Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NATIONAL PRACTITIONER DATA BANK: USEFULNESS AND IMPACT OF REPORTS TO HOSPITALS

FEBRUARY 1993

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FEBRUARY 1993 OEI-01-90-00520

EXECUTIVE SUMMARY

PURPOSE

The purpose of this study is to assess the utility to hospitals of the information in the National Practitioner Data Bank.

BACKGROUND

Since September 1, 1990, the National Practitioner Data Bank has received and maintained records of malpractice payments and adverse actions taken by hospitals, other health care entities, licensing boards, and professional societies against licensed health care practitioners. It provides hospitals and other health care entities with information relating to the professional competence and conduct of physicians, dentists, and other health care practitioners. It is operated by a contractor to the Health Resources and Services Administration (HRSA) of the Public Health Service (PHS).

Under the Health Care Quality Improvement Act of 1986, hospitals are required to query the Data Bank about every physician and dentist who applies for privileges. Hospitals must query about all practitioners with clinical privileges at least once every two years. They have the option of querying about any practitioner with privileges (or who is seeking privileges) at any time. The Data Bank information is intended to help hospitals make decisions about hiring, credentialing, and disciplining practitioners.

There has been much debate about the utility of this information to hospitals and about how they use it. Some observers note that much of the information was already readily available through other sources. Critics of the current reporting requirements have argued that reports of malpractice payments, particularly of small dollar settlements, are not useful in determining the professional competence or conduct of practitioners. Some practitioner groups are worried that Data Bank reports prejudice hospitals against the reported practitioners, while hospitals and others argue that hospitals do not make judgments based solely on the reports and that they follow up on the reports to get more detail.

This report answers basic questions about the usefulness and impact of the information in the Data Bank to hospitals at an early stage in the Data Bank's operation. The results are based on a survey of hospitals who have received reports of malpractice payments or adverse actions from the Data Bank. We sampled 200 matches -- instances when a querying hospital received a report of a specific incident -- from the universe of 19,122 hospital matches from the initiation of the Data Bank through March 19, 1992 and received 142 responses. Our findings can be projected to this universe of matches. Appendix A gives details of our methodology and provides information about the reports, practitioners, and hospitals included in this study.

FINDINGS

USEFULNESS TO HOSPITALS: A majority of Data Bank reports were useful to hospitals.

Measured by both objective and subjective criteria, the Data Bank appears to be providing valuable information to hospitals.

- Forty percent of Data Bank reports have provided information previously unknown to hospital staffs.

- The Data Bank has delivered accurate reports to hospitals.

- The Data Bank's average response time has been improving steadily. Over an 18 month period, median response time has dropped from 123 days to 26 days.

- Hospital officials found 58 percent of Data Bank reports to be useful. As the Data Bank's response time has improved, so has the proportion of reports rated useful.

- The most frequently cited reason for Data Bank reports' usefulness was that they confirmed information about practitioners that hospital officials already knew. Other reasons cited include the reports' help in making judgments about practitioners' competency and their provision of information not already known.

- Neither the source of reports nor, for malpractice reports, the payment amount affected the proportion of Data Bank reports that hospital officials rated useful.

IMPACT ON DECISIONS: Data Bank reports rarely led hospitals to make privileging decisions they would not have made without the reports, even when the reports provided information that hospitals did not already know.

We evaluated impact on decisions by asking hospitals the following question: Would your decision regarding the practitioner have been different if you had not received the Data Bank report?

- According to hospital officials, if hospitals had not received the Data Bank reports, their privileging decisions would have been different one percent of the time.

- Eighty percent of Data Bank reports had little chance to have an impact on hospitals' privileging decisions. Each of these reports either arrived after the decision was made or duplicated available information.

- Nineteen percent of Data Bank reports arrived before hospitals' decisions were finalized and contained information that neither the practitioner involved nor

any other sources had provided, but did not have an impact on hospitals' privileging decisions.

RECOMMENDATIONS

Our findings indicate that the usefulness and impact of the information in the Data Bank are strongly affected by the timeliness of the reports. Our recommendations identify steps that PHS **and** hospitals need to take to improve the timeliness of Data Bank reports, since PHS shares the responsibility for timeliness with the hospitals that query the Data Bank.

The PHS should seek to reduce further the time between query and response, and should make this a high priority in its next contract for operation of the Data Bank. The PHS should publish recently established performance indicators relating to response time in its annual report on the Data Bank.

The Joint Commission for Accreditation of Healthcare Organizations (JCAHO) should establish guidelines on how quickly hospitals should query the Data Bank after receiving applications for privileges.

COMMENTS ON THE DRAFT REPORT

We received comments on our draft report from the Public Health Service (PHS), the Assistant Secretary for Management and Budget (ASMB), the Assistant Secretary for Planning and Evaluation (ASPE), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Hospital Association (AHA), and the American Medical Association (AMA). The PHS and JCAHO are examining ways to implement the recommendations we directed to them. In appendix C, we reproduce each set of comments in full and provide our responses to them.

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INTRODUCTION

PURPOSE

The purpose of this study is to assess the utility to hospitals of the information in the National Practitioner Data Bank.

BACKGROUND

Since September 1, 1990, the National Practitioner Data Bank has received and maintained records of malpractice payments and adverse actions taken by hospitals, other health care entities, licensing boards, and professional societies against licensed health care practitioners.[1] It provides hospitals and other health care entities with information relating to the professional competence and conduct of physicians, dentists, and other health care practitioners. The Data Bank was established by Title IV of the Health Care Quality Improvement Act of 1986 (P.L. 99-660), as amended, and is funded by user fees and Federal outlays. It is operated by Paramax Systems Corporation (a subsidiary of Unisys Corporation) under contract to the Health Resources and Services Administration (HRSA) of the Public Health Service (PHS).

Hospitals are required to request information from the Data Bank about every physician and dentist who applies for appointment. Hospitals must query about all medical and dental staff and other health care practitioners with clinical privileges at least once every two years. They have the option of querying about any practitioner with privileges (or who is seeking privileges) at any time. The Data Bank is intended to provide information to hospitals to help them make decisions about hiring, granting privileges to, and disciplining practitioners.

As of March 19, 1992, hospitals had received, in response to queries, 19,122 reports of malpractice payments or adverse actions against physicians, dentists, and other health care practitioners. We summarized in detail the profile of these "matches" in a report released in April 1992.[2]

There has been much debate about the utility of this information to hospitals and about how they use it. Some observers note that much of the information was already readily available through other sources. Critics of the current reporting requirements have argued that reports of malpractice payments, particularly of small dollar settlements, are not useful in determining the professional competence or conduct of practitioners. Some practitioner groups are worried that Data Bank reports prejudice hospitals against the reported practitioners, while hospitals and others argue that hospitals do not make judgments based solely on the reports and that they follow up on the reports to get more detail.

METHODOLOGY

This report answers basic questions about the usefulness and impact of the information in the Data Bank to hospitals at an early stage in the Data Bank's operation. The report does not address the utility of responses from the Data Bank that state that no information is on file for the practitioners involved. The results are based on a survey of hospitals that have received reports of malpractice payments or adverse actions (also known as disciplinary actions) from the Data Bank. We sampled 200 matches -- instances when a querying hospital received a report of a specific incident -- from the universe of 19,122 hospital matches from the initiation of the Data Bank through March 19, 1992. We received 142 responses. Our findings can be projected to this universe of matches.

Our sample was stratified to include equal numbers of malpractice and adverse action reports. Because there have been far more malpractice reports than adverse action reports received by hospitals, when we analyzed the responses we gave each response about an adverse action report much less weight than each response about a malpractice payment report. Appendix A gives details of our methodology and provides information about the reports, practitioners, and hospitals included in this study.

This report is one in our series of studies on the National Practitioner Data Bank. In April 1992, we released two final reports entitled "National Practitioner Data Bank: Malpractice Reporting Requirements" (OEI-01-90-00521) and "National Practitioner Data Bank: Profile of Matches" (OEI-01-90-00522). We have also produced a report on the utility to State licensing boards of Data Bank information (OEI-01-90-00523).

Our review was conducted in accordance with the *Interim Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

USEFULNESS TO HOSPITALS: A majority of Data Bank reports were useful to hospitals.

Whether a report from the Data Bank is useful to a hospital depends on several factors. Some factors can be determined objectively, such as whether the report provides new information or duplicates other reports, whether it is accurate, and whether the report arrives at the hospital in time to be used in the privileging process. Other factors are more subjective, such as whether the information is relevant to the reported practitioner's competency and professionalism. Measured by both objective and subjective criteria, the Data Bank appears to be providing valuable information to hospitals.

- Forty percent of Data Bank reports have provided information previously unknown to hospital staffs.

When it created the Data Bank, Congress perceived that hospitals were not obtaining complete information about the practitioners to whom they granted privileges. One measure of the Data Bank's usefulness, therefore, is the extent to which it adds to hospitals' knowledge by providing information hospitals do not obtain elsewhere. So far, a substantial number of reports--40 percent overall--have given hospitals information that no other sources had provided to them.

Hospitals find that practitioners often fail to reveal their own histories of malpractice payments and adverse actions. Forty-seven percent of Data Bank reports gave hospitals information that the practitioners named in those reports did not provide.[3] These practitioners did not necessarily break any rules. Whether complete disclosure is required of practitioners depends on individual hospitals' application procedures.

Hospitals also find that they do not always get important information from their own State licensing boards. When hospitals received reports on adverse actions from the Data Bank that were originally submitted by licensing boards in the hospitals' own States, the Data Bank reports represented the hospitals' only knowledge of the adverse actions twenty percent[4] of the time. Another 10 percent[5] of the time, hospitals learned of the board actions from sources other than the Data Bank, but not from the boards themselves. Whether this communication gap is the fault of boards (for not providing information to hospitals) or of hospitals (for not requesting information from boards), we cannot say.

Hospitals have even more trouble learning of other hospitals' clinical privilege actions. Half of the Data Bank reports on clinical privilege actions provided information otherwise unavailable.[6]

Surprisingly, hospitals were more likely to be aware of malpractice payments and adverse actions occurring in other States than of payments and adverse actions occurring in their own States. Hospitals were aware of information contained in 85 percent[7] of reports from other States, but in only 55 percent of reports from their own States.[8] There is no clear explanation for this, except that because most of the reports came from sources within the same State, a small number of out-of-state reports about which hospitals had information drove the difference.[9]

- The Data Bank has delivered accurate reports to hospitals.

During the planning and early implementation of the Data Bank, some observers feared that erroneous information about practitioners could be relayed from the Data Bank to Data Bank queriers.[10] But the Data Bank's safeguards, such as allowing practitioners to dispute reports against them, seem effective in preventing the release of incorrect reports. Hospitals had almost no complaints about the reliability of information in Data Bank reports. No hospital in our sample responded that the Data Bank report it received was inaccurate.[11] Hospitals evaluated, or had a chance to evaluate, the accuracy of the information by comparing it to information they had already received or by making inquiries of other sources after they received the reports. Their judgments, therefore, are good indicators of the accuracy of the reports.

Furthermore, there is some evidence that reporters to the Data Bank--malpractice insurers, licensing boards, and so on--are complying fully with reporting requirements. Only one hospital said that the response it received from the Data Bank was incomplete, *i.e.*, that the Data Bank should have had additional information on the practitioner in question.[12] We cannot judge, however, whether or not underreporting is a significant problem. Although it seems that the Data Bank has full information on those practitioners who are reported, there remains the possibility that practitioners who should have been reported to the Data Bank never were.

- The Data Bank's average response time has been steadily improving. Over an 18 month period, median response time has dropped from 123 days to 26 days.

Timeliness is an important factor in the usefulness of Data Bank reports. In specifying the timing of required queries, Federal regulations imply that information from the Data Bank should be used when hospitals consider practitioners' applications for clinical privileges. For Data Bank reports to be used in this manner, they must arrive at hospitals before the privileging decisions are made. When the Data Bank first opened, it was not responding efficiently to queries.[13] For queries submitted in the third quarter of 1990, just 44 percent of reports arrived before hospitals made the final decisions on the practitioners involved.[14] The proportion arriving in time rose to 66 percent[15] in the first quarter of 1992.

The Data Bank's performance is better reflected by response time than by on-time arrivals, because Data Bank operators have no control over the time allowed by

hospitals between submitting a query and making a final decision. If a hospital submits a query just a day before making a decision, the Data Bank has no chance to respond in time. The Data Bank has shown great improvement in response time since its opening. Median response time was 123 days for queries that were submitted in the third quarter of 1990, but by the first quarter of 1992, median response time had fallen to 26 days.[16]

The Data Bank's poor response time early in its history was partly due to the problem of "partial matches." A partial match occurs when a query and a report match on some pieces of identifying information, but on too few to confirm that the practitioners named in the query and in the report are the same person.[17] Partial matches require human review to determine if they are indeed true matches.[18] They constituted about 40 percent of all matches through March 1992, and at least 25 percent of the reports received by our survey respondents. Until January 1992, the Data Bank computers could not be programmed to accept the results of human reviews, and all queries resulting in partial matches were placed on hold. This means some queries made in 1990 and 1991 did not generate reports in response for over a year. Now that the needed computer program has been written, partial matches are resolved with approximately one week's delay.

- Hospital officials found 58 percent of Data Bank reports to be useful. As the Data Bank's response time has improved, so has the proportion of reports rated useful.

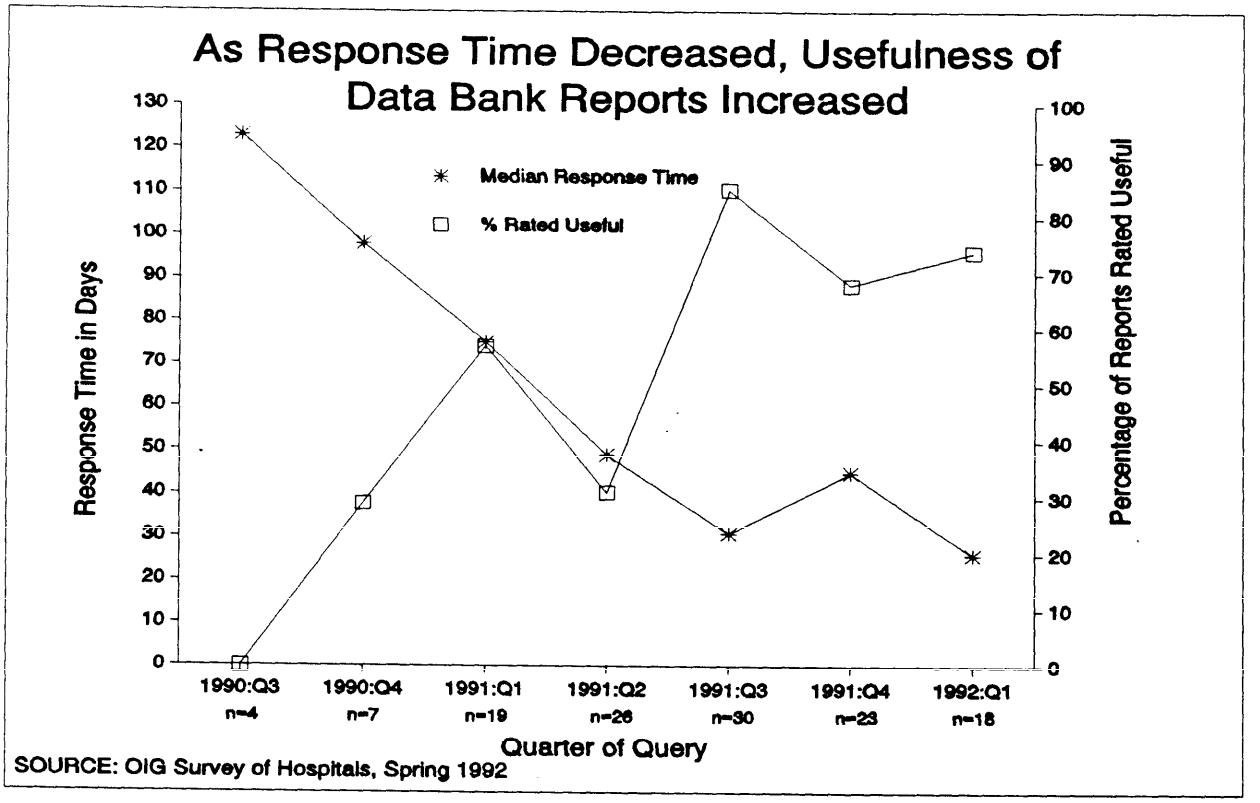
Measured by hospital officials' assessments, a moderate majority (58 percent) of Data Bank reports received between September 1, 1990, and March 19, 1992, have been useful. A key determinant of a report's usefulness is its timeliness. As response times have fallen since 1990, usefulness ratings have risen. None of the reports that matched queries made in the third quarter of 1990 were judged useful, compared with 74 percent[19] of reports that matched queries made in the first quarter of 1992 (figure 1).

- The most frequently cited reason for Data Bank reports' usefulness was that they confirmed information about practitioners that hospital officials already knew. Other reasons cited include the reports' help in making judgments about practitioners' competency and their provision of information not already known.

Of the reports hospital officials considered useful, 60 percent[20] were deemed useful at least in part because they confirmed other available information. The next most frequently cited reasons were that they helped hospitals to judge practitioners' competency (37 percent[21] of useful reports) and that they provided information unavailable elsewhere (30 percent[22] of useful reports).[23]

Not all hospital officials valued reports that confirmed available information. Of the reports considered not useful, hospital officials considered 52 percent[24] not useful precisely because they were duplicative.

FIGURE 1



SOURCE: OIG Survey of Hospitals, Spring 1992

- Neither the source of reports nor, for malpractice reports, the payment amount affected the proportion of Data Bank reports that hospital officials rated useful.

There were no significant differences in the percentage of reports judged useful because of the type of incident involved (payment *vs.* adverse action), amount of malpractice payment, location of report (in-State *vs.* out-of-State), or type of adverse action (table 1). These results are contrary to expectations. We anticipated that certain types of information held in the Data Bank would prove more useful to hospitals than others. We thought that reports of adverse actions would be more useful than reports of malpractice payments, for example, and that reports of large malpractice payments would be more useful than reports of small ones.

Some groups, notably the American Medical Association and the Physicians Insurance Association of America, have argued that small malpractice payments are not indicative of incompetence and should not be reported to the Data Bank. The equal amounts of large and small malpractice payments rated useful confirms our conclusion that small payments should continue to be reported.[25] (For further discussion of malpractice payment reporting, see our April 1992 report, "National Practitioner Data Bank: Malpractice Reporting Requirements.")

TABLE 1

USEFULNESS TO HOSPITALS OF DIFFERENT TYPES OF DATA BANK REPORTS

Type of report	Reports considered useful
Incident involved	
Malpractice payment	59%
Adverse action	57%
Amount of malpractice payment	
Less than $30,000	57%
$30,000 or more	61%
Type of adverse action	
Board licensure action	53%
Hospital privileges action	64%
Location of report	
Out-of-State	81%
In-State	56%

Note: None of these differences is significant at the 95 percent confidence level.

SOURCE: OIG Survey of Hospitals, Spring 1992

IMPACT ON DECISIONS: Data Bank reports rarely led hospitals to make privileging decisions they would not have made without the reports, even when the reports provided information that hospitals did not already know.

The impact that receiving information from the Data Bank has on hospitals can be characterized in several ways. Impact may include giving hospital administrators confidence that they have complete information about their medical staffs. It may include adding information to practitioners' files that could be used in the future should questions arise. But Data Bank reports can have their most direct impact by affecting the outcome of decisions on practitioners who have just applied for new or continued hospital privileges. For this reason, we asked hospitals the following question: Would your decision regarding the practitioner have been different if you had not received the Data Bank report? Because our measurement of impact focused on the privileges decisions, we did not include in this analysis any situations when the decisions were still pending. Sixteen percent of Data Bank reports involved

practitioners for whom the hospitals' privileging decisions were still pending at the time of our survey.

- According to hospital officials, if hospitals had not received the Data Bank reports, their privileging decisions would have been different one percent of the time.

Some hospitals that made adverse decisions on privileges would have made them even in the absence of a report from the Data Bank. Eight percent[26] of Data Bank reports were on practitioners whose privileges were later revoked, denied, or restricted by the hospital requesting the report. A small proportion of these reports (one percent of all reports) provided information that caused hospitals to deny, revoke, or restrict privileges that they otherwise would have granted. In these cases, the information provided by the Data Bank was a key factor in the decision (see box, next page).

- Eighty percent of Data Bank reports had little chance to have an impact on hospitals' privileging decisions. Each of these reports either arrived after the decision was made or duplicated available information.

There were a variety of reasons why it was unlikely for Data Bank reports to have an impact on privileging decisions. When hospitals received reports after their privileging decisions had been made, the reports clearly could not affect the initial granting of privileges. Theoretically, reports received after a decision to grant privileges could have caused hospitals to decide to revoke privileges, but according to a credentialing expert at the Joint Commission for Accreditation of Hospitals, revoking privileges once they have been granted is an extremely difficult process. When hospitals were already aware from other sources of the information in the Data Bank reports, the reports themselves were unlikely to affect privileging decisions. Hospital officials who received confirming information may have felt more confident about decisions they were planning to make, but they probably would not **alter** their decisions based on duplicative information.

Eighty percent of the reports had little chance of having an impact on decisions, for the following reasons:

Eight percent[27] of reports named practitioners who did not go through the privilege decision process. These practitioners either withdrew their applications (6 percent) or requested only temporary privileges (2 percent).

Thirty-eight percent of reports were not received prior to hospitals making decisions. For eighteen percent, the hospitals did not query the Data Bank until after the decisions and for twenty percent, they queried in advance of the decisions.

WHEN THE DATA BANK MAKES A DIFFERENCE

The information in National Practitioner Data Bank reports has caused some hospitals to revoke practitioners' privileges. The following three cases were included in our sample:

- In January 1991, a physician was put on five year probation by a State medical licensing board. The board reported this information to the Data Bank, citing the physician's incompetence, malpractice, and/or negligence. Eleven months later he applied for hospital credentials within the same State and did not disclose this information. The hospital made a query to the Data Bank 12 days after receipt of the application and received a response 16 days later. The response included notice of the probation along with 5 other reports. The hospital was not aware of the probation from any other source. Six days later his application was denied.

- In August 1991, a physician who had applied for privileges in December 1989 was granted them after an extensive delay due to an incomplete application. Also in August, the hospital learned from the Data Bank that the physician had resigned from another hospital six months earlier while he was under investigation for incompetence or misconduct. The Data Bank also reported two other incidents. The hospital was not aware of the resignation from any other source. The next month, the hospital revoked the physician's privileges.

- In October 1990, a physician applied for privileges to a hospital which queried the Data Bank in November 1990. The hospital granted temporary privileges, with the final decision pending review of the Data Bank information. In December 1990, the physician resigned privileges at another hospital where he was under investigation for incompetence and this hospital reported the information to the Data Bank. The Data Bank response detailing this action came to the querying hospital in February 1991 and provided information the hospital had not received from any other source. At this time the hospital acted to suspend the physician's privileges indefinitely. Before the suspension could be resolved, the physician resigned.

SOURCE: OIG Survey of Hospitals, Spring 1992

Thirty-four percent of reports, though received by hospitals before credentialing decisions were made, provided only information already known to the hospitals.

The remaining 20 percent of reports were received prior to the decision and provided information that was not available elsewhere. These reports had the potential for having an impact on hospital privileging decisions. One percent[28] of the reports did cause hospitals to alter decisions (see above), leaving nineteen percent which had the potential to have an impact on decisions but did not.

- Nineteen percent of Data Bank reports arrived before hospitals' decisions were finalized and contained information that neither the practitioner involved nor any other sources had provided, but did not cause the hospitals to alter their privileging decisions.

Some hospitals explain that the Data Bank reports, even when they are received prior to the decision and do not duplicate information from other sources, are not useful. About half of such reports were considered not useful, most often because they could not help judge competency or professionalism. Hospitals found the other half useful, but did not alter decisions based on the information. In all of these cases, regardless of whether they found the reports useful, hospitals granted full privileges to the practitioners named in the reports.[29]

Although Data Bank reports are not necessarily in themselves firm evidence of incompetence or unprofessionalism, practitioners who do not disclose information contained in the reports may be misrepresenting their applications for privileges.[30] Practitioners are expected to inform hospitals of the malpractice payments and adverse actions that are reported to the Data Bank.[31]

Many reports that provided new information but did not affect privileging decisions involved small malpractice payments ($30,000 or less) or minor adverse actions (for example, a small fine for having submitted a false medical claim). It appears that some hospital boards do not believe that either these incidents or the practitioners' failures to disclose them are serious enough to warrant adverse privilege decisions.

Other reports detail serious actions that alone might call into question the practitioners' ability or behavior and, because they were not disclosed by the practitioners, could also raise concerns about the practitioners' trustworthiness. For example, one doctor resigned his privileges at a hospital just before a scheduled disciplinary hearing at which he faced a three-month suspension. Nine months later, he applied to another hospital and failed to report his earlier resignation. In another case, a dentist had been barred by a State licensing board from practicing on young children except within a hospital setting. He failed to report this action in his application. In both of these cases, hospital officials said that the reports of these incidents they got from the Data Bank were useful because they provided information unavailable elsewhere. In the first case, a hospital official said the Data Bank information helped the hospital judge the doctor's professionalism and that it led to an

investigation of the circumstances surrounding the previous resignation. Nevertheless, both practitioners were granted privileges as requested.

RECOMMENDATIONS

Our findings indicate that the usefulness and impact of the information in the Data Bank are strongly affected by the timeliness of the reports. In fact, this is the only area the Data Bank administrators can affect that appears to need improvement **and** has an impact on the usefulness of the Data Bank reports.

Our recommendations, therefore, identify steps that PHS and hospitals need to take to improve the timeliness of Data Bank reports, since PHS shares the responsibility for timeliness with the hospitals that query the Data Bank. Hospitals also have responsibility for much of the impact of the Data Bank. Reports from the Data Bank, particularly those that provide information not available from other sources, should be important considerations in hospitals' privileging decisions.

The PHS should seek to reduce further the time between query and response, and should make this a high priority in its next contract for operation of the Data Bank. The PHS should publish recently established performance indicators relating to response time in its annual report on the Data Bank.

While we are encouraged by the improvements PHS has made in response time, this progress must continue. The PHS and its contractor have contractual standards for turnaround time (5 working days for single name queries and 20 working days for multiple name queries). The contractor is currently meeting them most of the time.[32] The contractor processes queries by reentering information submitted on paper into their computerized system. While current standards may represent the limits of timeliness in a paper-based system, the PHS could likely improve overall response time if the querying and reporting system were electronic. The PHS has recently completed testing a new system for handling electronic queries and began implementing diskette and telephone queries in September 1992. We welcome these innovations and suggest that the PHS consider testing on-line queries and responses. The PHS could also focus on ways to reduce the number of "partial matches," which, unlike most matches, require human intervention to complete.

The PHS is in the process of determining priorities and strategies for procuring its second contract for administration of the Data Bank (the current contract expires on December 31, 1993). The PHS should assure that timeliness is given a primary focus in the next contract.

The PHS recently established performance indicators concerning response time. The PHS tracks the average response time on a weekly basis. In order to assure public accountability, the PHS should include these statistics in the Data Bank annual report and report them at the Data Bank Executive Committee meetings.

The Joint Commission for Accreditation of Healthcare Organizations (JCAHO) should establish guidelines on how quickly hospitals should query the Data Bank after receiving applications for privileges.

In order for the Data Bank reports to be useful, they have to be available to hospitals at key decision points. Hospitals that make queries to the Data Bank after privileging decisions limit themselves to retrospective disciplinary actions. Sixteen percent of reports were received after the privileging decisions were made because the hospitals did not query until after the decisions.[33]

The JCAHO is responsible for reviewing hospitals' policies and procedures and thus qualifying them for Federal reimbursement. The JCAHO in its current hospital accreditation manual does not mention the National Practitioner Data Bank, but it does in a supplemental guide which clarifies the intent of the manual. According to this guide, hospitals are expected to request information from the Data Bank for every new applicant and are expected to query at least once every two years for currently credentialed staff (in compliance with Federal law). The JCAHO encourages hospitals to consider this information when making decisions on applications. The JCAHO manual and supplement do not specify how quickly this inquiry should be made after receipt of the application. Therefore, hospitals may be fully complying with the intent of JCAHO, yet may not have any chance of receiving information before making their decisions. The JCAHO should establish guidelines to make it likely that hospitals receive information prior to making a decision.

COMMENTS ON THE DRAFT REPORT

From within the Department of Health and Human Services, we received comments on our draft report from the Public Health Service (PHS), the Assistant Secretary for Management and Budget (ASMB), and the Assistant Secretary for Planning and Evaluation (ASPE). We also received comments from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Hospital Association (AHA), and the American Medical Association (AMA). In appendix C, we reproduce these comments in full and provide our responses to them.

The PHS concurred with our recommendations and has begun to implement them.

The ASMB concurred with our recommendations and suggested three additional recommendations. We agree with the intent of ASMB's suggestions, and direct PHS's attention to them. Nevertheless, as we explain in appendix C, we chose not to incorporate ASMB's recommendations into our report.

The ASPE raised concerns about whether our report successfully answers the question of how useful Data Bank information is to hospitals. At ASPE's suggestion, we have provided more precise statistical information than was contained in the draft report. For reasons provided in appendix C, however, we disagree with some of ASPE's interpretations of our results.

The JCAHO, in response to our recommendation, will consider adding guidelines on the timeliness of queries to the Data Bank in its next accreditation survey.

The AHA, though pleased that the Data Bank is providing complete and accurate information, perceives the Data Bank as merely a "back-up tool" in hospital credentialing and questions whether the Data Bank's usefulness justifies its costs. We believe that the high percentage of reports supplying new information demonstrates that the Data Bank is more than a "back-up tool." The AHA also questions the wisdom of developing new JCAHO guidelines for querying when many hospitals have already established such guidelines on their own. We believe that action by JCAHO would simplify rather than complicate hospital policy establishment.

The AMA criticized our sampling methodology and questioned our interpretation of some of our survey results. We explain in appendix C that our sampling methodology was appropriate given the purpose of our study, and we offer further explanation of our interpretations.

APPENDIX A

METHODOLOGY

We collected the data presented in this report through a mail survey of hospitals conducted from April to June 1992. Our survey sample was drawn from the universe of all Data Bank matches involving hospitals between September 1, 1990, and March 19, 1992. A match is a pairing of a report and a query to the Data Bank that name the same practitioner. We requested and received from Paramax Systems Corporation a computer file containing records of all Data Bank queries and reports that identified the same practitioner. We restructured and analyzed the data using Version 6.04 of the SAS System for Personal Computers.

We drew a stratified random sample of 200 matches from the universe of 19,122 matches.[34] The sample consisted of 100 matches involving malpractice payment reports and 100 matches involving adverse action reports.

In April 1992, we mailed a questionnaire about each report to the hospital involved. There were 195 hospitals that received questionnaires; five hospitals were each sent questionnaires on two different practitioners. We followed this with a second mailing to nonrespondents, then follow-up telephone calls to remaining nonrespondents. All responses used in the analysis were received by June 12. Appendix B shows the questionnaire and simple frequencies.

Questionnaires were addressed to the person whose name appeared on the original query to the Data Bank. Most respondents held the position of medical staff coordinator or the equivalent. A few respondents were the chief executive officers of their hospitals.

Our response rate was 71 percent. Responses were evenly split by type of Data Bank report (72 adverse action reports and 70 malpractice payment reports). The reports on which we received responses appear to represent fairly the reports in the universe of matches. For example, of the 70 responses about malpractice payment reports, 53 percent were for payments of $50,000 or less; overall, 47 percent of the matches were for payments of $50,000 or less.

Fifty-seven percent of the respondents queried the Data Bank because of mandatory two-year review requirements, 42 percent queried on initial privileging or employment applications, and one queried for professional review purposes. Of the 72 responses based on adverse actions, 51 percent were state licensing board actions, 47 percent were hospital clinical privileges actions and 1 was a professional society membership action. The most commonly specified reason for adverse action was incompetence/malpractice/negligence (14 percent); the most commonly cited type of act or omission cited in the malpractice actions was surgery-related (36 percent). Ninety-seven percent of the respondents queried about physicians (the other

practitioners were dentists and podiatrists). The specialties of the physicians are listed in table A.

Analysis of nonrespondents showed no significant differences between respondents and nonrespondents according to bed size, teaching status, hospital ownership, or services offered. (We obtained this information on all hospitals in our sample from the American Hospital Association's *Guide to the Health Care Field*, 1992 edition.)

There were 141 hospitals represented in the responses. Of the five hospitals that had been sent two questionnaires, one returned both and four did not respond at all. Respondent hospitals are profiled in table B.

Because adverse action matches represented 51 percent of the survey responses but only 11.5 percent of the universe, we assigned weights to each observation that allow us to extrapolate to the universe of matches. These weights equaled 1.80 for malpractice payment matches and 0.23 for adverse action matches. All statistics presented in this report were computed using these weights, except for those statistics that pertain only to either the subsample of malpractice payment matches or to the subsample of adverse action matches.

Without the weights, the analyses would have been overly representative of adverse actions. In some cases, this would not have made much of a difference. For example, 58.4 percent of reports were rated useful when weighting was done, while 57.7 percent were rated useful without weighting. The weighting was more important in other cases. Using weighted figures, 47 percent of reports yielded information that the practitioners named in those reports did not provide; using unweighted figures, 52 percent of reports yielded this type of information. Table C compares some of the weighted and unweighted figures.

Unless otherwise noted, survey results presented as percentages have a margin of error of approximately 7 percent at a 90 percent confidence level. For example, we are 90 percent confident that the true percentage of Data Bank results judged useful is between 51 and 65 percent (58 percent plus or minus 7 percent).

TABLE A

TYPES OF PRACTITIONERS

Type of practitioner	Number of matches	Percentage of matches
TOTAL	142	100.0
PHYSICIANS	137	96.5
General Surgery	23	16.2
Family Medicine	21	14.8
Internal Medicine	12	8.5
Orthopedic Surgery	11	7.8
Emergency Medicine	9	6.3
Pediatrics	7	4.9
Neurological Surgery	7	4.9
Obstetrics and Gynecology	7	4.9
Urology	5	3.5
General Medicine	4	2.8
Anesthesiology	4	2.8
Ophthalmology	3	2.1
Radiology	3	2.1
Other or Missing	3	2.1
Cardiac Surgery	2	1.4
Cardiology	2	1.4
Gynecology (Osteopathic)	2	1.4
Gastroenterology	2	1.4
Eye, Ear, Nose, and Throat	2	1.4
Plastic Surgery	2	1.4
Psychiatry	2	1.4
Thoracic Surgery	2	1.4
Oncology	1	0.7
Allergy	1	0.7
DENTISTS and ORAL SURGEONS	4	2.8
PODIATRISTS	1	0.7

SOURCE: OIG Survey of Hospitals, Spring 1992

TABLE B

PROFILE OF RESPONDENT HOSPITALS

TEACHING STATUS		
Status	Number of Hospitals	Percent of All Hospitals
Teaching	43	30.3
Non-Teaching	98	69.0
HOSPITAL OWNERSHIP		
Control	Number of Hospitals	Percent of All Hospitals
Government-owned	23	16.2
Nongovernment Not-for-profit	96	67.6
Investor-owned	22	15.5
Partnership	1	0.7
Corporation	21	14.8
BED SIZE - TOTAL FACILITY		
Bed Size	Number of Hospitals	Percent of All Hospitals
Under 100 Beds	25	17.6
100 - 199 Beds	33	23.2
200 - 299 Beds	29	20.4
300 - 399 Beds	22	15.5
400 - 499 Beds	9	6.3
500 or More Beds	23	16.2

SOURCE: OIG Survey of Hospitals, Spring 1992

TABLE C

WEIGHTED VS. UNWEIGHTED RESULTS

Analysis	Weighted	Unweighted
How many reports were rated useful?	58.4%	57.7%
How many reports were actively reviewed by at least one hospital official?	74.0%	73.2%
How many reports that were received on time were actively reviewed by at least one hospital official?	86.5%	88.1%
Of reports found useful, how many reports were judged so at least in part because they confirmed other available information?	59.6%	54.9%
Of reports found useful, how many reports were judged so at least in part because they were helpful in judging competency?	37.4%	31.7%
How many reports gave hospitals information that was otherwise unavailable?	39.7%	38.7%
How many reports gave hospitals information that the practitioner involved in the report did not provide?	47.1%	52.1%
How many reports had a direct impact on a hospital's credentialing decision?	0.5%	2.1%
How many reports were on practitioners whose privileges were revoked, denied, or restricted by the hospital?	8.1%	11.3%
How many reports had little chance of making a direct impact on a privileging decision?	80.3%	82.8%

Source: OIG Survey of Hospitals, Spring 1992

APPENDIX B

SUMMARY OF HOSPITALS' RESPONSES TO OIG MAIL SURVEY

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

USE AND UTILITY OF THE *NATIONAL PRACTITIONER DATA BANK*

NOTE: The first 29 questions in this survey concern the case of Practitioner A, whose identity is given on the last page of this questionnaire. Unless otherwise specified, please confine your responses to your knowledge of the particular practitioner and event referred to on that page.

BASIC FACTS AND CHRONOLOGY

1	What is Practitioner A's specialty? ***27 different specialties represented.***		1
2	On what date did Practitioner A sign an application requesting privileges (either new or continued) at your hospital?	***None: 5*** ***Earliest: 10/18/89*** ***Latest: 4/27/92*** ***No answer: 3***	2
3	On what date did you request information about Practitioner A from the National Practitioner Data Bank?	***Earliest: 7/11/90*** ***Latest: 2/29/92*** ***No answer: 6***	3
4	On what date did you receive a response from the Data Bank? *(Write "NR" if you have not yet received a response.)*	***Never received: 2*** ***Earliest: 11/9/90*** ***Latest: 5/2/92*** ***No answer: 9***	4
5	On what date did the hospital board make its initial decision regarding Practitioner A's privileges? *(Write "PENDING" if board's initial decision has not yet been made, then skip to 14.)*	***No decision necessary: 13*** ***Still pending: 20*** ***Earliest: 5/21/90*** ***Latest: 4/23/92*** ***No answer: 2***	5
6	Was the hospital board's *initial* decision a temporary one pending further information?	***Yes: 13*** ***No: 98*** ***Not app.: 1*** ***No answer: 30***	6
7	*(Skip if you answered NO to 6)* On what date did the hospital make its final decision regarding Practitioner A's privileges? *(Write "PENDING" if board's final decision has not yet been made, then answer 8 through 13 with respect to the board's initial decision.)*	***Still pending: 1*** ***Earliest: 1/2/91*** ***Latest: 2/6/92*** ***No answer: 129***	7

8	Were privileges granted to Practitioner A as requested by Practitioner A?	*Yes: 96* *No: 15* *Not app.: 1* *Other: 1* *No answer: 29*	8
9	*(Skip if you answered YES to 8)* Were Practitioner A's privileges denied (for initial application) or revoked (for renewal application)?	*Yes: 7* *No: 8* *Not app.: 1* *No answer: 126*	9
10	*(Skip if you answered YES to 8 or 9)* Were Practitioner A's privileges restricted or amended in any way?	*Yes: 8* *No: 2* *Not app.: 1* *No answer: 131*	10
11	*(Skip if you answered YES to 8 or 9 or NO to 10)* In what way were Practitioner A's privileges restricted or amended?		11
a	All privileges suspended (IF YES, FOR HOW LONG?_____)	*Yes: 1*	a
b	May not perform certain procedures	*Yes: 5*	b
c	May perform certain procedures only with another practitioner	*Yes: 0*	c
d	May co-admit patients only	*Yes: 0*	d
e	Mandatory consultation for certain conditions	*Yes: 0*	e
f	Mandatory review before patient admission or discharge	*Yes: 0*	f
g	Proctor assigned to review Practitioner A's work	*Yes: 1*	g
h	Other (IF YES, SPECIFY:_____)	*Yes: 4*	h
12	*(Skip if you answered YES to 8 or 9 or NO to 10)* Were these restrictions on Practitioner A's privileges in place prior to the application?	*Yes: 2* *No: 5* *Other: 1* *No answer: 134*	12

13	*(Skip if you answered YES to 8 or 9 or NO to 10)* Which of the following best describes the restrictions applied to Practitioner A's privileges?	*(Check one)*	13
a	Routine (*e.g.,* procedure(s) not approved at this hospital, restriction applied to all new hires, etc.)	*5*	a
b	Specific to Practitioner A (*e.g.,* applied because of particular event(s) in Practitioner A's history)	*3*	b
14	Were any other actions taken with regard to Practitioner A's employment, privileges, or credentials (*e.g.,* education requirements, drug testing, etc.)? (IF YES, EXPLAIN: _____ _____ _____)	***Yes: 18*** ***No: 110*** ***Not app.: 1*** ***Other: 2*** ***No answer: 11***	14

AVAILABILITY AND ACCURACY OF INFORMATION

15	Were you aware, from sources other than the Data Bank, of the adverse action or malpractice payment mentioned on the last page of this form?	***Yes: 84*** ***No: 55*** ***Other: 2*** ***No answer: 1***	15

16 *(Skip if you answered NO to 15)* 16
From which of the following sources were you aware of the adverse action or malpractice payment?

a	Practitioner A (self-report)	*Yes: 67* *No: 17* *Other: 1* *No answer: 57*	a
b	Licensing board in your state	*Yes: 31* *No: 54* *No answer: 57*	b
c	Licensing board in another state	*Yes: 3* *No: 82* *No answer: 57*	c
d	Malpractice insurer in your state	*Yes: 7* *No: 77* *Other: 1* *No answer: 57*	d
e	Malpractice insurer in another state	*No: 85* *No answer: 57*	e
f	Other hospital in your state	*Yes: 16* *No: 69* *No answer: 57*	f
g	Hospital in another state	*Yes: 3* *No: 82* *No answer: 57*	g
h	Professional society in your state	*Yes: 3* *No: 82* *No answer: 57*	h
i	Professional society in another state	*No: 85* *No answer: 57*	i
j	Other source in your state (IF YES, SPECIFY: _____)	*Yes: 12* *No: 73* *No answer: 57*	j
k	Other source in another state (IF YES, SPECIFY: _____)	*Yes: 1* *No: 84* *No answer: 57*	k

17	*(Skip if you answered NO to 15)* Was the information you received in the Data Bank response inconsistent in any way with the information reported by any of the above sources? (IF YES, WHICH SOURCES? _____ ***Practitioner: 1*** ***Insurer in-State: 1*** ***No answer: 1***)	***Yes: 3*** ***No: 82*** ***Other: 1*** ***No answer: 56***	17
18	Did you make additional inquiries (for example, to a malpractice insurer or another hospital) to confirm the accuracy of the Data Bank response or to obtain more detailed information on its content?	***Yes: 32*** ***No: 108*** ***Other: 1*** ***No answer: 1***	18
19	*(Skip if you answered NO to 18)* Did your additional inquiries show the Data Bank response to be accurate? (IF NO, EXPLAIN: _____ _____ _____)	***Yes: 28*** ***No: 1*** ***Other: 3*** ***No answer: 110***	19

NOTE: Questions 20-23 refer to the entire Data Bank response, not just to the report attached to this questionnaire. Therefore, if you received more than one report from the Data Bank on Practitioner A, please consider them all in answering Questions 20-23.

20	Were you aware of any disciplinary actions or malpractice payments involving Practitioner A that were <u>not</u> contained in the response from the Data Bank?	***Yes: 9*** ***No: 131*** ***Not app.: 1*** ***No answer: 1***	20
21	*(Skip if you answered NO to 20)* How many disciplinary actions and malpractice payments were you aware of that were <u>not</u> contained in the response from the Data Bank?		21
a	Number of disciplinary actions	***0: 5*** ***1: 3***	a
b	Number of malpractice payments	***0: 2*** ***1: 4*** ***2: 1*** ***5: 2***	b

22	*(Skip if you answered NO to 20)* How many of these disciplinary actions and malpractice payments occurred <u>after</u> September 1, 1990?		22
a	Number of disciplinary actions	***0: 7***	a
b	Number of malpractice payments	***0: 6*** ***4: 1***	b
23	*(Skip if you answered NO to 20)* Which of the following sources provided information about disciplinary actions or malpractice payments that were <u>not</u> contained in the response from the Data Bank?		23
a	Practitioner A (self-report)	***Yes: 7***	a
b	Licensing board in your state	***Yes: 0***	b
c	Licensing board in another state	***Yes: 0***	c
d	Malpractice insurer in your state	***Yes: 0***	d
e	Malpractice insurer in another state	***Yes: 1***	e
f	Other hospital in your state	***Yes: 0***	f
g	Hospital in another state	***Yes: 1***	g
h	Professional society in your state	***Yes: 0***	h
i	Professional society in another state	***Yes: 0***	i
j	Other source in your state (IF YES, SPECIFY: _____)	***Yes: 2***	j
k	Other source in another state (IF YES, SPECIFY: _____)	***Yes: 1***	k

CONSIDERATION OF INFORMATION

24	Based on the notes in Practitioner A's file and your personal knowledge of Practitioner A's application, which of the following people or groups had access to and used the response from the Data Bank in making a decision regarding Practitioner A's application?		24
a		Department chair	*Yes: 80* *No: 46* *Not app.: 8* *Other: 2* *No answer: 6*
b		Chief of medical staff	*Yes: 71* *No: 58* *Not app.: 5* *Other: 2* *No answer: 6*
c		Hospital administration (CEO, Vice President, etc.)	*Yes: 67* *No: 62* *Not app.: 5* *Other: 2* *No answer: 6*
d		Credentials committee	*Yes: 80* *No: 45* *Not app.: 9* *Other: 2* *No answer: 6*
e		Medical staff executive committee	*Yes: 66* *No: 62* *Not app.: 6* *Other: 2* *No answer: 6*
f		Hospital board subcommittee	*Yes: 28* *No: 90* *Not app.: 15* *Other: 2* *No answer: 7*
g		Full hospital board	*Yes: 59* *No: 69* *Not app.: 5* *Other: 2* *No answer: 7*

UTILITY OF INFORMATION

25	Including the report on the last page, how many Data Bank reports on Practitioner A did you receive in total from this request?	***Mean: 1.53*** ***S.D.: 1.02***	25
26	*(Skip if you answered "1" to 25)* Overall, was the information contained in the complete Data Bank response (*i.e.*, all reports combined) useful to you?	***Yes: 24*** ***No: 14*** ***Other: 1*** ***No answer: 103***	26
	IF YES, WHY?	*(Check all that apply)*	
a	Information was unavailable elsewhere	***5***	a
b	Information confirmed other reports that were available elsewhere	***16***	b
c	Information helped us to judge practitioner's competency	***10***	c
d	Information helped us to judge practitioner's professionalism	***10***	d
e	Other (EXPLAIN: _____)	***2***	e
	IF NO, WHY NOT?	*(Check all that apply)*	
f	Information was available elsewhere	***10***	f
g	Information was inaccurate	***0***	g
h	Information did not help us to judge practitioner's competency or professionalism	***7***	h
i	Information was not provided in a timely manner	***7***	i
j	Other (EXPLAIN: _____)	***3***	j

27	*(Skip if you answered "1" to 25)* Would your decision regarding Practitioner A have been different if you had not received the reports from the Data Bank? (IF YES, HOW?)	***Yes: 2*** ***No: 35*** ***Other: 3*** ***No answer: 102***	27
		(If YES, check one.)	
a	Would have granted requested privileges	***1***	a
b	Would not have granted requested privileges	***0***	b
c	Would have restricted privileges	***0***	c
d	Would not have restricted privileges	***0***	d
e	Other (EXPLAIN: _____)	***1***	e
28	Overall, was the information contained in the Data Bank report on the last page useful to you?	***Yes: 82*** ***No: 54*** ***Other: 4*** ***No answer: 2***	28
	IF YES, WHY?	*(Check all that apply)*	
a	Information was unavailable elsewhere	***28***	a
b	Information confirmed other reports that were available elsewhere	***45***	b
c	Information helped us to judge practitioner's competency	***26***	c
d	Information helped us to judge practitioner's professionalism	***17***	d
e	Other (EXPLAIN: _____)	***8***	e
	IF NO, WHY NOT?	*(Check all that apply)*	
f	Information was available elsewhere	***34***	f
g	Information was inaccurate	***1***	g
h	Information did not help us to judge practitioner's competency or professionalism	***26***	h
i	Information was not provided in a timely manner	***26***	i
j	Other (EXPLAIN: _____)	***12***	j

29	Would your decision regarding Practitioner A's privileges have been different if you had not received the report on the last page from the Data Bank? (IF YES, HOW?)	***Yes: 3*** ***No: 120*** ***Not app.: 2*** ***Other: 11*** ***No answer: 6***	29
		(If YES, check one.)	
a	Would have granted requested privileges	***2***	a
b	Would not have granted requested privileges	***0***	b
c	Would have restricted privileges	***0***	c
d	Would not have restricted privileges	***0***	d
e	Other (EXPLAIN: _____)	***1***	e

NOTE: The remaining questions do not concern the specific case of Practitioner A, but rather your general experience with and attitudes about the Data Bank.

GENERAL QUESTIONS ON THE NATIONAL PRACTITIONER DATA BANK

30	How, if at all, have the other parts of your credentialing procedures been affected by the availability of the Data Bank? ***Thirty-four said the process has been slowed down; 20 of these specifically attributed the problem to delays in Data Bank responses. Ten mentioned the additional cost of queries.***	30

31	Please rate the following four types of information maintained in the Data Bank in terms of their usefulness to you--in practice or in theory--in the practitioner credentialing process. (Let 1 = extremely useful and 4 = not at all useful.)		31
a	Hospital disciplinary actions/privilege restrictions	RATING: ***Mean: 1.79*** ***S.D.: 1.08***	a
b	Licensing board actions	RATING: ***Mean: 1.85*** ***S.D.: 1.08***	b
c	Malpractice payments	RATING: ***Mean: 2.21*** ***S.D.: 1.10***	c
d	Professional society disciplinary actions	RATING: ***Mean: 2.50*** ***S.D.: 1.18***	d
32	What kind of information <u>not</u> currently maintained by the Data Bank would be useful to you? ***No specific type of information was mentioned by more than 6 respondents.***		32
33	Please list any additional comments and suggestions you have about the operation of the National Practitioner Data Bank. ***The most common suggestion, made by 20 respondents, was to improve the timeliness of Data Bank responses. Other areas in which improvement is desired include Data Bank forms, the help line, and billing procedures. Each was mentioned by 11 respondents.***		33

This is the end of the survey. Thank you for taking the time to complete it.

APPENDIX C

DETAILED COMMENTS ON THE DRAFT REPORT AND OIG RESPONSE TO THE COMMENTS

In this appendix, we present in full the comments on the draft report offered by the Public Health Service (PHS), the Assistant Secretary for Management and Budget (ASMB), the Assistant Secretary for Planning and Evaluation (ASPE), the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the American Hospital Association (AHA), and the American Medical Association (AMA). We also present our response to each set of comments.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Memorandum

Date DEC 8 1992

From Assistant Secretary for Health

Subject Office of Inspector General (OIG) Draft Report "National Practitioner Data Bank--Usefulness and Impact of Reports to Hospitals," OEI-01-90-00520

To Acting Inspector General, OS

Attached are the PHS comments on the subject OIG draft report on the usefulness and impact of the information in the National Practitioner Data Bank (Data Bank) to hospitals.

We concur with the OIG report's recommendations and are implementing the corrective actions to (1) further reduce the time between query and response and make this a high priority in the next contract for operation of the Data Bank, and (2) publish the established performance indicators relating to the response time in the annual report of the Data Bank.

In addition, we plan to (1) provide a copy of the final OIG report to the Joint Commission on Accreditation of Healthcare Organizations, and (2) recommend that they consider incorporating standards into their upcoming scoring guidelines and Accreditation Manual for Hospitals addressing how quickly hospitals should query the Data Bank after receiving applications for privileges.

James O. Mason

James O. Mason, M.D., Dr.P.H.

Attachment

COMMENTS OF THE PUBLIC HEALTH SERVICE ON THE OFFICE OF INSPECTOR GENERAL (OIG) DRAFT REPORT "NATIONAL PRACTITIONER DATA BANK -- USEFULNESS AND IMPACT OF REPORTS TO HOSPITALS" OEI-01-90-00520

OIG RECOMMENDATION

The PHS should seek to further reduce the time between query and response, and should make this a high priority in its next contract for operation of the Data Bank.

PHS COMMENT

We concur. As acknowledged by OIG in the draft report, we have already initiated actions to further reduce the time between query and response by automating the query process. Software for providing electronic queries is being distributed to approximately 2,000 hospitals and, so far, over 500 electronic queries have been processed with positive results. The first set of electronic queries was processed within 48 hours of their receipt. We are also planning to design and implement electronic query responses before the end of the current Data Bank contract.

We have also initiated actions to make the reduction of time a high priority in the next contract for operation of the Data Bank. In June 1992, HRSA assembled a team to focus on the competition for the next Data Bank contract. The team has held several workshops and meetings to assess the needs and preferences of the Data Bank users. Based on interactions with the users, the team is well aware of the need for and the importance of reducing the time between query and response.

As the team proceeds to develop the request for proposals for a new Data Bank contract, primary consideration is being given to providing direct on-line transmission of queries and reports, and of system outputs. The turnaround time between query and response will be greatly reduced by using the "on-line" approach.

OIG RECOMMENDATION

The PHS should publish recently established performance indicators relating to the response time in its annual report on the Data Bank.

PHS COMMENT

We concur. We will work with the contractor to include the performance indicator statistics in (1) the Data Bank's annual report, and (2) reports to the Data Bank Executive Committee.

OIG RECOMMENDATION

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) should establish guidelines on how quickly hospitals should query the Data Bank after receiving applications for privileges.

PHS COMMENT

We concur. We will recommend to JCAHO that they consider incorporating standards into their upcoming scoring guidelines and Accreditation Manual for Hospitals addressing how quickly hospitals should query the Data Bank after receiving applications for privileges. The recommendation is consistent with JCAHO's efforts to strengthen credentials review and professional peer review processes. Upon receipt of the final OIG report, we plan to send a copy of the report together with our recommendation as stated above to JCAHO.

OIG RESPONSE TO PHS COMMENTS

We are encouraged by PHS's actions to date toward minimizing response times and its pledge to publish related performance indicators. We direct PHS's attention to comments on our report from ASMB, which contain additional suggestions for PHS. Although we have not added these suggestions to our report, we believe they may have merit.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

OCT 23 1992

MEMORANDUM TO: Bryan B. Mitchell
Principal Deputy Inspector General

FROM: Arnold R. Tompkins
Assistant Secretary for Management and Budget

SUBJECT: OIG Draft Report: "National Practitioner Data Bank: Usefulness and Impact of Reports to Hospitals" OEI-01-90-00520

Thank you for the opportunity to review your draft report, "National Practitioner Data Bank: Usefulness and Impact of Reports to Hospitals." Overall, we concur with the findings and recommendations contained in the report. We would, however, like to offer some comments and several additional recommendations (attached).

If your staff have any questions about this response, please have them call Neil J. Stillman, Deputy Assistant Secretary for Information Resources Management, at 690-6162, or Joanne Amato, Office of Information Resources Management, at 690-8358.

Attachment

OIG Draft Report
"National Practitioner Data Bank:
Usefulness and Impact of Reports to Hospitals"

Overall, we concur with your findings. We would, however, like to suggest several additional recommendations, as follows:

- One of your recommendations suggests that PHS make improving query response time a high priority in the next contract. We agree, but believe that this should also be a high priority for the current contract. We agree that PHS has made considerable improvement in this area over the first 18 months. Since contractual standards for turnaround time exist, we think that additional emphasis for timeliness needs to be placed on the current contractor and that the contractor be held accountable for maintaining this standard. The report indicates that the current system contract expires in December, 1993. However, PHS is in the process of requesting a ten-month extension to the current contract. We would not want to delay the enforcement of this requirement for two years or more.

- A recent GAO study concluded that timeliness would be improved considerably if the Data Bank required the use of Social Security Numbers (SSN) for inquiries. This would allow for more accurate matching of data and fewer exception reports (which require manual investigation to resolve). A major reason for delayed response time to queries is that the inquiry does not always contain enough unique identifying information to result in an accurate match. This problem is greatly reduced by the use of the SSN. The use of the SSN is currently voluntary. We recommend that PHS be encouraged to seek legislative authority that would require the use of Social Security Numbers for reports and inquiries to the Data Bank.

- Although hospital officials found 58 percent of Data Bank reports useful, your report indicates that Data Bank reports rarely affected hospital privileging decisions. The report goes on to say that those hospitals that did not consider the reports useful felt this way because the reports did not help them to judge the competency or professionalism of the applicant. We suggest that PHS work with Data Bank customers in defining additional data needs that will increase the usefulness of these reports, as part of the new system design requirements.

As noted in your report, PHS is currently in the process of determining priorities and strategies for procuring its second contract for administration of the Data Bank. The Office of Information Resources Management has been given the responsibility to provide technical support to this effort. It is our opinion that the new system design should support a virtually paperless environment and provide interactive access to the user. We believe that this type of design will not only cut down on errors significantly, but can also reduce costs and increase the timeliness of responses to our customers.

OIG RESPONSE TO ASMB COMMENTS

We agree with the spirit of all of ASMB's suggestions; nevertheless, we have not incorporated them into our report. We believe that PHS, by introducing electronic querying capabilities, is already striving to improve response time during the current contract. We believe that PHS's work with the Data Bank Executive Committee and regular communications with user groups constitute sufficient efforts to identify additional data needs. (Furthermore, the hospitals we surveyed were given the opportunity to identify useful additional data, but no type of data was identified by more than a handful of respondents.) Finally, although we recognize that the use of Social Security Numbers could speed the matching of reports and queries, we cannot endorse this proposal without analyzing its costs, benefits, and privacy implications.

DEC 24 1992

TO: Bryan B. Mitchell
Principal Deputy Inspector General

FROM: Assistant Secretary for
Planning and Evaluation

SUBJECT: Comments on the Draft Report, "National Practitioner Data Bank: Usefulness and Impact of Reports to Hospitals"

This OIG report addresses an important issue, the usefulness of the data from the National Practitioner Data Bank (NPDB) to hospitals and entities who grant privileges to practitioners. Unfortunately, for the reasons detailed below, I am concerned that the information provided in the draft report fails to materially deal with, and does not substantially answer, the issue of concern. Indeed, those data used by OIG to conclude the NPDB is useful could be used as well to support the opposite conclusion: because the NPDB data generally have not been employed as key components in hospitals' privileging determinations, the purpose intended by Congress, the NPDB's usefulness has been low.

First, the reader has no basis for determining the extent to which the sample matches queried accurately reflect, statistically, the universe. Absent a power analysis, or at least confidence intervals, the appropriateness of weighting responses up to the universe of hospitals is unclear.

Second, the "usefulness" dimension lacks precision, operational substance and specificity. The key determinant used in the report to test accuracy seems to be whether hospital respondents <u>believe</u> the NPDB data were accurate. To determine accuracy by polling opinion, the real basis of OIG's conclusion here, lacks any substantial rigor.

On the dimension of uniqueness, providing data not elsewhere available, the NPDB appears to have scored well: nearly 40 percent of respondents indicated the NPDB reports provided at least <u>some</u> information not otherwise available to them and approximately half indicated the NPDB gave them information not provided by the involved practitioner.

These data, however, seem to have had very modest decisional consequences. Only 2 percent (3 of 142) said they would have made a different decision without the data bank report -- that is, with virtually no exception, the data bank report did not make a difference to the granting of privileges. Moreover, approximately 40 percent of respondents said the information was not useful (questions 26 and 28). And, for those responding that the data were "useful," the modal explanation given was that the NPDB report confirmed information secured elsewhere.

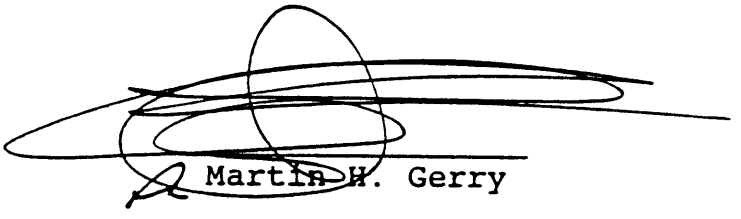
In sum, conclusions of the OIG report -- if the data on which it is based are statistically valid -- seem to support are three-fold:

1. Information on which decision makers appear to have made their privilege determinations was readily available from other sources.

2. Hospitals did not use the NPDB information in the way Congress intended, i.e., to determine the competence of physicians. They indicated that information about small payments (defined as $30,000 on page 7) is useful generally (page 7) but not in determining the competence of practitioners (page 10, where small payments are redefined, without explanation, as less than $20,000).

3. On balance, based on hospitals' reported responses, the data bank seems to provide nice-to-know information which has had little impact in deciding whether to grant privileges.

If you have any questions regarding these comments, please contact Elise D. Smith at 690-6870.



OIG RESPONSE TO ASPE COMMENTS

The ASPE notes that although a majority of hospitals surveyed rated the reports they received "useful," a very low number of hospitals cited an effect of Data Bank reports on privileging decisions. The ASPE argues that these data lead the reader to "opposite conclusion[s]."

This argument, we believe, confuses the distinction we make in the report between usefulness and impact. Usefulness measures the reliability and uniqueness of Data Bank reports and, more importantly, hospital officials' attitudes toward them. Impact, on the other hand, measures the actions that hospital officials took after receiving reports. A report that has no impact can still be useful if the user perceives it to be so.

The ASPE criticizes our definition and measurement of "usefulness." We disagree with ASPE's criticism. We believe it was appropriate for us to allow our survey respondents to interpret our questions on usefulness as they saw fit. What ASPE sees as a lack of "precision, operational substance, and specificity," we see as a chance for hospitals to assess the Data Bank's information on their own terms.

We question ASPE's second conclusion on page 2 of its comments. Our results do not necessarily demonstrate that hospitals are not using the Data Bank to determine the competence of physicians. True, few hospitals have denied privilege requests from physicians who have been reported to the Data Bank. But Congress surely did not intend that the privileges of all or even most practitioners reported to the Data Bank be denied. Furthermore, Congress likely did not intend that reports from the Data Bank be sufficient information on which to base privileging decisions. We believe that by contributing to the information available to hospitals the Data Bank is helping hospital officials to judge the conduct and character of practitioners, even when the officials ultimately decide to grant privileges as requested.

At ASPE's suggestion, we have changed our report so that we consistently define small malpractice payments as being under $30,000. We have also provided, in the methodology section and with endnotes, confidence intervals for the statistics we present.

Joint Commission
on Accreditation of Healthcare Organizations

November 4, 1992

Bryan B. Mitchell
Principal Deputy Inspector General
Office of the Inspector General
Department of Health and Human Services
Wilbur J. Cohen Building - Rm. 5250
330 Independence Ave., S.W.
Washington, DC 20201

Dear Mr. Mitchell:

This is in response to your letter of October 5, 1992 which invites the comments of the Joint Commission on Accreditation of Healthcare Organizations on your draft inspection report. "National Practitioner Data Bank: Usefulness and Impact of Reports to Hospitals." This report recommends that the Joint Commission establish guidelines on how quickly hospitals should query the Data Bank (NPDB) after receiving applications for privileges.

Joint Commission accreditation standards for hospitals presently require that there be medical staff, and governing body bylaws and that these complementary documents specify the timeframes within which requests for medical staff membership and privileges be acted upon. We would be pleased to consider inclusion of a specification in our accreditation survey scoring guidelines that would direct attention to the need for the timely seeking of information from the NPDB as an integral of evaluating applications for privileges.

We commend you and your staff for this thorough and thoughtful review of the operation of the NPDB, and trust that the foregoing response will be helpful to you.

Sincerely,

Dennis S. O'Leary, M.D.
President

American Hospital Association

AHA

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To call writer, telephone

November 25, 1992

Mr. David R. Veroff
Office of Inspector General
Office of Evaluation and Inspections
Region 1
John F. Kennedy Federal Building
Boston, MA 02203

Re: National Practitioner Data Bank: Usefulness and Impact of Reports to Hospitals

Dear Mr. Veroff

On behalf of the American Hospital Association (AHA) and its more than 5,200 hospitals, I welcome the opportunity to comment on your draft report "National Practitioner Data Bank: Usefulness and Impact of Reports to Hospitals." Since AHA members are principal users of Data Bank information and the chief financial support for Data Bank operations, the AHA is very interested in knowing how hospitals use Data Bank information and whether hospitals find the information useful during their credentialing and privileging process.

With respect to "Usefulness to Hospitals," the Office of Inspector General (OIG) makes the following findings that the AHA wishes to comment on:

- Forty percent of Data Bank reports have provided information previously unknown to hospital staffs.
- The Data Bank has delivered accurate reports to hospitals.
- The Data Bank's average time has been improving steadily.
- Hospital officials found 58 percent of Data Bank reports to be useful (*e.g.*, they confirmed information, etc.)

AHA Comments: One of the purposes of the Data Bank is to become a national repository for adverse action and malpractice information. Since individual states have different reporting criteria, it has been difficult, if not impossible, for hospitals in one state to receive practitioner information from hospitals in a second state. We are pleased that the Data Bank is meeting this challenge and is filling this information gap.

Since hospitals simply do not have the capacity to verify all information that comes to them from numerous sources, we are pleased that the system set up by the Data Bank is providing hospitals with accurate reports and confirming information hospitals had received from other sources.

OIG RESPONSE TO JCAHO COMMENTS

We thank JCAHO for considering a specification related to timely querying of the Data Bank. We direct JCAHO's attention to PHS's comments, which detail PHS's intent to work with JCAHO on this matter.

With respect to "Impact on Decisions," the OIG made the following findings:

- If hospitals had not received the Data Bank reports, their privileging decisions would have been different one percent of the time.

- Eighty percent of Data Bank reports had little chance to have an impact on hospitals' privileging decisions.

- Nineteen percent of Data Bank reports arrived before hospitals' decisions were finalized and contained information that neither the practitioner involved nor any other sources had provided, but did not have an impact on hospitals' privileging decisions.

AHA Comments: We find this part of the OIG report to be most telling. We were surprised that although hospitals may have received information they did not already have on practitioners, the information did not affect the hospitals' privileging decisions. This may be due, in part, to the newness of the Data Bank and the need for hospitals to integrate Data Bank reports into their privileging processes. On the other hand, this may also speak to the care and attention hospitals already devote to credentialing and the sufficiency of physician information provided by other sources.

With the Data Bank playing only a supplemental role, as a "back-up" tool to compare practitioner information, we question whether the Secretary of Health and Human Services can justify the high administrative and financial burdens on hospitals to support a back-up tool. If the Data Bank should expand to include licensing data on all practitioners, the administrative and financial burdens would increase, whereas the utility of the information during the credentialing process would still remain questionable.

Finally, the OIG recommends that the Public Health Service seek to further reduce the time between query and response and that the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) should establish guidelines on how quickly hospitals should query the Data Bank after receiving applications for privileges. We agree that the time between querying and Data Bank response should be improved. This will become more of an imperative if the Data Bank should expand to include licensing information on all practitioners. The AHA, however, has reservations with the recommendation that the JCAHO develop querying guidelines for hospitals, since most hospitals, by now, have developed their own procedures for querying and reporting to the Data Bank. These procedures may vary from one institution to another, depending upon the size of the institution and the number of practitioners who are privileged and credentialed. To request that the JCAHO establish guidelines, could further complicate the already complex querying responsibilities placed upon hospitals by the Health Care Quality Improvement Act.

The OIG and Public Health Service will need to study the long term effect the Data Bank has upon peer review to determine how Data Bank reports are used by hospitals in privileging practitioners. The AHA has recently distributed a survey to a small number of hospitals that will look further at the effect of the Data Bank on peer review, operational concerns of hospitals, cost/benefit ratios, and suggested Data Bank improvements. Once we have reviewed the results of that survey, we will be in a better position to comment on the effects of the Data Bank.

In summary, although we are pleased that the Data Bank is able to furnish hospitals with practitioner information they may not already have, we are concerned that this information has not had a more positive, influential ~~impact on~~ credentialing and privileging. No further

expansions would appear to be justifiable at this time given the current questions raised concerning the Data Bank's utility. Another study looking at this direct effect should be instituted by the OIG within the next two years.

If you should have any questions regarding our comments, feel free to contact Ila S. Rothschild at 312/280-6682.

Sincerely

Fredric J. Entin
Senior Vice President
and General Counsel

OIG RESPONSE TO AHA COMMENTS

Although the AHA is pleased with the information that the Data Bank is providing, it questions the cost-effectiveness of the Data Bank as a "back-up tool." We believe our report makes clear that in many cases the Data Bank provides information unavailable through any other source, and that in at least three cases it alone has led hospitals to deny privileges to practitioners. We believe the Data Bank is much more than a back-up tool.

We disagree that guidelines from JCAHO will complicate hospitals' querying practices. Instead, we believe that such guidelines will highlight the importance of timely querying and will establish minimum standards in that regard. We trust that JCAHO will consider the concerns of all sizes and types of hospitals in formulating its guidelines.

American Medical Association
Physicians dedicated to the health of America

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January 5, 1993

Bryan B. Mitchell
Acting Inspector General
Department of Health and Human Services
Office of Inspector General
330 Independence Avenue, SW
Washington DC 20201

RE: Draft Report, NPDB:USEFULNESS & IMPACT OF REPORTS TO HOSPITALS

Dear Mr. Mitchell:

The American Medical Association (AMA) is pleased to respond to your request for comments on the Office of the Inspector General's (OIG) draft report, NATIONAL PRACTITIONER DATA BANK: USEFULNESS AND IMPACT OF REPORTS TO HOSPITALS, September, 1992. The stated purpose of this study was to assess the utility to hospitals of the information in the National Practitioner Data Bank (NPDB).

After carefully reviewing the September draft report, the AMA concludes that the draft report only partially fulfilled its intended purpose. There are serious flaws in the draft report that should be corrected before release of a final draft.

The most serious deficiency in the draft report is that it totally ignores the overwhelming majority of NPDB reports to hospitals (over 1.5 million) and uses as its survey universe only the small number of reports that indicate an adverse action or malpractice payment (19,122). In fact, the draft report does not even disclose the number of reports sent to hospitals that indicated no adverse actions or malpractice payments on behalf of a practitioner.

There is no good rationale presented in the draft for excluding some 99% of NPDB reports from the survey universe. A valid measure of the utility of the NPDB to hospitals would require the inclusion of all users who are required to query, to pay, and who receive information.

The survey results presented in the draft may be misleading as a consequence of the narrow survey universe. The draft

concludes that a majority of NPDB reports were "useful" to hospitals. The definition of "usefulness" includes reports that merely confirm what the hospital already knew. This definition of usefulness is equally applicable to hospitals that receive reports confirming that there were no adverse actions or malpractice payments. Whether or not the majority of such reports would be considered "useful" is an important question left unanswered by the draft report.

The inappropriately narrow survey universe also affects the most significant and relevant finding in the draft--the proportion of reports that had any impact at all on the credentialling decision. The draft states that the reports in its survey universe "rarely" led hospitals to make credentialling decisions they would not have made without the reports. The actual weighted result was that only 0.5% of reports in the survey universe (of 19,122 reports) had any impact. If the survey universe had included the 1.5 million reports that indicated no adverse actions or malpractice payments, a truer picture of the impact of NPDB reports would emerge and the draft's characterization of actual impact being "rare" would be seen as a gross exaggeration.

Another deficiency of the survey is that the question regarding the "usefulness" of NPDB reports had little relation to the central purpose of assessing the utility of the NPDB to hospitals. The finding that a majority of surveyed reports were found "useful" is nearly meaningless. "Usefulness" includes everything from reports that merely confirm information already known, but which was not felt to have any bearing on the credentialling decision, to reports that contained previously unknown information helpful in judging competency. An assessment of the utility of the NPDB should focus on the purpose for which it was created. Otherwise, even an ordinary telephone directory, which verifies the correct address of the practitioner could be found as "useful" to hospital credentialling as the NPDB.

The draft also misinterprets the survey results regarding large and small malpractice payment reports and erroneously concludes that small malpractice payments (less than $30,000) should continue to be reported. The draft bases this conclusion on the finding that an equal amount of large and small payments were rated "useful."

Two additional relevant findings suggest the opposite conclusion: First, the draft states that many of the reports that provided information not previously known to the hospital, but did not affect privileging decisions, involved small malpractice payments. The draft concludes that hospital boards apparently do not consider these incidents serious enough to

warrant adverse privilege decisions. Second, in a footnote, the draft reveals that, even among hospitals that rated malpractice payment reports "useful", only 25% found small payments helpful in judging competency. (Large malpractice judgments showed an equally weak correlation with judging competence but this hardly justifies reporting small malpractice payments, which account for 44% of reports but only 4% of payments.)

We urge you to consider our comments carefully in order to assess adequately the utility to hospitals of the information in the NPDB..

Sincerely,

James S. Todd, MD

OIG RESPONSE TO AMA COMMENTS

We draw an important distinction between "the utility of the Data Bank to hospitals" and "the utility to hospitals of *the information in* the Data Bank." In this study, we hoped to determine which of the many types of information collected by the Data Bank were most helpful to users. (As it turned out, there were no significant differences among the types of information we evaluated.) We surveyed only hospitals that had experienced matches because only they had been exposed to this information. We also examined what impact, if any, reports from the Data Bank have had on privileging decisions. We assumed there would be no impact on decisions about practitioners who had never been reported to the Data Bank, so there was no need to include nonmatches in our sample.

The AMA takes issue with our definition of "usefulness." As we stated above in our response to comments from ASPE, we think that usefulness is properly defined by users.

The AMA argues against our conclusion that small malpractice payments continue to be reported to the Data Bank. Its argument is based on our findings that reports of small payments do not cause hospitals to make adverse decisions on privileging and rarely help hospitals judge the competence of practitioners. But there are valid reasons for retaining information in the Data Bank even under those circumstances, such as judging the veracity of statements made on practitioners' applications. In any case, we believe that hospitals are best qualified to judge the utility of small payment reports. We remind AMA that 57 percent of the recipients of small payment reports considered those reports useful, and that small payment reports are apparently just as useful as any other type of report.

We agree with AMA on two points: (1) that the utility of nonmatches remains unknown, and (2) that adverse privileging decisions resulting from Data Bank queries are even rarer than is suggested by our report. These questions could be addressed in a future study of the Data Bank, one which considers nonmatches as well as matches. We feel, however, that such a study would be premature at this point. The Data Bank's current match rate is artificially low because it has not had time to accumulate a significant number of reports and because its users are apparently still learning how best to utilize the information it provides.

APPENDIX D

NOTES

1. Actions that must be reported include adverse decisions on hospital privileges, including voluntary resignation; actions taken by State licensing boards on licenses, including suspension, denial, restriction, and revocation; and losses of membership in professional societies.

2. OIG Final Inspection Report, "National Practitioner Data Bank: Profile of Matches," OEI-01-90-00522.

3. The percentage of reports yielding information not provided by practitioners (47) is larger than the percentage of reports not provided by any source (40) because hospitals can be informed of a malpractice payment or disciplinary action by sources other than the practitioner.

4. Ninety percent confidence interval: 8 percent to 32 percent.

5. Ninety percent confidence interval: 1 percent to 19 percent.

6. Ninety percent confidence interval: 35 percent to 65 percent.

7. Ninety percent confidence interval: 69 percent to 100 percent.

8. This difference is statistically significant (Pearson's chi-squared = 4.38, $df = 1$, $p = .036$). Adverse action reports were defined as coming from out of State if the State of the reporting entity was different from the hospital's State. Because many physicians use out-of-State insurance companies, malpractice payment reports were defined as coming from out of State if the hospital's State was different from the practitioner's work state.

9. Hospitals responding to our survey were already aware of the six malpractice reports from out-of-State sources. Because of our weighting scheme, these reports overshadowed the out-of-state adverse action reports, which hospitals were less likely to know about.

10. M. Holoweiko, "The malpractice data bank is turning into a Frankenstein," *Medical Economics*, May 6, 1991, pp. 120-133.

11. One hospital answered "no" to the question of whether the Data Bank report was accurate. The respondent explained that the Data Bank report had disclosed a letter of admonition from a State licensing board that the board itself had not disclosed to the hospital. Although the Data Bank report was inconsistent with another source of information in this case, it was not inaccurate.

12. This hospital said it knew of four malpractice payments made on one practitioner's behalf since the Data Bank opened that were not mentioned in the Data Bank response. The hospital found out about these payments from the practitioner involved and from another hospital.

13. All references to queries in this report refer to queries about practitioners who had been reported to the Data Bank. We do not have any information about queries to the Data Bank that did not result in matches.

14. This proportion is calculated from only 4.06 weighted observations. The margin of error is 41 percent.

15. Ninety percent confidence interval: 49 percent to 83 percent.

16. We defined response time as the time a hospital had to wait between submitting a query to the Data Bank and receiving a report. We report the median rather than the mean because the mean was affected by a small number of very long response times.

    The Data Bank operators use a different measure of response time to assess their performance, because they have no control over the time that queries and responses are in the mail. They look only at the time between a query's arrival at their facilities and the time they mail a response back to the querier. For a further discussion of response and processing times, see page 12 and note 21.

17. For example, they might match on name and date of birth, but not on license number or other unique identifier fields.

18. Human operators can examine information such as address and medical school. Partial matches are only considered true matches if two operators reach that conclusion independently.

19. Ninety percent confidence interval: 58 percent to 90 percent.

20. Ninety percent confidence interval: 51 percent to 69 percent.

21. Ninety percent confidence interval: 28 percent to 46 percent.

22. Ninety percent confidence interval: 22 percent to 38 percent.

23. Totals do not add to 100 percent because respondents could give multiple answers.

24. Ninety percent confidence interval: 41 percent to 63 percent.

25. These reports were also rated similarly in terms of usefulness in judging competency. Twenty-five percent of reports on malpractice payments under $30,000 were found to useful because they helped judged competency, while 23

percent of reports on payments of $30,000 or more were found useful for this reason. Twenty-nine percent of the smaller dollar payments were found not useful because they did not help judge competency or professionalism, while 20 percent of larger payments were judged not useful for this reason.

26. Ninety percent confidence interval: 4 percent to 12 percent.

27. Ninety percent confidence interval: 4 percent to 12 percent.

28. Ninety percent confidence interval: 0 percent to 2 percent.

29. In one case, the practitioner's requested credentials were restricted somewhat because the hospital did not perform certain procedures.

30. In some cases, practitioners did not fail to disclose requested information. In these cases, the application forms were worded so that complete disclosure was not required. For example, they may have been required to say whether or not a malpractice payment had been made on their behalf, but not required to give the details of the payment that were available in the Data Bank.

31. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) rates each hospital on the rigor of the hospital's reporting requirements. It expects hospitals to require physicians to fully disclose disciplinary actions, voluntary surrenders of licenses or privileges, and malpractice judgments and settlements.

32. On pages 4 and 5, we note that recent response times, as reported by hospitals in our survey, average 26 days. We calculated response time as the number of days between the dates our respondents requested information from the Data Bank and the dates they received Data Bank reports (see questions 3 and 4, appendix B, page B-2). Response time, therefore, includes the time it takes to mail queries to the Data Bank and the time it takes to mail responses to hospitals as well as the processing time at the Data Bank. Unisys' turnaround time is only the processing time. Therefore, our finding is not necessarily inconsistent with the PHS reports that show it is usually meeting its goals.

33. This figure differs from the 18 percent cited on page 10 because pending decisions were not included in the analysis on page 10.

34. Although the universe of hospital matches as of March 19, 1992, numbered 19,122, our sample was drawn from only 19,111 of those matches. There were 11 matches involving hospitals that were excluded from the universe when our sample was drawn because at that time they were erroneously coded. We do not believe that the exclusion of this small number of matches introduced bias into our study. To remain consistent with our earlier "Profile of Matches" report, which gave the correct figure, we refer in this report to the true universe of 19,122 rather than the sample pool of 19,111.