

National Practitioner Data Bank Combined Annual Report 2007, 2008, and 2009

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U.S. Department of Health and Human Services
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Division of Practitioner Data Bank



Table of Contents

Executive Summary	6
I. Background: National Practitioner Data Bank.....	7
A. Annual Reporting.....	7
B. Mission.....	7
C. Health Care Quality and Improvement Act	8
D. Reports	9
E. Queries.....	10
F. Confidentiality of NPDB Information	14
G. Civil Liability Protection.....	14
II. Management of the NPDB	15
A. The Division of Practitioner Data Bank.....	15
B. NPDB Executive Committee.....	15
III. Review of 2007	16
A. System Improvements 2007.....	16
Proactive Disclosure Service	16
Reports	16
B. Policy Activities 2007.....	17
1. Regulations	17
2. Outreach Efforts	18
C. Research Activities 2007	19
1. Research and Evaluation.....	19
D. Compliance Activities 2007	19
1. Reports	19
IV. Review of 2008	21
A. System Improvements 2008.....	21
1. Proactive Disclosure Service	21
2. Reports and Queries	21
B. Policy Activities 2008.....	23
1. Outreach Efforts	23
C. Research Activities 2008	23
1. Research and Evaluation.....	23
D. Compliance Activities 2008	24
1. Reports	24
V. Review of 2009.....	25
A. System Improvements 2009.....	25
1. Proactive Disclosure Service	25
2. Reports and Queries	26
B. Policy Activities 2009.....	28
1. Regulations	28
2. Outreach Efforts	28
C. Research Activities 2009	29
1. Research and Evaluation.....	29
D. Compliance Activities 2009	29
1. Reports	29

VI. Programmatic Data: 2007, 2008 and 2009	30
A. NPDB Reports	31
B. Medical Malpractice Payment Reports and Adverse Action Reports.....	32
C. Adverse Action Reports by Type	33
D. Medical Malpractice Payment Reports by Practitioner	37
E. Types of Queries	39
F. Secretarial Reviews for Adverse Action Reports and Medical Malpractice Payment Reports	44
VII. Appendix.....	46
Appendix A. Executive Committee: Organizational Representatives	47
Appendix B. NPDB Milestones	48
Appendix C. Glossary of Acronyms	52
Appendix D. Tables with NPDB Data	54

List of Graphs and Tables

- Graph 1. Number of Medical Malpractice and Adverse Action Reports by Year (2000 - 2009)**
- Graph 2. Percentages of Medical Malpractice and Adverse Action Reports by Year (2000 - 2009)**
- Graph 3. Number of Adverse Action Reports by Year (2000 - 2009)**
- Graph 4. Number of Adverse Action Reports by Entity Type and Year (2000 - 2009)**
- Graph 5. Percentages of Adverse Action Reports by Entity Type and Year (2000 - 2009)**
- Graph 6. Number of Medical Malpractice Reports by Year (2000 - 2009)**
- Graph 7. Number of Medical Malpractice Reports by Practitioner Type and Year (2000 - 2009)**
- Graph 8. Percentages of Medical Malpractice Reports by Practitioner Type and Year (2000 - 2009)**
- Graph 9. Number of Hospital and Voluntary Queries by Year (2000 - 2009)**
- Graph 10. Percentages of Hospital and Voluntary Queries by Year (2000 - 2009)**
- Graph 11. Number of Entities Voluntarily Querying the NPDB by Year (2000 - 2009)**
- Graph 12. Number of Voluntary Queries by Entity and Year (2000 - 2009)**
- Graph 13. Number of Requests for Secretarial Reviews by Report Type and Year (2000 - 2009)**
- Table 1. Number and Percent Distribution of Reports by Report Type, From 2000 to 2009**
- Table 2. Number of Reports Received and Percent Change by Report Type, From 2000 to 2009**

- Table 3. Number, Percent Distribution, and Percent Change of Medical Malpractice Payment Reports by Practitioner Type, From 2000 to 2005**
- Table 4. Number, Percent Distribution, and Percent Change of Medical Malpractice Payment Reports by Practitioner Type, From 2005 to 2009**
- Table 5. Queries by Type of Querying Entity, From 2000 to 2004**
- Table 6. Queries by Type of Querying Entity, From 2005 to 2009**
- Table 7. Requests for Secretarial Review by Report Type, From 2000 to 2004**
- Table 8. Requests for Secretarial Review by Report Type, From 2005 to 2009**
- Table 9. Actual and Adjusted Medical Malpractice Payment Reports and Ratio of Adjusted Medical Practitioner Reports by State, Physicians and Dentists, Cumulative From September 1, 1990 Through 2009**
- Table 10. Number of Medical Malpractice Payment Reports by State, From 2005 to 2009 – Physicians**
- Table 11. Number of Medical Malpractice Payment Reports by State, From 2005 to 2009 – Dentists**
- Table 12. Currently Active Registered Non-Federal Hospitals that Have Never Reported to the National Practitioner Data Bank by State**
- Table 13. Outcomes of Requests Submitted for Secretarial Review by Year (2000-2008)**
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Executive Summary

The National Practitioner Data Bank (NPDB) was created by the *Health Care Quality Improvement Act of 1986* and implemented in 1990. Initially, the Data Bank's purposes were to 1) collect and disseminate information about physicians and dentists to prevent incompetent or unprofessional practitioners from moving from one jurisdiction to another without disclosure or discovery of the physician's or dentist's previous damaging or incompetent performance, and 2) to promote professional peer review activities. The overarching intent was to improve patient safety and quality of care.

This report highlights annual data from 2007, 2008 and 2009, but also provides trend data over 10 years for context. Among the more interesting trends was the increase in overall reporting and querying activity by health care entities. Modest gains occurred in all entity categories, including Hospitals, State Licensing Boards, Managed Care Organizations, Professional Societies, and Medical Malpractice insurers. The entity entitled "Other Health Care Entities," however, showed the greatest increase when compared to all other entities. The following entities included within this category were: ambulatory surgical centers, group medical practices, nursing facilities, community health centers and others.

There were many program improvements from 2007 through 2009. Programmatic system changes were based on suggestions from Data Bank users and stakeholders at Bureau of Health Professions, Division of Practitioner Data Bank (DPDB) held Policy Forums and User Review Panels. System enhancements since 2007 included a more expeditious process for correcting a revision-to-action report. Reporters and subjects (practitioners with reports) were given more space (4,000 characters) to create a report narrative or subject statement. This, much needed change provided those that query a clearer picture and understanding of what led to the report submission.

The Proactive Disclosure Service (PDS) was introduced in April 2007 using a series of technical assistance conference calls partnering DPDB personnel with potential PDS subscribers. Many useful suggestions and system changes resulted from these calls. A simplified enrollment process was instituted via the subject's Integrated Querying and Reporting Service (IQRS) database and an automatic renewal process. In 2008, PDS was made available to Querying and Reporting XML Service (QRXS) users. Health care entities enrolled almost 500,000 practitioners by December 2009. The response to the new service was very positive as indicated by re-enrollment rates of over 90 percent.

The Data Bank emphasized "going green" starting in 2007. As a result, the quarterly *NPDB-HIPDB Data Bank News* became available electronically. Previous issues were archived on the Data Bank Web site for reference purposes. A number of Data Bank documents were also made available electronically.

This report shows that from 2007 through 2009 the Data Bank made progress to support improvement in quality health care and patient safety by insuring a safer provider workforce.

I. Background: National Practitioner Data Bank

A. Annual Reporting

The National Practitioner Data Bank (NPDB) Annual Reports are developed and posted for users of the Data Bank, stakeholders and the general public on the NPDB Web site <http://www.npdb-hipdb.hrsa.gov/AnnualReport>. This is the first combined report covering 3 years, 2007, 2008, and 2009. The report contains programmatic data, trends, and informational updates for these 3 years while providing greater context with data from the decade starting in 2000. For first time readers, the report summarizes NPDB requirements and other critical information to provide background. The Appendix hosts a compendium of statistical tables, a timeline of significant NPDB events, a listing of Executive Committee organizations and a glossary of acronyms used in the narrative.

The NPDB is currently housed in the Health Resources and Services Administration (HRSA), Bureau of Health Professions (BHP). In 2008, the BHP underwent organizational changes. The Practitioner Data Bank Branch (PDBB), which first managed the NPDB, became the Division of Practitioner Data Banks (DPDB). To prevent confusion, the “Division of Practitioner Data Banks” or “DPDB” will be used throughout this combined report when referring to the management of the NPDB.

B. Mission

The mission of HRSA is to improve health and achieve health equity through access to quality services, a skilled health workforce, and innovative programs. The NPDB plays an important role in ensuring quality health care and a skilled health workforce by providing critical information to health care entities about practitioners. The DPDB is committed to the development and operation of cost-effective and efficient systems that offer accurate, reliable, and timely information on practitioners, providers, and suppliers to credentialing, privileging, and government authorities. The DPDB strives to be the preeminent source of information for the health care industry by administering the NPDB so that it is valued by those who use the information, those who provide the information, as well as those affected by the information.

C. Health Care Quality and Improvement Act

The legislation that created the NPDB was enacted by the U.S. Congress under Title IV of Public Law 99-660, the *Health Care Quality Improvement Act of 1986 (HCQIA)*. The issues that led to the *HCQIA* were:

- The increasing occurrence of medical malpractice and the need to improve the quality of medical care;
- The national need to restrict the ability of incompetent physicians from moving from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance;
- The need for effective professional peer review to protect the public;
- The threat of private monetary damage liability under Federal laws preventing physicians from participating in effective professional peer review; and
- The national need to provide incentives and protection for physicians engaging in effective professional peer review.

The NPDB, implemented in 1990, serves as an electronic repository, to collect and release certain information related to the professional competence and conduct of physicians, dentists, and, in some cases, other health care practitioners. The establishment of the NPDB represented an important step by the U.S. Department of Health and Human Services (HHS) to improve the quality of health care for all Americans. State licensing boards, hospitals and other health care entities, and professional societies are expected to identify, discipline and report on those who engage in specific unprofessional behavior. The implementation of the NPDB was meant to prevent incompetent physicians, dentists, and other health care practitioners from moving State to State without disclosure or discovery of previous medical malpractice payment or adverse action histories.

The NPDB serves primarily as an alert or flagging system intended to facilitate a comprehensive review of health care practitioners' professional credentials. The information contained in the NPDB is intended to direct discrete inquiry into, and scrutiny of a practitioner's licensure, clinical privileges, professional society memberships, and medical malpractice payment history.

The *HCQIA* specified that the NPDB must make NPDB reports available to hospitals, health care entities with formal peer review, professional societies with formal peer review, State licensing authorities, health care practitioners (self-query), researchers (non-identifiable data only), and in limited circumstances, plaintiffs' attorneys. This same information, however, must not be disclosed to the general public. It was expected that the information contained in the NPDB be considered together with other relevant data in evaluating a practitioner's credentials. The NPDB

does not collect full records of reported incidents or actions and is not designed to be the sole source of information about a practitioner. For example, if a NPDB report indicated that a settlement was made by or on behalf of a practitioner, it should not be assumed that negligence was involved.

Initially, the NPDB only collected and released information under Title IV. However, in 1987 Congress passed Public Law 100-93, Section 5(b) of the *Medicare and Medicaid Patient and Program Protection Act of 1987* (Section 1921 of the *Social Security Act*), authorizing the Government to collect information concerning sanctions taken by State licensing authorities against all health care practitioners and entities.

In 1997, under an Interagency Agreement (IAA) with HRSA, the Centers for Medicare & Medicaid Services (CMS), and the HHS Office of Inspector General (OIG), Medicaid and Medicare Exclusions were included in the NPDB. Later that same year the NPDB made CMS reinstatement reports available to registered users. Thus, Adverse Action Reports (AAR) submitted to the NPDB expanded from adverse professional review actions related to licensure, clinical privileges, and professional society membership to practitioner exclusions from Medicare and Medicaid.

D. Reports

Part B of P.L. 99-660 of the *HCQIA* mandated that a report be submitted to the NPDB for any payment, including settlements, made as a result of a malpractice claim or suit and for adverse actions against the clinical privileges, State licensure, or professional society membership of physicians and dentists and, in some cases, other health care practitioners who are licensed or otherwise authorized by a State to provide health care services. Mandated NPDB reporters became obligated to report these medical malpractice payments and adverse actions taken on or after September 1, 1990. With the exception of reports on Medicare/Medicaid Exclusions, the NPDB cannot accept any report with a date of payment or a date of action prior to September 1, 1990.

To be eligible to **report** to the NPDB, an entity must be one of the following (See Table 1.):

- A national or international organization that makes a medical malpractice payment;
- A board of medical examiners or a State licensing board taking an adverse action against a physician or dentist;
- A health care entity that takes an adverse clinical privileging action as a result of professional review; or
- A professional society that takes an adverse membership action as a result of professional review. Each entity must certify its eligibility to use the NPDB in writing.

Reports are also collected from private and government entities, including the Armed Forces, located in the 50 States and U.S. territories.¹ To improve the reporting of government entities the Secretary of HHS developed a series of Memoranda of Agreement (MOA) with all relevant Federal agencies/departments. Section 432(b) of the Act mandated that the Secretary establish an MOA with the Secretaries of Defense and Veterans Affairs to apply provisions of the Act to hospitals, other facilities, and health care providers under their jurisdictions. Section 432(c) stipulated that the Secretary also enter into an MOA with the Administrators of the U.S. Department of Justice (DOJ), Drug Enforcement Administration (DEA) to ensure the reporting of practitioners whose registrations to dispense controlled substances be suspended or revoked under Section 304 of the *Controlled Substances Act*.

The Secretary has government agreements in place with the following to ensure compliance with all NPDB related laws.

- Centers for Medicare & Medicaid Services (Interagency Agreement or IAA)
- Department of Defense (MOA)
- Department of Justice which includes the Bureau of Prisons and Drug Enforcement Agency (MOA)
- Department of Veterans Affairs (MOA)
- Public Health Service Contractors and Employees (HHS Policy Directive)

Whenever the NPDB receives a new, revised, corrected, or voided report, a Subject Notification Document (SND) is mailed to the practitioner named in the report within one business day, using the address supplied by the reporting organization. If an SND is returned to the NPDB by the post office as undeliverable, that information is added to the report, along with the address to which the subject's report was sent, the date it was sent, and an explanation that the subject did not receive a copy of the report because it was undeliverable.

E. Queries

Access to information in the NPDB is available to entities that meet the eligibility requirements defined in the provisions of [P.L. 99-660](#), [P.L. 100-93](#), and the [NPDB regulations](#). These entities

¹In 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, Palau, Guam, the Northern Mariana Islands, the Federated States of Micronesia, and the Marshall Islands.

are listed below. In order to access NPDB data about practitioners, entities that meet the eligibility requirements must first register with the Data Bank.

Based on the *HCQIA* as amended, and its governing regulations, NPDB information is available to (Figure 1):

- Hospitals requesting information concerning a practitioner on their medical staff or applying to the medical staff for clinical privileges or to whom they have granted clinical privileges, or with respect to professional review activity;
- Health care entities, including managed care organizations (MCOs), that have entered or may be entering employment or affiliation relationships with a practitioner or to which the practitioner applied for clinical privileges or appointment to the medical staff, or with respect to professional review activity;
- Boards of medical examiners or other State licensing boards;
- Practitioners requesting information about themselves;
- Attorneys or individuals representing themselves upon submission of proof that a hospital failed to submit a mandatory query;
- Practitioner related professional societies; and
- Persons or entities requesting information in a form which does not identify any particular entity or practitioner (non-identifiable data).

Registered eligible entities query about practitioners who have or are requesting State licensure, medical staff membership, or professional society membership. Medical malpractice insurers cannot query the NPDB.²

The NPDB also may be queried in two other circumstances. Health care practitioners may self-query the NPDB at any time. They may only query themselves, not other practitioners. A plaintiff or an attorney for a plaintiff in a civil action against a hospital may query the NPDB about a specific practitioner in limited circumstances. This is possible only when independently obtained evidence, submitted to HHS, discloses that the hospital did not make a required query on the practitioner. If this is proven, the attorney or plaintiff is provided with information that the hospital would have received if it had queried the practitioner as mandated. This information may only be used against the hospital.

²Self-insured health care entities may query for peer review but not for “insurance” purposes.

As mandated by law, user fees, not taxpayer dollars, are used to pay for NPDB operations. All those that query the NPDB must pay \$4.75 for each practitioner about whom information is requested. Queries must be paid for by credit card or via automatic electronic funds transfer (EFT). In 2008 and 2009 a self-query cost \$8.00 in the NPDB. Self-queries are more expensive to process because they require some manual intervention.

Figure 1
Reporting and Querying the NPDB 2007 - 2009

Entity	Report	Query
State Medical and Dental Boards	<ul style="list-style-type: none"> ✚ Must report on licensure disciplinary actions, e.g., revocation, suspension, voluntary surrender while under investigation, license restriction due to professional incompetence or conduct 	<ul style="list-style-type: none"> ✚ May query at any time
Other State Licensing Boards	<ul style="list-style-type: none"> ✚ Do not report 	<ul style="list-style-type: none"> ✚ May query at any time
Hospitals	<ul style="list-style-type: none"> ✚ Must report on adverse professional review actions related to professional competence or conduct that impact physician or dentist privileges or panel membership for more than 30 days ✚ Must report a physician's or dentist's voluntary surrender or restriction of his/her clinical privileges/panel membership while being investigated for possible professional incompetence or improper professional conduct or in return for an entity not conducting an investigation or taking a reportable professional review action. ✚ Must report revisions to actions ✚ May report on adverse actions against other health care practitioners 	<ul style="list-style-type: none"> ✚ Must query all applicants for medical staff appointments or granting, adding to/expanding clinical privileges ✚ Must query all physicians, dentists and other health care practitioners on staff, every 2 years to renew clinical privileges and when deemed necessary
Health Plan or Other Health Care Entity	<ul style="list-style-type: none"> ✚ Reports as noted for Hospitals 	<ul style="list-style-type: none"> ✚ May query at any time
Professional Societies	<ul style="list-style-type: none"> ✚ Must report on adverse professional review actions based on reasons related to professional competence or professional conduct that adversely affects a physician's or a dentist's membership ✚ Must report on revisions to such actions ✚ May report on other health care practitioners for these actions 	<ul style="list-style-type: none"> ✚ May query at any time
Physicians, Dentists, and Other Practitioners	<ul style="list-style-type: none"> ✚ May not self-report 	<ul style="list-style-type: none"> ✚ May self-query
Medical Malpractice Payers	<ul style="list-style-type: none"> ✚ Must report all medical malpractice payments when an entity makes a payment for the benefit of a health care practitioner in settlement of, or in satisfaction in whole or in part of, a claim or judgment against that practitioner 	<ul style="list-style-type: none"> ✚ May not query
U.S. DEA	<ul style="list-style-type: none"> ✚ Must report revocations or voluntary surrenders of the Drug Enforcement Administration (DEA) registration numbers used for prescribing controlled substances 	<ul style="list-style-type: none"> ✚ May not query
HHS Office of Inspector General	<ul style="list-style-type: none"> ✚ Must report exclusions from Medicare/Medicaid programs against physicians, dentists, and other health care practitioners 	<ul style="list-style-type: none"> ✚ May not query
Plaintiff's Attorneys	<ul style="list-style-type: none"> ✚ Do not report 	<ul style="list-style-type: none"> ✚ May query when a hospital failed to query on the practitioner and also named him/her in an action or claim in the NPDB

F. Confidentiality of NPDB Information

Information reported to the NPDB is considered confidential and cannot be disclosed except as specified in the NPDB regulations. The [Privacy Act of 1974](#) protects the contents of Federal records, such as those contained in the NPDB, from disclosure. In this instance, the data from the records are aggregated and do not disclose the identity of the practitioners in the NPDB. Those authorized to query the NPDB must use NPDB information solely for the purposes provided. The HHS, Office of Inspector General (OIG), has the authority to impose civil monetary penalties on those who violate the confidentiality provisions of Title IV.³ Persons, organizations, or entities that receive NPDB information either directly or indirectly are subject to the confidentiality provisions and the imposition of a civil monetary penalty of up to \$11,000 for each offense if they violate these provisions.

In addition, the NPDB may not disclose information about practitioners to medical malpractice insurers or to the public. Individuals who knowingly and willfully query the NPDB under false pretenses or who fraudulently gain access to NPDB information face criminal and civil penalties. Similar criminal penalties exist for individuals who knowingly and willfully report to the NPDB under false pretenses.

G. Civil Liability Protection

To encourage and support professional review activity of physicians and dentists, Part A of Title IV provides that the professional review bodies of hospitals and other health care entities, and persons serving on or otherwise assisting such bodies, are offered immunity from private damages in civil suits under Federal or State law. Immunity provisions apply when professional review responsibilities are conducted with the reasonable belief of furthering the quality of health care and with proper regard for due process.

³ Information reported under this subchapter is considered confidential and shall not be disclosed (other than to the physician or practitioner involved) except with respect to professional review activity, as necessary to carry out subsections (b) and (c) of section 11135 of this title (as specified in regulations by the Secretary), or in accordance with regulations of the Secretary promulgated pursuant to subsection (a) of this section. Nothing in this subsection shall prevent the disclosure of such information by a party which is otherwise authorized, under applicable State law, to make such disclosure. Information reported under this subchapter that is in a form that does not permit the identification of any particular health care entity, physician, other health care practitioner, or patient shall not be considered confidential.

II. Management of the NPDB

A. The Division of Practitioner Data Bank

The Division of Practitioner Data Banks is responsible for the management of the NPDB. DPDB collaborates with other HHS agencies, other Federal entities, State licensing authorities and State and local professional organizations to ensure the completeness, accuracy and timeliness of the data in the NPDB. The division consists of three branches: the Policy Analysis Branch, Operations and Administration Branch, and the Research and Disputes Branch. DPDB employs the technology services of a contractor to support the NPDB.

B. NPDB Executive Committee

The NPDB Executive Committee was established in February 1989 to provide guidance, recommendations for improvement, and health care expertise to the NPDB contractor on NPDB operations. The NPDB Executive Committee is not a congressionally appointed committee and therefore has no legal authority over the NPDB. However, the committee, through its work with the contractor, provides valued feedback to NPDB processes.

The committee is comprised of 32 organizational representatives from HRSA and other federal agencies, various health professions, national health organizations, State professional licensing bodies, medical malpractice insurers, and the public (Appendix A). The Committee serves as a forum for these organizations with a vested interest in the NPDB to discuss operations and policy. A Chair and Vice Chair of the Committee are elected for two-year terms by the Executive Committee members. Non-federal organizations have three-year renewable staggered terms. Federal agencies, such as the U.S. Department of Defense (DoD) and the HHS OIG, participate on the Committee without term limits. The Executive Committee meets periodically with the contractor and the DPDB.

III. Review of 2007

A. System Improvements 2007

1. Proactive Disclosure Service

- a) *PDS Implementation* - The Proactive Disclosure Service (PDS) was implemented in May 2007. It provides continuous monitoring of subjects in the NPDB. After enrolling a subject, the system notifies the entity within one business day when a new or updated report is submitted on the subject. Queriers still have the choice to use the traditional query. This is a one-time query resulting in the receipt of a response generated from all Data Bank, the NPDB and the Healthcare Integrity and Protection Data Bank (HIPDB), information on the queried practitioner or organization. The HIPDB, also managed by the DPDB, was established by Section 1128E of the *Social Security Act* to combat fraud and abuse in health insurance and health care delivery and to promote quality care. The HIPDB contains certain final adverse actions against health care practitioners, providers, and suppliers. The term Data Bank is used to mean both the NPDB and HIPDB.

2. Reports

- a) *DPDB Data Integrity and Evaluation Team Efforts* – The Team focused on the timeliness of State licensure authorities’ reporting of adverse actions. This effort included: informing/reminding State licensure boards about the NPDB and HIPDB reporting requirements that mandate submission of reports within 30 days of the date of the final action; providing each board with its own reporting data on timeliness; and requesting action plans from State boards, not in compliance. The timeliness of adverse action reports from State licensure boards improved from 2006 to 2007.
- b) *Expansion of Section A in Reports* – Section A (demographics) of all report types was successfully modified to simplify the process for changing an entity’s name and address when necessary.
- c) *Character and Narrative Enhancements* – The character limit in a report narrative field and the subject statement field was increased from 2,000 to 4,000 characters. A “character counter” was added to display the number of characters being used while typing. The text areas for these fields were enlarged to allow for more text per screen.
- d) *New Option for Adverse Action Reporting* – Entities in the past could only select “Yes” or “No” in response to whether a reinstatement was automatic at completion of an adverse action period. A third response, “Yes, with conditions,” was made

available to entities. This change required entities to submit a Revision-to-Action-Report when a report was updated using this new option.

- e) *Addition of a Timeframe Compliance Notice* – All Interface Control Document Transfer Program (ITP) report responses added a reporting timeframe compliance notice, similar to that provided in the Integrated Querying and Reporting Service (IQRS). This change informed the reporter if he/she was compliant with the mandatory timeframe. Further information on ITP and IQRS can be found at [ITP](#) and [IQRS](#).
- f) *More Efficient Revision-to-Action-Report* – Reporters gained the capability to make corrections to the Revision-to-Action-Report within the IQRS. Reporters no longer have to void the Revision-to-Action-Report and then submit a new report.
- g) *Addition of Adverse Action Codes* – The NPDB added adverse action codes for reports submitted through the IQRS, the ITP, and the Querying and Reporting [XML](#) Service ([QRXS](#)). The new codes affected Clinical Privileges Reports and Federal and State Licensure Reports. As part of this effort, the DPDB worked with the National Council of State Boards of Nursing to develop a category of adverse action codes that reflected actions taken by boards that were part of the Nurse Licensure Compact.
- h) *Improved Reporting with Quality Improvement Checks* – A sample of 181 Clinical Privileges Action Reports was analyzed by the DPDB to determine if the narratives in each report were deemed sufficient for the NPDB requirements. Twenty-one percent (N = 39) of these reports were considered “factually insufficient” for the NPDB. The DPDB contacted all of the entities to request modifications to these reports to comply with legal requirements and to benefit those that query the NPDB.

B. Policy Activities 2007

1. Regulations

- a) *Preparation for Section 1921* – The proposed regulations to implement *Section 1921* of the *Social Security Act* were reviewed by HHS.⁴ The intent of *Section 1921* was to expand querying and reporting to the NPDB to include adverse licensure actions and any negative actions or findings by State licensing authorities, peer

⁴ This report was published in September 2011. The implementation of *Section 1921* occurred on March 1, 2010. Adverse Action Reports were no longer restricted to issues related to professional competence and conduct; reporting became required for all licensed health care practitioners, not just on physicians and dentists as well as those actions taken against health care entities; access to *Section 1921* information became available to agencies administering federal and State health care programs, Quality Improvement Organizations (QIOs), State Medicaid Fraud Control Units, the U.S. Comptroller General, the U.S. Attorney General and other law enforcement personnel and health care entities. Those eligible to query the NPDB were given access to *Section 1921* reports.

review organizations, or private accreditation organizations against health care practitioners and entities.

2. Outreach Efforts

- a) *Educating External Partners* – DPDB gave 29 professional presentations across the country. Policy forums took place at national meetings of Associations and at stand-alone events throughout the U.S., including New York and Atlanta. Participants shared and collected information about NPDB quality improvement and system enhancements.
- b) *Spreading the Word* – DPDB responded to unsolicited requests from professional groups to write articles for several professional organizations. Examples of publications include the following:
 - *Proactive Disclosure Service Summary*, National Association Medical Staff Services (NAMSS)
 - *Update of Reporting of Speech-Language Pathologists and Audiologists to the NPDB and HIPDB*, National Council of State Boards of Examiners for Speech-Language Pathology and Audiology
 - *Proactive Disclosure Service Prototype Article*; State NAMSS Affiliates
 - *Data Bank Offer New 24/7 Querying Service to Hospitals and Other Health Care Entities*, American Society for Healthcare Risk Management (ASHRM)
 - *Reporting to the National Practitioner Data Bank: Medical Malpractice Payments that Are the Product of High-Low Settlement Agreements*, The Virginia Bar Association
- c) *Executive Committee* - The DPDB reviewed the composition of the Executive Committee prior to the implementation of *Section 1921*. It was noted that the membership of the Executive Committee needed to be expanded to include the professional organizations of other health care practitioners and regulatory boards. Thus, it was proposed that the Executive Committee increase the membership by three to five organizations. An Expansion Workgroup was formed through volunteers from the Executive Committee. The goal of the workgroup was to provide a recommendation to the contractor regarding potential new organizations for the NPDB Executive Committee. The DPDB provided administrative and operational support to the workgroup throughout the process.

C. Research Activities 2007

1. Research and Evaluation

- a) *Responding to Research Requests* – The DPDB conducted statistical analyses of NPDB data in response to ongoing internal requests as well as those from 13 external sources such as other government agencies, the media, universities, and private sector sources.
- b) *Updating the Public Use Data File* – The DPDB updated the NPDB Public Use Data File on a quarterly basis. In 2007 the Public Use Data File was downloaded from the NPDB-HIPDB Web site 2,862 times.
- c) *Customer Satisfaction Survey* - HRSA/BHPr/DPDB contracted with the Gallup Organization to conduct a survey of NPDB and HIPDB users to: identify methods for improving the Data Bank; determine how Data Bank data and information are used; and ascertain the value of the Data Bank for licensing and privileging decisions. Analysis was targeted for 2009.
- d) *“PreP 4 Patient Safety”* – As part of the *PreP 4 Patient Safety* pilot project, HRSA contracted with the Citizen Advocacy Center to develop a pro-active framework to avert risk and promote patient safety. This framework was targeted for State medical, nursing, and other health care practitioner licensing boards to use with hospitals and other health care entities to identify, remediate, and monitor practitioners with deficiencies, which have not risen to disciplinary or legal actions.

D. Compliance Activities 2007

1. Reports

- a) *Evaluating Timeliness of Reports* – The DPDB evaluated timeliness of reporting by State. Timely reports (70 percent or greater) were submitted by State licensing boards in only four States - Alabama, Florida, Washington, and Wisconsin.
- b) *Improving Report Compliance* – The DPDB collaborated with reporting entities to improve compliance and to streamline reporting processes. Entities included the DEA, Medicaid Fraud Control Units (MFCU), the National Council of State Boards of Nursing, the Federation of Chiropractic Licensing Boards, and the National Association of Boards of Pharmacy.

- c) *Monitoring Compliance* – The DPDB and the NPDB contractor monitored and analyzed the eligibility of NPDB registrants, checked for violations of confidentiality rules, and ensured that medical malpractice and adverse actions were being reported to the NPDB.

IV. Review of 2008

A. System Improvements 2008

1. Proactive Disclosure Service (PDS)

- a) *PDS Made Permanent* - The PDS was made a permanent service of the NPDB for automatic and continuous querying of enrolled practitioners. Nearly 18 months after implementation, the PDS Prototype successfully completed a full monitoring cycle, including the opportunity for entities to renew their PDS enrollments for an additional year. Ninety-seven percent of PDS users renewed their enrollment with the service.
- b) *Matched PDS Reports in PDF Format* – PDS subscribers received matched responses in PDF. This enhancement streamlined document printing especially for auditing purposes.
- c) *Removing PDS Enrolled Practitioners* – IQRS users were given the ability to specify a future cancellation date for PDS practitioners on the Submitter Certification screen. This change was important for PDS subscribers that employed locum tenens practitioners due to the temporary nature of their work. For example, if a practitioner was scheduled to leave the organization at a specified time, an entity flagged the PDS cancellation date without any further effort. Entities also modified or removed the future cancellation date if the employment circumstances changed.

2. Reports and Queries

- a) *Upgrading the Report Change Notices* – Report Change Notices were made available electronically through the IQRS. A Report Change Notice alerted all recipients when an original report was modified (e.g., the reporter corrected the report or the subject added a statement to the report). Previously these notices were only available in paper format and delivered via U.S. mail. This enhancement enabled users to access the information online, thus, expediting notification.
- b) *Improving User Notifications* – Users were allowed to elect to receive a number of notifications from the NPDB using their User Account Information Screen. Users simply entered a valid email address and specified notification preferences. The subject line on each email notification informed the user at a glance about the contents of the email.

The following email notifications were made available using this process:

- For queries, reports, and PDS enrollment responses;
 - For the electronic Data Bank newsletter (e-newsletter);
 - For administrative events, e.g., registration renewal and expiration, registration profile updates, and entity/agent relationship activities; and
 - For notifications regarding agent status.
- c) *Upgrading the Process of Voiding a Report* - Beginning in September 2008, all entities were required to provide a reason when voiding a report. The reason then appeared in Report Verification Documents, Subject Notification Documents, PDS report disclosures, and report change notifications. *Note: Reports with related Revision-to-Action Reports could not be voided until the corresponding Revision-to-Action Reports were voided.*
- d) *Expanded Access to Billing Receipts* – Beginning in September 2008, Data Bank users were allowed to view charge receipts dating back to July 1, 2000. Previously, users could only view receipts within the last 60 days.
- e) *Querying and Reporting XML Service (QRXS) Basic Improvements* – Enhancements to the QRXS improved submission and response file formats. The enhancements enabled QRXS users to take advantage of the same functionalities that IQRS users enjoyed. QRXS offered many technical benefits over the legacy Interface Control Document Transfer Program (ITP) service. QRXS enhancements included:
- Users began receiving Data Bank Correspondence.
 - Users began resetting their own expired passwords using the Password Reset Service.
 - Email addresses of QRXS users began being stored in the Data Bank.
- f) *QRXS Querying* – Beginning in June 2008, QRXS users were able to query the Data Bank and obtain instant validation of a query submission. The confirmation contained the batch Data Bank Control Number (DCN), the subject information for each subject submitted, and the status for each subject. If a subject did not pass the validation, a list of errors was provided for the submitter to correct. Unlike the ITP,

the QRXS did not charge submitters for queries that were rejected because of data problems.

- g) *Report Changes* – Entities received electronic notifications by email regarding report changes, e.g., report corrections and notices of report disputes. The Data Bank also began alerting users to view and download Report Change Notifications from the IQRS and the QRXS. All users became required to have a valid email address on file to receive these electronic notifications. If the paper version of notifications was no longer desired then the Entity Data Bank Administrator could opt out of this service by selecting a notification preference using the IQRS.

B. Policy Activities 2008

1. Outreach Efforts

- a) *Preparation for Section 1921* – The Executive Committee contacted health care professional and legal regulatory boards and professional associations to seek out additional members to the Executive Committee.
- b) *Educating External Partners* – The DPDB gave 17 professional presentations across the country. Policy forums took place at national meetings of Associations and at stand-alone events. Participants shared and collected information about NPDB quality improvement and system enhancements.
- c) *Implementing an Electronic Newsletter* – The NPDB-HIPDB Data Bank News was made available electronically for all users with email addresses stored in the Data Bank. The paper version was mailed to users via U.S. Postal Service unless they opted out. Entities could read, download, print, and share the electronic newsletter with other interested colleagues at their convenience. Current and archived newsletters are posted on the Data Bank Web site.

C. Research Activities 2008

1. Research and Evaluation

- a) *Responding to Research Requests* – The DPDB conducted statistical analyses of NPDB data in response to ongoing internal requests as well as those from 24 external sources such as other government agencies, the media, universities, and private sector sources.
- b) *Updating the Public Use Data File* – The DPDB updated the NPDB Public Use Data File quarterly. These non-identifiable data continued to be used by researchers who authored valuable reports for Data Bank users. In 2008 the Public Use Data File was downloaded from the NPDB-HIPDB Web site 2,949 times.

- c) *Customer Satisfaction Survey* - Data collection for the national survey of the NPDB and HIPDB with users was conducted under contract for HRSA/BHPr/DPDB with the Gallup Organization. After cleaning the data, multiple data sets were generated.

D. Compliance Activities 2008

1. Reports

- a) *Compliance Efforts* – In 2008, the DPDB and the NPDB contractor continued to review the timeliness of report submissions. They concentrated on notifying hospitals of their mandatory requirements to: 1) query the NPDB at the time of hire and every 2 years for all practitioners on the hospital's medical staff; and 2) report professional review actions that adversely affect clinical privileges for more than 30 days.
- b) *Improving Report Compliance* – The DPDB and the NPDB contractor collaborated with a number of reporting entities to improve compliance and to streamline the reporting processes. These entities included the DEA, MFCUs, the National Council of State Boards of Nursing, the Federation of Chiropractic Licensing Boards, and the National Association of Boards of Pharmacy.

V. Review of 2009

A. System Improvements 2009

1. Proactive Disclosure Service (PDS)

- a) *Automatic Renewal* – In April 2009, entities were allowed to elect to automatically renew PDS enrollments. This new feature saved time for users since they did not need to renew each enrolled practitioner at the end of each year.
- b) *Search Features* – Two new “search by report” features benefitted PDS subscribers that enrolled large numbers of practitioners in PDS. The search features were made available on the Search for Subjects screen. Subscribers were allowed to search for practitioners with reports by: 1) entering a date range for the search in the Report Disclosure Date Range field; or 2) searching the Report Process Date Range field for only new disclosures since the last query date.
- c) *Updated Enrollment Documents* – PDS subscribers were provided with the ability to update and replace enrollment documents after each renewal of a practitioner’s enrollment. The system was programmed with options to request and print or save new enrollment confirmation documents. Subscribers were still required to request enrollment confirmation documents for batch renewals within 60 days of renewal. Upon request, PDS subscribers were allowed to:
 - Receive updated enrollment confirmations when they renewed or canceled their PDS enrollments;
 - Select the option to include or not include reports on the practitioners with enrollment confirmations;
 - Receive batch enrollment confirmations for renewals; and
 - Receive batch confirmations for cancellations, including scheduled future cancellations.
- d) *Increase Number of Enrollment Confirmations* - High-volume, PDS subscribing entities were provided with the opportunity to request up to 1,000 enrollment confirmations at a time on the Manage Subjects screen, an increase from the previous limit of 100. Associated with this change, entities were provided with the option to include, or not include, all of the reports associated with the enrollment confirmations.

- e) *PDS Monthly Email Summary* – Subscribers were given the opportunity to receive a personalized monthly email with a summary of their entity’s PDS activity via the Notification Preferences screen. The individualized email provided the entity with the monthly number of:
- Enrollments requiring renewal;
 - Disclosures received during the month;
 - New subjects enrolled during the month;
 - Subjects renewed during the month;
 - Subjects cancelled during the month; and
 - Total enrolled subjects

2. Reports and Queries

- a) *Consolidated Query Responses* – In January 2009, Data Bank users started receiving consolidated query responses in a single document from the NPDB and the HIPDB. The response indicated (with a checked box) if the report was maintained under statutes for Title IV (NPDB), *Section 1921* (as of March 1, 2010), or Section 1128E (HIPDB). Previously, entities that elected query privileges for both the NPDB and HIPDB received two separate responses; one response from the NPDB and one from the HIPDB. This change resulted in one report even if it was maintained in both the NPDB and the HIPDB. The Data Bank is dedicated to reducing the consumption of natural resources such as paper.
- b) *On-line Self-Queries* – The Data Bank enabled practitioners to receive self-query results on-line starting November 9, 2009. This new feature expedited the process by providing self-query results electronically. Previously, practitioners could only receive their self-query results through the U.S. mail. Practitioners began receiving an email alerting them that their results were available. This feature saved practitioners’ time and simplified the self-query process.
- c) *Expanded Entity List* – In June 2009, when Data Bank Administrators completed the biennial Data Bank registration renewal, they were prompted to select a category from a new and expanded list. The list was designed to assist users in choosing the category that best described their organization. Prior to this change only a single primary function existed for a hospital. With this added feature hospitals were allowed to renew their Data Bank registration using 9 sub-categories for types of hospitals.

- d) *Enhancing Medical School Name Field* – The Medical School Name field was improved by adding a drop-down list of medical schools from which to choose. For example, if a user typed “LSU” into the school name field, two school names displayed: “LSU-New Orleans,” and “LUS-Shreveport.” This was done to assure greater accuracy of this variable. Prior to this change many data entry errors were made making some of the information unreliable. When a school could not be found in the drop-down list the user still had the option to type in the school name (up to 200 characters).
- e) *Batch Submission Query Charges* – In August 2009, the system began charging all queries in a batch submission. This was done one batch at a time for the NPDB and for the HIPDB separately. Previously, if a query from a batch submission was held up in the processing phase, the system would charge for that query separately from the rest of the batch. If a query result continues to require additional processing time, the query is charged along with the batch. This system change improved the response time and allowed for easier financial reconciliations.
- f) *Double-sided Format* – Beginning August 31, 2009, all output documents mailed to users were printed in double-sided format, thus reducing the size of the document. This was another Data Bank effort to save natural resources.
- g) *Phase-out of ITP* – The Data Bank began phasing out the ITP and replacing it with the QRXS. The QRXS had the advantage of allowing high-volume users to query and report to the Data Bank using their own information and credentialing systems. As a result, the Data Bank no longer had to develop enhancements to the ITP and interface features for the PDS. As the next generation interface, the QRXS offered numerous benefits over the ITP interface. QRXS used an industry standard eXtensible Mark up Language (XML) format that improved the exchange of data between the user and the Data Bank. The QRXS provided real-time data validation. To assist with the transition a test environment was created for QRXS submissions.
- h) *QRXS and PDS* – Beginning June 15, 2009, entities using the QRXS were able to enroll practitioners in the PDS. As the Data Bank’s next generation interface for large-volume entities that query and report, the QRXS enabled users to:
- Submit PDS enrollments;
 - Submit PDS enrollment updates;
 - Submit PDS enrollment renewals;
 - Receive PDS report disclosures;
 - Request ad hoc enrollment confirmations; and

■ Cancel PDS enrollments.

- i) *Transition from ITP to QRXS Made Easier* – In August 2009 PDS subscribers using the ITP were able to transition to the QRXS by electing to receive their report disclosures and report change notices via the QRXS, even for subjects originally enrolled via ITP. This was accomplished using the Notification Preferences screen.
- j) *Report Void Reasons via ITP/QRXS* – In August 2009 the Data Bank began collecting the reasons for voiding a report via the ITP and QRXS. Previously this information was only collected for reports voided via the IQRS.
- k) *Vendor ID Required* – In August 2009 the Data Bank began requiring that all QRXS submissions include a valid Vendor ID. The Vendor ID enabled the Data Bank to match the vendor to its file submission which facilitated the work of the Data Bank’s Customer Service Center.
- l) *QRXS Supports Proxy Authentication* – Some QRXS users connected through proxy servers that required authentication and needed a user name and password as another layer of security. The QRXS client interface, in August 2009, began supporting these servers.

B. Policy Activities 2009

1. Regulations

- a) *Preparation for Section 1921* - The regulations implementing *Section 1921* of the *Social Security Act* were in the final stage of the Federal review process. *Section 1921* regulations amend 45 CFR Part 60, which govern the NPDB. The DPDB began plans for working with entities and agencies affected by *Section 1921* requirements. (To view the final regulations click on [FRN](#)).
- b) *Responding to Changes Due to Section 1921* – The DPDB expanded the on-line NPDB Interactive Training program to include *Section 1921* information, pertinent to NPDB and HIPDB. (To view the program click on [NPDB Interactive Training Program](#).)
- c) *Reviewing and Reporting Codes* – The DPDB identified necessary changes to existing codes and the need for new codes to improve reporting accuracy and information value.

2. Outreach Efforts

- a) *Preparation for Section 1921* – The DPDB added three new organizational members to the NPDB Executive Committee (See Appendix A).
- b) *Educating External Partners* – The DPDB gave 20 professional presentations across the country. Policy forums took place at national meetings of Associations and at stand-alone events including Boston, MA and Dallas, TX. Participants shared and collected information about NPDB quality improvement and system enhancements.
- c) *Opportunities for Sharing and Feedback* – The DPDB hosted two third-party software vendor forums via teleconference. Participants included developers and end users. Ideas were shared on how to best transition from ITP to QRXS. The forums also provided an opportunity to discuss Interface Control Document changes that are related to *Section 1921* implementation, the PDS, and the QRXS.

C. Research Activities 2009

1. Research and Evaluation

- a) *Responding to Research Requests* – The DPDB conducted statistical analyses of NPDB data in response to ongoing internal requests as well as those from 32 external sources such as other government agencies, the media, universities, and private sector sources.
- b) *Updating the Public Use Data File* – The DPDB updated the NPDB Public Use Data File quarterly. In 2009 the Public Use Data File was downloaded from the NPDB-HIPDB Web site 2,697 times.
- c) *Customer Satisfaction Survey* – Analysis of the national survey of NPDB and HIPDB users, conducted in 2008 by the HRSA/BHPr/DPDB contractor, the Gallup Organization, continued throughout 2009.

D. Compliance Activities 2009

1. Reports

- a) *Compliance Efforts* – In 2009, the DPDB and the NPDB contractor reviewed hospital compliance with reporting and querying. Hospitals were contacted by mail and telephone to inform them of their status with the NPDB and to remind them of their reporting and querying requirements.
- b) *Improving Report Compliance* – Planning began for evaluation of all aspects of compliance with the Data Bank's mandates.

VI. Programmatic Data: 2007, 2008 and 2009

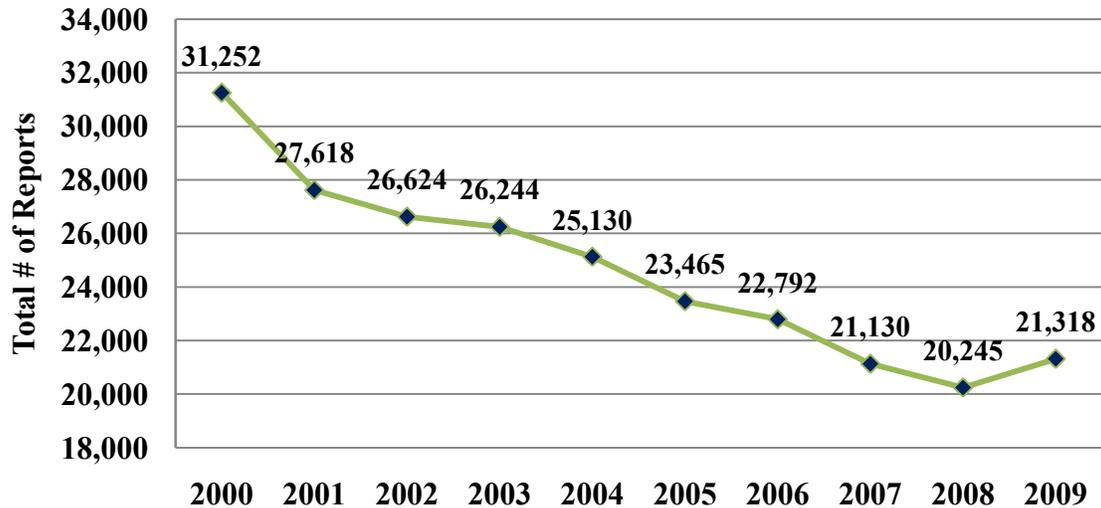
In this combined report, data were trended for the past 10 years to provide context for the reporting years 2007, 2008, and 2009. The most salient variables are listed and depicted in graphs below:

- NPDB Reports
- Adverse Action (AAR) and Medical Malpractice Payment (MMPR) Reports
- Adverse Action Reports by Type
- Medical Malpractice Payment Reports by Type of Practitioner
- Types of Queries
- Secretarial Reviews for Adverse Action Reports and Medical Malpractice Payment Reports
- Outcomes of Secretarial Reviews

A. NPDB Reports

The number of reports submitted to the NPDB steadily decreased between 2000 and 2008 while in 2009 there was a 5 percent increase in the number of reports.

Graph 1.
Number of Medical Malpractice and Adverse Actions Reports by Year (2000-2009)



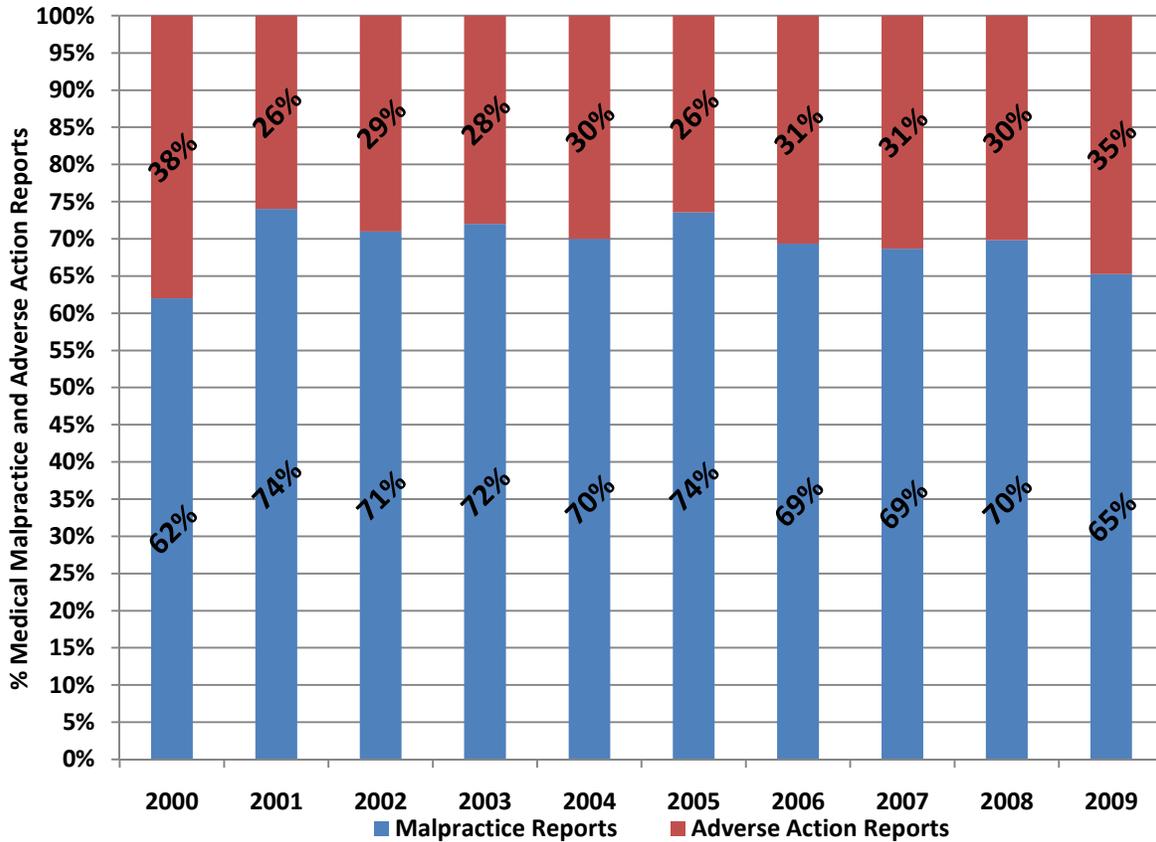
The reasons for the 35 percent decline from 2000 and 2008 were unclear. Possible causes included, but were not limited to, a decrease in medical malpractice payments, adverse actions, and/or hospital and board reporting.

There was a 4 percent decrease between 2007 and 2008 but a 5 percent increase between 2008 and 2009. In all, there was less than a 1 percent increase in the number of NPDB reports between 2007 and 2009, indicating minimum change over the three year period.

B. Medical Malpractice Payment Reports and Adverse Action Reports

In Graph 2 (Appendix D., Tables 1. and 2.) NPDB reports were stratified by type, medical malpractice payments or adverse actions. The yearly proportions of adverse action and medical malpractice payment reports changed moderately across the 10 years.

Graph 2.
Percent of Medical Malpractice and Adverse Action Reports by Year
(2000-2009)



From 2000 to 2009 medical malpractice payments accounted for between 62 to 74 percent of the NPDB reports while adverse actions accounted for 26 to 38 percent of the total number of NPDB reports over the same time period.

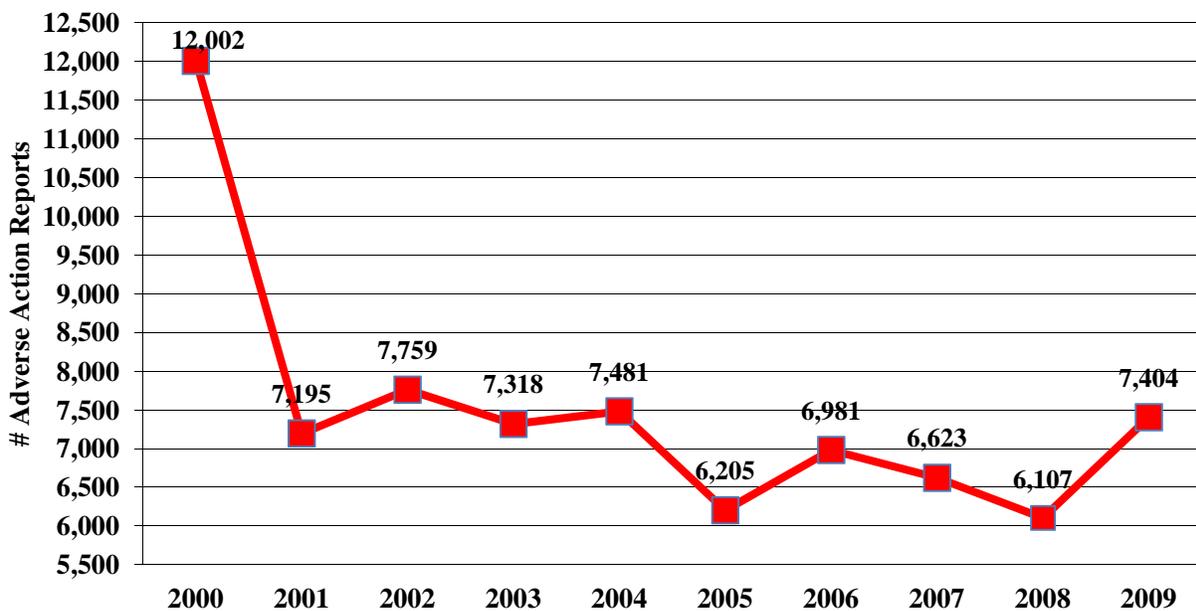
For 2007, 2008 and 2009, Adverse Action Reports (AARs) accounted for 31 percent, 30 percent and 35 percent respectively. Medical Malpractice Payment Reports fluctuated during 2007, 2008 and 2009 from 69 percent, to 70 percent and then down to 65 percent respectively.

C. Adverse Action Reports by Type

To further understand the AARs submitted to the NPDB, the AARs were divided by type of report. The five types reviewed included reports submitted related to: (1) State licensure; (2) clinical privileges; (3) professional society membership; (4) DEA certification to prescribe controlled substances; and/or (5) Medicare and Medicaid exclusions.

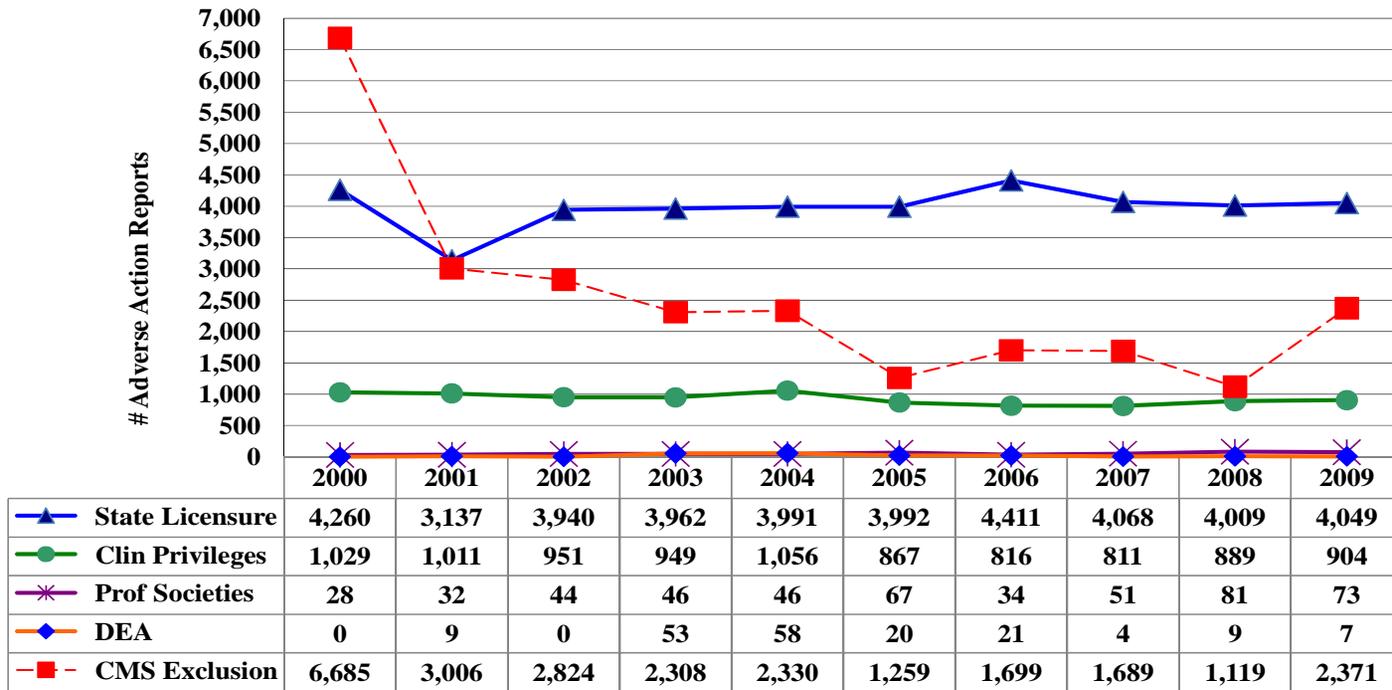
Graph 3 depicts the fluctuations in the number of overall AARs over the 10 year period being studied.

Graph 3.
Number of Adverse Action Reports by Year (2000 – 2009)



Graph 4 describes the AARs by the five types from 2000 - 2009.

Graph 4.
Number of Adverse Action Reports by Type and Year (2000-2009)



From 2000 to 2009, there was a significant outlier in number of AARs by type for Centers for Medicare & Medicaid Services (CMS) exclusions. This was most noticeable in the year 2000. The outlier also impacted the total number of AARs for the same year. The substantial increase in the number of AARs for CMS exclusions was reviewed by the DPDB to identify any possible observable correlates. There was only one known observation that could have impacted the sharp increase in AARs. In 2000, CMS made a concerted effort to respond to DPDB's request to address a backlog of AARs. Without the benefit of other data, a causal relationship could not be determined.

When the 2000 outlier was removed, the primary basis for an AAR was consistently related to State licensure, ranging from 3,137 reports in 2001 to a high of 4,411 in 2006. From 2007 to 2009, the number of AARs remained stable at slightly over 4,000 for each of the 3 years.

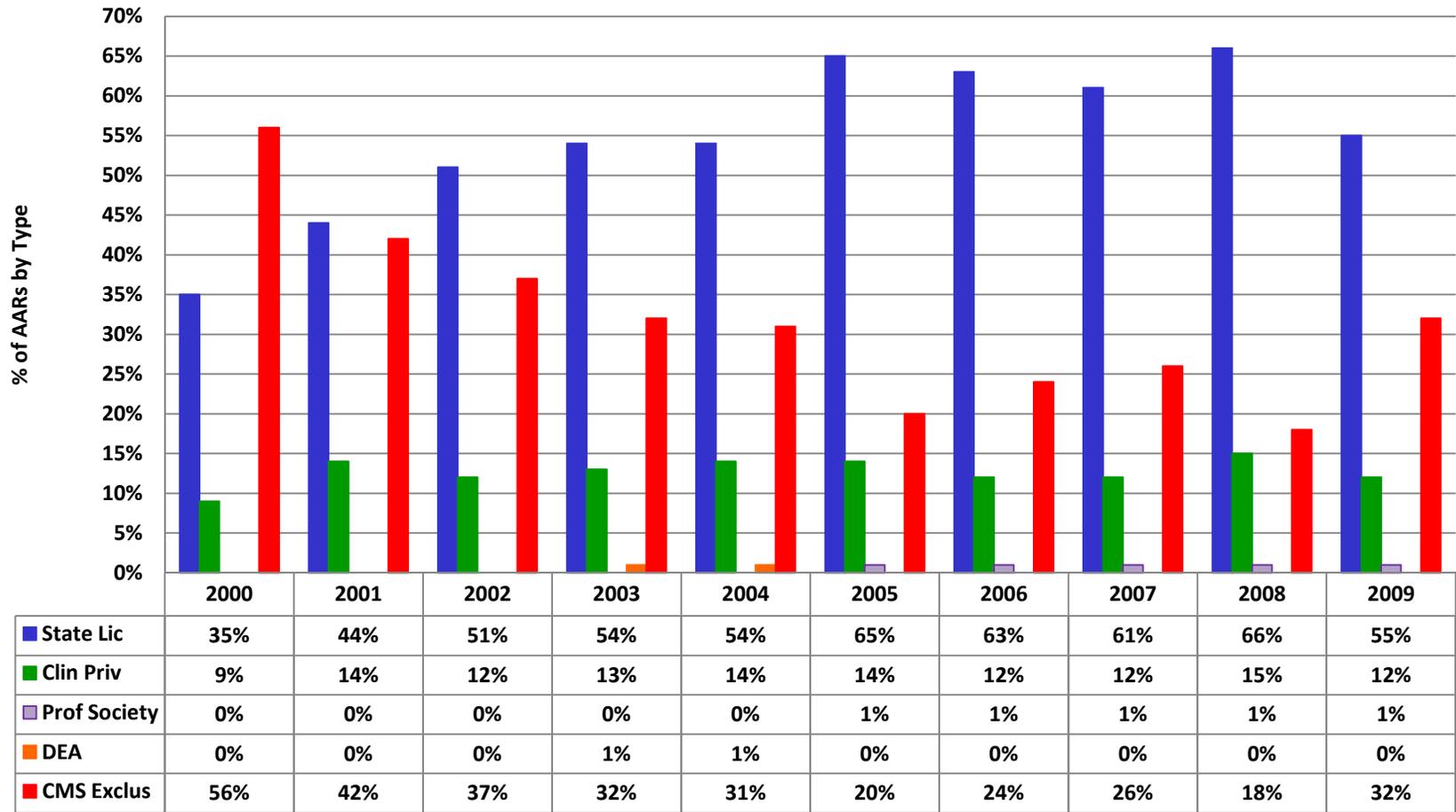
The second most common reason for submitting an AAR was due to CMS exclusions. In 2000 when CMS was known to submit the backlog of AARs, 6,685 reports were added to the NPDB, substantially greater than any other single year. From 2001 to 2009, the number of AARs due to CMS exclusions fluctuated between 1,119 (2008) and 3,006 (2001).

For the years 2007, 2008 and 2009 there was considerable variability in the number of AARs due to CMS exclusions, 1,689 (<1% decrease), 1,119 (34% decrease), and 2,371 (112% increase) respectively. The causes of these variations were unclear. In 2008, DPDB provided technical assistance to Medicaid Fraud Control Units and other agencies to improve reporting compliance. However, it was not possible to determine if this technical assistance had a causal effect on the more than doubling of reports in 2009.

When analyzed, the fewest number of AARs was consistently related to professional society memberships, less than 82 per year, or DEA certification, 58 or less per year.

In Graph 5 below AARs are depicted proportionately by type from 2000 to 2009.

**Graph 5.
Percentages of Adverse Action Reports by Type and Year (2000-2009)**



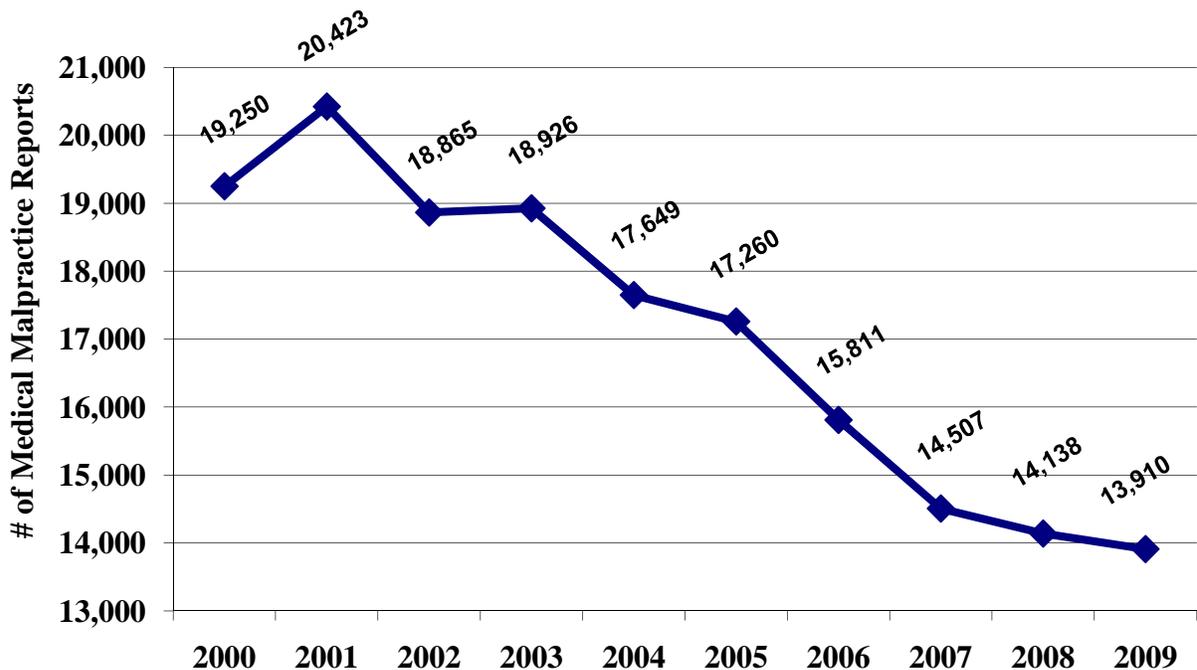
As discussed for Graph 4, State licensing issues and CMS exclusions (Graph 5) served as the bases for the majority of AARs from 2000-2009. Impact on professional society membership and loss of DEA numbers were negligible comparatively. As noted above the variations from year to year could not be explained from these data. However, the abrupt fluctuations warrant continued longitudinal tracking with other variables and more in depth analysis.

D. Medical Malpractice Payment Reports by Practitioner

The *Health Care Quality Improvement Act of 1986* (HCQIA) mandates that all medical malpractice payments be reported to the NPDB. All such payments, whether judgments or settlements and regardless of the dollar amount, made on behalf of health care practitioners must be submitted to the NPDB via the submission of a Medical Malpractice Payment Report (MMPR). (In cases where a MMPR is filed on a practitioner and one or more additional practitioners are named in the claim, reports on all practitioners involved must also be submitted to the NPDB.)

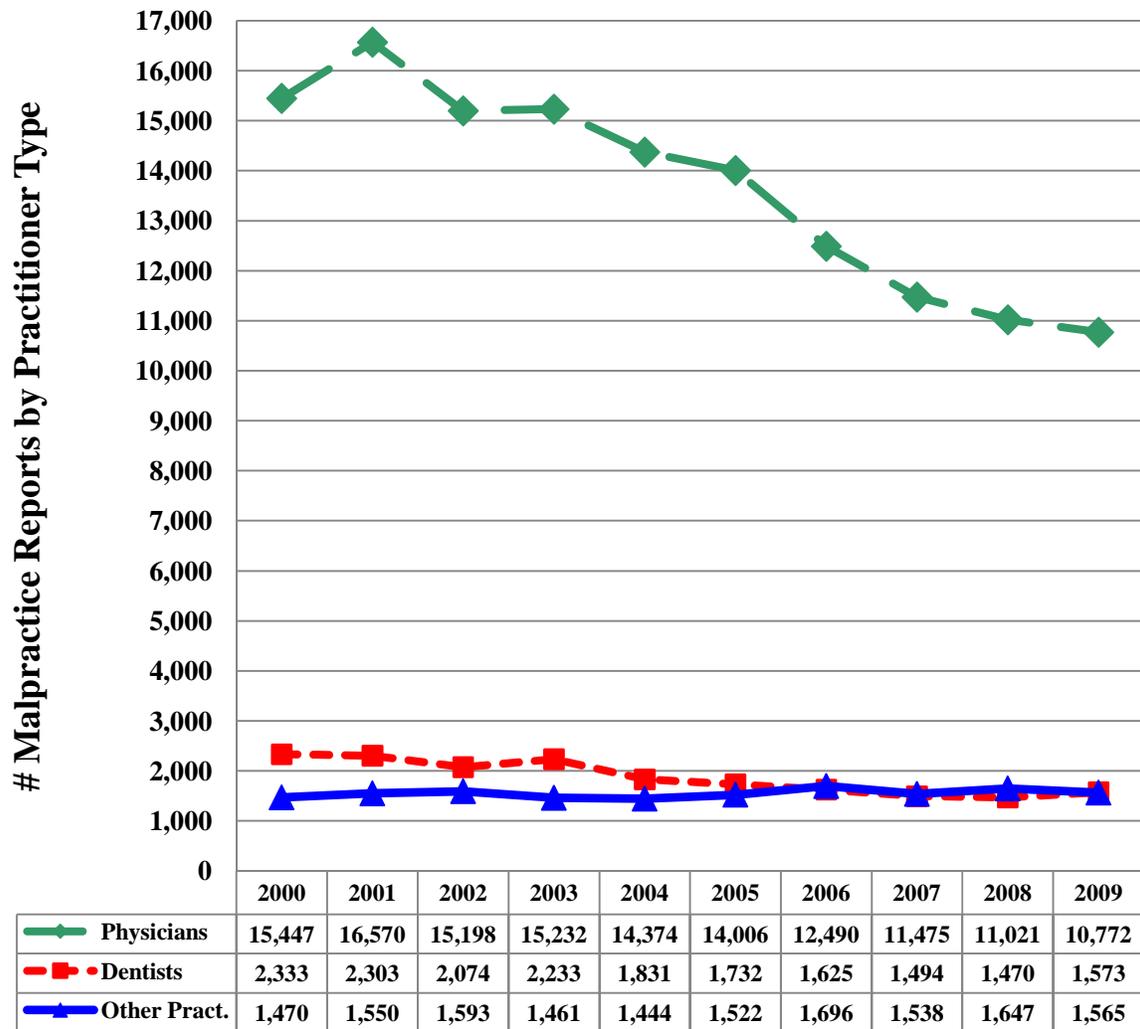
Graph 6 reveals a relatively steady decline in the number of MMPRs from 2001 to 2009, accounting for a 32 percent decrease over the 9 years. The dollar amount of payouts is not represented in Graph 6.

Graph 6.
Number of Medical Malpractice Reports by Year (2000 – 2009)

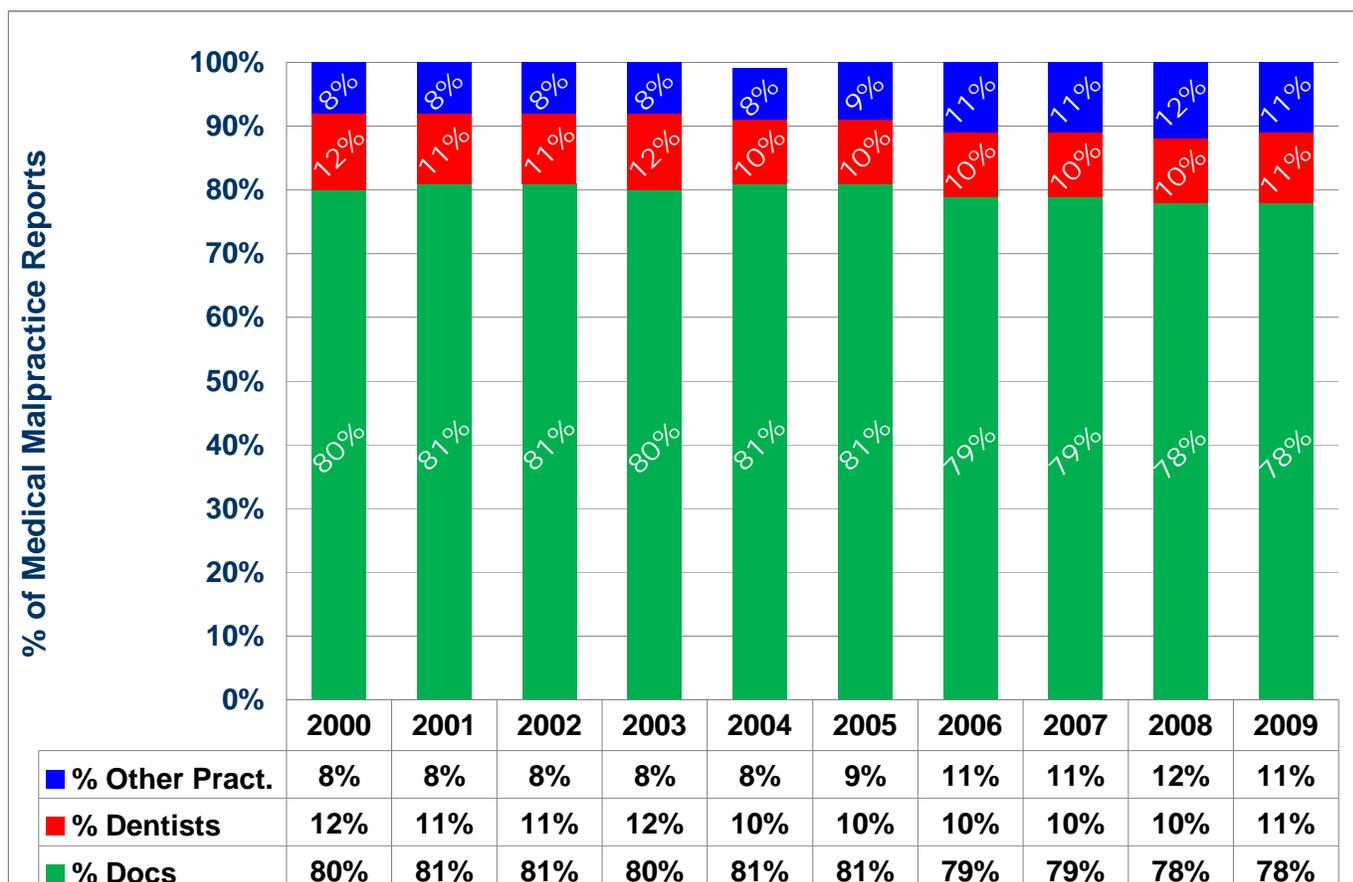


The ratio of physicians to dentists in the United States is substantial, with the number of physicians being much greater. In 2009, the ratio of physicians to dentists was approximately 5.5:1. Thus, it was not surprising for the NPDB to receive more MMPRs on physicians compared to dentists as is clearly depicted in Graphs 7 (number of MMPRs) and Graph 8 (percent).

Graph 7.
Number of Medical Malpractice Reports by Practitioner Type and Year (2000-2009)



Graph 8.
Percentages of Medical Malpractice Reports by Practitioner Type and Year (2000 – 2009)

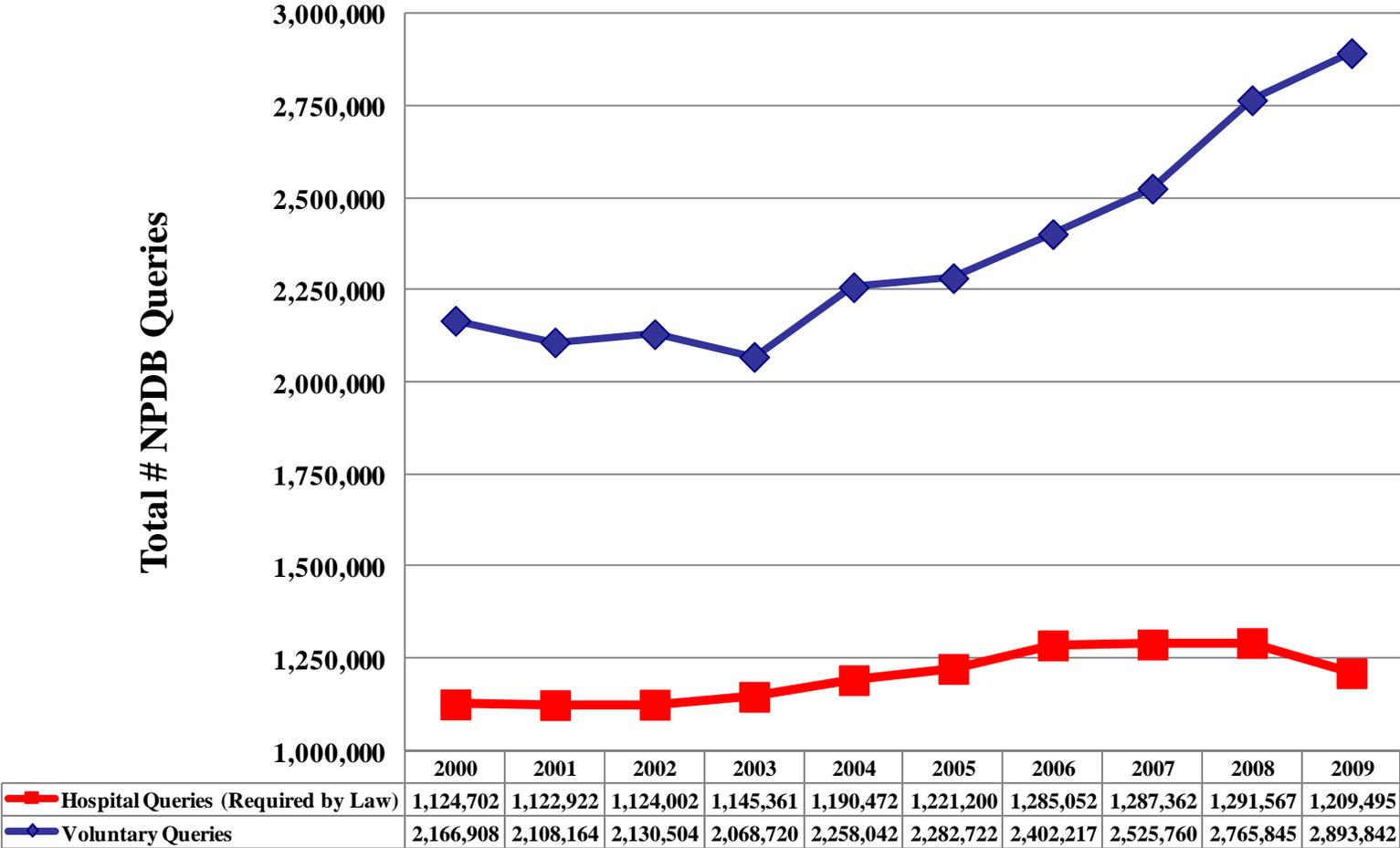


The number (Graph 7) of MMPRs for physicians ranged from a high of 16,570 in 2001 to a low of 10,772 in 2009, a 35 percent decrease in 9 years. From 2007 to 2009 the number of MMPRs began to flatten with only a 6 percent decrease (11,475 to 10,772). As expected, percentages (Graph 8) of MMPRs filed by practitioner type remained relatively stable over the years especially from 2007 to 2009.

E. Types of Queries

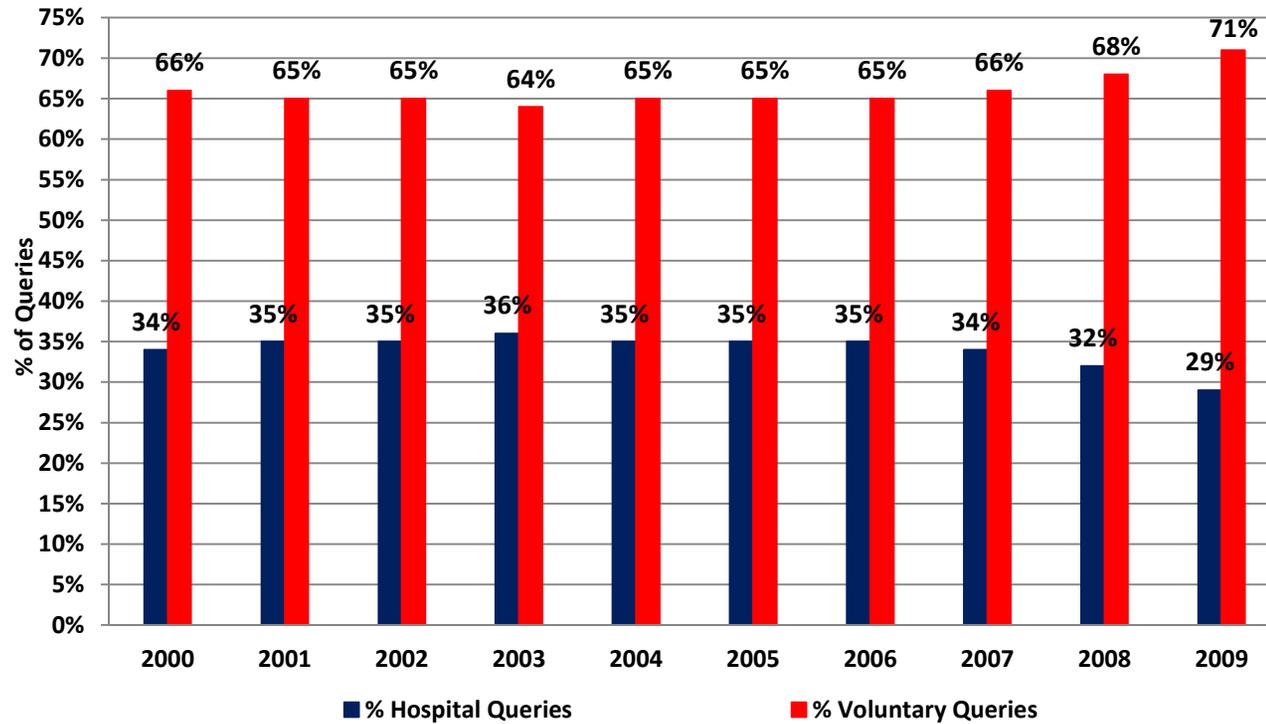
For analysis, queries were divided into mandatory queriers (hospitals) and voluntary queriers. Voluntary queries were conducted by State licensing boards, managed care organizations, professional societies and other health care entities. The number of voluntary queries exceeded those done by hospitals annually. From 2007 to 2009 the number of voluntary queries increased by almost 15 percent while the number of hospital queries declined by 6 percent. (Graph 9)

Graph 9.
Number of Queries Made by Hospitals and Voluntary Entities by Year (2000-2009)



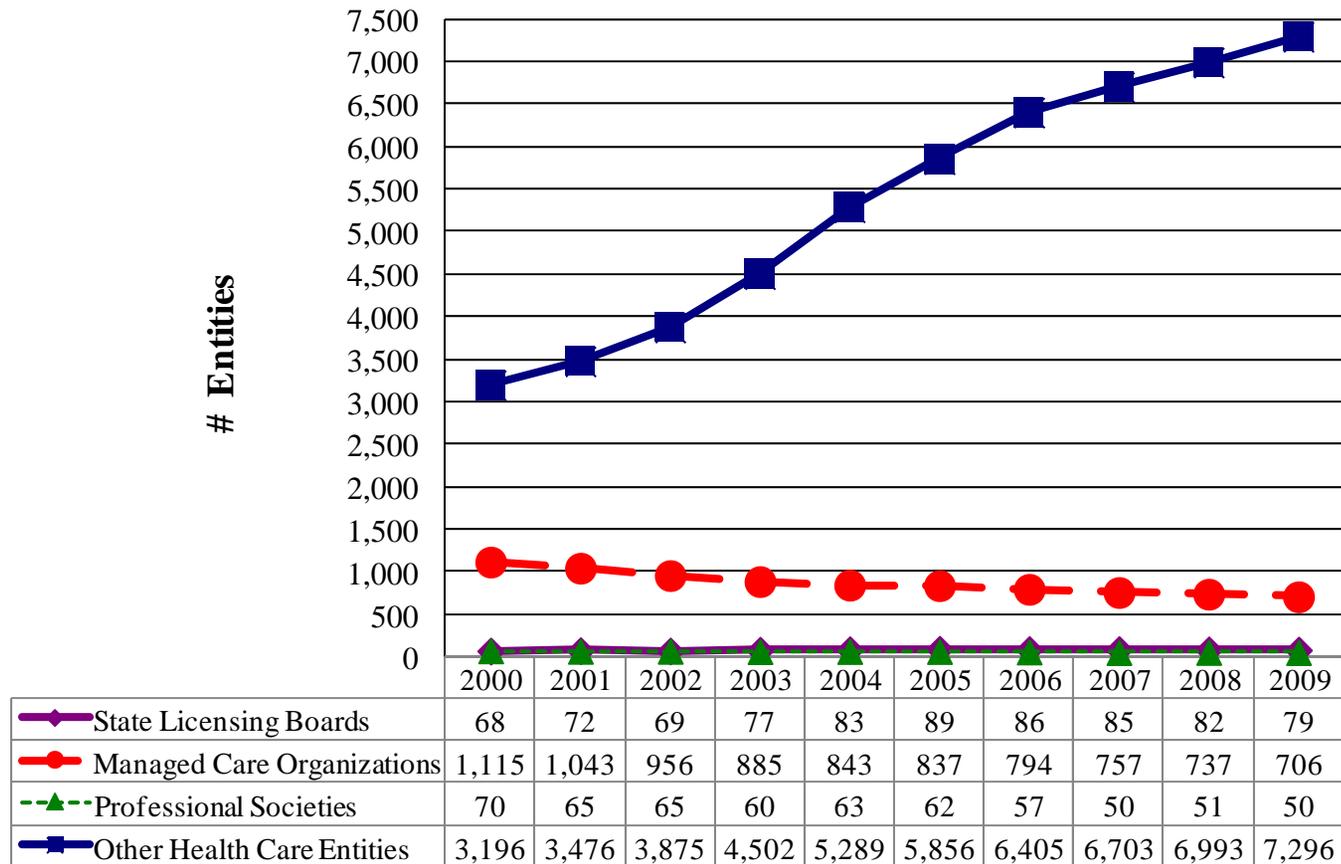
In Graph 10, it is evident that the percentage of voluntary queries surpassed that of hospitals for all 10 years.

Graph 10.
Percentages of Hospital and Voluntary Queries by Year (2000 – 2009)



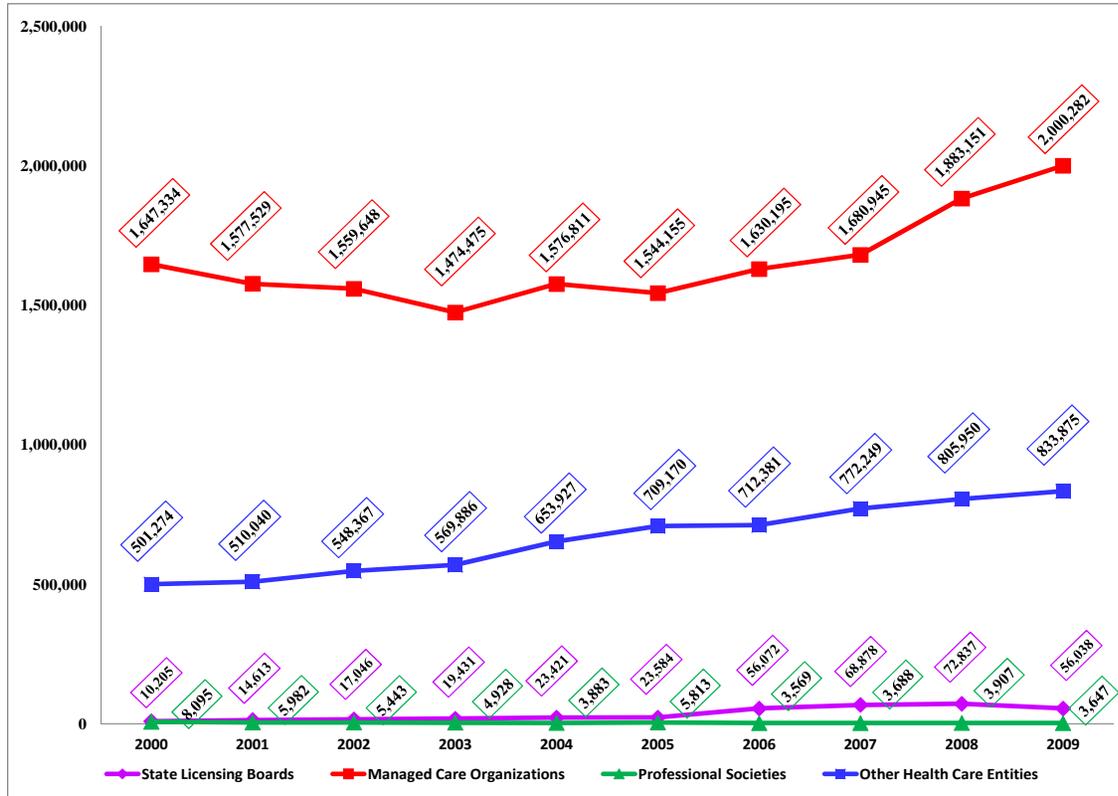
As shown in Graph 11, there is a large discrepancy between the number of Other Health Care Entities that conducted voluntary querying compared to those of State Licensing Boards, Professional Societies, and Managed Care Organizations for each of the 10 years. Between 2000 and 2009, moreover, the number of Other Health Care Entities that conducted voluntary queries grew steadily, whereas the queries by the other 3 entities remained relatively stable.

Graph 11.
Number of Entities Voluntarily Querying the NPDB by Year (2000 – 2009)



In Graph 12 there is a significant discrepancy between the numbers of voluntary queries made by Managed Care Organizations and those made by State Licensing Boards, Professional Societies, and Other Health Care Entities. The annual number of voluntary queries for MCOs grew by a quarter-million, and Other Health Care Entities experienced similar growth.

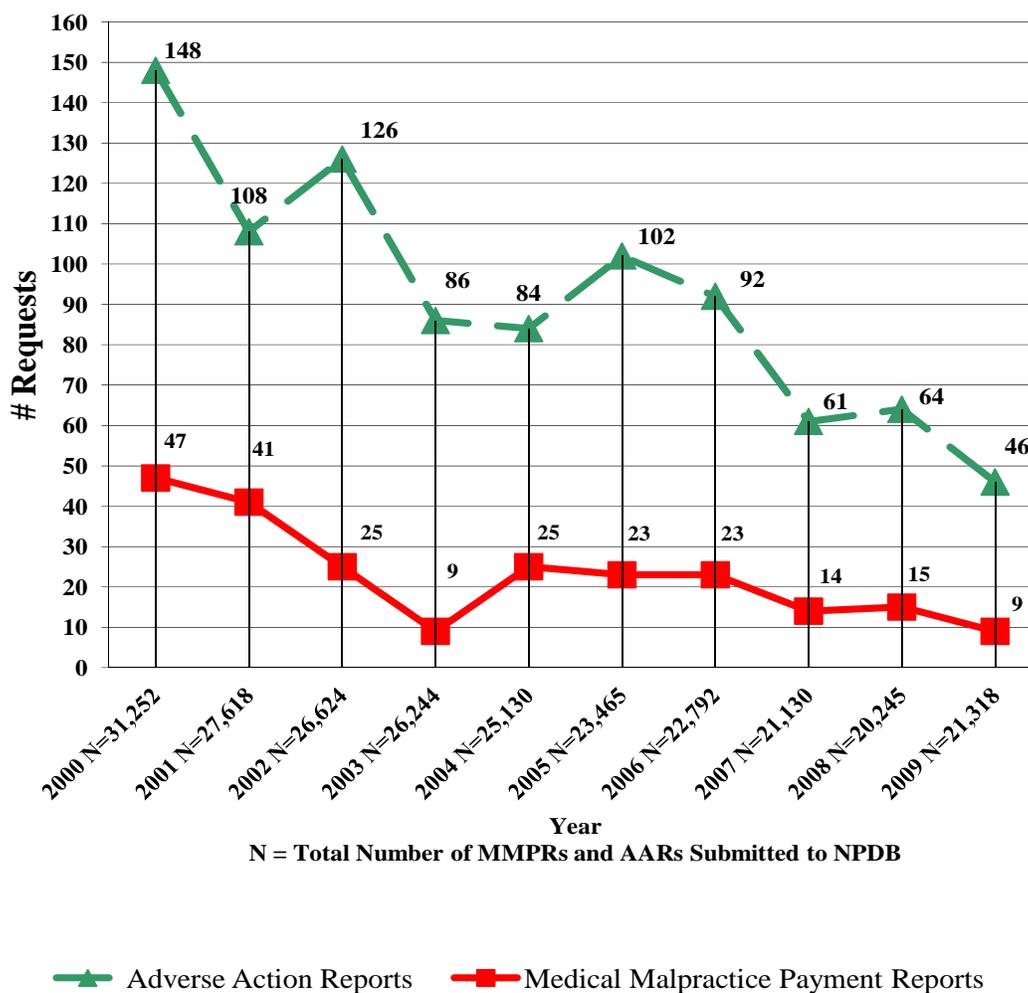
Graph 12.
Voluntary Queries by Type (2000 – 2009)



F. Secretarial Reviews for Adverse Action Reports and Medical Malpractice Payment Reports

The Secretarial Review process allows practitioners the opportunity to elevate a disputed report that was unable to be resolved between the reporter and the subject of the report. The Secretary's designee of HHS reviews the case and determines whether the report is accurate, complete, timely, or relevant. This means that reviews are limited to whether the report was submitted in accordance with the Data Bank reporting requirements. The Secretary does not review the underlying decision to make a malpractice payment or take an adverse action. The report must first be placed in dispute for at least 30 days before one may request a review of the report by the Secretary's designee.

Graph 13.
Number of Requests for Secretarial Reviews by Report Type and Year (2000- 2009)



Of the total number of reports submitted to the NPDB and HIPDB, 1 percent or fewer receive requests for Secretarial Reviews. From 2007 through 2009 well below 1 percent of all reports received a request for a secretarial review. For further information see Table 13 in the Appendix.

VII. Appendix

Appendix A. EXECUTIVE COMMITTEE: ORGANIZATIONAL REPRESENTATIVES

1. AARP
2. American Association of Dental Boards
3. American Association of Health Plans
4. American College of Obstetricians and Gynecologists
5. American College of Surgeons
6. American Dental Association
7. American Health Lawyers Association
8. American Hospital Association
9. American Insurance Association
10. American Medical Association
11. American Nurses Association
12. American Osteopathic Association
13. American Podiatric Medical Association
14. Centers for Medicare & Medicaid Services
15. Council of Medical Specialty Societies
16. Federation of Chiropractic Licensing Boards
17. Federation of State Medical Boards
18. Health Resources and Services Administration
19. Horthy, Springer & Mattern, P.C.
20. National Association Medical Staff Services (NAMSS)
21. National Committee for Quality Assurance
22. National Council of State Boards of Nursing
23. Physician Insurers Association of America
24. Public Citizen Health Research Group
25. Risk Management Foundation of the Harvard Medical Institutions
26. SRA International, Inc.
27. The Council on Licensure, Enforcement and Regulation
28. The Joint Commission
29. The Medical Protective Company
30. U.S. Department of Defense
31. U.S. Department of Health and Human Services, Office of Inspector General
32. U.S. Department of Veterans Affairs

Appendix B. NPDB MILESTONES

YEAR	NPDB MILESTONES
1986	<p>Health Care Quality Improvement Act Enacted</p> <ul style="list-style-type: none"> ✚ Congress passed the <i>Health Care Quality Improvement Act of 1986 (HCQIA)</i>. The intent of <i>HCQIA</i> was to prevent incompetent practitioners from moving State to State without disclosure or discovery of previous damaging or incompetent performance and to protect peer review bodies from private monetary damage liability. ✚ President Ronald Reagan signed Title IV of Public Law 99-660, <i>HCQIA</i>, which led to the National Practitioner Data Bank's (NPDB) establishment.
1988	<p>NPDB Formed</p> <ul style="list-style-type: none"> ✚ HHS, HRSA, BHPPr began developing the NPDB. HRSA contracted with first contractor to develop and operate the NPDB.
1989	<p>Publication of Final Regulations</p> <ul style="list-style-type: none"> ✚ Final NPDB regulations (45 CFR part 60) were published in the Federal Register. ✚ NPDB Executive Committee convened its first meeting.
1990	<p>Implementation of NPDB</p> <ul style="list-style-type: none"> ✚ Operating out of Camarillo, CA the NPDB was implemented September 1 and began collecting reports on medical malpractice payments and adverse licensure, clinical privileges and professional society membership actions taken against physicians, dentists and other licensed health care practitioners. Hospitals, health care entities and State licensing boards began querying the NPDB. ✚ The NPDB was designed to be self-supporting through query fees. All transactions became paper-based. ✚ Average query response time was six weeks. ✚ The first NPDB Guidebook was published, providing policy guidance to users.
1991	<p>NPDB Processed Queries</p> <ul style="list-style-type: none"> ✚ NPDB processed 809,900 queries, an average of 16,000 names per week.
1992	<p>Electronic Querying Introduced</p> <ul style="list-style-type: none"> ✚ Electronic querying was introduced using new QPRAC software, version 1.0. Queries were submitted via modem or diskette; responses were returned on paper. ✚ Average query response time was reduced to one week.
1993	<p>NPDB Endorsed by the National Committee for Quality Assurance</p> <ul style="list-style-type: none"> ✚ Endorsing the value of NPDB, the NCQA adopted an accreditation standard encouraging managed care organizations to query the NPDB. ✚ BHPPr's Division of Quality Assurance (manager of the NPDB) received the 1993 Federal Leadership Award for its efforts to reduce paper processing. ✚ NPDB accepted query payments by credit card.

YEAR	NPDB MILESTONES
1994	<p>Practitioner Statement Added to Reports</p> <ul style="list-style-type: none"> ✚ A practitioner with a report in the NPDB could add his or her own statement to the report, which became available to queriers. ✚ NPDB implemented automated fee collection through Electronic Funds Transfer. Individuals and entities that query could preauthorize the NPDB to debit their bank accounts directly for query fees. ✚ QPRAC version 2.0 was introduced, allowing the NPDB to respond electronically to queries. ✚ HRSA contracted with the second contractor to develop and operate the 2nd Generation NPDB. ✚ More than 1.5 million queries were processed, an average of 30,000 per week. More than half of all queries became electronic. ✚ Average query response time was two to three days.
1995	<p>NPDB Collected Its 100,000th Report</p> <ul style="list-style-type: none"> ✚ Since its implementation in 1990 the NPDB collected its 100,000th report. ✚ All paper queries, except practitioner self-queries, were eliminated. ✚ Voluntary queries, submitted by entities not mandated by law, outnumbered mandated queries for the first time. ✚ Responses to queries became more comprehensive. If the subject of a report requested a Secretarial Review then the response for each query included this information as well as the status of the Secretarial Review.
1996	<p>Health Insurance Portability and Accountability Act Enacted</p> <ul style="list-style-type: none"> ✚ The Secretary of HHS, acting through the OIG, was directed by the <i>Health Insurance Portability and Accountability Act</i> of 1996 to create the Healthcare Integrity and Protection Data Bank (HIPDB) to combat fraud and abuse in health insurance and health care delivery. ✚ Final regulations governing the HIPDB were codified as 45 CFR Part 61. ✚ NPDB users could submit reports and update registration information electronically using QPRAC version 3.0. ✚ The Blizzard of '96 blankets the Washington, D.C. area with 20 inches of snow. Although the Division of Quality Assurance employees were not able to get to work, the NPDB received and processed more than 20,000 queries. ✚ More than 2.7 million queries were processed, an average of 52,000 per week. ✚ Average query response time was six hours or less.
1997	<p>HRSA Coordinated NPDB with HIPDB</p> <ul style="list-style-type: none"> ✚ Because of the NPDB's success, HHS OIG asked BHP's Division of Quality Assurance to design, develop and operate the new HIPDB. By law, the operations of the NPDB and HIPDB were required to be coordinated together. ✚ NPDB queries generated information about Medicare and Medicaid exclusions.

YEAR	NPDB MILESTONES
1998	<p>Health Care Entities Queried More than 15 Million Times</p> <ul style="list-style-type: none"> ✚ State licensing boards, hospitals, and other health care entities queried the NPDB more than 15 million times since 1990. ✚ The NPDB collected its 200,000th report.
1999	<p>NPDB and HIPDB Became Web Based</p> <ul style="list-style-type: none"> ✚ For the first time, the NPDB and the HIPDB began accepting reports and single name queries using a secure Internet site. This was made possible with the IQRS. ✚ More than 3.2 million NPDB queries were processed during the year, an average of six queries a minute, 24 hours a day, 365 days a year, or a query approximately every 10 seconds.
2000	<p>NPDB Turned 10 Years Old</p> <ul style="list-style-type: none"> ✚ NPDB celebrated 10 years of successful operations. ✚ NPDB entered the new millennium Y2K-trouble free. ✚ HIPDB opened for querying. ✚ Average query response time was 4 hours. ✚ The Data Bank introduced the Interface Control Document Transfer Program, an alternative to the IQRS for large-volume users. This change allowed interoperability between the computer systems of those that query and report and the Data Bank.
2001	<p>Web Based Self-Query Service Began</p> <ul style="list-style-type: none"> ✚ Improvements were made to the self-query service so that practitioners were able to submit self-query data electronically through the NPDB-HIPDB's secure Web site. After transmitting a self-query, the process was completed by printing and mailing the notarized self-query application to the Data Bank. Self-queries were processed within 48 hours and self-query status could be tracked on-line. ✚ BHPPr's Division of Quality Assurance was renamed the Division of Practitioner Data Banks.
2002	<p>NPDB Received Recognition</p> <ul style="list-style-type: none"> ✚ The DPDB received an Electronic Government Trailblazer Award for the NPDB-HIPDB. This award highlighted Federal, State, local and international government programs that had successfully implemented the most innovative information systems in e-Government. ✚ The Data Bank introduced the on-line Report Response Service for efficient processing of self-queries, while maintaining strict security standards. The Report Response Service allowed report subjects to electronically maintain current address information with the Data Bank; add, modify, or remove Subject Statements; initiate or withdraw disputes; and elevate or withdraw requests for Secretarial Reviews on-line. Previously, subjects performed these functions via paper correspondence.
2003	<p>IQRS Introduced Web Based Entity and Agent Registration</p> <ul style="list-style-type: none"> ✚ The Data Bank introduced on-line entity and authorized agent registration, replacing the paper registration forms and paper-based registration process. On-screen instructions and help file information provided immediate assistance, enabling simplified on-line registration. ✚ The number of registered users of the Data Bank reached 16,000.

YEAR	NPDB MILESTONES
2004	<p>Data Bank Won Excellence.Gov Award</p> <ul style="list-style-type: none"> ✚ The NPDB-HIPDB program was awarded the 2004 Excellence.Gov Award. In addition, the Data Bank was also recognized as one of the "Top 5" Federal E-Government Programs of 2004. The awards were bestowed on Federal organizations with outstanding information technology (IT) achievements in the public service arena. The Excellence.Gov Award focused on governance models used in e-Government projects that cross organizations. ✚ The Data Bank made IQRS report and query histories available to users, enabling them to obtain a summary of subjects queried or reported on over the previous four years.
2005	<p>Querying and Reporting XML Service Introduced</p> <ul style="list-style-type: none"> ✚ The Data Bank introduced the QRXS, an alternative to the IQRS and the ITP for users who wanted their computer systems to interface directly with the Data Bank. ✚ Average query response time was less than two hours. ✚ The NPDB processed over 36 million queries since 1991 and maintained over 375,000 reports.
2006	<p>IQRS Query Workflow Streamlined</p> <ul style="list-style-type: none"> ✚ The IQRS query workflow was streamlined, making submitting queries easier and more intuitive. ✚ Average query response time was less than one hour. ✚ An improved registration renewal process was completed. Over 16,500 entities and agents updated their registrations with the Data Bank using the new procedure.
2007	<p>Proactive Disclosure Service Prototype Launched</p> <ul style="list-style-type: none"> ✚ The PDS was implemented on April 30, 2007. ✚ PDS subscribers received notification of new reports within one business day.
2008	<p>PDS Became a Permanent Service</p> <ul style="list-style-type: none"> ✚ The PDS became a permanent service for automatic and continuous querying of enrolled practitioners in the NPDB and the HIPDB. ✚ Nearly 18 months after implementation, the PDS successfully completed a full monitoring cycle, including the opportunity for entities to renew their PDS registration. The renewal rate after year one was 97 percent.
2009	<p>Interface Control Document Transfer Program Phased Out for Querying and Reporting XML Service</p> <ul style="list-style-type: none"> ✚ The QRXS, the next generation interface for high-volume users, started replacing and phasing out the ICD ITP. ✚ The QRXS used an industry standard XML format that improved the exchange of data between the user and the Data Bank. The QRXS provided real-time data validation.

Appendix C. GLOSSARY OF ACRONYMS

<u>ACRONYM</u>	<u>COMPLETE NAME OF ABBREVIATION</u>
• AAR	Adverse Action Report
• AHA	American Hospital Association
• BHP _r	Bureau of Health Professions
• CMS	Centers for Medicare & Medicaid Services
• DBID	Data Bank Identification Number
• DCN	Data Bank Control Number
• DEA	Drug Enforcement Administration
• D.O.	Doctor of Osteopathy
• DoD	U.S. Department of Defense
• DOJ	U.S. Department of Justice
• DPDB	Division of Practitioner Data Bank
• EFT	Electronic Funds Transfer
• HCQIA	<i>Health Care Quality Improvement Act of 1986</i>
• HHS	U.S. Department of Health and Human Services
• HIPAA	<i>Health Insurance Portability and Accountability Act</i>
• HIPDB	Healthcare Integrity and Protection Data Bank
• HMO	Health Maintenance Organization
• HRSA	Health Resources and Services Administration
• IAA	Interagency Agreement
• ICD	Interface Control Document
• IQRS	Integrated Querying and Reporting Service
• ITP	Interface Control Document (ICD) Transfer Program
• JOCR	Judgment or Conviction Report
• MCO	Managed Care Organization
• M.D.	Doctor of Medicine (Allopathic Physician)
• MFCU	Medicaid Fraud Control Units
• MMPR	Medical Malpractice Payment Report
• MOA	Memorandum of Agreement
• MOU	Memorandum of Understanding
• NAIC	National Association of Insurance Commissioners
• NAMSS	National Association Medical Staff Services
• NCQA	National Committee for Quality Assurance
• NPDB	National Practitioner Data Bank

<u>ACRONYM</u>	<u>COMPLETE NAME OF ABBREVIATION</u>
• OIG	Office of the Inspector General
• PDS	Proactive Disclosure Service
• PRO	Professional Review Organization
• QIO	Quality Improvement Organization
• QRXS	Querying and Reporting Extensible Markup Language Service
• SND	Subject Notification Document
• VA	U.S. Department of Veterans Affairs
• XML	Extensible Markup Language

Appendix D. DATA TABLES

Table 1: Number and Percent Distribution of Reports by Report Type, From 2000 to 2009

Report Type	2000		2001		2002		2003		2004	
	Number	Percent								
Malpractice Payment Reports	19,250	61.6%	20,423	73.9%	18,865	70.9%	18,926	72.1%	17,649	70.2%
Adverse Action Reports¹	12,002	38.4%	7,195	26.1%	7,759	29.1%	7,318	27.9%	7,481	29.8%
State Licensure	4,260	13.6%	3,137	11.4%	3,940	14.8%	3,962	15.1%	3,991	15.9%
Clinical Privilege	1,029	3.3%	1,011	3.7%	951	3.6%	949	3.6%	1,056	4.2%
Professional Society Membership	28	0.1%	32	0.1%	44	0.2%	46	0.2%	46	0.2%
DEA	0	0.0%	9	0.0%	0	0.0%	53	0.2%	58	0.2%
Medicare/Medicaid Exclusion	6,685	21.4%	3,006	10.9%	2,824	10.6%	2,308	8.8%	2,330	9.3%
All Reports	31,252	100.0%	27,618	100.0%	26,624	100.0%	26,244	100.0%	25,130	100.0%

Report Type	2005		2006		2007		2008		2009	
	Number	Percent								
Malpractice Payment Reports	17,260	73.6%	15,811	69.4%	14,507	68.7%	14,138	69.8%	13,914	65.3%
Adverse Action Reports¹	6,205	26.4%	6,981	30.6%	6,623	31.3%	6,107	30.2%	7,404	34.7%
State Licensure	3,992	17.0%	4,411	19.4%	4,068	19.3%	4,009	19.8%	4,049	19.0%
Clinical Privilege	867	3.7%	816	3.6%	811	3.8%	889	4.4%	904	4.2%
Professional Society Membership	67	0.3%	34	0.1%	51	0.2%	81	0.4%	73	0.3%
DEA	20	0.1%	21	0.1%	4	0.0%	9	0.0%	7	0.0%
Medicare/Medicaid Exclusion	1,259	5.4%	1,699	7.5%	1,689	8.0%	1,119	5.5%	2,371	11.1%
All Reports	23,465	100.0%	22,792	100.0%	21,130	100.0%	20,245	100.0%	21,318	100.0%

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

1. "Adverse Action Reports" include the reports of state licensure actions, clinical privilege actions, professional society membership, Medicare and Medicaid exclusions and US Drug Enforcement Administration (DEA) actions.

Table 2: Number of Reports Received and Percent Change by Report Type, From 2000 to 2009

Report Type	2000		2001		2002		2003		2004	
	Number	% Change 1999-2000	Number	% Change 2000-2001	Number	% Change 2001-2002	Number	% Change 2002-2003	Number	% Change 2003-2004
Malpractice Payment Reports	19,250	2.4%	20,423	6.1%	18,865	-7.6%	18,926	0.3%	17,649	-6.7%
Adverse Action Reports¹	12,002	62.8%	7,195	-40.1%	7,759	7.8%	7,318	-5.7%	7,481	2.2%
State Licensure	4,260	6.4%	3,137	-26.4%	3,940	25.6%	3,962	0.6%	3,991	0.7%
Clinical Privilege	1,029	13.6%	1,011	-1.7%	951	-5.9%	949	-0.2%	1,056	11.3%
Professional Society Membership	28	55.6%	32	14.3%	44	37.5%	46	4.5%	46	0.0%
DEA	0	-100.0%	9	...	0	-100.0%	53	...	58	9.4%
Medicare/Medicaid Exclusion	6,685	180.5%	3,006	-55.0%	2,824	-6.1%	2,308	-18.3%	2,330	1.0%
All Reports	31,252	19.4%	27,618	-11.6%	26,624	-3.6%	26,244	-1.4%	25,130	-4.2%

Report Type	2005		2006		2007		2008		2009	
	Number	% Change 2004-2005	Number	% Change 2005-2006	Number	% Change 2006-2007	Number	% Change 2007-2008	Number	% Change 2008-2009
Malpractice Payment Reports	17,260	-2.2%	15,811	-8.4%	14,507	-8.2%	14,138	-2.5%	13,914	-1.6%
Adverse Action Reports¹	6,205	-17.1%	6,981	12.5%	6,623	-5.1%	6,107	-7.8%	7,404	21.2%
State Licensure	3,992	0.0%	4,411	10.5%	4,068	-7.8%	4,009	-1.5%	4,049	1.0%
Clinical Privilege	867	-17.9%	816	-5.9%	811	-0.6%	889	9.6%	904	1.7%
Professional Society Membership	67	45.7%	34	-49.3%	51	50.0%	81	58.8%	73	-9.9%
DEA	20	-65.5%	21	5.0%	4	-81.0%	9	125.0%	7	-22.2%
Medicare/Medicaid Exclusion	1,259	-46.0%	1,699	34.9%	1,689	-0.6%	1,119	-33.7%	2,371	111.9%
All Reports	23,465	-6.6%	22,792	-2.9%	21,130	-7.3%	20,245	-4.2%	21,318	5.3%

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

1. "Adverse Action Reports" include the reports of state licensure actions, clinical privilege actions, professional society membership, Medicare and Medicaid exclusions and US Drug Enforcement Administration (DEA) actions.

Table 3: Number, Percent Distribution, and Percent Change of Medical Malpractice Payment Reports by Practitioner Type, From 2000 to 2004

Practitioner Type ¹	2000			2001			2002		
	Number	Percent	% Change 1999-2000	Number	Percent	% Change 2000-2001	Number	Percent	% Change 2001-2002
Physicians	15,447	80.2%	3.4%	16,570	81.1%	7.3%	15,198	80.6%	-8.3%
Dentists	2,333	12.1%	0.1%	2,303	11.3%	-1.3%	2,074	11.0%	-9.9%
Other Practitioners	1,470	7.6%	-3.2%	1,550	7.6%	5.4%	1,593	8.4%	2.8%
All Practitioners	19,250	100.0%	2.4%	20,423	100.0%	6.1%	18,865	100.0%	-7.6%

Practitioner Type ¹	2003			2004		
	Number	Percent	% Change 2002-2003	Number	Percent	% Change 2003-2004
Physicians	15,232	80.5%	0.2%	14,374	81.4%	-5.6%
Dentists	2,233	11.8%	7.7%	1,831	10.4%	-18.0%
Other Practitioners	1,461	7.7%	-8.3%	1,444	8.2%	-1.2%
All Practitioners	18,926	100.0%	0.3%	17,649	100.0%	-6.7%

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

1. The "Physicians" category includes allopathic (M.D.) physicians, allopathic interns and residents, osteopathic (D.O.) physicians, and osteopathic interns and residents. The "Dentists" category includes dentists and dental residents. The "Other Practitioners" category includes other health care practitioners, non-health care professionals, and non-specified professionals.

Table 4: Number, Percent Distribution, and Percent Change of Medical Malpractice Payment Reports by Practitioner Type, From 2005 to 2009

Practitioner Type ¹	2005			2006			2007		
	Number	Percent	% Change 2004-2005	Number	Percent	% Change 2005-2006	Number	Percent	% Change 2006-2007
Physicians	14,006	81.1%	-2.6%	12,490	79.0%	-10.8%	11,475	79.1%	-8.1%
Dentists	1,732	10.0%	-5.4%	1,625	10.3%	-6.2%	1,494	10.3%	-8.1%
Other Practitioners	1,522	8.8%	5.4%	1,696	10.7%	11.4%	1,538	10.6%	-9.3%
All Practitioners	17,260	100.0%	-2.2%	15,811	100.0%	-8.4%	14,507	100.0%	-8.2%

Practitioner Type ¹	2008			2009		
	Number	Percent	% Change 2007-2008	Number ²	Percent	% Change 2008-2009
Physicians	11,021	78.0%	-4.0%	10,772	77.4%	-2.3%
Dentists	1,470	10.4%	-1.6%	1,573	11.3%	7.0%
Other Practitioners	1,647	11.6%	7.1%	1,565	11.3%	-5.0%
All Practitioners	14,138	100.0%	-2.5%	13,910	100.0%	-1.6%

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

1. The "Physicians" category includes allopathic (M.D.) physicians, allopathic interns and residents, osteopathic (D.O.) physicians, and osteopathic interns and residents. The "Dentists" category includes dentists and dental residents. The "Other Practitioners" category includes other health care practitioners, non-health care professionals, and non-specified professionals.

2. In 2009, 4 Medical Malpractice Payment Reports that are missing data necessary to calculate payment or malpractice reason are excluded.

Table 5: Queries by Type of Querying Entity, From 2000 to 2004

Entity Type ¹	2000			2001			2002		
	Number of Querying Entities	Number of Queries ²	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	5,834	1,124,702	34.2%	5,809	1,122,922	34.8%	5,867	1,124,002	34.5%
Voluntary Queriers									
State Licensing Boards	68	10,205	0.3%	72	14,613	0.5%	69	17,046	0.5%
Managed Care Organizations	1,115	1,647,334	50.0%	1,043	1,577,529	48.8%	956	1,559,648	47.9%
Professional Societies	70	8,095	0.2%	65	5,982	0.2%	65	5,443	0.2%
Other Health Care Entities	3,196	501,274	15.2%	3,476	510,040	15.8%	3,875	548,367	16.8%
Total Voluntary Queriers	4,449	2,166,908	65.8%	4,656	2,108,164	65.2%	4,965	2,130,504	65.5%
Total	10,283	3,291,610	100.0%	10,465	3,231,086	100.0%	10,832	3,254,506	100.0%

Entity Type ¹	2003			2004		
	Number of Querying Entities	Number of Queries	Percent of Queries	Number of Querying Entities	Number of Queries	Percent of Queries
Required Queriers						
Hospitals	5,910	1,145,361	35.6%	5,995	1,190,472	34.5%
Voluntary Queriers						
State Licensing Boards	77	19,431	0.6%	83	23,421	0.7%
Managed Care Organizations	885	1,474,475	45.9%	843	1,576,811	45.7%
Professional Societies	60	4,928	0.2%	63	3,883	0.1%
Other Health Care Entities	4,502	569,886	17.7%	5,289	653,927	19.0%
Total Voluntary Queriers	5,524	2,068,720	64.4%	6,278	2,258,042	65.5%
Total	11,434	3,214,081	100.0%	12,273	3,448,514	100.0%

1. "Entity Type" is based on how an entity was registered on the last day of 2009 and may be different from previous years. Thus, the number of queriers for each entity type also may vary slightly from the number shown in annual reports for previous years. A single entity may have more than one registration at a time or over the years.

2. Queries listed in this table include all queries submitted by entities, including practitioner self-queries submitted electronically by entities for practitioners in 2000.

Table 6: Queries by Type of Querying Entity, From 2005 to 2009

Entity Type ¹	2005			2006			2007		
	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	6,005	1,221,200	34.9%	6,046	1,285,052	34.9%	6,042	1,287,362	33.8%
Voluntary Queriers									
State Licensing Boards	89	23,584	0.7%	86	56,072	1.5%	85	68,878	1.8%
Managed Care Organizations	837	1,544,155	44.1%	794	1,630,195	44.2%	757	1,680,945	44.1%
Professional Societies	62	5,813	0.2%	57	3,569	0.1%	50	3,688	0.1%
Other Health Care Entities	5,856	709,170	20.2%	6,405	712,381	19.3%	6,703	772,249	20.3%
Total Voluntary Queriers	6,844	2,282,722	65.1%	7,342	2,402,217	65.1%	7,595	2,525,760	66.2%
Total	12,849	3,503,922	100.0%	13,388	3,687,269	100.0%	13,637	3,813,122	100.0%

Entity Type ¹	2008			2009		
	Number of Querying Entities	Number of Queries	Percent of Queries	Number of Querying Entities	Number of Queries	Percent of Queries
Required Queriers						
Hospitals	6,007	1,291,567	31.8%	5,874	1,209,495	29.5%
Voluntary Queriers						
State Licensing Boards	82	72,837	1.8%	79	56,038	1.4%
Managed Care Organizations	737	1,883,151	46.4%	706	2,000,282	48.7%
Professional Societies	51	3,907	0.1%	50	3,647	0.1%
Other Health Care Entities	6,993	805,950	19.9%	7,296	833,875	20.3%
Total Voluntary Queriers	7,863	2,765,845	68.2%	8,131	2,893,842	70.5%
Total	13,870	4,057,412	100.0%	14,005	4,103,337	100.0%

1. "Entity Type" is based on how an entity was registered on the last day of 2009 and may be different from previous years. Thus, the number of queriers for each entity type also may vary slightly from the number shown in annual reports for previous years. A single entity may have more than one registration at a time or over the years.

Table 7: Requests for Secretarial Review by Report Type, From 2000 to 2004

Category	2000			2001			2002		
	Number	Percent	% Change 1999-2000	Number	Percent	% Change 2000-2001	Number	Percent	% Change 2001-2002
Adverse Action Reports	148	75.9%	72.1%	108	72.5%	-27.0%	126	83.4%	16.7%
State Licensure Actions	88	59.5%	175.0%	42	38.9%	-52.3%	44	34.9%	4.8%
Clinical Privileges Actions	42	28.4%	-20.8%	47	43.5%	11.9%	70	55.6%	48.9%
Professional Society Actions	2	1.4%	100.0%	1	0.9%	-50.0%	1	0.8%	0.0%
Medicare/Medicaid Exclusions	16	10.8%	---	18	16.7%	12.5%	11	8.7%	-38.9%
Medical Malpractice Payment Reports	47	24.1%	-6.0%	41	27.5%	-12.8%	25	16.6%	-39.0%
Total	195	100.0%	43.4%	149	100.0%	-23.6%	151	100.0%	1.3%

Category	2003			2004		
	Number	Percent	% Change 2002-2003	Number	Percent	% Change 2003-2004
Adverse Action Reports	86	90.5%	-31.7%	84	77.1%	-2.3%
State Licensure Actions	31	36.0%	-29.5%	27	32.1%	-12.9%
Clinical Privileges Actions	50	58.1%	-28.6%	56	66.7%	12.0%
Professional Society Actions	2	2.3%	100.0%	0	0.0%	-100.0%
Medicare/Medicaid Exclusions	3	3.5%	-72.7%	1	1.2%	-66.7%
Medical Malpractice Payment Reports	9	9.5%	-64.0%	25	22.9%	177.8%
Total	95	100.0%	-37.1%	109	100.0%	14.7%

This table includes reports in the NPDB and HIPDB as of the end of the current year.

Table 8: Requests for Secretarial Review by Report Type, From 2005 to 2009

Category	2005			2006			2007		
	Number	Percent	% Change 2004-2005	Number	Percent	% Change 2005-2006	Number	Percent	% Change 2006-2007
Adverse Action Reports	102	81.6%	21.4%	92	80.0%	-9.8%	61	81.3%	-33.7%
State Licensure Actions	35	34.3%	29.6%	30	32.6%	-14.3%	15	24.6%	-50.0%
Clinical Privileges Actions	65	63.7%	16.1%	61	66.3%	-6.2%	44	72.1%	-27.9%
Professional Society Actions	0	0.0%	---	1	1.1%	---	1	1.6%	0.0%
Medicare/Medicaid Exclusions	2	2.0%	100.0%	0	0.0%	-100.0%	1	1.6%	---
Medical Malpractice Payment Reports	23	18.4%	-8.0%	23	20.0%	0.0%	14	18.7%	-39.1%
Total	125	100.0%	14.7%	115	100.0%	-8.0%	75	100.0%	-34.8%

Category	2008			2009		
	Number	Percent	% Change 2007-2008	Number	Percent	% Change 2008-2009
Adverse Action Reports	64	81.0%	4.9%	46	83.6%	-28.1%
State Licensure Actions	17	26.6%	13.3%	11	23.9%	-35.3%
Clinical Privileges Actions	46	71.9%	4.5%	34	73.9%	-26.1%
Professional Society Actions	0	0.0%	-100.0%	1	2.2%	---
Medicare/Medicaid Exclusions	1	1.6%	0.0%	0	0.0%	-100.0%
Medical Malpractice Payment Reports	15	19.0%	7.1%	9	16.4%	-40.0%
Total	79	100.0%	5.3%	55	100.0%	-30.4%

This table includes reports in the NPDB and HIPDB as of the end of the current year. Percent changes that cannot be calculated because no reports were submitted in the base year for the calculation are indicated by "---".

Table 9: Actual and Adjusted Medical Malpractice Payment Reports and Ratio of Adjusted Medical Practitioner Reports by State, Physicians and Dentists, Cumulative From September 1, 1990 Through 2009

State	Physicians*		Dentists*		Ratio of Adjusted Physician Reports to Adjusted Dentist Reports	Ratio of Adjusted Dentist Reports to Adjusted Physician Reports
	Number of Reports	Adjusted Number of Reports**	Number of Reports	Adjusted Number of Reports**		
Alabama	1,107	1,096	210	210	5.22	0.19
Alaska	342	342	96	95	3.60	0.28
Arizona	4,384	4,355	665	665	6.55	0.15
Arkansas	1,304	1,293	175	175	7.39	0.14
California	26,957	26,907	8,853	8,853	3.04	0.33
Colorado	2,918	2,891	540	540	5.35	0.19
Connecticut	2,929	2,923	678	678	4.31	0.23
Delaware	685	668	66	66	10.12	0.10
District of Columbia	1,022	1,019	156	156	6.53	0.15
Florida**	19,470	19,375	2,188	2,188	8.86	0.11
Georgia	4,959	4,934	779	779	6.33	0.16
Hawaii	618	618	157	157	3.94	0.25
Idaho	590	586	88	88	6.66	0.15
Illinois	10,653	10,622	1,629	1,629	6.52	0.15
Indiana**	5,206	3,504	468	438	8.00	0.13
Iowa	2,098	2,094	252	252	8.31	0.12
Kansas**	3,086	2,051	293	290	7.07	0.14
Kentucky	3,022	2,995	413	413	7.25	0.14
Louisiana**	5,450	3,592	482	447	8.04	0.12
Maine	778	774	135	135	5.73	0.17
Maryland	4,518	4,499	933	933	4.82	0.21

Table 9 (Continued)

State	Physicians*		Dentists*		Ratio of Adjusted Physician Reports to Adjusted Dentist Reports	Ratio of Adjusted Dentist Reports to Adjusted Physician Reports
	Number of Reports	Adjusted Number of Reports**	Number of Reports	Adjusted Number of Reports**		
Massachusetts	5,217	5,200	1,125	1,125	4.62	0.22
Michigan	13,097	13,080	1,757	1,757	7.44	0.13
Minnesota	1,979	1,963	365	365	5.38	0.19
Mississippi	2,071	2,061	173	172	11.98	0.08
Missouri	4,811	4,655	600	600	7.76	0.13
Montana	1,144	1,140	100	100	11.40	0.09
Nebraska**	1,423	1,098	159	159	6.91	0.14
Nevada	1,658	1,652	275	275	6.01	0.17
New Hampshire	1,015	1,014	192	192	5.28	0.19
New Jersey	11,248	11,102	1,516	1,516	7.32	0.14
New Mexico**	1,908	1,471	245	245	6.00	0.17
New York	35,223	35,178	5,592	5,592	6.29	0.16
North Carolina	4,007	3,966	354	354	11.20	0.09
North Dakota	455	450	45	45	10.00	0.10
Ohio	10,405	10,378	1,359	1,359	7.64	0.13
Oklahoma	2,350	2,324	438	438	5.31	0.19
Oregon	1,840	1,835	343	343	5.35	0.19
Pennsylvania**	22,889	15,746	2,693	2,693	5.85	0.17
Rhode Island	1,145	1,141	159	159	7.18	0.14
South Carolina**	2,561	2,005	189	180	11.14	0.09
South Dakota	475	471	77	77	6.12	0.16
Tennessee	3,322	3,301	398	398	8.29	0.12
Texas	18,083	18,031	2,301	2,301	7.84	0.13
Utah	1,909	1,905	549	549	3.47	0.29
Vermont	494	493	101	101	4.88	0.20

Table 9 (Continued)

State	Physicians*		Dentists*		Ratio of Adjusted Physician Reports to Adjusted Dentist Reports	Ratio of Adjusted Dentist Reports to Adjusted Physician Reports
	Number of Reports	Adjusted Number of Reports**	Number of Reports	Adjusted Number of Reports**		
Virginia	3,721	3,707	616	616	6.02	0.17
Washington	4,237	4,226	1,368	1,368	3.09	0.32
West Virginia	2,429	2,424	183	183	13.25	0.08
Wisconsin**	2,017	1,747	547	547	3.19	0.31
Wyoming	452	450	46	46	9.78	0.10
All Jurisdictions***	269,150	254,819	43,276	43,197	5.90	0.17

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

* The "Physicians" category includes allopathic (M.D.) physicians, allopathic interns and residents, osteopathic (D.O.) physicians, and osteopathic interns and residents. The "Dentists" category includes dentists and dental residents.

** 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 double asterisks have or had 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.

*** The total includes reports for American Samoa, Guam, Federated States of Micronesia, Northern Mariana Islands, Palau, Puerto Rico, U.S. Virgin Islands, and Armed Forces locations overseas (3,449 actual reports and 3,447 adjusted reports for physicians; 150 actual reports and 150 adjusted reports for dentists); and additional 25 reports (20 reports for physicians and 5 reports for dentists) that lack information about the State are also included in the total.

Table 10: Number of Medical Malpractice Payment Reports by State, From 2005 to 2009 - Physicians*

State	2005		2006		2007		2008		2009	
	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	49	48	61	60	45	45	49	49	37	37
Alaska	22	22	26	26	11	11	9	9	13	13
Arizona	293	291	234	232	207	206	178	175	182	180
Arkansas	76	74	60	60	52	52	55	55	57	56
California	1,191	1,188	1,075	1,073	999	989	962	959	1,003	1,001
Colorado	135	135	146	146	110	108	143	141	134	130
Connecticut	149	148	172	172	156	155	126	126	120	120
Delaware	34	34	37	35	20	19	27	26	29	29
District of Columbia	61	61	80	80	26	26	33	33	24	24
Florida**	1,148	1,141	907	905	871	868	964	954	887	883
Georgia	282	279	277	276	269	269	245	244	215	212
Hawaii	19	19	19	19	28	28	21	21	33	33
Idaho	41	41	33	32	28	28	21	21	31	31
Illinois	485	482	427	426	421	417	378	375	347	346
Indiana**	201	131	234	158	225	171	209	154	214	189
Iowa	112	112	79	79	69	69	90	89	83	83
Kansas**	187	132	159	101	144	100	137	90	126	74
Kentucky	169	166	168	167	129	127	136	135	121	121
Louisiana**	314	193	364	200	316	169	353	202	297	157
Maine	44	43	37	37	50	49	45	45	39	38
Maryland	250	248	219	215	205	204	212	211	218	216

Table 10 (Continued)

State	2005		2006		2007		2008		2009	
	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**
Massachusetts	268	266	273	270	293	292	271	270	329	328
Michigan	471	468	398	398	432	432	517	516	386	383
Minnesota	78	77	73	73	94	92	72	72	66	65
Mississippi	92	91	107	107	99	98	87	85	78	78
Missouri	235	224	220	216	228	219	138	131	191	182
Montana	51	50	51	51	61	61	65	65	46	45
Nebraska**	194	111	73	45	57	44	63	43	51	41
Nevada	112	111	90	90	90	90	82	81	86	85
New Hampshire	57	57	39	39	45	45	50	50	54	54
New Jersey	727	712	575	570	559	540	471	455	567	557
New Mexico**	151	88	107	89	122	75	77	63	87	65
New York	1,823	1,818	1,930	1,926	1,633	1,630	1,488	1,486	1,418	1,416
North Carolina	200	196	164	164	155	153	156	154	125	125
North Dakota	31	31	16	16	20	19	14	14	21	21
Ohio	440	438	359	356	241	238	239	239	226	226
Oklahoma	182	181	136	134	170	168	151	150	166	166
Oregon	81	80	94	94	95	95	105	105	90	90
Pennsylvania**	1,126	727	994	691	868	607	860	633	847	626
Rhode Island	41	41	55	55	64	64	46	45	47	46
South Carolina**	192	137	197	144	211	165	152	121	131	112
South Dakota	37	37	22	21	22	21	36	36	25	25
Tennessee	168	166	171	170	166	165	160	158	152	150
Texas	1,059	1,054	673	670	587	585	502	501	512	508
Utah	106	106	86	86	81	80	81	81	96	95
Vermont	16	16	22	22	10	10	17	17	24	24

Table 10 (Continued)

State	2005		2006		2007		2008		2009	
	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**
Virginia	167	167	163	162	135	134	130	130	151	151
Washington	192	192	193	192	171	171	146	145	144	144
West Virginia	83	82	85	85	76	75	90	90	89	89
Wisconsin**	91	85	78	71	62	58	72	70	75	60
Wyoming	28	28	19	19	13	12	13	13	13	13
All Jurisdictions***	14,006	13,070	12,490	11,738	11,475	10,782	11,021	10,410	10,772	10,212

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

* The "Physicians" category includes allopathic (M.D.) physicians, allopathic interns and residents, osteopathic (D.O.) physicians, and osteopathic interns and residents.

** 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 double asterisks have or had 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.

*** The total includes reports for American Samoa, Federated States of Micronesia, Guam, Northern Mariana Islands, Puerto Rico, U.S. Virgin Islands, and Armed Forces locations overseas (245 reports in 2005, 213 reports in 2006, 234 reports in 2007, 277 reports in 2008, and 269 reports in 2009).

Table 11: Number of Medical Malpractice Payment Reports by State, From 2005 to 2009 - Dentists*

State	2005		2006		2007		2008		2009	
	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	8	8	9	9	9	9	6	6	7	7
Alaska	8	8	6	6	1	1	3	3	5	5
Arizona	28	28	26	26	31	31	25	25	34	34
Arkansas	13	13	6	6	7	7	5	5	0	0
California	344	344	331	331	328	328	310	310	310	310
Colorado	28	28	19	19	19	19	24	24	27	27
Connecticut	25	25	22	22	24	24	24	24	34	34
Delaware	1	1	2	2	2	2	2	2	0	0
District of Columbia	7	7	4	4	6	6	7	7	3	3
Florida**	102	102	75	75	79	79	81	81	102	102
Georgia	37	37	18	18	25	25	19	19	36	36
Hawaii	9	9	6	6	9	9	4	4	8	8
Idaho	3	3	5	5	5	5	6	6	4	4
Illinois	48	48	71	71	47	47	53	53	48	48
Indiana**	17	13	13	13	13	13	17	17	18	18
Iowa	10	10	9	9	10	10	10	10	11	11
Kansas**	14	14	13	13	14	13	8	8	7	7
Kentucky	17	17	9	9	10	10	12	12	17	17
Louisiana**	17	16	19	15	18	17	20	19	14	11
Maine	3	3	12	12	4	4	3	3	5	5
Maryland	23	23	30	30	23	23	22	22	36	36
Massachusetts	49	49	37	37	21	21	43	43	36	36
Michigan	58	58	34	34	41	41	33	33	53	53
Minnesota	6	6	8	8	13	13	12	12	17	17
Mississippi	8	8	5	5	9	9	4	4	5	5

Table 11 (Continued)

State	2005		2006		2007		2008		2009	
	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**
Missouri	13	13	20	20	17	17	10	10	17	17
Montana	7	7	0	0	2	2	7	7	3	3
Nebraska**	11	11	2	2	8	8	3	3	3	3
Nevada	11	11	17	17	6	6	21	21	17	17
New Hampshire	9	9	5	5	8	8	6	6	6	6
New Jersey	57	57	56	56	52	52	72	72	66	66
New Mexico**	13	13	19	19	13	13	10	10	10	10
New York	295	295	325	325	249	249	224	224	265	265
North Carolina	13	13	20	20	12	12	16	16	16	16
North Dakota	2	2	3	3	1	1	3	3	1	1
Ohio	47	47	37	37	45	45	40	40	32	32
Oklahoma	13	13	16	16	9	9	11	11	33	33
Oregon	16	16	9	9	17	17	16	16	15	15
Pennsylvania**	86	86	111	111	75	75	89	89	77	77
Rhode Island	6	6	8	8	7	7	13	13	4	4
South Carolina**	9	8	5	5	6	6	11	9	9	8
South Dakota	4	4	3	3	12	12	3	3	0	0
Tennessee	16	16	8	8	29	29	16	16	11	11
Texas	79	79	74	74	66	66	54	54	42	42
Utah	14	14	17	17	10	10	7	7	18	18
Vermont	4	4	4	4	5	5	3	3	5	5
Virginia	40	40	19	19	12	12	24	24	18	18
Washington	49	49	40	40	37	37	26	26	40	40
West Virginia	7	7	3	3	1	1	6	6	7	7
Wisconsin**	17	17	7	7	17	17	14	14	16	16
Wyoming	2	2	1	1	1	1	3	3	1	1

Table 11 (Continued)

State	2005		2006		2007		2008		2009	
	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**
All Jurisdictions-***	1,732	1,726	1,625	1,621	1,494	1,492	1470	1467	1573	1569

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

*The "Dentists" category includes dentists and dental residents.

** 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 or had 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 Annual Report narrative for additional details.

*** The total includes reports for American Samoa, Puerto Rico, and U.S. Virgin Islands (9 reports in 2005, 7 reports in 2006, 9 reports in 2007, 9 reports in 2008, and 4 reports in 2009).

Table 12: Currently Active Registered Non-Federal Hospitals That Have Never Reported to the National Practitioner Data Bank by State*

State	Number of Hospitals with "Active" NPDB Registrations	Number of "Active" Hospitals that Have Never Reported	Percent of Hospitals that Have Never Reported
Alabama	112	64	57.1%
Alaska	20	9	45.0%
Arizona	90	42	46.7%
Arkansas	98	45	45.9%
California	417	126	30.2%
Colorado	87	50	57.5%
Connecticut	40	9	22.5%
Delaware	11	4	36.4%
District of Columbia	16	6	37.5%
Florida	235	103	43.8%
Georgia	177	72	40.7%
Hawaii	27	13	48.1%
Idaho	49	30	61.2%
Illinois	209	77	36.8%
Indiana	156	77	49.4%
Iowa	115	70	60.9%
Kansas	152	102	67.1%
Kentucky	111	55	49.5%
Louisiana	197	134	68.0%
Maine	41	14	34.1%
Maryland	61	20	32.8%
Massachusetts	112	49	43.8%
Michigan	168	60	35.7%
Minnesota	135	82	60.7%

Table 12 (Continued)

State	Number of Hospitals with "Active" NPDB Registrations	Number of "Active" Hospitals that Have Never Reported	Percent of Hospitals that Have Never Reported
Mississippi	97	52	53.6%
Missouri	144	72	50.0%
Montana	54	34	63.0%
Nebraska	92	61	66.3%
Nevada	43	22	51.2%
New Hampshire	30	8	26.7%
New Jersey	97	32	33.0%
New Mexico	43	20	46.5%
New York	237	58	24.5%
North Carolina	127	51	40.2%
North Dakota	47	34	72.3%
Ohio	223	102	45.7%
Oklahoma	144	91	63.2%
Oregon	62	18	29.0%
Pennsylvania	239	100	41.8%
Rhode Island	16	3	18.8%
South Carolina	78	37	47.4%
South Dakota	57	43	75.4%
Tennessee	144	68	47.2%
Texas	524	334	63.7%
Utah	51	20	39.2%
Vermont	16	4	25.0%
Virginia	110	39	35.5%
Washington	93	38	40.9%
West Virginia	62	28	45.2%
Wisconsin	137	69	50.4%
Wyoming	29	19	65.5%
All Jurisdictions**	5,885	2,808	47.7%

Table 12 (Continued)

* "Currently active" registered hospitals are those listed by the NPDB as having active status registrations on December 31, 2009. A few hospitals have more than one registration and are included more than once in this table. Non-Federal hospitals are hospitals not owned and operated by the Federal government.

** The total includes hospitals in Guam, Northern Mariana Islands, Puerto Rico, and U.S. Virgin Islands (53 hospitals with active registrations, 38 hospitals which have never reported).

Table 13. Outcomes of Requests ** Submitted for Secretarial Review by Year (2000-2008)*

*Data for Year 2009 Incomplete and is Omitted

** Requests made for reports submitted to both NPDB and HIPDB

SECRETARIAL REVIEWS	2000	2001	2002	2003	2004	2005	2006	2007	2008
Requests for Secretarial Review									
Adverse Action Reports (AAR)	148	108	126	86	84	102	92	61	64
Medical Malpractice Payment Reports (MMR)	47	41	25	9	25	23	23	14	15
Total # Reports Requested for Secretarial Review	195	149	151	95	109	125	115	75	79
Percentages of Requests for Secretarial Review									
% Adverse Action Reports	76%	72%	83%	91%	77%	82%	80%	81%	81%
% Medical Malpractice Reports	24%	28%	17%	9%	23%	18%	20%	19%	19%
Secretarial Review Outcomes (AAR and MMR)									
# Reports Determined Beyond Scope of Secretary	123	108	98	48	53	52	47	37	20
% Reports Determined Beyond Scope of Secretary	63%	73%	65%	51%	49%	42%	40%	49%	25%
# Reports Voided by Secretary	0	2	2	1	1	4	3	2	1
% Reports Voided by Secretary	0%	1%	1%	1%	1%	3%	3%	3%	1%
# Reports Closed by Intervening Action	66	36	49	42	54	63	63	34	25
% Reports Closed by Intervening Action	34%	24%	32%	44%	50%	50%	55%	45%	32%
# Reports Closed by Practitioner	4	1	1	4	1	1	0	1	1
% Reports Closed by Practitioner	2%	1%	1%	4%	1%	1%	0%	1%	1%
# Reports Unresolved as of December 31, 2009	0	0	0	0	0	2	1	1	31
% Reports Unresolved as of December 31, 2009	0%	0%	0%	0%	0%	2%	1%	1%	39%
# Reports Changed by Secretary	2	2	1	0	0	3	1	0	1
% Reports Changed by Secretary	1%	1%	1%	0%	0%	2%	1%	0%	1%