found “no match” responses useful²¹, presumably because they confirm that practitioners have had no reports in over six years. At the end of 2000 a no-match response to a query confirmed that a practitioner has had no reports in over ten years. These responses will become even more valuable as the NPDB matures.

DISPUTED REPORTS AND SECRETARIAL REVIEWS ANALYSIS

This section primarily presents descriptive statistics concerning 2000 disputed reports and Secretarial Reviews. For comparative purposes, information is provided for each of the most recent five years (1996 through 2000) as well as cumulatively from the opening of the NPDB on September 1, 1990 through December 31, 2000.

²¹Office of Inspector General, DHHS. National Practitioner NPDB Reports to Hospitals: Their Usefulness and Impact. OEI-01-94-00030. April 1995. Office of Inspector General, DHHS. National Practitioner Data Bank Reports to Managed Care Organizations: Their Usefulness and Impact. OEI-01-94-00032. April 1995. The Division of Quality Assurance conducted a new survey examining this issue and others during 2000. Results are expected during 2001.

At the end of 2000, there were 1,755 licensure reports, 1,495 clinical privileges reports, 32 professional society membership reports, 13 DEA reports, 181 exclusion actions, and 7,811 Malpractice Payment Reports under dispute by the practitioners named in the reports. Exclusion Reports for actions taken prior to August 21, 1996²⁰ cannot be disputed with the NPDB. Disputed reports constitute 4.7 percent of all licensure reports, 15.6 percent of all clinical privileges reports, 9.1 percent of professional society membership reports, 4.4 percent of DEA reports, and 4.1 percent of Malpractice Payment Reports. Practitioners who have disputed reports first attempt to negotiate with entities that filed the reports to revise or void the reports before requesting Secretarial review. The fact that a report is disputed simply means that the practitioner disagrees with the accuracy of the report but has not filed a formal request for Secretarial Review. When disputed reports are disclosed to queriers, queriers are notified that the practitioner disputes the accuracy of the report.

If practitioners are dissatisfied with the results of their efforts to have reporters modify or void disputed reports they may seek a "Secretarial Review." Although practitioners may request Secretarial Review for any reason, the only reasons that can be considered by the Secretary are that the report was not required or permitted to be filed or that the report did not accurately describe the malpractice payment which was made and the related allegations or the action which was taken and the reasons stated by the reporting entity for taking action. All other reasons (such as a claim that although a malpractice payment was made for the benefit of the named practitioner, the named practitioner did not really commit malpractice or that there were extenuating circumstances), are "outside the scope of review." Practitioners may explain these matters in their statement in the report. The Secretary can only remove a report from the NPDB if it was not legally required or permitted to be submitted. The Secretary can change a report only if it did not accurately reflect the malpractice payment and its related allegations or the action taken and the stated reasons the entity took the action. The Secretary may administratively dismiss requests for Secretarial Review if the practitioner does not provide required information or if the matter is resolved with the reporting entity to the satisfaction of the practitioner while the Secretarial Review is in process.

Table 25 presents information on this level of review. Requests for review by the Secretary increased by 9.1 percent from 1999 to 2000. A total of 120 requests for review by the Secretary was received during 2000 compared to 110 in 1999. Bearing in mind that requests for Secretarial Review during a given year cannot be tied directly to either reports or disputes received during the same year, we can still approximate the relationship between requests for Secretarial Review, disputes, and

²²Exclusion actions taken before August 21, 1996 are included in the NPDB by a memorandum of agreement between HRSA, HCFA, and OIG. Exclusion actions taken on August 21, 1996 and later are reported to the HIPDB by law and are disputed under the normal process. HIPDB Secretarial Review decisions on these reports also apply to the NPDB.

reports. During 2000, the number of new requests for Secretarial Review was about 0.3 percent of the number of new Malpractice Payment Reports and Adverse Action Reports received.

As Table 25 shows, reportable action reports were more likely to be appealed to the Secretary than were Malpractice Payment Reports. During 2000, 58.3 percent (70 requests) of all requests for Secretarial Review concerned reportable actions (i.e., licensure, clinical privileges, or professional society membership reports) even though only 15.5 percent of all 2000 reports fell in this category. Since the opening of the NPDB reportable actions have represented a much larger proportion of Secretarial Reviews than would be expected from the number of reportable action reports received by the NPDB. Within the reportable action category, clinical privileges reports are the most likely to be involved in Secretarial Review.

Table 26 presents data on the outcome of requests for Secretarial Review. At the end of 2000, 72 (60 percent) of the 120 requests for Secretarial Review received during the year remained unresolved. Of the 48 new 2000 cases which were resolved, only one (2.1 percent) was resolved in a way favorable to the practitioner (Secretarial decision in favor of the practitioner). Reports were not changed (Secretary decided in favor of entity or alleged facts were “Out-of-Scope”²³) in 44 cases (91.7 percent of the 2000 cases which were resolved).

Because of the increasing number of unresolved requests for Secretarial Review, DQA is adding staff to process its requests, many of which raise complex issues and require considerable staff time to resolve fairly and accurately.

Table 27 presents cumulative information on Secretarial Reviews by report type and outcome. By the end of 2000 only 11.5 percent of all closed requests for Secretarial Review had resulted in a determination in favor of the practitioner.²⁴ At the end of 2000, 5.8 percent of all requests for Secretarial Review remained unresolved. Only 36 (7 percent) of the total of 514 Malpractice Payment Reports with completed Secretarial Reviews (the total number of requests minus the number of unresolved requests) have been changed because the Secretary decided in favor of the practitioner. In the case of reviews of privileges actions, 71 (14 percent) of the 508 closed requests resulted in a change in favor of the practitioner. For licensure actions and professional society membership actions, these numbers were 48 (17.8 percent) of 250 closed requests and 2 (15.4 percent) of 13 closed requests, respectively.

²³ “Out-of-Scope” determinations are made when the issues at dispute can not be reviewed because they don’t challenge the information’s accuracy or its requirement to be reported to the NPDB.

²⁴ These closed requests determined in favor of the practitioner do not include all outcomes favorable to the practitioner. Some requests could be administratively dismissed if an entity makes changes to the report that are favorable and acceptable to the practitioner during the Secretarial Review process.

THE NATIONAL PRACTITIONER DATA BANK 10-YEAR TIMELINE CELEBRATING 10 YEARS OF HELPING TO IMPROVE THE QUALITY OF AMERICA'S HEALTH CARE SYSTEM

1986 The Health Care Quality Improvement Act of 1986

- Congress passes the HCQIA. This legislation is intended to protect peer review bodies from private money damage liability and to prevent incompetent practitioners from moving State to State without disclosure or discovery of previous damaging or incompetent performance.
- President Ronald Reagan signs Title IV of Public Law 99-660, the HCQIA, which led to the NPDB's establishment.

1988 Development of the NPDB

- DHHS, HRSA, BHPPr begins developing the NPDB. HRSA contracts with Unisys Corporation to develop and operate the NPDB.

1989 Final Regulations Published

- Final NPDB regulations (45 CFR part 60) are published in the Federal Register.
- NPDB Executive Committee convenes its first meeting.

1990 NPDB Opens to Support Peer Review and Credentialing

- Based in Camarillo, California, NPDB opens September 1st and begins collecting reports on medical malpractice payments and adverse licensure, clinical privileges and professional society membership actions taken against practitioners. Hospitals, health care entities and State licensing boards begin querying the NPDB.
- The system is designed to be self-supporting through query fees. All transactions are on paper.
- Average query response time is six weeks.
- The first NPDB Guidebook is published, providing policy guidance to NPDB users.

1991 NPDB Processes Queries

- In its first full year of operation, the NPDB processes 809,900 queries, an average of 16,000 names per week.

1992 Electronic Querying Introduced

- Electronic querying is introduced using new QPRAC software, version 1.0. Queries may be submitted via modem or diskette; responses are returned on paper. Average query response time is reduced to one week.

1993 NPDB Receives NCQA Endorsement and Federal Leadership Award

- Endorsing the value of NPDB data, the National Committee for Quality Assurance adopts an accreditation standard encouraging health maintenance organizations to query the NPDB.
- BHPr's DQA, which manages the NPDB, receives a 1993 Federal Leadership Award for its efforts to reduce paper processing by the NPDB.
- NPDB accepts query payments by credit card.

1994 Practitioners May Add Statements to Reports

- A practitioner with a report in the NPDB may now add his or her own statement to the report. The statement will be disclosed to all queriers who receive the report.
- NPDB implements automated fee collection through Electronic Funds Transfer. Queriers can pre-authorize the NPDB to debit their bank accounts directly for query fees.
- QPRAC version 2.0 is introduced, allowing the NPDB to respond electronically to queries.
- HRSA contracts with SRA to develop and operate the "Second Generation" NPDB.
- More than 1.5 million queries are processed this year, an average of 30,000 per week. More than half of all queries are electronic.
- Average query response time is two to three days.

1995 NPDB Collects Its 100,000th Report

- All paper queries, except practitioner self-queries, are eliminated.
- The NPDB received its 100,000th report (a \$29,999 malpractice payment for a California physician).
- SRA begins operating the "Second Generation" of the NPDB in Fairfax, Virginia.
- Voluntary queries (submitted by entities not required by law to query) outnumber required queries for the first time.
- Responses to queries now include whether Secretarial Review of the report has been requested and the status of any such review.

1996 Electronic Reporting Introduced

- NPDB users can submit reports and update registration information electronically using QPRAC version 3.0.
- The Blizzard of '96 blankets the Washington, DC, area with 20 inches of snow. Although no

NPDB staff are able to get to the office, the NPDB processes more than 20,000 queries.

- More than 2.7 million queries are processed this year, an average of 52,000 per week.
- Average query response time is six hours or less.

1997 HRSA Asked to Design, Develop and Operate New Data Bank in Coordination with NPDB

- Because of the NPDB's success, DHHS OIG asks BHPr's DQA to design, develop and operate the new HIPDB — a health care fraud and abuse prevention database. By law, NPDB and HIPDB must coordinate reporting.
- NPDB queriers begin receiving Medicare and Medicaid exclusion information on practitioners.

1998 NPDB Processes Its 15th Million Query

- State licensing boards, hospitals, and other health care entities have queried the NPDB more than 15 million times since 1990.
- NPDB processes its 1,000th Secretarial Review of a disputed report since 1990.
- NPDB receives its 200,000th report.

1999 NPDB Begins Operating on the Internet

- For the first time, the NPDB begins accepting reports and single name queries submitted through a secure Internet site using the new IQRS.
- More than 3.2 million NPDB queries are processed during the year, an average of six queries a minute, 24 hours a day, 365 days a year, or one query approximately every 10 seconds.
- Average query response time is four to six hours.

2000 NPDB Turns 10 Years Old

- NPDB enters the new millennium Y2K-trouble free.
- Multiple name querying and subject databases are available for NPDB users on the Internet.
- NPDB celebrates 10 years of successful operation.
- Third Generation Contract Awarded to SRA.

NPDB CELEBRATES TENTH ANNIVERSARY

Two celebratory events marked the tenth anniversary of the NPDB. The NPDB 10-Year Anniversary Celebration on September 18 and the NPDB Tenth Anniversary Research Forum on November 13 recognized the contributions the NPDB has made to licensing, credentialing, and medical malpractice and discipline research.

More than 100 people involved in the implementation and maintenance of the NPDB over the years attended the celebration in Bethesda, Maryland. Speakers who helped shape the NPDB over the years shared their experiences. They included Dr. Sam Shekar, HRSA Associate Administrator for Health Professions; Ernst Volgeneau, President of SRA, the current NPDB contractor; Dr. James Winn of the Federation of State Medical Boards; Jodi Schirling of National Association Medical Staff Services; and Tom Croft, DQA Director. Mr. Croft, who had served 35 years in the federal government, announced his retirement at the event.

The second celebratory event, the NPDB Tenth Anniversary Research Forum, brought more than 75 people to the Natcher Center at the National Institutes of Health Campus in Bethesda, Maryland. The forum, moderated by Dr. Mary Wakefield of George Mason University, celebrated the NPDB's contributions to medical malpractice and discipline research through its research data and public use file. It brought together researchers from universities, health care organizations, and federal agencies to present information, exchange ideas and develop working linkages and relationships. The participants also made progress toward improving the NPDB research database and exploring topics for future research.

The keynote address by Dr. Peter Budetti of the Institute for Health Services Research and Policy Studies at Northwestern University on the NPDB's birth, development, and contributions to research was a major highlight of the event. Two panels chaired by Dr. Robert A. Berenson, HCFA, and Dr. David T. Stern, University of Michigan, presented medical malpractice and discipline research done by federal agencies and universities, respectively.

Both events spotlighted the NPDB's mission of insuring the quality of medical care delivered by our country's healthcare practitioners by making sure review boards and other organizations have information to assess individual practitioners' responsibility for errors and professional misconduct.

The NPDB, which opened on September 1, 1990, has made great strides, from paper form processing and 809,000 queries in 1991, to an Internet-based, paperless system and 3.29 million queries, one every 10 seconds, in 2000. From electronic billing procedures to a state-of-the-art computer reporting and query system, the NPDB innovatively, accurately and responsibly manages information. The NPDB received a Federal Leadership Award in 1993 for its innovative efforts toward a fully electronic data system. Those early efforts have led to today's Internet-based reporting and querying system, the IQRS.

At the end of its 10th year the NPDB has sent copies of reports of payments, adverse actions and exclusions in response to 2.3 million requests. In response to more than 20.3 million requests, the NPDB has certified practitioners' lack of malpractice payments, adverse actions, or exclusions, thus confirming their good records.

CONCLUSION

NPDB operations continued to improve during 2000. As this Annual Report shows, the number of reportable actions, Malpractice Payment Reports, and queries continue to increase. The number of reports in the NPDB now exceeds 260,000 and the total number of queries is greater than 22.3 million. Although Malpractice Payment Reports still represent the majority of reports in the NPDB, more reportable actions (e.g., MMERs, licensure, clinical privileges, professional society membership, Federal Licensure and DEA reports) have been entered into the NPDB. State licensing boards have steadily increased their submission of reports to the NPDB over the past ten years. Yet, it is doubtful the NPDB is receiving all reportable actions taken by State licensing boards, professional societies, hospitals, and other eligible health care entities.

However, as NPDB information accumulates, the NPDB's value as a source of aggregate information and public use data for research expands, and its usefulness as an information clearinghouse for eligible queriers about specific practitioners grows. Over time, the data generated will provide useful information on trends in malpractice payments, adverse actions, and professional disciplinary behavior. Most importantly, however, the NPDB will continue to benefit the public by serving as an information clearinghouse that facilitates comprehensive peer review, and thereby, improves U.S. health care quality.

The "Third Generation" contract for the Data Banks was awarded to SRA, which will continue to update and improve the IQRS. System improvements – most notably the transfer from QPRAC software to the IQRS and improvements to the IQRS web site, such as online entity registering and increased password security – continue to be made to better serve the NPDB's customers. The continuing work to educate users about the NPDB, while using NAIC and Public Citizen data in reporting compliance efforts, ensures the NPDB will remain a prime source of medical malpractice and discipline information on practitioners for queriers.

GLOSSARY OF ACRONYMS

BHPr – Bureau of Health Professions

DEA – Drug Enforcement Agency

DHHS – Department of Health and Human Services

DOD – Department of Defense

DQA – Division of Quality Assurance

DVA – Department of Veterans Affairs

HCFA – Health Care Financing Administration

HCQIA – Health Care Quality Improvement Act of 1986

HIPDB – Healthcare Integrity and Protection Data Bank

HMO – Health Maintenance Organization

HRSA – Health Resources and Services Administration

ICD – Interface Control Document

IQRS – Integrated Querying and Report Service

NAIC – National Association of Insurance Commissioners

NPDB – National Practitioner Data Bank

OIG – Office of Inspector General

PREP – Practitioner Remediation and Enhancement Partnership

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**TABLE 1: Practitioners with Reports
(National Practitioner Data Bank, September 1, 1990 - December 31, 2000)**

Practitioner Type	Number of Practitioners with Reports*	Number of Reports*	Reports per Practitioner with Reports*
Physicians**	114,522	194,483	1.70
Dentists	23,130	36,677	1.59
Nurses and Nursing-related Practitioners	10,259	11,716	1.14
Chiropractors	4,826	6,203	1.29
Podiatrists and Podiatric-related Practitioners	3,164	5,344	1.69
Pharmacists and Pharmacy Assistants	1,790	2,020	1.13
Psychology-related Practitioners	1,013	1,351	1.33
Physician Assistants and Medical Assistants	605	736	1.22
Physical Therapists and Related Practitioners	507	541	1.07
Optical-related Practitioners	418	531	1.27
Counselors	355	452	1.27
Social Workers	188	215	1.14
Technologists	110	122	1.11
Emergency Medical Practitioners	89	121	1.36
Dental Assistants, Technicians, Hygienists	49	52	1.06
Occupational Therapists and Related Practitioners	35	36	1.03
Acupuncturists	34	37	1.09
Respiratory Therapists and Related Practitioners	23	24	1.04
Audiologists	20	22	1.10
Denturists	9	17	1.89
Psychiatric Technicians and Aides	8	15	1.88
Homeopaths and Naturopaths	6	9	1.50
Dieticians	4	5	1.25
Prosthetists	4	6	1.50
Speech and Language-Related Practitioners	3	3	1.00
Non-Healthcare Practitioners***	2,887	3,031	1.05
Unspecified or Unknown***	261	296	1.13
Total	164,320	264,065	1.61

* Reports include medical malpractice payment reports, adverse action reports, clinical privilege reports, professional society membership reports, Drug Enforcement Administration actions, and Medicare/Medicaid exclusion reports.

** Of the Physicians with reports, at least 106,899 (93.3%) are allopathic physicians, interns, and residents; and at least 6,427 (5.6%) are osteopathic physicians, interns, and residents. For 1,196 (1%) of the reports whether the physician is an allopath or an osteopath could not be determined. At least 179,704 (92.4%) of the reports for physicians are for allopathic physicians, interns, and residents; and at least 12,127 (6.2%) of the physician reports are for osteopathic physicians, interns, and residents. The ratio of reports per practitioner for identified allopathic physicians was 1.68; it was 1.89 for identified osteopathic physicians. 2,652 (1.4%) reports for physicians did not have a specific license field designated; the ratio of reports to practitioners for these physicians was 2.22.

*** The reports for practitioners with license summary information defined as "unspecified or unknown" or "non-healthcare practitioner" are Medicare/Medicaid exclusion reports. Reports for the "non-health care practitioners" are being removed from the NPDB.

**TABLE 2: Number and Percent Distribution of Reports by Report Type, Last Five Years and Cumulative
(National Practitioner Data Bank, September 1, 1990 - December 31, 2000)**

Report Type	1996		1997		1998		1999		2000		Cumulative 9/1/90-12/31/00	
	Number	Percent	Number	Percent								
Reportable Action Reports*	5,203	21.3%	5,069	16.3%	5,345	21.0%	5,188	19.4%	5,703	15.5%	47,904	18.1%
Licensure	4,248	17.4%	4,141	13.3%	4,397	17.3%	4,100	15.4%	4,593	12.5%	37,664	14.3%
Clinical Privileges	927	3.8%	870	2.8%	861	3.4%	1,008	3.8%	1,080	2.9%	9,593	3.6%
Professional Society Membership	28	0.1%	32	0.1%	31	0.1%	18	0.1%	30	0.1%	353	0.1%
Federal Licensure & Drug Enforcement Agency	0	0.0%	26	0.1%	56	0.2%	62	0.2%	0	0.0%	294	0.1%
Medicare/Medicaid Exclusions	0	0.0%	7,813	25.1%	2,370	9.3%	2,473	9.3%	11,567	31.5%	24,223	9.2%
Medical Malpractice Payment Reports	19,264	78.7%	18,298	58.7%	17,681	69.6%	19,020	71.3%	19,493	53.0%	191,938	72.7%
Total	24,467	100.0%	31,180	100.0%	25,396	100.0%	26,681	100.0%	36,763	100.0%	264,065	100.0%

**Reportable Actions* include truly adverse actions (revocations, probations, suspensions, reprimands, etc.) as well as non-adverse actions reported as adverse actions (restorations and reinstatements).

This table includes only disclosable reports in the NPDB as of December 31, 2000. The numbers of reports for 1996 through 1999 may differ from those shown in previous Annual Reports because of voided reports and the fact that modified reports are now counted in the year they were originally submitted, not the year they were modified.

Medicare/Medicaid Exclusions were first reported during 1997. Reports that year include exclusion actions taken in previous years if the practitioner had not been reinstated. The number of exclusion reports in 2000 includes reports to the HIPDB and the NPDB. A total for 2,887 exclusion reports for non-healthcare practitioners placed in the NPDB during 2000 and included in its count for 2000 are being removed from the NPDB.

**TABLE 3: Number of Reports Received and Percent Change, by Report Type, Last Five Years
(National Practitioner Data Bank, 1996 - 2000)**

Report Type	1996		1997		1998		1999		2000	
	Number	% Change 1995-1996	Number	% Change 1996-1997	Number	% Change 1997-1998	Number	% Change 1998-1999	Number	% Change 1999-2000
Reportable Action Reports*	5,203	9.8%	5,069	-2.6%	5,345	5.4%	5,188	-2.9%	5,703	9.9%
Licensure	4,248	9.9%	4,141	-2.5%	4,397	6.2%	4,100	-6.8%	4,593	12.0%
Clinical Privileges	927	10.2%	870	-6.1%	861	-1.0%	1,008	17.1%	1,080	7.1%
Professional Society Membership	28	-20.0%	32	14.3%	31	-3.1%	18	-41.9%	30	66.7%
Federal Licensure & Drug Enforcement Agency	0	---	26	---	56	115.4%	62	10.7%	0	---
Medicare/Medicaid Exclusions	0	---	7,813	---	2,370	-69.7%	2,473	4.3%	11,567	367.7%
Medical Malpractice Payment Reports	19,264	7.0%	18,298	-5.0%	17,681	-3.4%	19,020	7.6%	19,493	2.5%
Total	24,467	7.6%	31,180	27.4%	25,396	-18.6%	26,681	5.1%	36,763	37.8%

*"Reportable Actions" include truly adverse actions (revocations, probations, suspensions, reprimands, etc.) as well as non-adverse actions reported as "Adverse Actions" (restorations and reinstatements)

This table includes only disclosable reports in the NPDB as of December 31, 2000. The numbers of reports for 1996 through 1999 may differ from those shown in previous Annual Reports because of voided reports and the fact that modified reports are now counted in the year they were originally submitted, not the year they were modified.

Medicare/Medicaid Exclusions were first reported during 1997. Reports that year include exclusion actions taken in previous years if the practitioner had not been reinstated. The number of exclusion reports in 2000 includes reports to the HIPDB and the NPDB. A total of 2,887 exclusion reports for non-healthcare practitioners placed in the NPDB during 2000 and included in the count for 2000 are being removed from the NPDB.

Percent changes from a zero base are indicated by "---."

TABLE 4: Number, Percent Distribution, and Percent Change of Malpractice Payment Reports by Practitioner Type, Last Five Years and Cumulative (National Practitioner Data Bank, 1996 - 2000)

Practitioner Type	1996			1997			1998		
	Number	Percent	% Change 1995-96	Number	Percent	% Change 1996-97	Number	Percent	% Change 1997-98
Physicians	15,275	79.3%	8.7%	14,609	79.9%	-4.4%	14,093	79.7%	-3.5%
Dentists	2,477	12.9%	-1.9%	2,429	13.3%	-1.9%	2,350	13.3%	-3.3%
Other Practitioners	1,510	7.8%	6.0%	1,255	6.9%	-16.9%	1,236	7.0%	-1.5%
Total*	19,262	100.0%	7.0%	18,293	100.0%	-5.0%	17,679	100.0%	-3.4%

Practitioner Type	1999			2000			Cumulative Total (9/1/1990 - 12/31/2000)	
	Number	Percent	% Change 1998-99	Number	Percent	% Change 1999-2000	Number	Percent
Physicians	15,125	79.6%	7.3%	15,622	80.3%	3.3%	149,211	77.8%
Dentists	2,352	12.4%	0.1%	2,366	12.2%	0.6%	27,094	14.1%
Other Practitioners	1,530	8.0%	23.8%	1,458	7.5%	-4.7%	15,541	8.1%
Total*	19,007	100.0%	7.5%	19,446	100.0%	2.3%	191,846	100.0%

*Totals for this table exclude practitioners for whom a practitioner type was not identified.

This table includes only disclosable reports in the NPDB as of December 31, 2000. The numbers of reports for 1996 through 1999 may differ from those shown in previous Annual Reports because of modifications and voided reports. Modified reports are now counted in the year they were originally submitted, not the year they were modified. Physicians include Allopathic and Osteopathic physicians and interns and residents. Dentists include dental residents.

TABLE 5: Number, Percent Distribution, and Percent Change of Reportable Actions and Medicare/Medicaid Exclusion Reports by Practitioner Type, Last Five (National Practitioner Data Bank, September 1, 1990 - December 31, 2000)

Report and Practitioner Type	1996			1997			1998			1999			2000			Cumulative		
	Percent % Change			Percent % Change			Percent % Change			Percent % Change			Percent % Change			Number	Total	Percent
	Number	Total	1996-1995	Number	Total	1996-1997	Number	Total	1997-1998	Number	Total	1998-1999	Number	Total	1999-2000			
Licensure	4,248	81.6%	10.0%	4,141	32.1%	-2.5%	4,397	57.0%	6.2%	4,071	53.4%	-7.4%	4,593	26.9%	12.8%	37,635	52.3%	
Physicians	3,561	68.4%	12.5%	3,287	25.5%	-7.7%	3,504	45.4%	6.6%	3,188	41.8%	-9.0%	3,536	20.7%	10.9%	29,903	41.6%	
Dentists	669	12.9%	-1.2%	822	6.4%	22.9%	848	11.0%	3.2%	861	11.3%	1.5%	1,048	6.1%	21.7%	7,585	10.5%	
Other ¹	18	0.3%	---	32	0.2%	77.8%	45	0.6%	40.6%	22	0.3%	-51.1%	9	0.1%	-59.1%	147	0.2%	
Clinical Privileges	927	17.8%	10.5%	870	6.8%	-6.1%	861	11.2%	-1.0%	1,006	13.2%	16.8%	1,080	6.3%	7.4%	9,590	13.3%	
Physicians	892	17.1%	9.7%	839	6.5%	-5.9%	803	10.4%	-4.3%	911	11.9%	13.4%	998	5.8%	9.5%	9,108	12.7%	
Dentists	15	0.3%	50.0%	11	0.1%	-26.7%	24	0.3%	118.2%	20	0.3%	-16.7%	24	0.1%	20.0%	158	0.2%	
Other ¹	20	0.4%	25.0%	20	0.2%	0.0%	34	0.4%	70.0%	75	1.0%	120.6%	58	0.3%	-22.7%	324	0.5%	
Professional Society Membership	28	0.5%	-20.0%	32	0.2%	14.3%	31	0.4%	-3.1%	18	0.2%	-41.9%	30	0.2%	66.7%	353	0.5%	
Physicians	26	0.5%	-16.1%	30	0.2%	15.4%	30	0.4%	0.0%	18	0.2%	-40.0%	28	0.2%	55.6%	326	0.5%	
Dentists	2	0.0%	-50.0%	2	0.0%	0.0%	1	0.0%	-50.0%	0	0.0%	---	0	0.0%	---	25	0.0%	
Other ¹	0	0.0%	---	0	0.0%	---	0	0.0%	---	0	0.0%	---	2	0.0%	---	2	0.0%	
Federal Licensure & Drug Enforcement Agency	0	0.0%	---	26	0.2%	---	56	0.7%	115.4%	62	0.8%	10.7%	0	0.0%	-100.0%	294	0.4%	
Physicians	0	0.0%	---	26	0.2%	---	52	0.7%	---	55	0.7%	0.7%	0	0.0%	-100.0%	283	0.4%	
Dentists	0	0.0%	---	0	0.0%	---	4	0.1%	---	6	0.1%	0.1%	0	0.0%	-100.0%	10	0.0%	
Other ¹	0	0.0%	---	0	0.0%	---	0	0.0%	---	1	0.0%	0.0%	0	0.0%	-100.0%	1	0.0%	
Medicare/Medicaid Exclusions	0	0.0%	---	7,813	60.7%	---	2,370	30.7%	-69.7%	2,473	32.4%	4.3%	11,401	66.7%	4.3%	24,057	33.4%	
Physicians	0	0.0%	---	2,287	17.8%	---	595	7.7%	-74.0%	495	6.5%	-16.8%	2,275	13.3%	-16.8%	5,652	7.9%	
Dentists	0	0.0%	---	758	5.9%	---	209	2.7%	-72.4%	174	2.3%	-16.7%	664	3.9%	-16.7%	1,805	2.5%	
Other ¹	0	0.0%	---	4,768	37.0%	---	1,566	20.3%	-67.2%	1,804	23.6%	15.2%	8,462	49.5%	15.2%	16,600	23.1%	
Total	5,203	100.0%	9.9%	12,882	100.0%	147.6%	7,715	100.0%	-40.1%	7,630	#####	-1.1%	17,104	#####	-1.1%	71,929	100.0%	

Reportable Actions include true adverse actions (e.g., revocations, probations, suspensions, reprimands, etc.) as well as non-adverse actions reported as Adverse Actions (e.g., restorations and reinstatements).

¹ "Other" includes healthcare practitioners, non-healthcare practitioners, and non-specified

Medicare/Medicaid Exclusions were first reported during 1997. Reports that year include exclusion actions taken in previous years if the practitioner had not been reinstated. The number of exclusion reports in 2000 includes reports to the HIPDB and the NPDB. Exclusion reports for non-healthcare practitioners are being removed from the NPDB.

This table includes only disclosable reports in the NPDB as of December 31, 2000. The numbers of reports for 1995 through 1998 may differ from those shown in previous Annual Reports because of voided reports and the fact that modified reports are now counted in the year they were originally submitted, not the year they were modified.

Percent changes from a zero base are indicated by "---."

**TABLE 6: Cumulative Physician and Dentist Malpractice Payments
(National Practitioner Data Bank, September 1, 1990 - December 31, 2000)**

State	Physicians		Dentists		Ratio of Dentist Reports to Physician Reports
	Number of Reports	Adjusted Number of Reports	Number of Reports	Adjusted Number of Reports	
Alabama	599	592	126	126	0.21
Alaska	186	186	51	50	0.27
Arizona	2,213	2,202	399	399	0.18
Arkansas	682	677	109	109	0.16
California	16,408	16,390	5,667	5,667	0.35
Colorado	1,616	1,602	329	329	0.20
Connecticut	1,465	1,463	420	420	0.29
Delaware	337	330	48	48	0.14
Florida*	9,645	9,611	1,343	1,343	0.14
Georgia	2,496	2,485	498	498	0.20
Hawaii	339	339	98	98	0.29
Idaho	307	307	44	44	0.14
Illinois	6,649	6,639	1,106	1,106	0.17
Indiana*	2,983	2,008	329	303	0.11
Iowa	1,164	1,162	148	148	0.13
Kansas*	1,706	1,143	188	186	0.11
Kentucky	1,479	1,468	272	272	0.18
Louisiana*	2,624	1,896	298	288	0.11
Maine	413	413	81	81	0.20
Maryland	2,275	2,270	632	632	0.28
Massachusetts	2,713	2,709	746	746	0.27
Michigan	8,277	8,272	1,297	1,297	0.16
Minnesota	1,184	1,178	257	257	0.22
Mississippi	1,096	1,092	104	103	0.09
Missouri	2,773	2,691	447	447	0.16
Montana	641	639	65	65	0.10
Nebraska*	623	534	103	103	0.17
Nevada	780	779	95	95	0.12
New Hampshire	574	574	125	125	0.22
New Jersey	5,589	5,556	884	884	0.16
New Mexico*	1,032	781	125	125	0.12
New York	19,376	19,360	2,790	2,790	0.14
North Carolina	2,250	2,227	218	218	0.10
North Dakota	244	241	24	24	0.10
Ohio	6,865	6,853	964	964	0.14
Oklahoma	980	965	250	250	0.26
Oregon	939	938	204	204	0.22
Pennsylvania*	12,768	8,946	1,813	1,813	0.14
Rhode Island	663	662	101	101	0.15
South Carolina*	999	841	96	95	0.10
South Dakota	228	227	50	50	0.22
Tennessee	1,722	1,709	244	244	0.14
Texas	10,397	10,373	1,596	1,596	0.15
Utah	1,050	1,049	411	411	0.39
Vermont	316	316	60	60	0.19
Virginia	2,155	2,151	414	414	0.19
Washington	2,472	2,466	737	737	0.30
West Virginia	1,436	1,433	114	114	0.08
Wisconsin*	1,212	1,009	368	368	0.30
Wyoming	266	265	20	20	0.08
Washington, DC	578	577	107	107	0.19
All Reports	149,192	142,003	27,089	27,048	0.18

This table includes only disclosable reports in the NPDB as of December 31, 2000.
The All Reports row includes jurisdictions not listed above (Puerto Rico, Virgin Islands, etc.).

* Adjusted columns exclude reports from State patient compensation and similar State funds which make payments in excess of amounts paid by a practitioner's primary malpractice carrier. When payments are made by these funds, two reports are filed with the NPDB (one from the primary insurer and one from the fund) whenever a total malpractice settlement or award exceeds a maximum set by the State for the practitioner's primary malpractice carrier. The States marked with asterisks have these funds. Thus, the adjusted columns provide an approximation of the number of incidents resulting in payments rather than the number of payments. These funds occasionally make payments for practitioners practicing in other States at the time of a malpractice event. See the text for a detailed explanation.

**TABLE 7: Physician Malpractice Payments, by State and Year, Last Five Years
(National Practitioner Data Bank, 1996 - 2000)**

State	1996		1997		1998		1999		2000	
	Number of Reports	Adjusted Number of Reports	Number of Reports	Adjusted Number of Reports	Number of Reports	Adjusted Number of Reports	Number of Reports	Adjusted Number of Reports	Number of Reports	Adjusted Number of Reports
Alabama	65	65	65	65	69	68	45	41	83	82
Alaska	31	31	16	16	15	15	20	20	17	17
Arizona	244	244	248	247	222	219	221	221	265	263
Arkansas	56	55	56	55	78	78	69	68	69	69
California	1,742	1,738	1,817	1,817	1,491	1,489	1,493	1,490	1,408	1,408
Colorado	150	146	158	157	152	148	147	147	146	145
Connecticut	126	125	138	138	145	145	156	156	167	167
Delaware	39	37	27	27	30	29	24	23	31	30
Florida*	1,093	1,087	1,110	1,110	1,047	1,043	1,054	1,050	1,238	1,235
Georgia	254	253	269	267	284	283	270	267	277	276
Hawaii	35	35	20	20	45	45	41	41	40	40
Idaho	33	33	31	31	26	26	34	34	33	33
Illinois	597	597	609	607	561	560	551	550	592	591
Indiana*	727	181	283	188	260	155	289	179	287	169
Iowa	133	133	130	130	109	109	73	72	121	121
Kansas*	157	84	217	157	151	92	184	123	189	124
Kentucky	136	133	154	154	127	125	153	153	188	187
Louisiana*	222	168	262	166	283	202	312	189	295	190
Maine	33	33	41	41	34	34	47	47	65	65
Maryland	241	241	229	228	254	254	238	237	249	249
Massachusetts	255	254	222	222	224	224	253	252	326	325
Michigan	666	666	651	651	736	735	749	749	667	665
Minnesota	123	123	95	94	75	75	84	84	87	86
Mississippi	117	116	129	128	116	116	112	112	116	116
Missouri	302	291	241	236	212	201	284	280	200	196
Montana	65	64	59	58	55	55	93	93	67	67
Nebraska*	60	48	68	58	58	51	53	49	78	59
Nevada	63	63	74	74	82	82	83	83	117	117
New Hampshire	66	66	50	50	57	57	42	42	64	64
New Jersey	525	522	459	454	570	567	480	479	619	611
New Mexico*	136	106	108	90	130	90	105	73	109	90
New York	1,781	1,779	1,829	1,828	1,951	1,950	2,031	2,031	2,113	2,111
North Carolina	227	222	233	231	227	225	200	192	218	217
North Dakota	30	30	18	18	23	21	22	22	16	16
Ohio	671	669	617	615	416	415	876	874	849	849
Oklahoma	101	101	69	63	81	81	77	74	104	103
Oregon	76	75	84	84	74	74	85	85	82	82
Pennsylvania*	1,413	949	1,366	923	1,148	744	1,437	976	1,405	877
Rhode Island	58	58	84	84	69	69	68	68	67	67
South Carolina*	94	79	120	101	139	116	143	111	160	124
South Dakota	23	23	27	27	27	27	15	15	26	26
Tennessee	146	144	190	188	151	148	189	188	180	179
Texas	1,090	1,085	895	891	974	973	1,022	1,019	1,121	1,119
Utah	122	122	100	100	86	86	113	113	105	105
Vermont	28	28	35	35	49	49	33	33	23	23
Virginia	215	214	186	185	247	246	230	230	200	199
Washington	231	230	257	257	268	267	325	325	211	211
West Virginia	117	116	124	124	144	144	131	131	169	169
Wisconsin*	135	115	85	68	79	63	73	58	76	71
Wyoming	32	32	20	20	30	30	30	30	26	26
Washington, DC	68	68	63	63	82	82	57	57	62	62
All Reports	15,273	14,000	14,608	13,811	14,092	13,311	15,125	14,245	15,622	14,691

This table includes only disclosable reports in the NPDB as of December 31, 2000.
The All Reports row includes jurisdictions not listed above (Puerto Rico, Virgin Islands, etc.).

* Adjusted columns exclude reports from State patient compensation and similar State funds which make payments in excess of amounts paid by a practitioner's primary malpractice carrier. When payments are made by these funds, two reports are filed with the NPDB (one from the primary insurer and one from the fund) whenever a total malpractice settlement or award exceeds a maximum set by the State for the practitioner's primary malpractice carrier. The States marked with asterisks have these funds. Thus, the adjusted columns provide an approximation of the number of incidents resulting in payment rather than the number of payments. These funds occasionally make payments for practitioners practicing in other States at the time of a malpractice event. See the text for a detailed explanation.

**TABLE 8: Dentist Malpractice Payments Reported, by State and Year, Last Five Years
(National Practitioner Data Bank, 1996 - 2000)**

State	1996		1997		1998		1999		2000	
	Number of Reports	Adjusted Number of Reports	Number of Reports	Adjusted Number of Reports	Number of Reports	Adjusted Number of Reports	Number of Reports	Adjusted Number of Reports	Number of Reports	Adjusted Number of Reports
Alabama	9	9	8	8	10	10	18	18	12	12
Alaska	4	4	0	0	5	5	3	2	7	7
Arizona	68	68	44	44	27	27	36	36	27	27
Arkansas	8	8	11	11	14	14	8	8	11	11
California	562	562	545	545	526	526	438	438	434	434
Colorado	41	41	32	32	18	18	34	34	21	21
Connecticut	44	44	27	27	33	33	26	26	36	36
Delaware	7	7	2	2	5	5	2	2	2	2
Florida*	126	126	153	153	118	118	116	116	119	119
Georgia	28	28	37	37	34	34	151	151	93	93
Hawaii	10	10	10	10	10	10	13	13	15	15
Idaho	4	4	6	6	7	7	4	4	2	2
Illinois	92	92	88	88	77	77	101	101	68	68
Indiana*	52	35	30	26	28	27	22	19	12	11
Iowa	13	13	8	8	12	12	12	12	7	7
Kansas*	13	12	18	18	13	13	17	17	8	8
Kentucky	15	15	25	25	27	27	16	16	13	13
Louisiana*	27	27	22	20	35	34	25	23	21	18
Maine	13	13	10	10	9	9	7	7	8	8
Maryland	34	34	51	51	41	41	41	41	66	66
Massachusetts	67	67	55	55	58	58	89	89	93	93
Michigan	67	67	85	85	81	81	114	114	71	71
Minnesota	18	18	24	24	12	12	11	11	19	19
Mississippi	12	12	11	11	23	23	4	4	11	10
Missouri	38	38	38	38	51	51	44	44	23	23
Montana	5	5	4	4	3	3	5	5	3	3
Nebraska*	3	3	7	7	1	1	4	4	6	6
Nevada	7	7	13	13	5	5	10	10	8	8
New Hampshire	11	11	13	13	8	8	3	3	5	5
New Jersey	83	83	97	97	69	69	63	63	46	46
New Mexico*	13	13	16	16	12	12	9	9	13	13
New York	209	209	254	254	237	237	226	226	390	390
North Carolina	20	20	30	30	16	16	20	20	11	11
North Dakota	2	2	0	0	2	2	3	3	5	5
Ohio	92	92	81	81	75	75	77	77	85	85
Oklahoma	12	12	21	21	17	17	18	18	70	70
Oregon	25	25	15	15	15	15	11	11	44	44
Pennsylvania*	154	154	158	158	145	145	124	124	164	164
Rhode Island	6	6	9	9	4	4	12	12	7	7
South Carolina*	5	5	6	6	4	4	18	18	12	11
South Dakota	4	4	3	3	1	1	5	5	5	5
Tennessee	19	19	22	22	24	24	24	24	26	26
Texas	198	198	119	119	250	250	91	91	93	93
Utah	16	16	18	18	14	14	16	16	13	13
Vermont	6	6	4	4	3	3	2	2	7	7
Virginia	43	43	34	34	54	54	85	85	37	37
Washington	114	114	86	86	62	62	114	114	56	56
West Virginia	8	8	6	6	11	11	10	10	10	10
Wisconsin*	28	28	44	44	24	24	27	27	26	26
Wyoming	4	4	0	0	2	2	2	2	2	2
Washington, DC	12	12	14	14	11	11	8	8	8	8
All Reports	2,477	2,459	2,429	2,423	2,350	2,348	2,352	2,346	2,366	2,360

This table includes only disclosable reports in the NPDB as of December 31, 2000
The All Reports row includes jurisdictions not listed above (Puerto Rico, Virgin Islands, etc.).

* Adjusted columns exclude reports from State patient compensation and similar State funds which make payments in excess of amounts paid by a practitioner's primary malpractice carrier. When payments are made by these funds, two reports are filed with the NPDB (one from the primary insurer and one from the fund) whenever a total malpractice settlement or award exceeds a maximum set by the State for the practitioner's primary malpractice insurer and one from the fund) whenever a total malpractice settlement or award exceeds a maximum set by the State for the practitioner's primary malpractice carrier. The States marked with asterisks have these funds. Thus, the adjusted columns provide an approximation of the number of incidents resulting in payment rather than the number of payments. These funds occasionally make payments for practitioners practicing in other States at the time of a malpractice event. See the text for a detailed explanation.

**TABLE 9: Mean and Median Physician Malpractice Payment and Mean Delay Between Incident and Payment by State
(National Practitioner Data Bank, September 1, 1990 - December 31, 2000)**

State	2000 Only		Cumulative			2000 Only Mean Delay Between Incident and Payment (Years)	Cumulative Mean Delay Between Incident and Payment (Years)
	Mean Payment	Median Payment	Mean Payment	Median Payment	Rank of Median		
Alabama	\$419,757	\$200,000	\$340,185	\$149,900	5	4.47	4.30
Alaska	190,851	100,000	215,891	75,357	33	4.17	3.92
Arizona	260,077	150,000	204,043	90,000	24	4.03	3.80
Arkansas	220,591	91,880	156,838	90,000	24	3.80	3.43
California	142,637	55,000	122,562	41,500	51	3.03	3.42
Colorado	236,919	84,997	163,957	55,000	48	3.67	3.33
Connecticut	432,536	200,000	321,721	135,000	6	5.84	5.45
Delaware	300,780	150,000	203,762	90,000	24	4.35	4.55
Florida*	259,354	175,000	215,619	125,000	7	3.96	4.06
Georgia	334,301	166,667	272,735	125,000	7	3.77	3.60
Hawaii	252,541	120,000	236,383	75,000	36	3.42	4.11
Idaho	259,187	100,000	206,974	50,000	49	3.33	3.33
Illinois	457,855	250,000	314,680	175,021	1	5.45	5.82
Indiana*	208,834	75,001	154,875	75,001	35	5.87	5.40
Iowa	224,947	100,000	158,868	64,875	46	3.26	3.19
Kansas**	152,740	175,000	164,208	106,000	15	3.77	4.03
Kentucky	173,676	75,000	181,917	75,000	36	4.45	4.07
Louisiana*	174,110	99,999	136,913	85,000	30	5.26	4.91
Maine	291,497	262,482	239,370	125,000	7	3.82	4.07
Maryland	282,403	150,000	241,140	115,000	13	4.82	4.74
Massachusetts	370,782	250,000	282,111	150,000	4	5.64	5.96
Michigan	118,501	85,000	100,363	67,500	43	4.28	4.35
Minnesota	219,533	100,000	176,093	72,555	41	2.99	3.16
Mississippi	211,725	127,750	187,358	97,500	22	4.29	4.05
Missouri	244,638	130,000	210,058	100,000	16	3.97	4.53
Montana	235,909	125,000	149,354	60,000	47	4.30	4.30
Nebraska*	181,255	116,250	118,679	70,000	42	3.65	3.89
Nevada	317,017	175,000	241,242	100,000	16	4.84	4.27
New Hampshire	265,192	111,000	242,281	125,000	7	4.70	4.85
New Jersey	309,435	175,000	237,788	115,000	13	5.65	6.24
New Mexico*	189,018	100,000	132,400	90,000	24	4.22	3.83
New York	299,572	150,000	256,071	125,000	7	6.28	7.06
North Carolina	312,132	132,500	237,975	100,000	16	3.93	3.66
North Dakota	294,939	143,750	167,869	77,500	32	3.31	3.49
Ohio	241,636	115,000	215,103	90,000	24	4.58	4.50
Oklahoma	275,620	121,000	241,215	75,128	34	3.56	3.85
Oregon	280,034	141,500	177,817	75,000	36	3.42	3.41
Pennsylvania*	250,754	192,755	211,680	150,710	3	5.71	5.99
Rhode Island	266,061	100,000	252,707	100,000	16	6.03	6.12
South Carolina*	181,771	100,000	157,092	93,750	23	4.34	4.66
South Dakota	208,319	100,000	199,158	65,500	44	3.34	3.48
Tennessee	195,664	100,000	216,666	87,500	29	3.71	3.61
Texas	194,039	110,000	175,346	100,000	16	3.68	3.90
Utah	242,311	90,000	148,231	49,950	50	3.34	3.50
Vermont	144,273	75,000	144,227	65,000	45	3.36	4.37
Virginia	227,289	150,000	189,753	100,000	16	4.00	3.79
Washington	238,655	90,000	193,612	75,000	36	4.34	4.38
West Virginia	254,881	100,000	202,043	80,000	31	5.26	5.68
Wisconsin*	358,075	162,857	322,035	125,000	7	4.54	4.89
Wyoming	252,422	100,000	162,380	75,000	36	3.18	3.19
Washington, DC	584,338	197,500	397,915	175,000	2	4.92	4.88
All Reports	\$248,947	\$125,000	\$202,301	\$99,500		4.66	4.83

This table includes only disclosable reports in the NPDB as of December 31, 2000. The All Reports row includes jurisdictions not listed above (Puerto Rico, Virgin Islands, etc.).

Rank for payments is based on the median payment amount for each State; 1 is highest, 51 is lowest

* These data are not adjusted for State compensation funds and other similar funds. Mean and median payments for States with payments made by these funds understate the actual mean and median of amounts received by claimants. Payments made by these funds may also affect mean delay times between incidents and payments. States with these funds are marked with an asterisk.

** The 2000 mean malpractice payment for Kansas was less than the median payment, which is very unusual. There were no very large payments to pull the mean above the median.

TABLE 10: Mean and Median Malpractice Payment Amounts (Actual and Inflation Adjusted) for Physicians by Malpractice Reason, 2000 and Cumulative (National Practitioner Data Bank, September 1, 1990 - December 31, 2000)

Malpractice Reason	2000 Only			Cumulative 9/1/1990 - 12/31/2000				
	Number of Payments	Mean Payment	Median Payment	Number of Payments	Actual Mean Payment	Median Payment	Inflation Adjusted Mean Payment	Median Payment
Diagnosis Related	5,608	\$277,291	\$160,000	49,895	\$223,086	\$116,432	\$247,725	\$129,587
Anesthesia Related	490	258,949	100,000	4,756	229,110	75,001	258,374	89,642
Surgery Related	4,284	197,572	100,000	40,748	163,168	75,000	181,611	87,313
Medication Related	818	187,907	85,000	8,816	149,269	50,000	168,009	54,968
IV & Blood Products Related	47	166,299	110,000	623	166,126	62,500	187,557	71,845
Obstetrics Related	1,291	417,181	225,000	12,953	352,503	195,000	395,725	207,340
Treatment Related	2,708	220,119	100,000	26,521	176,670	75,000	196,836	87,478
Monitoring Related	177	235,790	106,000	1,757	204,848	87,500	229,004	97,191
Equipment / Product Related	29	73,821	45,000	624	63,242	15,000	71,582	17,898
Miscellaneous	170	121,478	30,000	2,395	93,295	25,000	106,473	27,484
Total*	15,622	\$248,947	\$125,000	149,088	\$202,317	\$99,609	\$225,608	\$105,708

*Totals for this table exclude malpractice payments for which a malpractice reason was not specified.

This table includes only disclosable reports in the NPDB as of December 31, 2000.

TABLE 11: Mean Delay Between Incident and Payment by Malpractice Reason, All Practitioner Types, 2000 and Cumulative (National Practitioner Data Bank, September 1, 1990 - December 31, 2000)

Malpractice Reason	2000 Only		Cumulative, 9/1/1990 - 12/31/2000	
	Number of Payments	Mean Delay Between Incident and Payment (years)	Number of Payments	Mean Delay Between Incident and Payment (years)
Diagnosis Related	5,998	4.74	53,683	4.86
Anesthesia Related	561	3.73	5,756	3.59
Surgery Related	4,755	4.29	46,035	4.27
Medication Related	1,035	4.09	10,939	4.87
IV & Blood Products Related	60	4.80	785	4.81
Obstetrics Related	1,344	5.78	13,310	6.29
Treatment Related	5,017	4.15	52,704	4.31
Monitoring Related	259	4.99	2,505	4.93
Equipment / Product Related	57	3.39	929	5.54
Miscellaneous	316	4.07	3,753	4.71
Total*	19,402	4.48	190,399	4.63

This table includes only disclosable reports in the NPDB as of December 31, 2000. Malpractice payment reports that are missing data necessary to calculate payment delay are excluded.

*Totals for this table exclude malpractice payments for which a malpractice reason was not specified.

**TABLE 12: Nurse Malpractice Payments by Reason and Type of Nurse
(National Practitioner Data Bank, September 1, 1990 - December 31, 2000)**

Malpractice Reason	Number of Malpractice Payments				Total Number of Nurses
	Registered Nurses	Nurse Anesthetists	Nurse Midwives	Nurse Practitioners	
Diagnosis Related	131	7	23	63	224
Anesthesia Related	81	623	0	5	709
Surgery Related	219	38	6	1	264
Medication Related	346	21	1	20	388
IV & Blood Products Related	108	10	0	2	120
Obstetrics Related	198	6	193	9	406
Treatment Related	409	18	11	37	475
Monitoring Related	438	4	6	7	455
Equipment / Product Related	30	3	0	1	34
Miscellaneous	115	5	1	6	127
Total*	2,075	735	241	151	3,202

This table includes only disclosable reports in the NPDB as of December 31, 2000.

*Totals for this table exclude malpractice payments for which a malpractice reason was not specified.

TABLE 13: Mean and Median Malpractice Payment Amounts (Actual and Inflation Adjusted) for Nurses by Malpractice Reason, 2000 and Cumulative (National Practitioner Data Bank, September 1, 1990 - December 31, 2000)

Malpractice Reason	2000 Only			Cumulative, 9/1/1990 - 12/31/2000				
	Number of Payments	Mean Payment	Median Payment	Number of Payments	Actual Mean Payment	Median Payment	Inflation Adjusted Mean Payment	Median Payment
Diagnosis Related	36	\$308,146	\$200,000	224	\$312,803	\$125,000	\$352,794	\$125,000
Anesthesia Related	53	239,729	79,047	709	215,789	75,000	246,441	87,311
Surgery Related	19	257,207	65,000	264	171,700	32,750	186,601	38,417
Medication Related	67	255,129	25,500	388	212,118	41,485	236,682	47,982
IV & Blood Products Related	8	276,042	175,000	120	227,888	59,160	254,116	67,695
Obstetrics Related	49	444,491	210,000	406	400,595	200,000	441,752	213,189
Treatment Related	53	83,531	25,000	475	121,081	50,000	135,131	53,740
Monitoring Related	60	346,705	187,083	455	255,452	87,500	284,951	95,021
Equipment / Product Related	7	48,393	35,000	34	207,565	35,000	243,054	35,999
Miscellaneous	12	217,723	8,750	127	150,939	35,000	170,420	40,745
Total	364	\$269,090	\$82,700	3,202	\$231,309	\$66,951	\$258,726	\$77,752

This table includes only disclosable reports in the NPDB as of December 31, 2000. Malpractice payment reports which are missing data necessary to calculate payment delay or malpractice reason are excluded.

**TABLE 14: Nurse (Registered Nurses, Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners) Malpractice Payments by State
(National Practitioner Data Bank, September 1, 1990 - December 31, 2000)**

State	Number of Reports	Adjusted Number of Reports	Ratio of Adjusted Nurse Reports to 100 Adjusted Physician Reports**
Alabama	42	42	7.09
Alaska	8	8	4.30
Arizona	46	46	2.09
Arkansas	26	26	3.84
California	125	125	0.76
Colorado	49	49	3.06
Connecticut	21	21	1.44
Delaware	3	3	0.91
Florida	219	219	2.28
Georgia	97	97	3.90
Hawaii	7	7	2.06
Idaho	22	22	7.17
Illinois	138	138	2.08
Indiana*	16	12	0.60
Iowa	18	18	1.55
Kansas*	51	34	2.97
Kentucky	43	43	2.93
Louisiana*	116	100	5.27
Maine	9	9	2.18
Maryland	60	60	2.64
Massachusetts	198	198	7.31
Michigan	77	77	0.93
Minnesota	19	19	1.61
Mississippi	33	33	3.02
Missouri	136	136	5.05
Montana	7	7	1.10
Nebraska	26	26	4.87
Nevada	8	8	1.03
New Hampshire	25	25	4.36
New Jersey	392	392	7.06
New Mexico*	60	59	7.55
New York	173	173	0.89
North Carolina	48	48	2.16
North Dakota	4	4	1.66
Ohio	117	117	1.71
Oklahoma	45	45	4.66
Oregon	21	21	2.24
Pennsylvania*	97	88	0.98
Rhode Island	9	9	1.36
South Carolina*	15	14	1.66
South Dakota	10	10	4.41
Tennessee	82	82	4.80
Texas	305	305	2.94
Utah	11	11	1.05
Vermont	1	1	0.32
Virginia	49	49	2.28
Washington	44	44	1.78
West Virginia	19	19	1.33
Wisconsin*	26	24	2.38
Wyoming	8	8	3.02
Washington, DC	22	22	3.81
All Reports	3,208	3,158	2.22

This Table includes only disclosable reports in the NPDB as of December 31, 2000.
The "All Reports" row includes jurisdictions not listed above (Puerto Rico, Virgin Islands, Guam).

* The "Adjusted" column excludes reports from State patient compensation funds and other similar funds which make payments in excess of amounts paid by a practitioner's primary malpractice carrier. When payments are made by these funds, two reports are filed with the NPDB (one from the primary insurer and one from the fund) whenever a total malpractice settlement or award exceeds a maximum set by the State for the practitioner's primary malpractice carrier. States marked with asterisks have these funds. Thus, the adjusted columns provide an approximation of the number of incidents resulting in payments rather than the number of payments. See the text for details.

** The ratio of the adjusted number of nurse reports for every one hundred adjusted physician reports is calculated by dividing column 2 from this table by column 2 from Table 6 and multiplying by 100.

Table 15: Mean and Median Malpractice Payment Amounts (Actual and Inflation Adjusted) for Physician Assistants by Malpractice Reason, 2000 and Cumulative (National Practitioner Data Bank, September 1, 1990 - December 31, 2000)

Malpractice Reason	2000 Only			Cumulative, 9/1/1990 - 12/31/2000				
	Number of Payments	Mean Payment	Median Payment	Number of Payments	Actual Payment Mean Payment	Actual Payment Median Payment	Inflated Adjusted Payment Mean Payment	Inflated Adjusted Payment Median Payment
Diagnosis Related	39	\$175,051	\$125,000	238	\$135,817	\$72,500	\$146,007	\$78,642
Anesthesia Related	1	6,000	6,000	2	3,945	3,945	4,127	4,127
Surgery Related	2	100,000	100,000	22	76,211	38,500	85,564	41,971
Medication Related	4	82,188	85,625	39	60,687	25,000	67,047	27,488
IV & Blood Products Related	0	-	-	0	-	-	-	-
Obstetrics Related	0	-	-	1	750,000	750,000	792,812	792,812
Treatment Related	18	86,675	28,000	124	72,421	21,125	79,581	23,334
Monitoring Related	0	-	-	6	147,898	115,000	158,882	122,725
Equipment or Product Related	0	-	-	0	-	-	-	-
Miscellaneous	9	61,444	50,000	20	45,425	50,000	47,085	50,000
Total	73	\$129,793	\$67,500	452	\$105,978	\$50,000	\$114,626	\$50,370

This table includes only disclosable reports in the NPDB as of December 31, 2000. Malpractice payment reports which are missing data necessary to calculate payment delay or malpractice reason are excluded.

**TABLE 16: Currently Active Registered Non-Federal Hospitals That Have Never Reported to the National Practitioner Data Bank, by State
(National Practitioner Data Bank, September 1, 1990 - December 31, 2000)**

State	Number of Hospitals with "Active" NPDB Registration	Number of Hospitals that Have Never Reported	Percent of Hospitals that Have Never Reported
Alabama	115	75	65.2%
Alaska	17	11	64.7%
Arizona	74	28	37.8%
Arkansas	91	57	62.6%
California	453	158	34.9%
Colorado	68	30	44.1%
Connecticut	43	21	48.8%
Delaware	10	2	20.0%
Florida	222	100	45.0%
Georgia	179	88	49.2%
Hawaii	25	16	64.0%
Idaho	40	23	57.5%
Illinois	217	115	53.0%
Indiana	141	68	48.2%
Iowa	117	84	71.8%
Kansas	140	98	70.0%
Kentucky	114	69	60.5%
Louisiana	161	117	72.7%
Maine	42	21	50.0%
Maryland	70	24	34.3%
Massachusetts	109	58	53.2%
Michigan	160	62	38.8%
Minnesota	132	92	69.7%
Mississippi	95	68	71.6%
Missouri	134	72	53.7%
Montana	44	29	65.9%
Nebraska	84	59	70.2%
Nevada	33	20	60.6%
New Hampshire	30	13	43.3%
New Jersey	99	23	23.2%
New Mexico	41	22	53.7%
New York	257	98	38.1%
North Carolina	129	66	51.2%
North Dakota	45	32	71.1%
Ohio	202	84	41.6%
Oklahoma	134	85	63.4%
Oregon	64	23	35.9%
Pennsylvania	252	130	51.6%
Rhode Island	15	4	26.7%
South Carolina	72	33	45.8%
South Dakota	54	45	83.3%
Tennessee	139	83	59.7%
Texas	470	284	60.4%
Utah	47	27	57.4%
Vermont	17	9	52.9%
Virginia	106	46	43.4%
Washington	87	36	41.4%
West Virginia	59	29	49.2%
Wisconsin	131	78	59.5%
Wyoming	24	18	75.0%
Washington, D.C.	13	8	61.5%
Total	5,648	2,964	52.5%

*Currently active" registered hospitals are those listed by the NPDB in "active status" on December 31, 2000.

**TABLE 17: Cumulative Reportable Physician Licensure and Privileges Action Reports
(National Practitioner Data Bank, September 1, 1990 - December 31, 2000)**

State	Privileges Reports	Adverse Privileges Reports	Adverse Licensure Reports for In-State Physicians	Ratio of Adverse Privileges Reports to Adverse In-State Licensure Reports
Alabama	107	98	240	0.41
Alaska	17	16	57	0.28
Arizona	257	233	610	0.38
Arkansas	85	74	138	0.54
California	1,076	1,014	2,172	0.47
Colorado	179	173	666	0.26
Connecticut	87	83	337	0.25
Delaware	23	23	17	1.35
Florida	478	448	1,100	0.41
Georgia	281	267	485	0.55
Hawaii	48	44	33	1.33
Idaho	37	33	47	0.70
Illinois	240	226	570	0.40
Indiana	215	197	155	1.27
Iowa	79	75	251	0.30
Kansas	143	135	150	0.90
Kentucky	119	112	372	0.30
Louisiana	108	98	333	0.29
Maine	48	45	90	0.50
Maryland	226	214	649	0.33
Massachusetts	249	236	429	0.55
Michigan	324	300	950	0.32
Minnesota	143	137	244	0.56
Mississippi	62	59	324	0.18
Missouri	180	171	382	0.45
Montana	33	28	70	0.40
Nebraska	83	77	56	1.38
Nevada	110	99	81	1.22
New Hampshire	42	39	59	0.66
New Jersey	272	243	730	0.33
New Mexico	52	48	53	0.91
New York	679	628	1,421	0.44
North Carolina	171	155	235	0.66
North Dakota	32	29	85	0.34
Ohio	420	390	1,242	0.31
Oklahoma	161	147	409	0.36
Oregon	110	105	353	0.30
Pennsylvania	342	319	478	0.67
Rhode Island	40	37	93	0.40
South Carolina	112	105	250	0.42
South Dakota	13	13	21	0.62
Tennessee	148	134	249	0.54
Texas	620	575	1,475	0.39
Utah	50	49	91	0.54
Vermont	28	25	61	0.41
Virginia	205	189	356	0.53
Washington	249	228	301	0.76
West Virginia	75	66	205	0.32
Wisconsin	151	136	28	4.86
Wyoming	21	20	29	0.69
Washington, D.C.	33	32	12	2.67
All Reports	9,076	8,427	19,244	0.44

This table includes only disclosable reports in the NPDB as of December 31, 2000. Privileges reports are attributed to States on the basis of the physician's work state. Licensure reports are attributed according to the State of the board taking the action.

The "All Reports" row includes jurisdictions not listed above (Puerto Rico, Virgin Islands, etc.).

**Table 18: Cumulative Physician and Dentist Licensure Actions by State
(National Practitioner Data Bank, September 1, 1990 - December 31, 2000)**

State	Physicians					Dentists				
	Number of Reportable Licensure Actions	Number of Reportable Adverse Licensure Actions	Percent of Reportable Adverse Licensure Actions	Number of Adverse Licensure Actions for In-State Physicians	Percent of All Reportable Adverse Licensure Actions for In-State Physicians	Number of Reportable Licensure Actions	Number of Reportable Adverse Licensure Actions	Percent of Reportable Adverse Licensure Actions	Number of Adverse Licensure Actions for In-State Dentists	Percent of All Reportable Adverse Licensure Actions for In-State Dentists
Alabama	348	312	89.66%	243	77.88%	84	83	98.81%	80	96.39%
Alaska	107	100	93.46%	58	58.00%	41	39	95.12%	37	94.87%
Arizona	760	719	94.61%	610	84.84%	568	567	99.82%	545	96.12%
Arkansas	220	193	87.73%	150	77.72%	24	21	87.50%	21	100.00%
California	3,374	2,928	86.78%	2,176	74.32%	383	380	99.22%	360	94.74%
Colorado	868	798	91.94%	672	84.21%	447	444	99.33%	402	90.54%
Connecticut	452	432	95.58%	344	79.63%	141	129	91.49%	121	93.80%
Delaware	37	32	86.49%	17	53.13%	2	2	100.00%	2	100.00%
Florida	1,598	1,372	85.86%	1,137	82.87%	354	328	92.66%	308	93.90%
Georgia	790	701	88.73%	541	77.18%	139	139	100.00%	134	96.40%
Hawaii	77	75	97.40%	33	44.00%	7	7	100.00%	6	85.71%
Idaho	92	78	84.78%	47	60.26%	14	14	100.00%	13	92.86%
Illinois	1,014	802	79.09%	631	78.68%	441	309	70.07%	286	92.56%
Indiana	313	261	83.39%	155	59.39%	66	54	81.82%	46	85.19%
Iowa	502	433	86.25%	251	57.97%	156	153	98.08%	101	66.01%
Kansas	244	207	84.84%	176	85.02%	35	35	100.00%	33	94.29%
Kentucky	576	489	84.90%	372	76.07%	72	72	100.00%	70	97.22%
Louisiana	459	414	90.20%	333	80.43%	112	109	97.32%	106	97.25%
Maine	141	133	94.33%	91	68.42%	36	36	100.00%	32	88.89%
Maryland	880	834	94.77%	668	80.10%	160	145	90.63%	128	88.28%
Massachusetts	567	543	95.77%	433	79.74%	155	150	96.77%	137	91.33%
Michigan	1,425	1,250	87.72%	956	76.48%	422	380	90.05%	338	88.95%
Minnesota	432	349	80.79%	247	70.77%	188	145	77.13%	140	96.55%
Mississippi	487	451	92.61%	361	80.04%	60	57	95.00%	54	94.74%
Missouri	664	647	97.44%	401	61.98%	101	100	99.01%	83	83.00%
Montana	101	90	89.11%	72	80.00%	17	17	100.00%	15	88.24%
Nebraska	86	83	96.51%	56	67.47%	35	33	94.29%	25	75.76%
Nevada	120	120	100.00%	83	69.17%	30	29	96.67%	29	100.00%
New Hampshire	86	85	98.84%	60	70.59%	20	20	100.00%	19	95.00%
New Jersey	1,185	1,042	87.93%	731	70.15%	226	212	93.81%	203	95.75%
New Mexico	65	65	100.00%	54	83.08%	11	10	90.91%	9	90.00%
New York	2,719	2,704	99.45%	1,430	52.88%	382	379	99.21%	347	91.56%
North Carolina	414	348	84.06%	240	68.97%	237	229	96.62%	226	98.69%
North Dakota	174	134	77.01%	87	64.93%	1	1	100.00%	1	100.00%
Ohio	1,688	1,607	95.20%	1,242	77.29%	657	632	96.19%	620	98.10%
Oklahoma	550	471	85.64%	410	87.05%	92	91	98.91%	87	95.60%
Oregon	415	396	95.42%	367	92.68%	254	252	99.21%	235	93.25%
Pennsylvania	1,106	1,033	93.40%	576	55.76%	223	218	97.76%	165	75.69%
Rhode Island	136	126	92.65%	93	73.81%	14	14	100.00%	11	78.57%
South Carolina	398	297	74.62%	254	85.52%	57	57	100.00%	56	98.25%
South Dakota	41	38	92.68%	21	55.26%	3	3	100.00%	3	100.00%
Tennessee	373	315	84.45%	252	80.00%	147	134	91.16%	129	96.27%
Texas	1,911	1,693	88.59%	1,491	88.07%	277	274	98.92%	272	99.27%
Utah	157	131	83.44%	95	72.52%	50	37	74.00%	32	86.49%
Vermont	112	107	95.54%	61	57.01%	4	4	100.00%	2	50.00%
Virginia	1,219	1,109	90.98%	829	74.75%	626	598	95.53%	555	92.81%
Washington	597	480	80.40%	362	75.42%	158	146	92.41%	134	91.78%
West Virginia	451	380	84.26%	304	80.00%	9	9	100.00%	9	100.00%
Wisconsin	316	272	86.08%	205	75.37%	144	129	89.58%	118	91.47%
Wyoming	53	48	90.57%	31	64.58%	0	0	--	0	--
Washington, DC	81	72	88.89%	29	40.28%	2	2	100.00%	2	100.00%
All Reports	30,995	27,813	89.73%	20,550	73.89%	7,887	7,431	94.22%	6,890	92.72%

This table includes only disclosable reports in the NPDB as of December 31, 2000

The "All Reports" row includes jurisdictions not listed above (Virgin Islands, Northern Marianas, etc.).

**TABLE 19: Relationship Between Frequency of Malpractice Payments, One or More Reportable Actions, and One or More Exclusions for Physicians
(National Practitioner Data Bank, September 1, 1990 - December 31, 2000)**

Number of Malpractice Payment Reports	Number of Physicians	Physicians with One or More Reportable Actions		Physicians with One or More Exclusions	
		Number	Percent	Number	Percent
1	71,865	3,475	4.8%	468	0.7%
2	18,486	1,352	7.3%	179	1.0%
3	5,721	595	10.4%	86	1.5%
4	2,135	314	14.7%	39	1.8%
5	889	159	17.9%	25	2.8%
6	483	95	19.7%	15	3.1%
7	219	51	23.3%	9	4.1%
8	129	25	19.4%	6	4.7%
9	93	33	35.5%	4	4.3%
10 or more	221	92	41.6%	23	10.4%
Total	100,241	6,191	6.2%	854	0.9%

This table includes only disclosable reports in the NPDB as of December 31, 2000

**TABLE 20: Relationship Between Frequency of Reportable Action Reports, One or More Malpractice Payments, and One or More Exclusion Reports for Physicians
(National Practitioner Data Bank, September 1, 1990 - December 31, 2000)**

Physicians with Specific Number of Reportable Action Reports	Number of Physicians	Physicians with One or More Malpractice Payments		Physicians with One or More Exclusions	
		Number	Percent	Number	Percent
1	9,397	2,868	30.5%	784	8.3%
2	4,710	1,532	32.5%	671	14.2%
3	2,257	796	35.3%	425	18.8%
4	1,151	417	36.2%	234	20.3%
5	657	242	36.8%	158	24.0%
6	350	143	40.9%	101	28.9%
7	183	84	45.9%	46	25.1%
8	116	47	40.5%	37	31.9%
9	51	23	45.1%	20	39.2%
10 or more	112	39	34.8%	37	33.0%
Total	18,984	6,191	32.6%	2,513	13.2%

This table includes only disclosable reports in the NPDB as of December 31, 2000

**TABLE 21: Entities That Have Queried or Reported to the National Practitioner Data Bank at Least Once, by Entity Type
(National Practitioner Data Bank, September 1, 1990 - December 31, 2000)**

Entity Type	Active Status 12/31/00	Active At Any Time
Malpractice Payers	298	704
State Licensing Boards	126	172
Hospitals	5,879	7,509
HMOs, PPOs, Group Practices	1,425	2,098
Professional Societies	95	196
Other Health Care Entities	3,166	4,901
Total	10,989	15,580

The counts shown in this table are based on entity registrations. A few entities have registered more than once. The registration counts shown in this table may, therefore, slightly over-count the actual number of separate, individual entities in each category. Entities that may report both clinical privileges actions and malpractice payments, such as hospitals and HMOs, are instructed to register as health care entities, not malpractice payers, and are not double counted in this table.

**Table 22: Number, Percent, and Percent Change in Queries and Queries Matched, Last Five Years and Cumulative
(National Practitioner Data Bank, September, 1, 1990 - December 31, 2000)**

Query Type	1996	1997	1998	1999	2000	Cumulative 9/1/1990 - 12/31/2000
Entity Queries*						
Total Entity Queries	2,762,643	3,133,471	3,155,558	3,222,348	3,292,157	22,312,102
Queries Percent Increase from Previous Year	23.6%	13.4%	0.7%	2.1%	2.2%	
Matched Queries	291,078	359,255	374,002	401,277	416,827	2,286,539
Percent Matched	10.5%	11.5%	11.9%	12.5%	12.7%	10.2%
Matches Percent Increase from Previous Year	41.0%	23.4%	4.1%	7.3%	3.9%	
Self-Queries						
Total Practitioner Self Queries	45,344	52,603	48,287	41,418	33,296	339,415
Self-Queries Percent Increase From Previous Year	4.0%	16.0%	-8.2%	-14.2%	-19.6%	
Matched Self Queries	3,774	4,704	4,293	3,655	2,764	26,896
Self-Queries Percent Matched	8.3%	8.9%	8.9%	8.8%	8.3%	7.9%
Matches Percent Increase from Previous Year	19.7%	24.6%	-8.7%	-14.9%	-24.4%	
Total Queries (Entity and Self)	2,807,987	3,186,074	3,203,845	3,263,766	3,325,453	22,651,517
Total Matched (Entity and Self)	294,852	363,959	378,295	404,932	419,591	2,313,435
Total Percent Matched (Entity and Self)	10.5%	11.4%	11.8%	12.4%	12.6%	10.2%

*Entity queries exclude practitioner self-queries except those submitted electronically by entities using QPRAC during 1999 and 2000.

**Table 23: Queries by Type of Querying Entity, Last Five Years and Cumulative
(National Practitioner Data Bank, September 1, 1990 - December 31, 2000)**

Type of Querying Entity*	1996			1997			1998		
	Number of Querying Entities	Number of Queries	Percent of Queries	Number of Querying Entities	Number of Queries	Percent of Queries	Number of Querying Entities	Number of Queries	Percent of Queries
Required Queriers									
Hospitals	5,740	991,203	35.9%	5,791	1,035,244	33.0%	5,785	1,082,229	34.3%
Voluntary Queriers									
State Licensing Boards	41	9,555	0.3%	52	11,497	0.4%	59	10,984	0.3%
HMOs, PPOs, Group Practices	1,373	1,445,303	52.3%	1,583	1,666,819	53.2%	1,780	1,658,117	52.5%
Other Health Care Entities	1,276	307,717	11.1%	1,697	405,833	13.0%	2,119	388,964	12.3%
Professional Societies	61	8,865	0.3%	72	14,078	0.4%	93	15,264	0.5%
Total Voluntary Queriers	2,751	1,771,440	64.1%	3,404	2,098,227	67.0%	3,992	2,062,345	65.4%
Total**	8,491	2,762,643	100.0%	9,195	3,133,471	100.0%	9,836	3,155,558	100.0%

Type of Querying Entity*	1999			2000			Cumulative 9/1/90 - 12/31/00		
	Number of Querying Entities	Number of Queries	Percent of Queries	Number of Querying Entities	Number of Queries	Percent of Queries	Number of Querying Entities	Number of Queries	Percent of Queries
Required Queriers									
Hospitals	5,774	1,098,236	34.1%	5,791	1,118,828	34.0%	7,495	9,549,999	42.8%
Voluntary Queriers									
State Licensing Boards	60	10,285	0.3%	78	13,525	0.4%	130	98,543	0.4%
HMOs, PPOs, Group Practices	1,716	1,707,022	53.0%	1,695	1,776,852	54.0%	2,823	10,323,039	46.3%
Other Health Care Entities	2,357	393,557	12.2%	2,636	372,599	11.3%	4,090	2,263,691	10.1%
Professional Societies	89	13,248	0.4%	84	10,353	0.3%	186	76,830	0.3%
Total Voluntary Queriers	4,222	2,124,112	65.9%	4,493	2,173,329	66.0%	7,229	12,762,103	57.2%
Total**	9,996	3,222,348	100.0%	10,284	3,292,157	100.0%	14,724	22,312,102	100.0%

* The "Type of Querying Entity" is based on how the entity is currently registered and may be different from previous years. Thus, the number of entities and queriers within each entity type may vary slightly from previous reports.

** Excludes practitioner self-queries except those submitted electronically by entities using QPRAC during 1999 and 2000.

TABLE 24: Number of Queries by Practitioner Type
(National Practitioner Data Bank, October - November, 2000)

Practitioner Type	Queries --	
	October & November 2000	Percent of Total Queries
Accountant	14	0.00%
Acupuncturist	384	0.06%
Adult Care Facility Administrator	7	0.00%
Allopathic Physician (MD)	486,538	71.33%
Allopathic Physician Intern/Resident	2,628	0.39%
Art/Recreation Therapist	29	0.00%
Athletic Trainer	34	0.00%
Audiologist	759	0.11%
Bookkeeper	13	0.00%
Business Manager	13	0.00%
Business Owner	6	0.00%
Chiropractor	11,257	1.65%
Corporate Officer	10	0.00%
Cytotechnologist	17	0.00%
Dental Hygienist	315	0.05%
Dental Resident	42	0.01%
Dentist	29,996	4.40%
Denturist	8	0.00%
Dietician	198	0.03%
EMT, Basic	60	0.01%
EMT, Cardiac/Critical Care	24	0.00%
EMT, Intermediate	36	0.01%
EMT, Paramedic	104	0.02%
Home Health Maker (Homemaker)	8	0.00%
Hospital Administrator	7	0.00%
Insurance Agent	11	0.00%
Insurance Broker	14	0.00%
Licensed Practical or Vocational Nurse	670	0.10%
Long-Term Care Administrator	8	0.00%
Massage Therapist	520	0.08%
Medical Assistant	200	0.03%
Medical Technologist	131	0.02%
Mental Health Counselor	2,480	0.36%
Midwife, Lay (Non-nurse)	50	0.01%
Naturopath	97	0.01%
Nuclear Medicine Technologist	19	0.00%
Nurse Anesthetist	5,200	0.76%
Nurse Midwife	1,754	0.26%
Nurse Practitioner	7,945	1.16%
Nurse's Aide	87	0.01%
Nutritionist	61	0.01%
Occupational Therapist	1,353	0.20%
Occupational Therapy Assistant	42	0.01%
Ocularist	26	0.00%
Optician	102	0.01%
Optometrist	13,209	1.94%
Orthotics/Prosthetics fitter	141	0.02%
Osteopathic Physician	28,049	4.11%
Osteopathic Physician Intern/Resident	227	0.03%
Perfusionist	162	0.02%
Pharmacist	598	0.09%
Pharmacist, Nuclear	3	0.00%
Pharmacy Assistant	91	0.01%
Physical Therapist	7,272	1.07%
Physical Therapist Assistant	84	0.01%
Physician Assistant	7,307	1.07%
Physician Assistant, Osteopathic	177	0.03%
Psychiatric Technician	115	0.02%
Podiatrist	12,851	1.88%
Podiatrist Assistant	64	0.01%
Professional Counselor	4,611	0.68%
Professional Counselor, Alcohol	153	0.02%
Professional Counselor, Family/Marriage	3,864	0.57%
Professional Counselor, Substance Abuse	300	0.04%
Psychologist, Clinical	18,283	2.68%
Radiation Therapy Technologist	46	0.01%
Radiologic Technologist	185	0.03%
Registered (Professional) Nurse	11,172	1.64%
Rehabilitation Therapist	121	0.02%
Researcher, Clinical	26	0.00%
Respiratory Therapist	66	0.01%
Respiratory Therapy Technician	39	0.01%
Salesperson	22	0.00%
Social Worker, Clinical	17,697	2.59%
Speech/Language Pathologist	1,034	0.15%
Unclassified, Other Occupation	246	0.04%
Unspecified, Other Health Care Practitioner	601	0.09%
Total	682,093	100.00%

Queries for this sample period may not be representative of other times.

**Table 25: Requests for Secretarial Review by Report Type, Last Five Years and Cumulative
(National Practitioner Data Bank, September 1, 1990 - December 31, 2000)**

Category	1996			1997			1998		
	Number	Percent	Percent Change 1995-1996	Number	Percent	Percent Change 1996-1997	Number	Percent	Percent Change 1997-1998
Reportable Actions	79	65.8%	-30.1%	80	65.0%	1.3%	60	54.5%	-25.0%
Adverse Licensure Actions	27	22.5%	-40.0%	35	28.5%	29.6%	20	18.2%	-42.9%
Clinical Privileges	49	40.8%	-26.9%	45	36.6%	-8.2%	40	36.4%	-11.1%
Professional Society Membership	3	2.5%	200.0%	0	0.0%	0.0%	0	0.0%	0.0%
Exclusions or Debarments	0	0.0%	0.0%	0	0.0%	0.0%	0	0.0%	0.0%
Medical Malpractice Payments	41	34.2%	-71.3%*	43	35.0%	4.9%	50	45.5%	16.3%
Total	120	100.0%	-46.9%	123	100.0%	2.5%	110	100.0%	-10.6%

Category	1999			2000			Cumulative 09/1/1990 - 12/31/2000	
	Number	Percent	Percent Change 1998-1999	Number	Percent	Percent Change 1999-2000	Number	Percent
Reportable Actions	73	66.4%	21.7%	70	58.3%	-4.1%	830	61.0%
Adverse Licensure Actions	30	27.3%	50.0%	22	18.3%	-26.7%	270	19.8%
Clinical Privileges	42	38.2%	5.0%	35	29.2%	-16.7%	534	39.2%
Professional Society Membership	1	0.9%	---	2	1.7%	0.0%	15	1.1%
Exclusions or Debarments	0	0.0%	0.0%	11	0.0%	---	11	0.0%
Medical Malpractice Payments	37	33.6%	-26.0%	50	41.7%	35.1%	531	39.0%
Total	110	100.0%	0.0%	120	100.0%	9.1%	1,361	100.0%

* The percent change in requests for Secretarial Reviews from 1995 to 1996 is affected by an unusually large number of malpractice payment reviews closed in 1995.

Table 26: Distribution of Requests for Secretarial Review by Type of Outcome, Last Five Years and Cumulative (National Practitioner Data Bank, September 1, 1990 - December 31, 2000)

Outcome	1996			1997			1998		
	Number	Percent	Percent of Resolved Requests	Number	Percent	Percent of Resolved Requests	Number	Percent	Percent of Resolved Requests
Determination in Favor of Entity	48	40.0%	40.0%	59	48.0%	48.0%	59	53.6%	54.6%
Out of Scope	42	35.0%	35.0%	33	26.8%	26.8%	33	30.0%	30.6%
Determination in Favor of Practitioner	22	18.3%	18.3%	17	13.8%	13.8%	5	4.5%	4.6%
Other Outcome	8	6.7%	6.7%	14	11.4%	11.4%	11	10.0%	10.2%
Unresolved	0	0.0%	N/A	0	0.0%	N/A	2	1.8%	N/A
Total	120	100.0%	100.0%	123	100.0%	100.0%	110	100.0%	100.0%

Outcome	1999			2000			Cumulative		
	Number	Percent	Percent of Resolved Requests	Number	Percent	Percent of Resolved Requests	Number	Percent	Percent of Resolved Requests
Determination in Favor of Entity	52	47.3%	49.5%	14	11.7%	29.2%	533	39.1%	41.5%
Out of Scope	29	26.4%	27.6%	30	25.0%	62.5%	493	36.2%	38.4%
Determination in Favor of Practitioner	12	10.9%	11.4%	1	0.8%	2.1%	157	11.5%	12.2%
Other Outcome	12	10.9%	11.4%	3	2.5%	6.3%	101	7.4%	7.9%
Unresolved	5	4.5%	N/A	72	60.0%	N/A	79	5.8%	N/A
Total	110	100.0%	100.0%	120	100.0%	100.0%	1,363	100.0%	100.0%

This table represents the outcome of requests for Secretarial review based on the date of the request. For undated requests, the date the request was received by the Division of Quality Assurance was used.

**Table 27: Cumulative Resolved Requests for Secretarial Review by Report Type and Outcome Type
(National Practitioner Data Bank, September 1, 1990 - December 31, 2000)**

Outcome	Malpractice Payments		Licensure Actions		Clinical Privileges Actions	
	Number	Percent of Requests	Number	Percent of Requests	Number	Percent of Requests
Determination in Favor of Entity	157	29.1%	124	45.9%	248	46.4%
Out of Scope	291	53.9%	52	19.3%	148	27.7%
Determination in Favor of Practitioner	36	6.7%	48	17.8%	71	13.3%
Other Outcome	30	5.6%	26	9.6%	41	7.7%
Unresolved	26	4.8%	20	7.4%	26	4.9%
Total	540	100%	270	100%	534	100%

Outcome	Professional Society Membership		Exclusions		Total	
	Number	Percent of Requests	Number	Percent of Requests	Number	Percent of Requests
Determination in Favor of Entity	3	20.0%	0	0.0%	532	39.1%
Out of Scope	5	33.3%	0	0.0%	493	36.2%
Determination in Favor of Practitioner	2	13.3%	0	0.0%	157	11.5%
Other Outcome	3	20.0%	0	0.0%	100	7.3%
Unresolved	2	13.3%	11	100.0%	79	5.8%
Total	15	100%	11	100%	1,361	100%