



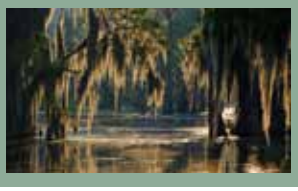

MGMA Medical Group Management Association Louisiana

Louisiana Lagniappe

The Official Newsletter of MGMA Louisiana

June 2016 • Issue 01

Upcoming Events

August 17-19, 2016

Annual Conference

The Roosevelt
New Orleans

For more information, visit www.lmgma.org.

From the President

President
Mary Alice Stanford, CMPE
Renal Associates Baton Rouge
Baton Rouge, LA

Summer is here! While summer has a reputation for slowing of pace and time for rest and relaxation, changes in the health care industry seems to be moving at an increasing pace year round. I recently had the opportunity to visit the offices of our Senators and Representatives on Capitol Hill to discuss a few bills of particular interest to my specialty society. While I have been personally frustrated that the political environment in our country has become contentious and unproductive over the past several years, I was surprised at how excited and proud I was to attend these meetings, and have my say. It was a great reminder to me that we still live in a democratic country, and while our system is not perfect, it is the best system, and that our voice matters. Each person I met with made it clear that they want to hear from us. Our legislative liaisons, Tim Barrett, CPA for national issues and Greg Ivy for state issues, work hard to keep us updated on legislative issues affecting health care. Be sure you have your say, and help to influence laws by contacting your legislators on issues important to your practice!

I hope you have enjoyed the FREE monthly webinars, a great benefit to membership! If you missed our June webinar Unprecedented Transformation for Reimbursement is here: Merit-Based Incentive Payment Systems, it is available to view On-Demand for 90 days. Visit our Members Only page to download the webinar. Practice Managers cannot be overeducated on this topic. In my opinion, it will be the biggest and most complicated transformation in health care that we have seen. You can look for this topic again at our **Annual Meeting and Conference being held August 17-19 at The Roosevelt in New Orleans**. I sincerely hope to see you there!

Please, at any time, let us know how we are doing. We know you have many choices on where to place your resources. We're glad you chose MGMA-LA, and want to make your membership valuable.

Yours,

Mary Alice

Legislative Update

Greg Ivey, The Pediatric Center, Sulphur, LA

Louisiana budget shortfall shrinks in latest estimate ahead of 'debate over priorities, 'how much money is available'

- BY Elizabeth Crisp| ecrisp@theadvocate.com

Louisiana's state budget shortfall is now estimated at about $600 million — 20 percent smaller than previously thought.

During a Monday budget briefing, Gov. John Bel Edwards' administration continued to caution legislators that the outlook for the state spending plan that begins July 1 still would require deep cuts to funding for scholarships awarded through the popular Taylor Opportunity Program for Students and other state support to higher education and health care, if legislators don't find ways to fill the remaining gap.

"It's going to be a debate over priorities and how much money is available," Commissioner of Administration Jay Dardenne told the Senate Finance Committee, explaining that the gap previously estimated at about $750 million has shrunk, thanks to savings expected when the state expands Medicaid under the federal Affordable Care Act later this year.

Dardenne said the figures could continue to shift — even as legislators look at other ways to carve out savings.

The House Appropriations Committee — the first step in the budgeting process — is expected to reveal its plans for the budget in the coming weeks. The budget bill, House Bill 1, is expected to make its way to the House floor as early as May 12, before the Senate gets its crack at it.

Edwards has presented a spending plan to legislators that would drastically change TOPS because of the cuts, if legislators don't move to raise more revenue, causing thousands of students to lose their scholarships.

The state previously faced a $2 billion hole in the coming year's budget, but legislators during a special session earlier this year raised taxes and made other cuts to begin to bridge the gap.

Lawmakers must pass a balanced budget but can't raise revenue during the current legislative session, under state law. Edwards, a Democrat who took office Jan. 11, is expected to call a second special session after the regular session ends June 6.

Edwards has frequently noted that he's looking to a new task force to come up with a short-term plan for filling the immediate gap, as well as long-range plans lawmakers can consider during the 2017 legislative session that will focus on financial issues.

Edwards said during a recent meeting with reporters that he expects the task force recommendations will be similar to recommendations that have been produced by groups in the past.

"I don't believe the proposals that we'll see coming out of the task force will be different from before," Edwards said.

Jim Richardson, an LSU economics professor who co-chairs the latest task force, said the group will spend the next month evaluating proposals that can be passed during the second special session.

But some legislators say they are looking for more from the state's new leader — as far as his vision for state services, including higher education, health care and the state's tax base.

"I hear nothing from the Governor's Office on where he wants to take the state on restructuring all these elements," said state Sen. Conrad Appel, R-Metairie. "Where are we going?"

He said that promoting bigger picture ideas for the state instill confidence in the government process.

"I'm thinking policy — big policy issues," he said. "That's the kind of stuff that I'm not hearing."

He added that short-term proposals "are frightening to citizens."

Already some lawmakers, including House Appropriations Chairman Cameron Henry, R-Metairie, have indicated they would prefer the state look elsewhere for cuts and spare TOPS in the crafting of the spending plan.

As the administration presented its latest figures to the Senate panel, the House Appropriations Committee approved a bill that would fund TOPS by cutting $183 million in professional, personal and consulting contracts. House Bill 74 now heads to the full House for consideration.

"Let's put some money where our mouth is and say we've cut some of these contracts," said state Rep. Dee Richard, of Thibodaux, who has no political party affiliation. "Let's save TOPS."

Contracts have become a popular point of contention among lawmakers who are cool to the idea of raising more taxes, after agreeing to sales tax hikes and other increases to bring in more than $1 billion for the state.

Randy Davis, assistant commissioner for Division of Administration, said Edwards' administration is in the process of evaluating contracts for possible cuts.

But officials agree it's not even clear how many professional and consulting contracts the state has, or how much they are worth.

"We're not sure what's out there," Richard said. "But it's a big figure."

SFY 2017 Reductions to Exec Budget

As of 04/12/2016

	SGF Reduction in Accordance with Constitution	SGF $
1	Portion of 2017 Deficit Assigned to DHH	($408.8)
2	Amount Assigned to DHH Program Offices and LGEs Significant reductions include: •OPH: Loss of 31 retail food sanitarians, retail food establishment inspections will be cut in half. •OBH: Inability to meet increasing demand for forensic inpatient beds, resulting in longer jail stays. •OCDD: Reduction limits capacity for "Request for Services Registry" to assess only 17% of potential recipients. •OAAS: Eliminate State Personal Assistance Services program which helps recipients avoid institutionalization. •OS: Reduction to health standards, fewer inspections done statewide to ensure patient safety. •LGEs: Significant reductions to behavioral health and services for the developmentally disabled.	($23.6)
3	**Balance Assigned to Medical Vendor Payments**	**($385.2)**

FFP Rate	62.26%
Match Rate	37.74%

		A	B
	Proposed Adjustments to 2017 Executive Budget	**SGF $**	**Total $**
4	Annualization of 2016 Expenditure Trends This adjustment reflects the expenditure trends DHH is seeing in the Spring of 2016. It reflects an update of projected 2017 expenditures with the most current data.	($62.5)	($165.7)
5	Refinancing of 2016 PPP Expenditures This is the annualization of the 2016 adjustment used to address the mid-year deficit.	$0.7	$27.5
6	Expansion Adjustments	($118.0)	($392.2)
7	UCC/DSH Reduction Due to Expansion Increase projected UCC/DSH reduction from 10% to 25%.	($56.5)	($149.6)
8	Annualize 2016 Pediatric Day Health Care Program Changes PDHC provides services to 612 children with complex medical conditions. In SFY 2015, DHH implemented a facility need review process to limit the number of new providers. In SFY 2016, it will change program policy to target resources to children requiring continuous skilled nursing care. This reduction annualizes this policy change.	($1.5)	($4.0)
9	Reduce Funding for Unfilled Waiver Slots •134 Adult Day Health Care Waiver - $1,502,808 •38 Children's Choice Waiver - $477,061 •130 Community Choices Waiver - $1,596,020 •119 Supports Waiver - $755,954	($1.6)	($4.2)
10	Eliminate Funding for Overtime for Waivers and LTC Services The Federal Department of Labor has amended regulations regarding domestic service employment, 78 FR 60454, which extends Fair Labor Standards Act (FLSA) protections to most home care workers to become effective October 13, 2015. The new regulations remove domestic service employees from the exemptions and grants them the Act's minimum-wage and overtime protections. DHH surveyed Home and Community Based Providers (HCBPs), and the findings indicate that most DSWs work up to 20 overtime hours per week. This rule will require HCBPs to pay overtime to DSWs. This is a new federal mandate. However, DHH is not currently appropriated funds to increase the current Medicaid provider rates to meet this requirement and there is a realistic concern that this Federal change will force providers to exit the system and reduce provider capacity of to meet recipient needs.	($21.0)	($55.6)
11	Reduce MCO PMPMs from 50% to 7% in the Actuarially Sound Range This reduction assumes MCO payments will be made at the floor of the rate range throughout SFY17. The MCO's are likely to say that the reduction will result in operating losses that threaten their financial viability forcing them to pass reductions on to providers or exit the market. 7 percent is effectively the floor of the rate range due to a 2% monthly withhold of the MCO's revenues to incent contract compliance. $84.0 million is associated with Physical Health services and $25.6 is associated with Specialized Behavioral Health services.	($38.9)	($103.0)

2016 MGMA-Louisiana Annual Conference

We have a wonderful speaker lineup for you this year!
Join us August 17-18 at The Roosevelt in New Orleans as we go...

Vice President
Tina Baus
SWLA Sports & Rehab Center
Lake Charles, LA

Take advantage of our Early Bird Registration!

Register by July 26 to receive $50 off of your registration fee

Click here to register now!

2016 Conference Schedule

WEDNESDAY, AUGUST 17

9:30am **Conference Registration Opens**

1:00pm-5:00pm **PRE-CONFERENCE WORKSHOP**
Audit-Proof Your Practice
Kim the Coder

5:00pm-7:00pm **Opening Reception**

THURSDAY, AUGUST 18

7:00am **Conference Registration Opens**

7:00am-8:00am **Exhibit Hall (Breakfast with Exhibitors)**

8:00am-8:15am **Welcome & Announcements**

8:15am-9:30am **GENERAL SESSION I**
Maximizing Patient Collections
Elizabeth Woodcock, MBA, FACMPE, CPC

9:30am-10:00am **Exhibit Hall (Break with Exhibitors)**

10:00am-11:00am **GENERAL SESSION II**
Washington Update
Suzanne Falk, MGMA Government Affairs Representative

11:15am-12:15pm **BREAKOUT I**

Breakout One
Missed Appointments = Missed Opportunities
Elizabeth Woodcock, MBA, FACMPE, CPC

Breakout Two
Clay Countryman, Breazeale, Sachse & Wilson, L.L.P, Baton Rouge, LA

Breakout Three
Lammico

12:00pm-1:00pm **Lunch**

1:00pm-2:00pm **BREAKOUT II**

Breakout One
ACMPE Update
Tara Allen, MBA, FACMPE

Breakout Two
Drugs in America
Bob Stutman and
Judge Jodi Debbrecht Switalksi

Breakout Three
Financial and Regulatory Compliance Issues
Alan Beason, CEO/Administrator
Cardiovascular Consultants, LLP

2:00pm-2:30pm **Exhibit Hall (Break with Exhibitors)**

2:30pm-3:00pm **MGMA-LA Business Meeting (Members Only)**

3:00pm-4:00pm **GENERAL SESSION III**
MIPS and APMs - Are You Ready?
Alan Beason, CEO/Administrator
Cardiovascular Consultants, LLP

4:30pm **Sponsor Party (By Invitation)**

5:00pm-7:00pm **Casino Night!**
Networking Reception in Exhibit Hall

FRIDAY, AUGUST 19

7:00am **Breakfast & Exhibits Open**

8:00am-9:30am **GENERAL SESSION IV**
Gen-Y: The New Physician, Employee and Patient Threat to Your Practice
Kyle Matthews, CMPE

9:30am-10:15pm **Exhibit Hall**
(Break and Prizes with Exhibitors)

10:15am-11:00am **BREAKOUT III**

Breakout One
10 Mistakes We Keep Making as Practice Managers
Kyle Matthews, CMPE

Breakout Two
No Excuse! An Accountable Approach to Unified Care and Patient Satisfaction
Jay Rifenbary, Rifenbary Training & Development, Saratoga Springs, NY

Breakout Three
Consolidation, Convergence and Cost Reduction in Healthcare IT & Telecommunications through a Managed Services Strategy
Ned Fasullo, Global Data Systems, Baton Rouge, LA

11:00am-12:00pm **GENERAL SESSION V**
No Excuse! Incorporating Core Values, Accountability and Balance into Your Life and Career
Jay Riffenbary, Rifenbary Training & Development, Saratoga Springs, NY

Medical Group Management Association
Louisiana

Pre-Conference Workshop

Audit-Proof Your Practice

Speaker: Kim the Coder - Kim Huey, MJ, CHC, CPC, CCS-P, PCS, CPO
August 17, 2016 1-5pm @ Roosevelt Hotel
Registration Fee: $75/person
$25 discount with full conference registration

Compliance Issues in Small Physician Practices

Small physician practices often become so caught up in the day-to-day functions that they do not have the time - or the resources - to guard against compliance issues. Beyond the coding issues are a whole range of other compliance considerations such as HIPAA, Stark and Anti-Kickback, Exclusions. This session covers common areas that small physician practices may neglect and suggests ways in which the practice can protect itself.

Designing and Implementing a Physician Auditing Program

Physician practices often know they need to audit but just don't know where to start. This session focuses on understanding and communicating the need for auditing in physician practices - not just coding and billing but also HIPAA, exclusions, physician relationships, employment policies, and more. We will share tools for establishing policies and procedure for auditing and monitoring. We will focus on tips for communicating audit results and effecting change.

About the Speaker

Kim Huey, MJ, CHC, CPC, CCS-P, PCS, CPO

Kim is an independent coding and reimbursement consultant, providing audit, training and oversight of coding and reimbursement functions for physicians.

Kim completed three years of pre-medical education at the University of Alabama before she decided that she preferred the business side of medicine. She completed a Bachelor's degree in Health Care Management and went on to obtain certification through the American Academy of Professional Coders and the American Health Information Management Association. Recognizing the important position of compliance in today's health care environment, she has also obtained certification as a Certified Professional Compliance Officer and has earned a Master of Jurisprudence in Health Law. Kim is also an AHIMA-approved ICD-10-CM Trainer and a member of the AHIMA Coding Community Council. She has authored articles for the Journal of AHIMA and the Health Care Compliance Association.

For thirty years, Kim has worked with providers in virtually all specialties, from General Surgery to Obstetrics/Gynecology to Oncology to Internal Medicine and beyond. She has spoken at the national conference of the American Academy of Professional Coders, the American Health Information Management Association, the Health Care Compliance Association, the Ingenix Essentials conference, Part B News' Medicare Billing 101 and has presented audio conferences for AHIMA, DecisionHealth, The Coding Institute, and Intelicode.

This is a separate fee from the MGMA-LA Annual Conference.

Note: If you would like to attend both the Pre-Conference Workshop and the MGMA-LA Annual Conference, we will offer a $25 discount off your conference registration. The discounts are noted above but to register online you will need a registration code. To receive this code, please contact Kristina at admin@lmgma.org. You may also use this discount if you are not attending the Pre-Conference workshop yourself, but are sending another staff member.

MGMA LOUISIANA **2016 ANNUAL CONFERENCE**

August 17-19, 2016 • The Roosevelt Hotel • New Orleans, LA

Hotel Information

Roosevelt Hotel

Baronne Street
New Orleans, LA

MGMA Louisiana is pleased to be back at the beautiful Roosevelt in the heart of downtown New Orleans for the 2016 Annual Conference. Louisiana healthcare professionals will not want to miss out as we go "All In" for Success! Please reserve your room by July 26 to receive the discounted group rate of $165.

To make your reservations, call (504) 648-1200 or use the online reservation sysytem.

Online Booking website: https://resweb.passkey.com/Resweb.do?mode=welcome_ei_new&eventID=14371678

An article from Annual Conference Keynote Speaker, Elizabeth Woodcock

MIPS: Coming Your Way

ELIZABETH WOODCOCK, MBA, FACMPE, CPC

The Centers for Medicare & Medicaid Services (CMS) released a Proposed Rule in the Federal Register. This massive, 962-page document describes the government's approach to future Medicare reimbursement, as required by the Medicare Access and CHIP Reauthorization Act (MACRA), which was signed into law in April of 2015. The new program is the Merit-based Incentive Payment System (MIPS), with the government's stated goal to transition to a new payment model based on an assimilation of the programs requested of physicians today. Instead of the Electronic Health Record (EHR) Incentive Program, the Physician Quality Reporting System (PQRS) and the Value-based Payment Modifier (VBPM), the government is fusing them together into a single payment platform.

The new payment model is based on a MIPS Composite Performance Score (CPS), calculated on a 0 to 100-point scale. The score, designed based on CMS' conversions of measures and activities to points, determines your Medicare payment adjustment – up or down. Geared to commence in 2019 as required by MACRA, CMS is using the coming year – calendar year 2017 – to base the initial reimbursement. Unlike past programs, this isn't a voluntary process. All physicians (except for new ones or those with only a trickle of Medicare business) are enlisted, as well as a vastly expanded list of health care professionals.

Let's break down the proposed categories of the MIPS CPS for the 2017 reporting year:

Quality: This category, which replaces the multitude of quality indicators being requested by the various government programs today, counts for 50% of the first year payment program. While PQRS required nine criteria, MIPS drops the count to six measures, offering new specialty measure sets as well as individual standards. From a reporting perspective, there are a multitude of methods by which to report, including most of those available by PQRS today.

Resource Use: Accounting for only 10% of the score, CMS also dubs this category as "costs"; designed to parlay the cost component of the VBPM program, the score is calculated based on a behind-the-scenes assessment of your Medicare claims, with no required reporting of data per se.

Clinical Practice Improvement Activities: A totally new category, this is probably the one that will bring the biggest surprise. Eligible health care professionals will report a minimum of one activity out of 90 proposed for a score to which 15% is attributed, with additional credit for more actions. The activities include care coordination and after-hours care, with most of the list of 90 falling under practice operations. Of note, if you are a patient-centered medical home, you automatically get the full credit for this category.

Advancing Care Information (ACI, the government's proposed new term for meaningful use [MU]): Replacing MU, this category, which accounts for 25% of the score, features the measures related to the use of an EHR system. Think of it like MU Phase 2, although fundamental changes are in store. These include participating as a group practice, dropping the "all or nothing" aspect of the program, and eliminating the measures related to computerized provider order entry (CPOE) and clinical decision support (CDS). Given the fact that physician assistants (with few exceptions) and nurse practitioners were not eligible to participate in MU in the first place, CMS is exempting these advanced practice providers from the ACI category. The tally for this category is centered on a base score, a performance assessment and even a bonus point. Just like MU today, you'll report a numerator, denominator or yes/no for the criteria. While there's a new name, the standards required for reporting are familiar, to include protecting health information, electronic prescribing and patient electronic access.

You may have heard that you can get out of the new MIPS program – and even qualify for a boost in reimbursement – by being a member of an "alternative payment model" (APM). That's correct, but CMS reveals – not surprisingly – that the model must be a specific so-called advanced APM. To be a qualifying APM participant, you are obligated to have a certain percentage of your patients or payments through an advanced APM during the reporting year (2017 for the 2019 payment adjustment, for example). These advanced APMs, which include CMS Innovation Models and Medicare Sharing Savings Program Tracks 2 and 3, must require participants to use an EHR system (more than 50%, for the first year, climbing to 75% by year two), base payment on quality (including at least one outcome measure) and take financial risk. The final criterion is really the deal breaker, with explicit financial risk standards.

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In essence, if you want to get out of MIPS and achieve an additional, automatic, lump sum bonus of 5% of your Medicare reimbursement, CMS is making sure that dodging the new payment structure puts you in an entity that mirrors the principles of MIPS.

CMS is accepting comments on the Proposed Rule now, so it will likely be the end of the year before we fully understand the new payment model. This leaves little time to prepare for the initial reporting period for MIPS, which commences January 1, 2017, with adjustments in 2019. According to CMS, you'll get your first feedback report in July 2017. Four percent is at risk, but more "losers" will drive the eligible bonus for high performers to 12% to ensure the required budget neutrality for the program. Plus, an additional 10% is available for "exceptional" performance. The potential upside is very compelling, but there are clearly a set of hoops to jump through to get there.

CMS is no longer dabbling in payment adjustments – either you're in, or you're out. Increase your knowledge base in the coming months, in order to ensure success in 2017.

For more information, click this link for CMS' summary of the proposal.

New FLSA Overtime Regs
Effective December 1

On May 18th, the U.S. Department of Labor released a final rule amending the requirements for overtime pay under the Fair Labor Standards Act (FLSA). Employees who work more than 40 hours in a week are entitled to overtime pay (1.5 times regular pay), unless they meet the requirements of either the job duties or wage level test. The new wage level rule for employees exempt from receiving overtime pay will increase from the current threshold of $23,660 to $47,476 annually. This change will be effective December 1, 2016 for businesses with gross annual income of more than $500,000 . This is anticipated to impact over 4 million employees nationwide, as well as the direct payroll cost and administrative cost to the related employers.

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The Exit Interview: A Tool for Litigation Avoidance and Corporate Healthcare Compliance

Reed Tinsley, CPA

It is important for all employers, including those in the health care industry, to conduct exit interviews with departing employees. The consistent use of exit interviews serves numerous purposes, including protection of sensitive business information, achievement of overall improvement in workplace environment, and curtailment of employee turnover.

Using the Exit Interview

Exit interviews provide additional benefits to entities that deal with and are regulated by the federal government, such as those in the health care industry. With the numerous regulations and certification requirements applicable to health care facilities, exit interviews should be part of an institution's overall compliance program. An effective health care compliance program will permit an entity to identify and address possible regulatory or statutory violations, as well as provide information necessary to assess the potential for litigation.

Health care facilities that participate in government reimbursement programs must be sensitive to fraud and abuse litigation under various statutes, including the antikickback statute, the Stark law (anti-self-referral), and a number of civil and criminal statutes addressing false claims and fraudulent billing. Attention to these compliance issues will, in turn, lessen the possibility that an entity will become the target of an investigation by the OIG, HCFA, HHS, the DOJ, or some other federal or state agency.

Health care employers should also use the exit interview to gauge the possibility for "general" employment litigation, such as a claim by a departing employee for wage payment, harassment, or discrimination.

In order to address issues of compliance, and to prevent or prepare for litigation, exit interviews should be used to elicit information concerning illegal or unethical behavior, workplace quality, personnel issues such as quality of training/supervision, and other issues stemming from the employment relationship generally.

Uncovering Damaging or Illegal Behavior

When probing the possibility of illegal or unethical behavior or practices in the workplace, a health care employer should explore whether an employee knows of circumstances suggesting that: 1) billing or medical records were altered; 2) false or misleading documents were submitted to a government agency; 3) expense reports were padded or falsified; 4) items of value were offered or accepted for referrals; or 5) legal or regulatory violations were covered up. To that end, the following topics should be explored:

- Did the employee witness any conduct that he or she would characterize as either unethical or illegal?
- Was the employee ever asked to engage in conduct that he or she believed to be either unethical or illegal?
- Has the employee heard rumors or reports of unethical or illegal conduct which he or she considered credible?
- Were any company documents, including documents created by the employee, removed from the institution and not returned? Does the employee have any copies of documents anywhere off premises?
- Has the employee ever given company documents to persons not employed by the facility? Has anyone else at the facility done so?
- Has any government investigator, agent, or attorney interviewed the employee or asked to interview the employee about possible unethical or illegal conduct relating to the facility?
- While employed with the company, did the employee or any family member own, operate, invest in, assist, or otherwise have an interest in any company or enterprise which competes with or does business in the health care industry?

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The above list is by no means exhaustive. The list should be expanded to address areas of concern for an employer; it should also be tailored to address the employment circumstances of each departing individual.

Employees in coding or billing departments provide but one example of the importance of the exit interview. Because those employees are directly involved with issues of reimbursement, they have a hand in creating the documents that are submitted to the government for payment. If these documents contain false information or statements, they may provide the basis for litigation under the False Claims Act. A civil action for a false claim will include, among other things, inquiry into an institution's awareness of government billing policies and requirements, as well as an examination of an institution's own billing practices and policies. The knowledge possessed by an employee involved with reimbursement is crucial because that knowledge may be imputed to the employer in litigation. Thus, it is imperative to learn what employees in reimbursement-related positions know before they leave the facility's employ.

Ascertaining the Possibility for Litigation

An employer should not overlook the use of the exit interview as a tool to explore general facets of the employment relationship. Discussion with a departing employee will enable an entity to identify and assess the possibility for civil litigation stemming from that individual's employment. This litigation can take many forms, but employers should be especially sensitive to the possibility that a departing employee may be harboring a claim of employment discrimination or harassment. To that end, the exit interview should focus on an individual's:

- Reason(s) for leaving. If the individual was terminated, it is crucial to examine his or her understanding of the events leading to the termination. A similar inquiry should be made if the departing employee was subject to disciplinary action.
- Beliefs concerning whether appropriate opportunities for advancement were available.
- Comments concerning the level of pay and provision of other benefits.
- Overall assessment of working conditions, including the workplace "dynamic" and interactions with supervisors and peers.

Health care institutions should also use the exit interview to learn more about an individual's assessment of workplace quality. Thus, topics that should be raised and discussed during an exit interview include an employee's opinion of the supervision he or she received, evaluation of the effectiveness of training, likes and dislikes about the institution and/or its policies, recommendations for change in the workplace, and overall assessment of working conditions.

Applying Information Learned

If the exit interview reveals that an employee encountered no illegal or unethical practices, the form used and notes made during the interview should be placed in the departing employee's personnel file. If, on the other hand, the interview reveals that an employee may have witnessed illegal or unethical practices, or if information is uncovered which suggests that a departing employee has a complaint of harassment or discrimination, counsel should be notified immediately. An investigation must follow in order to diffuse the situation, assess whether the employee has viable claims, plan for the possibility of litigation, and preserve testimony and documents, should litigation ensue.

Information uncovered during an exit interview simply cannot be ignored, and statements made by departing employees must be taken seriously. Using the exit interview to monitor the potential for wrongdoing, unethical behavior, unsafe or unsound business practices, and litigation will help the health care employer run a more efficient facility.

Reed Tinsley, CPA

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Local Chapters- Get involved!
Click below to see what is going on in a local chapter near you!

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