

2011 FALL IDN SUMMIT

PEER-TO-PEER LEARNING EXCHANGE RESEARCH REPORT

How to Have Your Shop in Order When the Auditor Walks in

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Introduction

If downward pressure on hospital costs wasn't already strong a few years ago, it is now. The Accountable Care Act of 2010 includes \$155 billion in hospital payment cuts over 10 years. As part of the reform law, a new Hospital Inpatient Value Based Purchasing Program begins soon, with 2% of Medicare payments at risk by 2016. A new measure of hospital quality, called "Medicare spending per beneficiary," will penalize higher cost hospitals under a formula that could take away far more than value-based purchasing. And the 2011 deficit reduction law has a number of provisions that could cut provider payments by hundreds of billions of dollars.

As hospitals and health systems look for new areas of savings, the supply chain department is being called upon to expand its purview into areas once reserved solely for physicians and clinicians. Resources for surgery; cardiac catheterization, electrophysiology and endoscopy labs; imaging; surgical case carts; and pharmacy have become part of the supply chain function in many organizations. Among the issues that come with these new responsibilities is one that might be called chain of custody. Clinical departments have legacy systems for inventory – sometimes no system at all. Some items are owned and on the books, others are owned but not fully accounted for. Some products are on consignment, but intermingled in sets with owned items and counted as owned inventory. When inventory items are in a drawer or in original packaging, they may leave inventory when placed in trays, but not be fully accounted for.

A number of problems arise from legacy supply arrangements in clinical areas of the hospital. One is that it is awfully difficult to corral costs if you don't even know what you own, purchase or have on consignment. Another – not fully accounting for specialty supplies – leaves the materials manager or supply chain professional in a dubious spot when he or she gets a call from the health system's internal auditor or the finance VP.

Lost in Translation

The ensuing conversation, an increasingly likely occurrence given the growing profile of supply chain, can be awkward at first. There is a lot of room for miscommunication, because auditors and supply chain professionals speak different languages and might have little understanding of what the other does.

Many internal auditors deal mainly with the revenue cycle, working with admitting, billing and collections. Historically, they have been involved in purchasing only when it comes to big ticket items or capital projects.

Auditors are beginning to want answers about whether controls exist to ensure the organization is paying prices that accurately reflect the terms of contracts with group purchasing organizations, other buying groups and vendors. They may view "contract compliance" as solely about price, not about sole source or multisource supply or meeting the percentage terms of participation.

On the other side of the conversation, supply chain professionals have likely never heard of terms such as computer-assisted audit techniques (CAAT) and Generally Accepted Auditing Standards. They may view auditors as trouble, when in fact auditors are often there to ensure that there isn't an opportunity for problems resulting from poor control of consigned items or incorrectly stating inventory value.

In fact, waiting for the auditor to show up is likely not the best policy. "The auditor can be a resource to reach out to, someone who is here to help in a consulting role," says Brian Mikel, IT audit manager, CHAN Healthcare Auditors. He formerly was materials management director at Saint Thomas Health, a four-hospital system based in Nashville. "You can tell the internal audit department, 'Hey, we just took over this whole new area in surgery and we are looking at these trays, and some are on inventory, some are not. What should be on inventory, what do we do about consigned items?'" he says.

Better to have a conversation early on with internal auditors than endure a year-end management comment by an external audit firm on irregularities in inventory practices. These types of management comments are far riskier to deal with when addressed to hospital leadership and/or the board of directors. Instead, internal auditors can help point out accounting irregularities far earlier in the process. They are on the same team and can help point out control weaknesses and allow time to implement solutions before external auditors arrive.

Risk Management

If the conversation doesn't happen, there are a number of implications. Having a balance sheet where the asset base is either overstated or understated has a significant implication for debt financing, as credit rating agencies and investment banks will be looking at any discrepancies with arriving at a rating or deciding whether to participate in a deal.

There are legal concerns over poorly tracked consignment items. When a hospital says it owns a product and the vendor says it is on consignment, disputes arise. Mikel uses an example of a common practice of vendors "borrowing" consignment stock from one hospital to bring to another that needs the item, but not telling the inventory manager. In some cases, an invoice is later submitted for the "borrowed" item, and nobody can track the item to prove it wasn't used.

Often, expensive supplies that could be procured on consignment continue to be procured as owned supplies, exposing the hospital to higher inventory carrying costs and losses due to product obsolescence or expiration.

If inventory valuation is not consistent from hospital to hospital or within facilities, it makes health system analysis and trending far less effective. You can't control costs and improve quality if you can't even figure out what you own or can acquire at a lower cost.

Even if auditors are more interested in price than participation in GPO contracts, price control carries great potential for accomplishing supply chain goals. When actual invoice prices don't add up to contract prices, you can't control spending or predict future spending.

Valuing Inventory

With the move into clinical areas, ensuring consistency in valuations of inventory across departments and from hospital to hospital becomes more critical. Established accounting guidelines come into play, ensuring assets versus expense are tracked in the same way.

Let's use the example of sterile surgery trays. Auditors want to make sure systems are in place to limit the variety of trays in play and manage those that are in play.

They want to ensure that materials managers have evaluated tray components to recognize obsolete and dead stock items. (Once opened, certain items cannot be returned to a vendor.) Auditors will ask how inventory personnel verify the contents of trays. Are tray components evaluated for lack of use/potential use? At what point are tray components expensed? Are identical tray components valued the same across the system?

Auditors look for strong controls on inventory, especially the proper use of materials management information systems (MMIS). These systems should be employed to weed out expired contracts, inactive vendors, duplicate items, inactive requisition identification codes, and controlling addition, revision and deletion of items.

All item costs should be under contract and entered into the MMIS system. The systems can then be used to weed out consigned inventory from owned inventory.

Auditors look to see if purchase orders are processed only after the product is actually used. Consigned items must be separately identifiable from hospital-owned inventory, and the hospital must control vendor access to the consigned inventory.

Auditors look to verify the process for ordering and accounting of consigned items. They seek to ensure that a consignment contract exists. They will look to verify a sample of consigned items against contract and/or invoice pricing to make sure payments match contract cost. They will obtain the hospital's inventory records to determine the accuracy of consigned inventory and ensure that inventory is closely managed.

System Controls

Then, there is the approval process for purchases. Again, with the move to clinical areas, a mix of processes is likely to be encountered. Some controls are automated, others manual. In some cases purchase orders are made, but auditors want to find out if check requests are used to bypass the approval process. A process needs to be created for handling special requisitions such as physician preference items not on any contracts. Who signs off and who has control?

Auditors look to see if accurate pricing is reflected on each purchase order and want to know how pricing is validated. That means a manual/automated check with the vendor needs to occur; vendors must send a confirmation back to purchasing that includes pricing, receipt of the purchase order, the unit of measure and the quantity.

There needs to be automated or manual processes to prevent off-contract purchases. (Again, an MMIS system is strongly encouraged.) These systems flag pricing discrepancies and lead to resolutions such as forcing payment matches through a modified purchase order price or credit following a return.

Using computer-assisted auditing techniques, auditors look at an array of factors in pricing and unit of measure to ensure they match, though there are some exceptions, such as for reprocessed items, which typically cost around half of new unit price. All reprocessed items need to be segregated on vendor purchase orders and invoices. The hospital has to have a system for resolving pricing and unit of measure discrepancies, especially for those involving electronic data interchange vendors, and have controls over payment when those discrepancies arise. It also has to have a system to determine the validity of items not found in either the local or corporate/GPO contract files.

Most regularly purchased items should have valid contracts assigned. The hospital needs to identify the frequency and number of items that should have associated contracts and evaluate the controls over contract entry, maintenance and review. The hospital must also determine how to detect and correct contract pricing discrepancies.

Auditors also perform analyses of information system security, which often take them to more than one department. They look to see if IT system security roles are set up to prevent conflicting responsibilities when it comes to purchasing. For example, a person should not be able to issue a purchase order, authorize its release and receive items. Auditors look to ensure that contract, item and vendor master file maintenance is restricted to a small number of users with non-conflicting roles.

Physician Preference Cards

Supply chain leaders need either a manual or automated system to specify products required for a surgeon's procedure. Hospitals are good about adding products to the list, but not about removing obsolete products. Sometimes products are added on an ad hoc basis because of a surgeon's demands, even if those items are not needed and are off-contract. One-off items wind up being left on cards, resulting in waste.

The cards are typically maintained by clinical personnel, but auditors seek coordination between surgery personnel and the MMIS to manage items and item conversions.

Auditors will look to verify the preference card update process and restrictions associated with data entry. They will act as detectives, shadowing the case cart pickers and asking about returns, waste and items picked that do not appear on the preference cards. They observe surgical case setup and tear-down to determine waste on the front end and back end of a surgical case. They interview surgical technicians to identify potential waste.

For a selected sample of surgical cases, they will go through the entire case to reconcile supplies picked, used, charted, charged and returned for a selected sample of surgical cases. From this, new processes can be created to control the use of the cards and eliminate wasteful spending. The resulting data can aid management, which may need to step in to point out the sources of waste to physicians who demand these preference items.

Conclusion

If your department is being called upon to take control of supplies in surgery and specialty clinical areas and auditors aren't asking the kind of questions mentioned above, know that they soon will be. Understanding what is likely to follow will help you brace for the storm.

Ultimately, the demands of value-based reimbursement are going to find their way to the supply chain function. Healthcare remains on a cost trajectory that is unsustainable from an economic perspective, with the Centers for Medicare and Medicaid Services foreseeing national health spending rising by 5.8% per year in the current decade at a time when our economy is barely growing at all. Auditors are there to help you achieve meaningful price and cost control, so be their ally in this cause. It is far easier to include the hospital's internal auditor on the front end versus having external auditors point out inventory problems for the hospital's leadership to address at the back end.

Purchasing has to do its part to control the cost of supplies. It is a necessity from a government regulatory point of view, but more importantly, it is the right thing to do in terms of fiscal responsibility.

Questions for Discussion

1. How can the internal auditor better understand what supply chain professionals are facing?
2. Ideally, what role should the internal audit bureau play in helping to control supply costs?
3. What is most difficult area of clinical supply spend to control?
4. How can you gain control of what is on physician preference cards?
5. How can interfacing the MMIS system and the surgery system enhance preference card control and how can internal audit help?
6. What will happen to inventory days on hand if implant trays are included in inventory?
7. What role should health system/hospital leadership play in helping to control clinical area supply costs?

Upcoming Webinar Opportunity:

How to Have Your Shop in Order When the Auditor Walks in

Moderated by Brian Mikel, IT Audit Director for Saint Thomas Health Services

Wednesday, Sept. 28, 2011 2:00 PM EDT

For more information, contact Lisa Ponssa, IDN Summit Director of Content

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