Physician Late Career Policies Under EEOC Attack

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Agenda

- Review Yale-New Haven Hospital's Policy
- Summarize EEOC's legal arguments
- Provide overview of studies and documentation supporting age-based late career policies
- Present alternative age-neutral options
- Policy recommendations

Yale's Late Career Practitioner Policy

- **Overview**
  - Since March, 2016, as a condition of appointment, continued appointment and reappointment, MDs, DOs, dentists, podiatrists and certain advanced practice providers who require medical staff clinical privileges and who are 70 years or older must undergo a neuropsychological screening evaluation and a basic ophthalmologic exam.
  - The evaluation and exam are conducted thereafter at the time of reappointment.

Yale's Late Career Practitioner Policy

- The cognitive function evaluation includes 16 tests which are administered by a neuropsychologist and focus on the following areas:
  - information processing
  - visual scanning and psychomotor efficiency
  - processing speed and accuracy
  - working memory
  - concentration
  - verbal fluency
  - executive function

Yale's Late Career Practitioner Policy

- Results are reviewed by a medical staff committee which then makes recommendations to the Credentials Committee.
- The medical staff physicians at the Hospital are not Hospital employees.

- **Results**
  - As of April, 2019, the Policy was applied to 145 individuals.
  - The age range was 70 to 84 – average age was 74.
  - 86% were men and 89% were physicians.
  - 14 were listed as "Borderline deficient"
  - 1 was listed as "Deficient"
  - 7 "Failed"

Yale's Late Career Practitioner Policy

- 5 were "N/A" because they refused testing and either resigned or changed their status.
- 80 "Passed"
- 38 "Qualified Passed"
  - 21 have been retested a second time and all "Passed" or "Qualified Passed"
- 18 demonstrated cognitive deficits that were likely to impair their ability to practice medicine independently
  - None were independently identified as having performance problems
  - All opted to voluntarily discontinue their practice or move to a closely proctored setting

Interrelationship between Hospital and Yale Medical School (“YMS”)

- Hospital and YMS operate under a 100-page Affiliation Agreement.
- Agreement fully integrates the operations of both.
- YMS has a large say on who heads each clinical department.
- All YMS faculty with appointments in clinical departments must obtain and maintain medical staff privileges at the Hospital.
- Hospital has a comprehensive appointment/reappointment process and ongoing monitoring and peer review procedures including the imposition of an FPPE or similar plan when warranted.

EEOC Complaint

- Plaintiff is a pathologist who filed a charge with the EEOC 30 days prior to filing of the lawsuit alleging violations of the Age Discrimination in Employment Act, 29 USC Section 621, et. seq. (“ADEA”) and the Americans with Disabilities Act, 42 USC Section 12101, et. seq., as amended by the Americans with Disabilities Act Amendment Act of 2008 (“ADA”).
- EEOC issued a Letter of Determination finding reasonable cause that the Hospital violated the ADEA and ADA with respect to the Plaintiff and other aggrieved individuals because the Policy only applied to practitioners who were 70 or older rather than to all practitioners irrespective of age.

EEOC Complaint

- EEOC issued a Notice of Failure of Conciliation on October 11, 2019 when efforts to reach an acceptable agreement failed.
- The EEOC Complaint was filed on February 9, 2020, in the U.S. District Court in the District of Connecticut.
- **ADEA Claim**
  - The ADEA makes it unlawful, among other things, for an employer:
    - to fail or refuse to hire or to discharge any individual or otherwise discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's age;

EEOC Complaint

  - To limit, segregate, or classify his employees in any way which would deprive or intend to deprive any individual of employment opportunities or otherwise adversely affect his status as an employee, because of such individual's age;
- Because the Policy applied only to those age 70 or above, the Plaintiff, who passed the examinations, and other employees were subjected to the stigma of being singled out because of their age and to unlawful discrimination and classification of applicants and employees in violation of the ADEA

EEOC Complaint

- The effect of the practices has been to deprive the Plaintiff and a class of applicants and employees age 70 and above of equal employment opportunities and otherwise to affect adversely their status as applicants or employees because of their age
- The unlawful employment practices complained of were willful within the meaning of the ADEA

EEOC Complaint

- **ADA Claims**
  - The ADA states that an employer “shall not require a medical examination and shall not make inquiries of an employee as to whether such employee in an individual with a disability or as to the nature or severity of the disability, unless such examination or inquiry is shown to be job-related and consistent with business necessity”
    (42 USC Section 12112(d)(4)(A))
  - The Policy’s ophthalmologic and neuropsychological exam are medical examinations under the ADA and their use on the Plaintiff and other employees solely on the basis of their age violates the ADA

EEOC Complaint

- The unlawful employment practices complained of were intentional and done with malice or with reckless indifference to the federally protected rights of the Plaintiff

EEOC Complaint

- **Interference with Rights Protected by the ADA**
  - The ADA makes it unlawful to “interfere with any individual in the exercise or enjoyment of any right granted or protected by [the ADA].”
  - Under the ADA, an employee has a right to enjoy employment free from unlawful medical examinations
  - By subjecting the Plaintiff and other YSM employees (and employees of other employers) whose employment with YSM (and other employers) requires the receipt and maintenance of medical staff privileges at the Hospital to medical examinations under the Policy, the Hospital has unlawfully interfered with these employer’s rights under the ADA

EEOC Complaint

- **Comment**
  - The EEOC in its EEOC Compliance Manual, Section 2 – Threshold Issues, has a Section entitled “Third-Party Interference with Employment Opportunities.” This Section provides as follows:
    - In addition to prohibiting employers from discriminating against their employees, Title VII, the ADEA, and the ADA prohibit a covered third-party employer from discriminatorily interfering with an individual’s employment opportunities with another employer.
    - While the third-party employer might, in some cases, be a joint employer, the principle described here applies even where an employment relationship has never existed between a third-party employer and the individual. This kind of liability is commonly known as “third-party interference.”

EEOC Complaint

  - The ADA specifically prohibits interference with rights protected under the statute. While Title VII and the ADEA do not include comparable provisions, they prohibit discrimination against “individuals”. Therefore, a charging party need not necessarily be an employee of the employer that is accused of discriminatory interference.
- The EEOC gives an example of how this third-party interference principle applies in the context of a hospital/physician relationship very similar to its arguments against Hospital.

EEOC Complaint

- Respondent is a hospital that receives emergency room services from ABC Medical Corp. CP is employed by ABC as the director of Respondent's emergency room. CP files a charge alleging that Respondent discriminated against her on the basis of age and sex by asking ABC to replace her with a younger male director. Respondent is a covered employer under Title VII and the ADEA. Under these circumstances, CP has a Title VII and ADEA claim against Respondent for interfering with her employment relationship with ABC. If Respondent exercises sufficient control over CP, it may also be a joint employer.

EEOC Complaint

- See Enforcement Guidance On Control By Third Parties Over The Employment Relationship Between An Individual And His/Her Direct Employer, EEOC Compliance Manual, Volume II, Appendix 605-F.
- See Sibley Memorial Hospital v. Wilson, 488 F.2d 1338, 1341 (D.C. Cir. 1973).

EEOC Complaint

- **But**
  - Plaintiff and most of the physicians are not employed by the Hospital – they are employed by the University
  - EEOC has alleged in its their complaint that all Physicians affected by the Policy are employees
  - EEOC, at this stage at the pleadings, is not required to set forth the basis of it's claim that the independent physicians are employees.
  - Independent contractors cannot seek protection under the ADEA or ADA

EEOC Complaint

- Absent a direct to employment relationship, a claimant must establish that, in this case, the Hospital has sufficient and direct control over the individual. Some factors include:
  - When, where, and how the individual performs the job
  - Does job require a high level of skill or expertise
  - Does the Hospital furnish the the tools, materials and equipment
  - Does the Hospital have a right to assign additional projects to the worker
  - Does the Hospital sets the hours of work and duration of the job
  - Is the individual paid by the hour, week, or month rather than the agreed cost of performing a particular job

EEOC Complaint

  - Does the individual hire and pay assistants
  - Can the Hospital discharge the individual

- A Hospital which has an existing late career policy or which is considering such a policy should consult with legal counsel to determine whether there have been court decisions within it's jurisdiction which have addressed these direct control factors to determine whether independent physicians will be treated as employees for purposes of Title VII, the ADEA or the ADA

Why have some medical staffs developed late career evaluation policies?

First, a lesson learned from the past …

Aging is not for sissies!

- FACTS: In the general population, aging negatively impacts
  - Vision
  - Hearing
  - Dexterity
  - Stamina
  - Cognition
  - Memory
  - Judgment
  - Etc.

Physicians are not immune from aging!

Profiles in Cognitive Aging

by Douglas H. Powell

Age-related differences in MicroCog total score

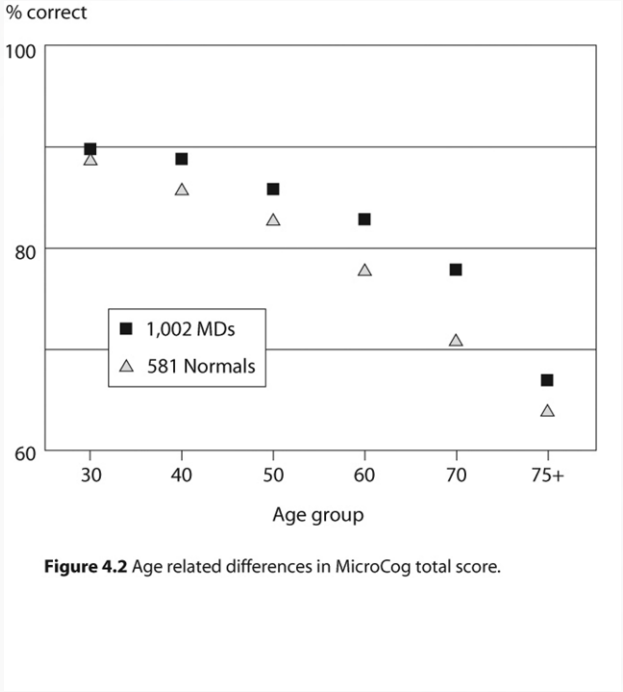


Figure 4.2 Age related differences in MicroCog total score.

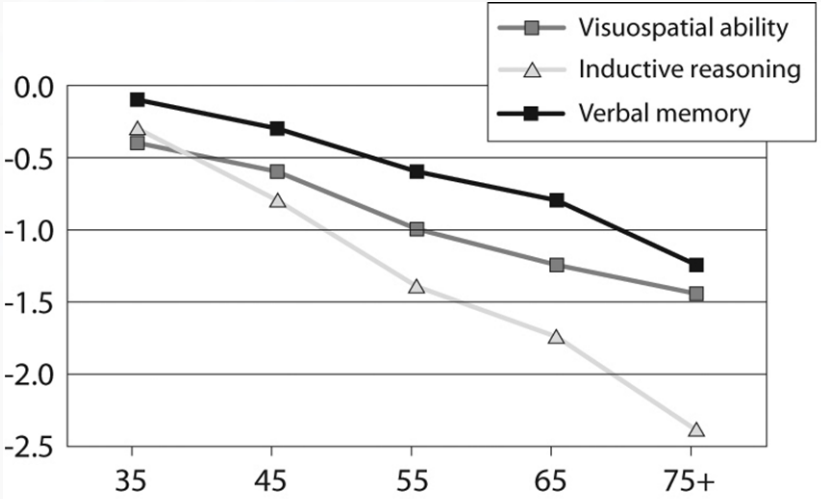


Figure 4.7 Age-related differences in memory, reasoning, and visuospatial ability of subjects aged 35-75; decline expressed in young adult (22-28) standard deviations. *Source:* Adapted from T. A. Salthouse, *Theoretical Perspectives on Cognitive Aging* (Hillsdale, N,J.: Erlbaum, 1991).

Is there evidence that aging can negatively impact practitioner clinical performance?

- Multiple published scientific studies demonstrate the negative effects of aging on **SOME** practitioners
- Early publications
  - Annals of Internal Medicine (2/2005)
  - Annals of Surgery (9/2006)
- Academic Medicine: *Predictors of Physician Performance on Competence Assessment: Findings from CPEP—Center for Personalized Education for Physicians* (6/2014)

Is there more evidence that aging can negatively impact practitioner clinical performance?

- AMA Report 5 of Council on Medical Education *Competency and the Aging Physician* (2015)
- California Public Protection and Physician Health, Inc (CPPPH)
  - *Assessing Late Career Practitioners: Policies and Procedures for Age-based Screening* (2015)
- Medicare: Analysis of 736,000+ hospitalizations managed by 18,800 hospitalist physicians (median physician age, 41 years) (2017)
  - Higher patient mortality was observed with care provided by older physicians with low volume
- . . . And lots more articles and studies -- Just Google the subject!

Who else has weighed in on this topic?

- JAMA: *Best Practices in Assessing Aging Physicians for Professional Competency* (1/2020)

- JAMA Editorial: *Opportunities and Challenges in Valuing and Evaluating Aging Physicians* (1/2020)

Other Industries

- Commercial pilots / Air traffic controllers
- FBI agents
- Judges (Depends on the State – e.g., 70, 72, 75)
- Public Safety (Law enforcement, Firefighters
  - Allowed but up to each agency
  - New York & Chicago—age 63
  - New Jersey State Police, age 55
- State drivers license regulations

What do regulators/accreditors say about assessing the impact of aging and health-related issues?

Applicability of Legislation

- **Americans with Disabilities Act (ADA) 1986**
  - Interpreted to apply to ability to exercise privileges with or without accommodation

- **Age Discrimination and Employment Act (ADEA) 1967**

Healthcare Regulations / Standards

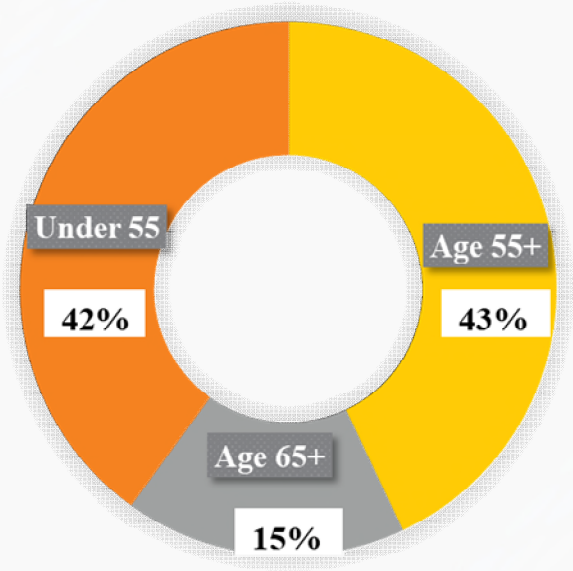
- CMS, TJC, HFAP, DNV GL require evaluation of health status upon application
  - TJC requires the applicant submit a statement that no health problems exist that could affect his/her ability to perform the privileges requested
  - Thereafter, the applicant's ability to perform must be evaluated, documented, and confirmed—by the medical staff leadership

TJC / AMA collaborate to create physician health standards

- The medical staff establishes a process to identify and manage matters of individual health for LIPs—separate from disciplinary actions. The process includes
  - Referral for evaluation, diagnosis and treatment
  - Education
  - Prevention of physical, psychiatric, or emotional illness
  - Facilitates confidential diagnosis, treatment and rehabilitation

Practicing Physicians in US by Age

33% increase* in # of practicing physicians 65+ since 1980



*Assoc Medical Colleges 2018

Dr. Martin Makary's observations

- Screening for physical and cognitive improvements can weed out those who should no longer be practicing while giving those who are fully functional the freedom to practice without the stigma of ageism.

Martin "Marty" Makary, MD, MPH
Chief of Minimally-Invasive Pancreas Surgery
Professor of Health Policy & Management
Johns Hopkins Hospital

Dr. Makary's observations (cont'd)

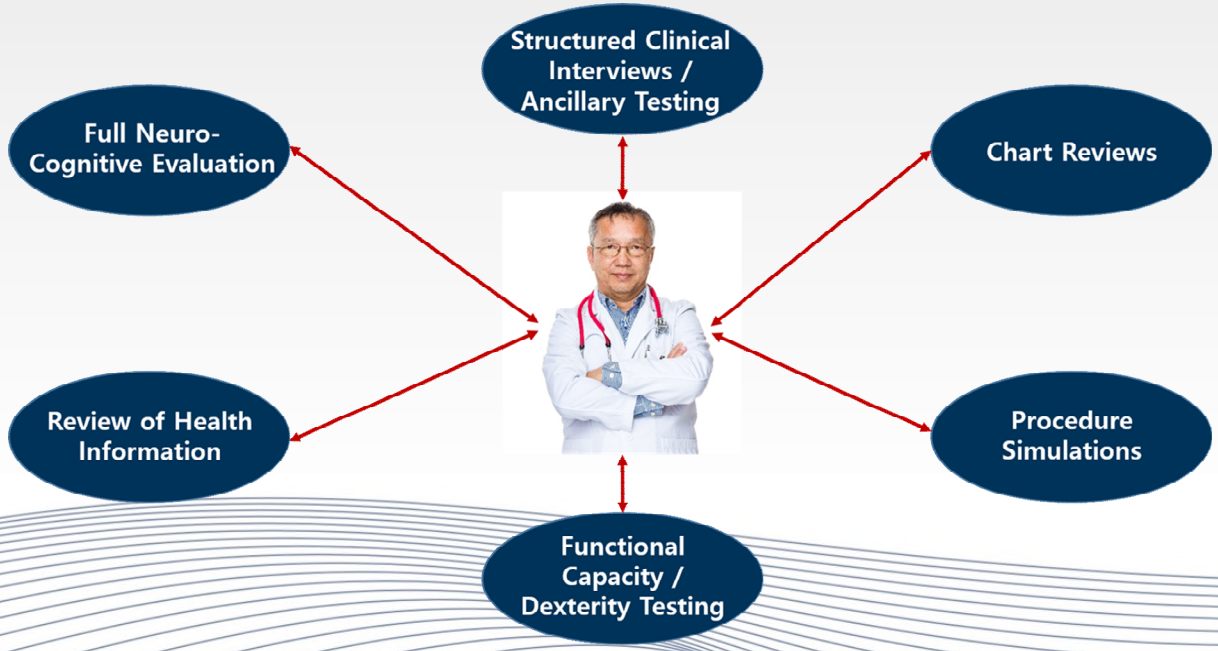
- An older doctor can be a font of wisdom and experience. However, "Fred Flintstone care" can be provided by doctors who have not kept pace

  For example, some older surgeons are "all over" minimally invasive surgery. However, many have just ignored minimally invasive techniques. Their patients may receive state-of-the-art care for 1976

Assessment & Evaluation Centers

- Federation State Medical Boards Physician Assessment Resources
  - Assessment programs, tools, referral process
  - Directory of US Assessment and Remedial Education Programs
  - www.fsmb.org/licensure/spex_plas/physician-assessment-referral-process

Fitness for Duty Evaluation



Aging is a risk factor for poor performance

Predictors of Physician Performance on Competence Assessment

E.S. Grace, E.F. Wenghofer, E.J. Korinek

https://www.cpepdoc.org/performance-predictors/

To identify factors associated with physician performance rating in a comprehensive competence assessment

- Retrospective analysis
- 683 physicians assessed at CPEP
- Evaluated as either safe or unsafe to practice
- Multivariate logistic regression

Grace, ES; Wenghofer, EF; Korinek, EJ. Predictors of Physician Performance on Competence Assessment: Findings from CPEP. *Acad Med*. 2014 Jun;89(6):912-9

Predictors Study Findings

- More likely to have unsafe outcome
  - For each year of increasing age
  - General practitioner (did not complete full residency)
  - In solo practice
  - Current or previous licensure action
- Less likely to have unsafe outcome
  - Board-certified
  - Practice scope matches training

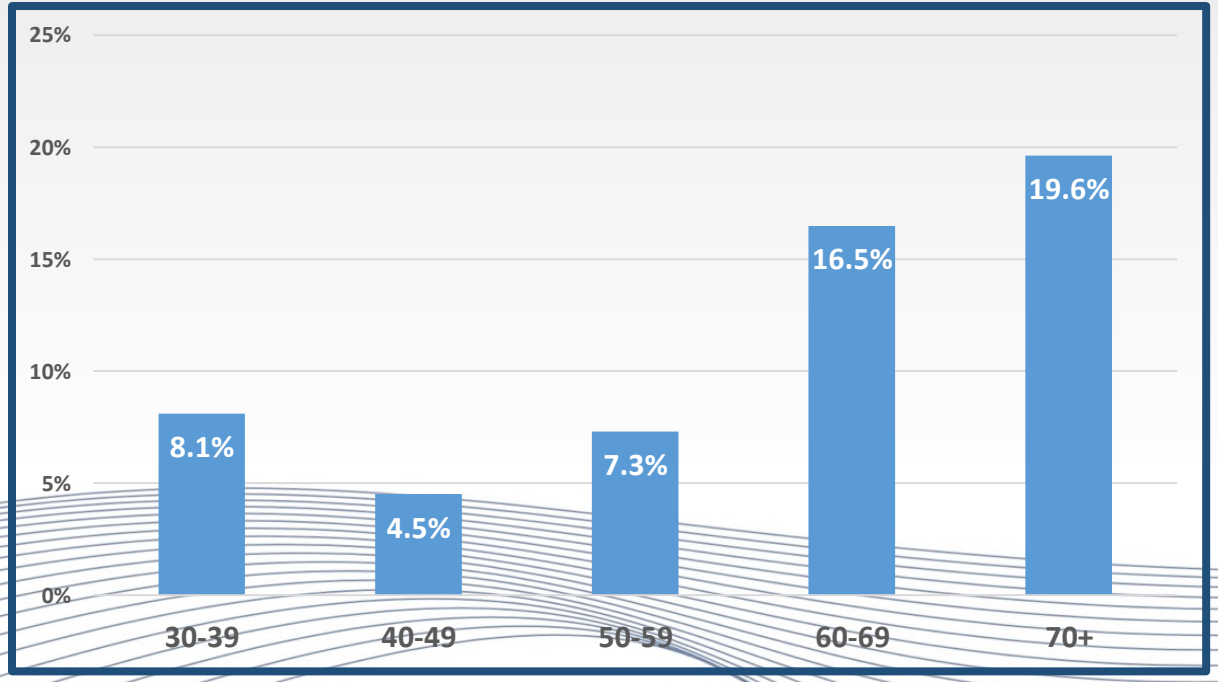
•Regression model accounted for 26% of variation

Grace, ES; Wenghofer, EF; Korinek, EJ. Predictors of Physician Performance on Competence Assessment: Findings from CPEP. Acad Med. 2014 Jun;89(6):912-9

Findings on Competence Assessment and Reentry Participants

Percent Evaluated Unsafe to Practice by Age Group

2015 -2019; N = 572 participants



UC San Diego PACE
Late Career Health Screening for Physicians and Healthcare Professionals (LCHS)

- **What it Is:** health screening intended for late career physicians or healthcare professionals who have reached a certain age (generally 70 and older), but otherwise have no known impairment or competency problems.
- **Purpose:** LCHS is designed to detect the presence of any physical, cognitive, or mental health problems affecting an individual's ability to practice medicine.
- **What it is NOT:** It is not intended to be used in "for cause" assessments of individuals who are suspected of having impairment.
- **Length:** ½ day

UC San Diego LCHS

- Review of self-report health questionnaires
- History and physical examination
- MicroCog™ Cognitive screening exam/MOCA®
- Mental health screen (PHQ-9, GAD-7)
- Substance use screen
- Dexterity test (for proceduralists only)
- Suturing simulation (for those that suture)

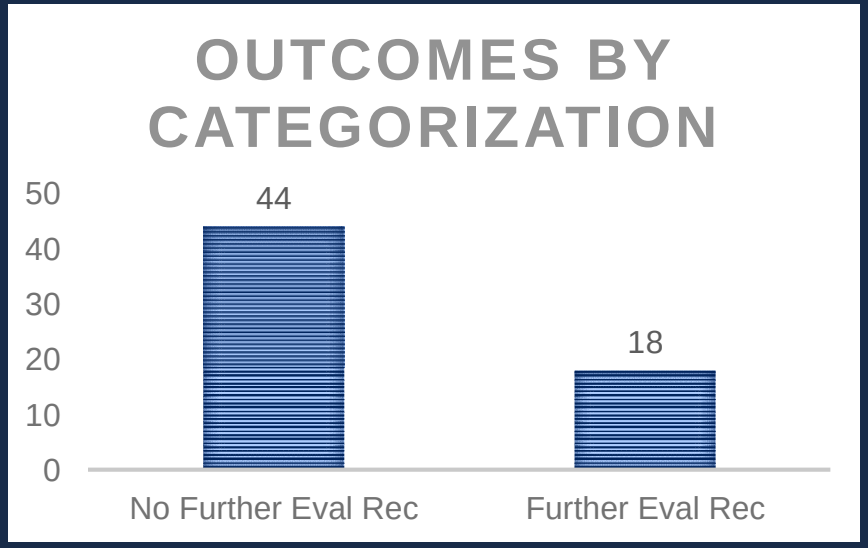
Final determinations

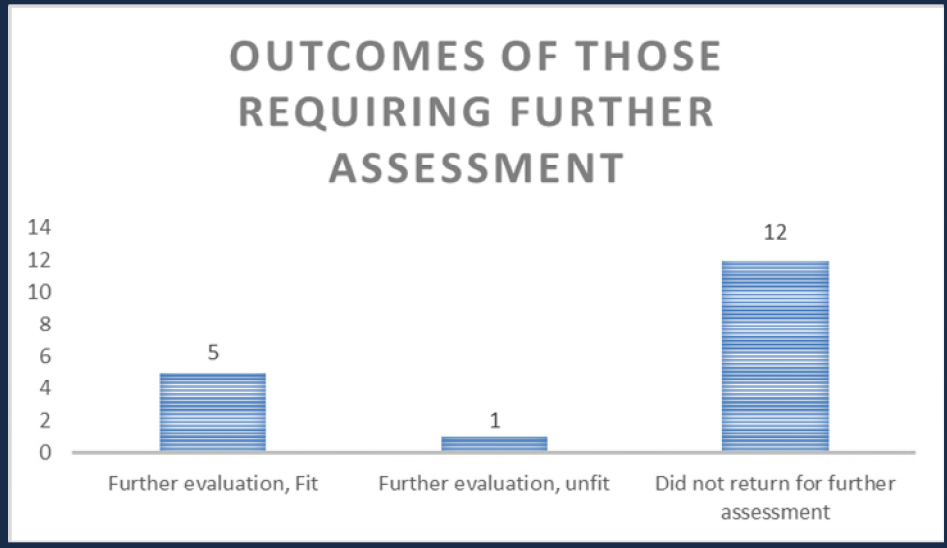
- NO FURTHER EVALUATION RECOMMENDED
  - Results either indicate
    - No presence of illness exists that interferes with the physician or healthcare professional's ability to safely perform the duties of his or her job
    - Presence of illness exists but currently does not interfere with the individual’s ability to safely perform the duties of his or her job. Reevaluation may be recommended depending on the expected course of any present illness(es).
- FURTHER EVALUATION RECOMMENDED
  - Results indicate a possible impairment exists due to a physical or mental health problem. For those identified with possible impairment a fitness for duty evaluation may be recommended.

Active work: Total evaluations 62, 7 Contracts (7/19)

Multiple assessments:	**2 assessments: 6**	**3 assessments: 1**	**4 assessments: 1**
Gender:	**Male: 52**	**Female: 10**	
Age:	**Oldest: 80 (rads, F.E.N.)**	**Youngest: 62 (NV Bd., fit)**	**Average: 72.4**
Referring organizations:	**Hosp/Med Grp: 60**	**State Board: 1**	**Other: 1**
Board Certified:	**Yes: 59**	**No: 3**	

Outcomes





UC San Diego
SCHOOL OF MEDICINE

Existing and Alternative Age Neutral Policies

- **Code of Conduct**
  - Code of Conduct policies typically identify areas of unacceptable conduct including different forms of harassment
    - These policies require physicians and other employees to document adverse or unacceptable behaviors, which could include suspected impairment, which are then reviewed, investigated and, if affirmed, typically results in a progressive remedial action approach starting with a warning but ultimately can include termination for repeated violations
- **Disruptive Behavior Policy**
  - Similar to Code of Conduct Policy

Existing and Alternative Age Neutral Policies

- **FPPE/OPPE Policies**
  - These policies identify specific criteria developed by each department which are then evaluated for new applicants as well as for existing physicians and practitioners on an ongoing basis
  - These policies, consistent with accreditation standards, are typically viewed as part of routine peer review including FPPE plans which are triggered by the identification of a pattern of adverse events and substandard care

Existing and Alternative Age Neutral Policies

- **Physician Wellness Committees**
  - Physician Wellness committees are designed to accept the referrals from medical staff leadership or committees when there is a reasonable suspicion that a physician may suffer from some form of physical, psychiatric or other impairment which could result in adverse patient consequences
  - This committee typically is multidisciplinary in nature, including a psychiatrist, which will then either conduct an initial evaluation which can take many forms or which may refer the physician to an outside agency for a more thorough evaluation including physicals, fitness for duty evaluation, or neuropsychological testing

Existing and Alternative Age Neutral Policies

- All of these policies are age neutral but rely on either self-reporting or the reporting of by peers and other individuals at the Hospital
  - Studies have demonstrated that there is significant under reporting even when suspected impairment, disruptive behavior and other forms of unacceptable conduct is observed.
- **Factors Associated with Cognitive Decline**
  - The various studies and publications which have observed certain quality of care, physical, psychological, cognitive and other deficits associated with aging have identified the following factors, some of which may already be tracked within an organization through one of the existing programs and policies identified above. These include but are not limited to the following:

Existing and Alternative Age Neutral Policies

- Disruptive behavior
- Fatigue, stress and burnout
- Decline in clinical performance
- Longer length of stays
- Incomplete medical records, inappropriate comments contained in medical records and documentation errors
- Prescription errors
- Billing mistakes
- Irrational business/patient care decisions
- Skill defects
- Patient complaints

Existing and Alternative Age Neutral Policies

- Office staff/peer observations of deficits
- Patient injuries
- Lawsuits
- Unsatisfactory peer review evaluations
- Failure to keep up with continuing medical education requirements
- Recertification failures
- Decreased processing speed
- Increased difficulty inhibiting irrelevant information
- Decreased hearing and visual acuity
- Decreased manual dexterity
- Decreased visuospatial ability

Existing and Alternative Age Neutral Policies

- Higher mortality rates
- Diagnostic errors
- Use of outdated medications and treatment forms and modalities

- **Alternative Approaches and Policies**
  - Incorporate all or some of the factors listed above into the routine appointment and reappointment application process in which these factors are investigated, identified and reflected in reports being sent to the Department Chair, the Credentials Committee, the MEC and eventually the Board of Directors

Existing and Alternative Age Neutral Policies

- Incorporate some or all of these factors into existing FPPE/OPPE policies which are then monitored on a continuous basis and reviewed, as appropriate, as part of collegial intervention and routine peer review processes
- Strongly recommend that physicians who reach a particular age or a certain number of years in practice that they voluntarily agree to take a physical, ophthalmologic, neuropsych evaluation or other evaluative process as deemed acceptable by the medical staff and Hospital
  - decision would be voluntary and refusal to do so should not result in any disciplinary action, reduction in staff category or other similar adverse outcome

Existing and Alternative Age Neutral Policies

- in the event that deficits are identified, the physician will be required to disclose the report so that it can be further reviewed and appropriate next steps taken
- If the practitioner does not agree to be voluntarily assessed, to the extent that the Hospital has not already incorporated the factors above into an FPPE/OPPE Policy, the Hospital could then do a concurrent or retrospective review of the practitioner's cases and other practices to determine whether there are any red flag factors which could result in further reviews or a requirement to undergo identified evaluations

Non-Disciplinary Remedial Measures

- As should be true with existing policies, the identification and confirmation of any problems relating to impairment or any form of deficit should not, absent extreme danger to patients, result in the imposition of disciplinary action.
- Hospitals and medical staffs should instead implement and apply its existing peer review policies and collegial intervention methods in order to identify the cause of any identified issues in order to allow the physician to address these issues and to attempt to identify other remedial steps short of disciplinary action.

Non-Disciplinary Remedial Measures

- Depending on the results of this review, it may be appropriate to then work with a Physician Wellness Committee which would serve as an advocate for the physician but also require a physical examination, ophthalmological test as well as neuropsych evaluations in order to identify whether the physician suffers from such defects that require that some form of support or alternative practice options should be considered.
- These other remedial measures can include the following:
  - Changing/limiting practice
  - External support
  - Retraining/reeducation
  - Eliminate or reduce procedural work

Non-Disciplinary Remedial Measures

- Allow more time in taking care of and treating patients
- Provide memory aides
- Provide or require consultations with other physicians for second opinions
- Reduced or removal from ED on call schedule
- Mandatory consultations
- Proctoring

Late Career Assessment Policy Development

- Find a champion . . . Better yet, find 2 or 3!
- Appoint a task force
  - Medical staff leaders (MEC, Credentials, Department Chairs)
  - Physician Advocate Committee
  - CMO / MSP
- Educate all involved
- Provide resources (articles, policies, info on testing modalities)

Policy Goals

- Protect the patient
- Support practitioners
- Protect practitioner rights
- Define a process for medical staff leaders and the organization

Policy Content

- Responsible parties
- Scope (e.g., all privileged practitioners)
- Event(s) that trigger Policy implementation
  - Age – Applies equally to all as of certain age
  - Life events
  - Performance outcomes
  - Behavior
  - Other

Policy Content

- Practitioner responsibilities
- Staff responsibilities (Individuals: MS, APP, hospital staff)
- Medical staff leader responsibilities
- Medical staff services responsibilities
- Scope of assessment (Who? What? How?)
- Documentation (Forms, etc.)
- Information flow
- Consequences

Other Aspects to Consider

- One-year appointments
- Increased peer review
- Skills lab
- Role of Physician Advocate Committee/Wellbeing Committee

Resources for Policy development

- California Public Protection and Physician Health, Inc (CPPPH)
  - *Assessing Late Career Practitioners: Policies and Procedures for Age-based Screening* (2015)

- Research, Research, Research ! ! !

Review & Approval Process

- Task Force recommendations vetted
  - Individuals affected
  - Department chairs
  - Credentials / MEC
- Formal review and recommendation
  - Credentials / MEC
- Approval
  - Governing body

So What Now?

- Hospitals with an Existing Age Based Physician Age Based Policy
  - Continue to apply the Policy and hope there is no legal challenge
  - Hold in abeyance pending outcome of the EEOC litigation – a long wait ahead
  - Consult with legal counsel to determine how courts within your jurisdiction have interpreted whether a non-employed individual or independent contractor is treated as an employee based on the control and other factors noted above
  - Consider implementing one of the alternative options/policies discussed above or some variation
  - Terminate the Policy but still track the red flag factors and act accordingly

So What Now?

- Hospitals and Medical Staffs Considering the Adoption of a Policy
  - Hold in abeyance pending outcome of the EEOC litigation – a long wait ahead
  - Consult with legal counsel to determine how courts within your jurisdiction have interpreted whether a non-employed individual or independent contractor is treated as an employee based on the control and other factors noted above
  - Consider implementing one of the alternative options/policies discussed above or some variation

Michael R. Callahan

A nationally recognized advisor to health care providers across the country, Michael Callahan provides deeply informed advice in all areas of Hospital-physician relations and health care regulatory compliance including EMTALA, HIPAA the Medicare CoPs and licensure accreditation standards. He is widely respected for his leading work on the Patient Safety Act from a regulatory Policy and litigation standpoint including the development of patient safety organizations (PSOs).

Practice focus

- Federal and state licensure and accreditation for Hospitals and health systems
- Hospital-physician relations including contracts, bylaws and peer review investigation and hearings
- PSOs and participating provider policies, compliance and litigation support
- CMS and state departments of health investigations
- Assisting health systems with medical staff integration

The knowledge to identify efficient and practical solutions

- Health systems, Hospitals and physician groups large and small, across the country come to Michael for practical, real-world guidance and answers to challenging legal and operational issues which Michael can provide quickly because of his many years of experience. He understands the reality of Hospital quality, peer review, risk management and related operational legal and regulatory complexities and can rely on a large client base in order to also provide better and comparative solutions.
- He also is sought out by many of the largest health systems around the country for his understanding and interpretation of the Patient Safety Act. In a case of first impression he advised a national pharmacy that became the first provider to successfully assert an evidentiary privilege under the Patient Safety Act. Since that case, he has represented or advised many Hospitals, physician groups and other licensed providers in creating or contracting with federally certified PSOs and has been directly involved in most of the major state appellate and federal court decisions interpreting the Patient Safety Act.

Carol Cairns, CPMSM, CPCS

- Healthcare consultant, speaker, author, and expert witness
- Specialties: medical staff organizations, credentialing, privileging, survey preparation, negligent credentialing
- Career of more than 45 years
- Advisory consultant with The Greeley Company 1996 – 2019.
- Author of numerous articles & books including first 6 editions of *Verify & Comply*
- Roles with The Joint Commission, HCPro, AMA, and NCQA
- Member of NAMSS since inception. NAMSS instructor from 1990-2017
- Frequent presenter at state and national organizations including NAMSS, The Greeley Company, AMA, HCPro
- Past member
  - Board of Directors Bylaws and Credentialing Committee of Presence Saint Joseph Medical Center (Joliet, Ill.)
  - Presence Central & Suburban Hospitals Network Board of Directors

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