FEATURE

Internal Audit Benchmarks in Healthcare Organizations

Learn where you stand

By Mike Michalowicz, CIA®, CCSA, CRMA, Bryon Neaman, CHIAP®, CIA®, CPA, and Rebecca Nilson, CIA®, CPA, CRMA

Internal audit (IA) functions in organizations worldwide and throughout most industries are undergoing significant change. Changes range from embracing the use of new methodologies and technologies to reframing how their people perform day-to-day operations as the future of work and performance expectations continue to unfold. IA functions within healthcare organizations are no exception.

The Association of Healthcare Internal Auditors (AHIA) and Protiviti conducted a survey in 2022 about internal functions and their organizational demographics for healthcare providers, payers and integrated delivery systems. The study captured detailed benchmarks around many aspects of an internal audit function including size, budgets, salaries and more.

Protiviti published the results of the survey in a comprehensive report, Tackling Traditional Audit Plan Concerns and Expanding Focus on Fraud, Third Parties and Data. The publication also provides commentary on good practices to audit top 10 identified priorities, many of the changes underway within the industry, and how the changes are affecting internal audit functions.

To complement the results and commentary provided in that paper, this article presents further insights and analysis on some of the more notable findings. The focus is on provider organizations' responses and what they reveal about internal auditing within the healthcare industry.

Methodology

For this inaugural survey, Protiviti and AHIA partnered to conduct a benchmarking survey with the purpose of collecting, reviewing, analyzing and summarizing data gathered from internal auditors in the healthcare industry. Surveys were sent in Spring 2022 to all AHIA members and consisted of 85 questions requiring varying response types.

Completed surveys were received from a total of 50 organizations. The responses include 44 respondents from healthcare provider organizations and 11 respondents from integrated provider and payer organizations. Additionally, five respondents were from healthcare payer organizations.

Prior to partnering with Protiviti in 2022, AHIA partnered with Louisiana State University in 2020 and prior to conduct similar biennial surveys and publish articles that compared current survey results with previous years. The articles included insights on audit practices, staffing, resource allocation and adoption of next-generation methodologies.

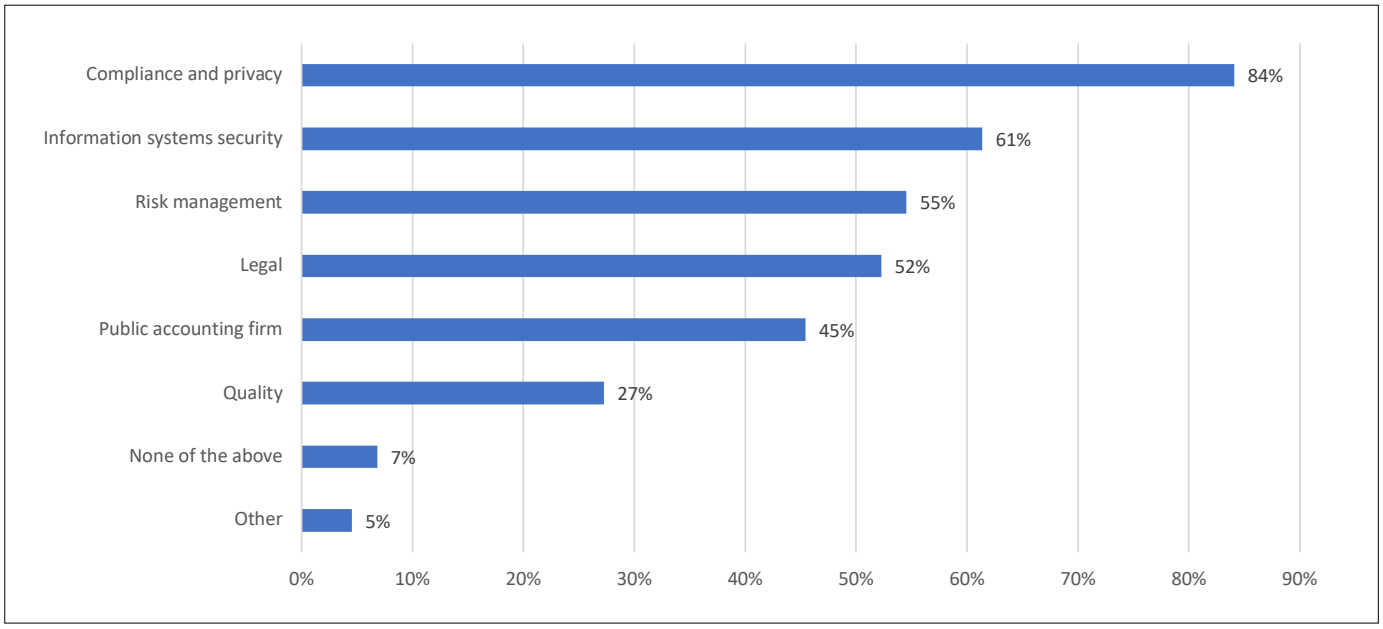
Survey results

Authority, purpose and reporting structure

Most respondents (77%) stated that they have an internal audit charter in place, with most describing their charter as a formal rather than an informal charter. Surprisingly, about a quarter of respondents (23%) either had an informal charter, no charter or were unsure. Consistent with the Institute of Internal Auditors (IIA) Professional Practice Standards, a formal internal audit charter defines the purpose, authority and responsibility of internal audit functions.

Additionally, more than half of respondents (52%) stated that their internal audit team reports administratively to either the Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of their organizations. The remaining respondents report to either the Chief Compliance Officer (9%), Chief Legal Officer (18%), Chief Operating Officer (5%), or Other (16%). A majority (73%) of respondents revealed that internal audit reports functionally to their organization's Board Audit and Compliance Committee.

Exhibit 1 – Coordination for internal control and risk management



Relationship with compliance, operations and other areas

When asked about the relationship between their internal audit function and compliance responsibilities, 77% of respondents stated that they have a stand-alone internal audit function with a separate compliance function. The remainder of respondents indicated that their internal audit and compliance functions are either combined (18%) or internal audit exists as stand-alone function without a compliance function (5%). No respondents stated that they have a stand-alone compliance function without a separate internal audit function.

When asked about the strategic partnership between operations and internal audit, 68% of respondents believe that the internal audit function is currently considered to be a strategic partner by operations.

Respondents were asked about the status of internal audit's relationship with the corporate compliance function over the last year. More than half (59%) of respondents feel the relationship has remained about the same, while 34% feel the relationship has improved and 7% feel the relationship has deteriorated.

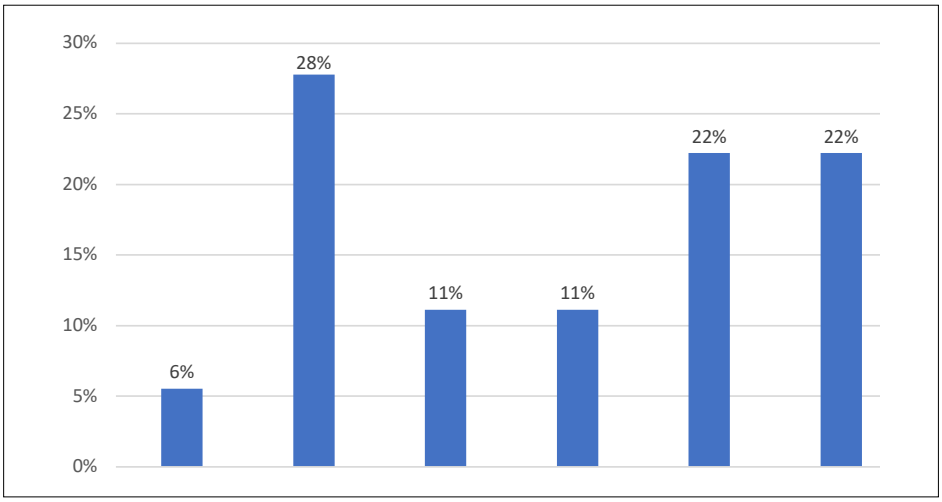
Exhibit 1 shows the various functions that internal audit coordinates with for internal control and risk management purposes.

Co-source partnerships

Co-sourcing is a common practice by internal auditing functions, with 66% of respondents indicating that they co-source with a strategic partner (third-party vendor) to execute the internal audit plan. The primary areas where co-sourced relationships are leveraged include information technology (IT), finance and accounting, compliance, revenue cycle, pharmacy, construction, clinical, coding and audits of third parties. The most common area of co-sourcing occurs with IT auditing, with 65% of respondents indicating it is an area of focus.

The high percentage of respondents who co-source with strategic partners could indicate the need to augment their existing internal audit staff skill sets with those of co-sourced strategic partners. Additionally, the existing tight labor market

Exhibit 2 – Year for next external QAR



and the challenge of recruiting and retaining internal auditors could also be a factor for internal audit functions to leverage co-source relationships.

Quality assurance reviews

When asked about their quality assurance review (QAR) process, 45% of respondents said they do not have a formal QAR process, and 27% of respondents said they conduct a formal QAR for conformance to the IIA Standards every five years. The balance of respondents conduct QARs periodically, but not necessarily every five years.

Most QARs are conducted by a third-party service provider (47%), followed by a self-assessment with external validation (37%), with the remaining 16% noting they plan to have a QAR but have not had one yet.

In terms of timing, 24% of respondents had their latest QAR review performed in 2021, with another 24% conducting it in 2022. Exhibit 2 indicates the year that respondents are planning to conduct their next external QAR.

Exhibit 3 – Annual budget by organization's annual gross revenue

	Annual gross revenue						
Annual internal audit budget (millions)	**< $100 million**	**$100–$499.99 million**	**$500–$999.99 million**	**$1–$4.99 billion**	**$5–$9.99 billion**	**$10–$19.99 billion**	**>$19.99 billion**
$3 to $4.9				5%		50%	50%
$2 to $2.9				5%	33%	33%	
$1.5 to $1.9				9%	17%		50%
$1.25 to $1.499				5%	50%		
$1 to $1.249	33%			5%			
$0.75 to $.999			25%	24%		17%	
$0.5 to $.749				27%			
$0.25 to $.499	67%	50%	25%	15%			
$0.1 to $0.249		50%	25%	5%			
Less than $0.1			25%				
Total	100%	100%	100%	100%	100%	100%	100%

The overall respondent results suggest an opportunity to revisit why formal QAR processes and reviews are not more pervasive for healthcare internal audit functions. Factors may include resource limitations and/or lack of interest from key stakeholders including audit committees and management. Some of the benefits of having a QAR performed include:

- Discovering new processes to increase effectiveness and value
- Enhancing credibility with your organization and business partners
- Identifying the right skill sets to re-align department staffing
- Demonstrating a commitment to professional practice standards

Annual budget relative to organizational revenue

Exhibit 3 summarizes respondents' annual internal budget relative to their organization's annual revenue. Most respondents are in organizations that have annual revenue between $1 billion to $4.99 billion.

The effects of the pandemic may have negatively affected healthcare internal audit budgets and created an anomaly compared to prior years. Healthcare provider organizations endured adverse patient volumes and negative profitability that resulted in reduced budget resources for internal audit functions. The pandemic highlighted the importance for internal audit to be agile and responsive and demonstrate their value.

Audit plan hours relative to organizational revenue

Exhibit 4 depicts the hours budgeted on the annual audit plan relative to their organization's annual revenue.

Exhibit 4 – Annual audit plan hours by organizational annual gross revenue

	Annual gross revenue						
Annual audit plan hours	**< $100 million**	**$100–$499.99 million**	**$500–$999.99 million**	**$1–$4.99 billion**	**$5–$9.99 billion**	**$10–$19.99 billion**	**>$19.99 billion**
1,000 to 1,999	33%		50%	5%			
2,000 to 3,999	33%	100%	25%	14%			
4,000 to 7,499	33%			29%	17%	17%	
7,500 to 9,999				24%	17%		
10,000 to 15,000				14%	50%	32%	100%
Other: 17,000				4%			
Other: 18,000				5%			
Other: 20,000					16%		
Other: 30,000						17%	
Other: 45,000						17%	
Other: Unsure						17%	
Other: No budget			25%				
Other: Not based on hours				5%			
Total	100%	100%	100%	100%	100%	100%	100%

Exhibit 5 – Average base salary by title

Title	Average base salary
Executive Vice President (EVP) or Senior Vice President (SVP) as CAE	$274,167
Vice President (VP) of Internal Audit as CAE	$268,667
Director of Internal Audit or Director of Internal Audit/Compliance as CAE	$164,125
Director of Internal Audit or Director of Internal Audit/Compliance (not CAE)	$156,364
Information Systems Auditor	$122,556
Manager of Internal Audit or Manager of Internal Audit/Compliance	$114,227
Medical Auditor	$105,000
Senior Auditor	$95,714
Compliance Auditor	$86,333
Staff Auditor or Specialist	$75,900
Administrative Support	$69,400

Salaries and years of experience

Exhibit 5 shows the average base salary of the internal audit staff members by title. Salary information and years of experience are self-reported and may vary based on a variety of factors, including types of total compensation, organizational type, location and organizational structure.

Overall salaries appear competitive, and the range of salaries shows no extreme variations.

Exhibit 6 details the breakdown in average years of experience by title, including experience in auditing, healthcare and total years. Vice Presidents (VP) of Internal Audit acting as CAE have an average of 22.2 years of experience, with 20 years of experience in auditing. Directors acting as CAE have an average of 18.4 years of experience in auditing, with an average of 12.8 years of experience in healthcare.

Exhibit 6 – Average years of experience by title

Title	Audit	Healthcare	Total
VP of Internal Audit as CAE	20.0	12.6	22.2
Director of Internal Audit or Director of Internal Audit/Compliance as CAE	18.4	12.8	19.4
Director of Internal Audit or Director of Internal Audit/Compliance (not CAE)	14.9	13.1	19.0
EVP or SVP as CAE	13.5	10.5	16.2
Information Systems Auditor	13.2	8.1	18.2
Manager of Internal Audit or Manager of Internal Audit / Compliance	12.2	9.3	14.2
Senior Auditor	11.1	8.5	14.1
Administrative Support	5.6	2.5	9.1
Staff Auditor or Specialist	4.8	5.9	7.3
Medical Auditor	4.6	7.0	10.1
EVP or SVP of Internal Audit (not CAE)	3.0	3.4	3.4
Compliance Auditor	3.0	6.4	9.3

Senior Auditors have an average of 11.1 years of auditing experience, with 8.5 years of experience in healthcare. Auditors (compliance, medical and staff/specialist) have an average of 4.1 years of experience in auditing, but 8.9 years of healthcare experience.

Auditors are the only subset of the respondents that had, on average, more years of experience in healthcare than auditing. The difference could indicate that auditors are being recruited from other healthcare disciplines and/or internal audit leaders value previous healthcare experience when hiring for the internal audit team.

Audit professionals in healthcare appear to be well experienced, which is important in a complex industry such as healthcare.

Staff size relative to organizational revenue

Internal audit function sizes vary depending on several factors including the scope and size of the organization, the degree of internal auditing that the organization conducts in-house and the year-to-year needs of the organization. Overall, 66% of respondent provider organizations co-source to execute the audit plan and 34% do not co-source. Exhibit 7 shows the number of the internal audit staff based on the organization's revenue and utilization of co-sourcing.

Anticipated changes to staff size

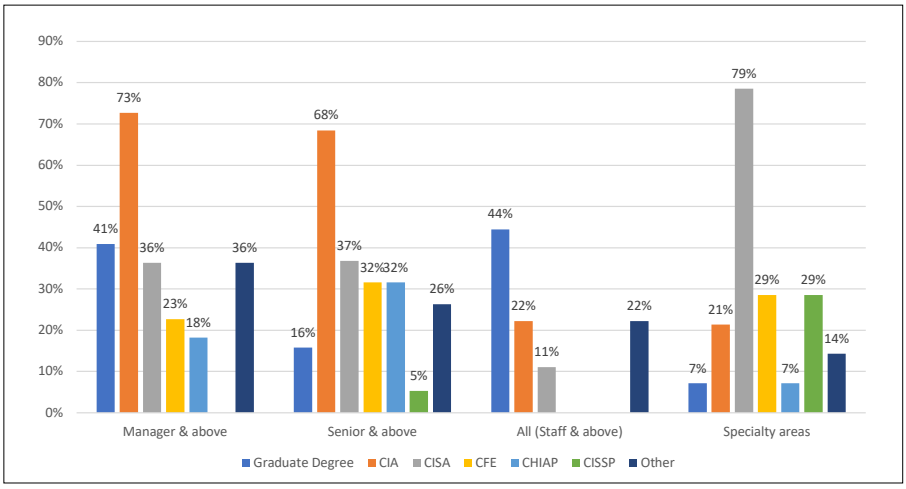
To help identify future trends and insights into auditing practices, respondents were asked a series of questions regarding what changes they anticipate to their internal audit staff size. Approximately 70% of respondents do not anticipate a change in the size of their audit staff within the next 12 months, while 25% anticipate an increase in their audit staff size during that same period.

When asked to consider a 24-month period, 55% of respondents do not anticipate a change in their audit staff size during that period, while 41% do anticipate increasing their audit staff size during that same period.

Exhibit 7 – Staff size by organizational annual gross revenue and co-sourcing status

	Annual gross revenue						
	< $100 million	**$100–$499.99 million**	**$500–$999.99 million**	**$1–$4.99 billion**	**$5–$9.99 billion**	**$10–$19.99 billion**	**>$19.99 billion**
Survey respondents	**7%**	**5%**	**10%**	**45%**	**14%**	**14%**	**5%**
Do not co-source	**33%**	**50%**	**25%**	**32%**	**50%**	**33%**	
1–2		100%	100%				
3–5	100%			33%		50%	
6–9				67%	67%		
10–14					33%		
15–19						50%	
Do co-source	**67%**	**50%**	**75%**	**68%**	**50%**	**67%**	**100%**
0 (fully outsourced)							50%
1–2		100%	100%	15%			
3–5	50%			46%			
6–9				31%	33%		
10–14	50%				33%		
15–19				8%	33%	25%	
>19						75%	50%

Exhibit 8 – Positions requiring certifications or advanced degrees



Overall, respondent results indicate a favorable view that staffing will be maintained at current resource levels. The expectation will be interesting to monitor recognizing the ongoing margin pressures many healthcare providers are facing.

Desired attributes of staff

The survey participants were asked to rank the top five attributes that they look for in their staff and deem most important from a development perspective. Auditing experience was ranked as the most important attribute, followed by critical thinking, accounting/finance experience, compliance, customer orientation, commitment to certification, and data analytics.

The results demonstrate a view that a diversity of skill sets coupled with industry knowledge and experience will further position their function as a trusted partner in their organization.

Source of staff

Survey respondents indicated that their primary source (82%) for recruiting internal audit staff came from experienced hires from other organizations. They responded that 15% of current internal audit staff were hired from other (non-internal audit) functions within their organization.

When asked how they are obtaining needed skill sets for their audits, 45% noted that they used co-sourcing resources. Additionally, financial incentives are leveraged to procure additional skill sets. Specifically, 27% noted using salary increases to recruit different skill sets, and the remaining respondents mentioned using bonuses and additional benefits or amenities as a means of recruiting different skillsets for their internal audit team.

Development hours and certifications

Within the internal auditing field, a multitude of certifications and designations require educational support and continuing education. On average, organizations provide and fund 36.5 hours of continuing professional education hours per year per staff member, and 20.5 hours of company training hours per year per staff member.

Respondents were asked to list the certifications where they have one or more staff members who possess that certification or advanced degree. The majority listed one or more of their staff as holding credentials as a Certified Internal Auditor®, Certified Public Accountant, Certified Financial Examiner, Master of Business Administration, Certified Information Systems Auditor, Certified Healthcare Internal Audit Professional®, and/or a master's degree. Also, 53% of respondents indicated that they have staff who do not have any certifications or advanced degrees.

Respondents were also asked which, if any, internal audit positions require certification or advanced degree by level. Exhibit 8 shows the results broken out by level. Many Managers and Above (73%) and Senior and Above (68%) have CIA® certifications. Additionally, 79% of respondents noted that their IT staff are required to have CISA certifications.

The survey results indicate the organizational commitment to certification and providing for annual professional development hours. The commitment not only can help attract potential new hires but will also motivate noncredentialed staff to keep developing.

Hours allocated by project compared to organizational revenue

The average number of hours spent per project (assurance, advisory and other types) and total number of projects completed per annual audit plan varies based on a multitude of factors, including scope and scale of audits, budgeting parameters, audit team capacity and organizational priorities.

Exhibits 9, 10 and 11 summarize the average number of hours spent per audit/projects on assurance, advisory and other projects, relative to the organization's gross annual revenue.

Exhibit 9 – Hours spent per advisory project by organizational gross annual revenue

	Annual gross revenue						
Hours for advisory audits/projects	< $100 million	$100–$499.99 million	$500–$999.99 million	$1–$4.99 billion	$5–$9.99 billion	$10–$19.99 billion	>$19.99 billion
<100	67%		25%	5%		33%	
100–199		50%	25%	52%	17%	33%	
200–299	33%	50%	50%	19%	50%	17%	50%
300–399				10%	17%		
>399				14%	16%	17%	50%
Total	100%	100%	100%	100%	100%	100%	100%

Exhibit 10 – Hours spent per assurance audit by organizational gross annual revenue

	Annual gross revenue						
Hours for assurance audits/projects	< $100 million	$100–$499.99 million	$500–$999.99 million	$1–$4.99 billion	$5–$9.99 billion	$10–$19.99 billion	>$19.99 billion
<100	50%			20%			
100-199		50%		20%	25%	25%	
200–299	50%	50%	50%	20%	25%	25%	
300–399			50%	20%	25%	25%	
>399				20%	25%	25%	100%
Total	100%	100%	100%	100%	100%	100%	100%

Exhibit 11 – Hours spent per project for other types of projects by organizational annual gross revenue

	Annual gross revenue						
Hours for other types of projects	< $100 million	$100–$499.99 million	$500–$999.99 million	$1–$4.99 billion	$5–$9.99 billion	$10–$19.99 billion	>$19.99 billion
<100	67%		50%	52%	17%	33%	50%
100–199		50%		28%	17%		50%
200–299	33%	50%	25%	5%	32%	67%	
300–399			25%	5%	17%		
>399				10%	17%		
Total	100%	100%	100%	100%	100%	100%	100%

Number of audits/projects by type by organizational revenue

Exhibits 12, 13 and 14 show the breakdown of the average number of internal audits/projects on advisory, assurance and other projects, relative to their organization's gross annual revenue. Many respondents reported 10 or fewer projects devoted to advisory, assurance and other.

Exhibit 12 – Number of advisory audits/projects by organizational gross annual revenue

	Annual gross revenue						
Number of advisory audits/projects	< $100 million	$100–$499.99 million	$500–$999.99 million	$1–$4.99 billion	$5–$9.99 billion	$10–$19.99 billion	>$19.99 billion
<10	67%	100%	100%	71%	100%	33%	50%
10–19				24%		17%	
20–25				5%			50%
26–29						17%	
>35	33%					33%	
Total	100%	100%	100%	100%	100%	100%	100%

Exhibit 13 – Number of assurance audits/projects by organizational gross annual revenue

	Annual gross revenue						
Number of assurance audits/projects	< $100 million	$100–$499.99 million	$500–$999.99 million	$1–$4.99 billion	$5–$9.99 billion	$10–$19.99 billion	>$19.99 billion
<9	67%	50%	50%	52%	17%		
10–19		50%	50%	38%	50%	33%	50%
20–25				10%	17%		50%
26–29						17%	
>35	33%				16%	50%	
Total	100%	100%	100%	100%	100%	100%	100%

Exhibit 14 – Number of other types of projects by organizational gross annual revenue

	Annual gross revenue						
Number of other types of projects	< $100 million	$100–$499.99 million	$500–$999.99 million	$1–$4.99 billion	$5–$9.99 billion	$10–$19.99 billion	>$19.99 billion
<10	33%	100%	100%	100%	50%	25%	100%
10-19	33%				50%	25%	
26-29						25%	
>35	34%					25%	
Total	100%	100%	100%	100%	100%	100%	100%

Results indicate that a focus on advisory and other projects supports core assurance audit efforts and further expands internal audit's scope and influence. However, a smaller proportion of hours are dedicated to advisory and other projects compared to core assurance activities. The ratio suggests that assurance activities continue be to the predominant focus on annual internal audit plans, probably due to an expectation of audit committees.

Exhibit 15 – Covid-19 audit plan adjustments

Respondents	Adjustments
30%	0%
24%	1–25%
30%	26–50%
8%	51-75%
8%	76–100%
100%	

Plans adjustments due to Covid-19

The Covid-19 pandemic caused a major operational shift for healthcare organizations. The shift left many healthcare organizations susceptible to risks that they may not have considered and/or factored into their operating and auditing planning.

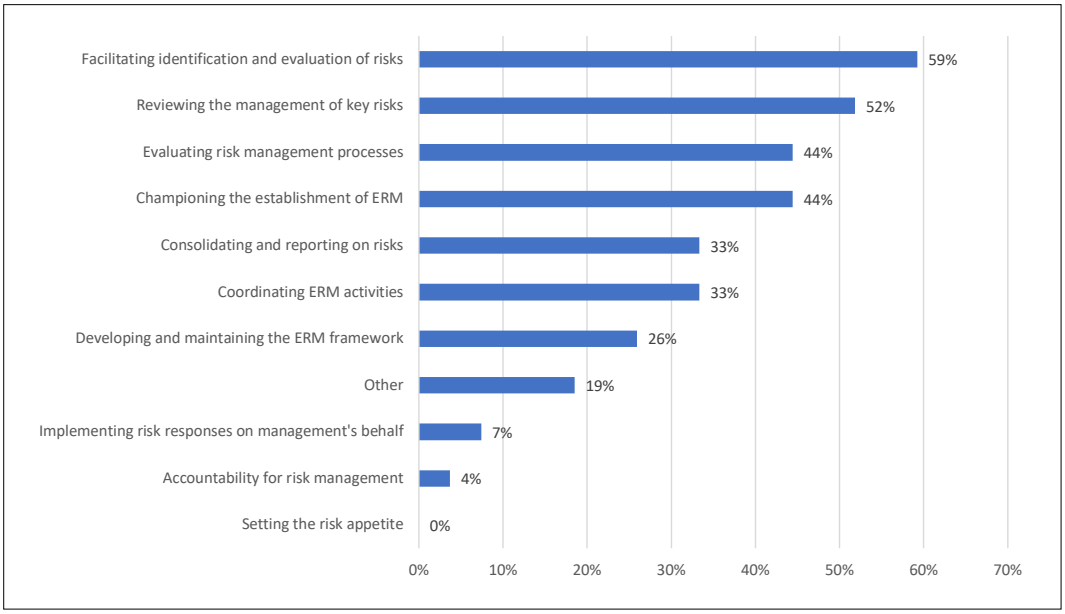
Respondents were asked to identify what percentage of the overall audit plan had to be adjusted due to the Covid-19 pandemic. Exhibit 15 summarizes the adjustments, which indicate the agility of healthcare internal audit teams.

Covid-19 caused internal audit to become more resourceful and innovative by remotely performing aspects of audits with technology. Many fieldwork steps such as observations (e.g., inventory verification, expired drug testing) had to be performed collaboratively with operational staff via tele-conferencing and other technology. The new approaches merit following post-pandemic to see if they are sustained based on benefits, time invested and cost effectiveness.

Exhibit 16 – Responsibility for compliance audits

Areas	Compliance	Internal audit	Combined (Compliance and IA)	Audited outside of Compliance and IA	Not audited	Total
340B pharmacy drugs	20%	28%	14%	18%	20%	100%
Advanced beneficiary notices	52%	11%	5%	9%	23%	100%
Clinical trial billing	40%	14%	9%	7%	30%	100%
Coding and billing	57%	5%	18%	11%	9%	100%
ICD-10 coding	70%	5%	2%	14%	9%	100%
Medicare conditions of participation	60%	2%	9%	11%	18%	100%
Medicare quality measures	38%	9%	7%	16%	30%	100%
National coverage determinations	64%	2%	7%	11%	16%	100%
Physician evaluation and management coding and billing	63%	5%	9%	9%	14%	100%
Physician procedural-based coding and billing	57%	5%	11%	11%	16%	100%
Privacy access audits	43%	23%	16%	9%	9%	100%
Provider based clinics	39%	16%	16%	11%	18%	100%
Two-midnight rule	48%	9%	9%	9%	25%	100%

Exhibit 17 – Internal audit role in the ERM process



Risk assessments updates and collaboration

The conduct of risk assessments varies in frequency and depth depending on the organization and changing needs. Regarding the frequency of risk assessments, all respondents reported conducting a risk assessment at least once a year, if not more frequently.

Most respondents (60%) noted that they conduct a risk assessment once per year. The remaining 40% reported conducting risk assessments continuously (24%), four times per year (10%), twice per year (4%), and three times per year (2%).

Regarding responsibility for conducting the assessments, 68% of respondents reported that internal audit and compliance work together to complete the risk assessment, and 22% reported that compliance and internal audit conduct their risk assessments independently. Additionally, 10% reported that another function, other than internal audit or compliance, conducts the risk assessment for their organization.

Internal audit, compliance and other complementary functions employ risk assessments of varying degrees of frequency and scope during the year. The respondent results suggest that internal audit functions value collaboration with and insights from other functions, including compliance. Collaboration ensures a holistic view of organizational risk that should result in effective and value-added audit plans.

Responsibility for compliance audits

Compliance audits are conducted throughout healthcare organizations and the subject matter complexity differs by topical area. The complexity requires some compliance audits to be performed not just by internal audit, but also by compliance and other functional areas or third-party service providers. Exhibit 16 summarizes respondents' answers on who performs certain compliance audits within their organization. The majority of the identified compliance audits are performed solely by the compliance function.

Internal audit and compliance should not work independently but rather collaboratively to determine which function is best positioned to perform audits. Additionally, if a function other than internal audit is leading the audit effort, determine what complementary support can be provided by internal audit (e.g., accounting, data analytics) to ensure a holistic and effective assessment.

Implementation of Sarbanes-Oxley

The Sarbanes-Oxley Act (SOX) of 2002 was passed by the U.S. Congress to "protect investors by improving the accuracy and reliability of corporate disclosures." Private companies are not required to be SOX-compliant.

Regarding their philosophy on SOX compliance, 64% of respondents said that SOX is not required and is not being implemented by their organization, while 11% of respondents said that they review SOX implications and implement as much as possible. An additional 11% of respondents said

that their organization has implemented all of SOX. Another 5% said that they implement SOX except for Section 302 (Management Certification) and 404 (Control Evaluation) and 2% implement only the sections that have been requested by a third party.

Implementation of enterprise risk management and the role of internal audit

Enterprise risk management (ERM) processes take a top-down approach to periodically help identify and assess the risks of specific business segments. ERM programs help provide a consistent vocabulary and risk reporting framework, make risk appetite discussions tangible and part of the annual planning process, enable risks to become strategic rather than just operational, and facilitate cross-functional forums for risks facing the enterprise.

Exhibit 18 – Total organizational employees

Number of employees	%
<1,000	0%
1,000–4,999	16%
5,000–9,999	18%
10,000–19,999	32%
20,000–34,999	9%
35,000–49,999	11%
>49,999	14%
Total	100%

Most respondents (61%) indicated that their organization has an ERM process, and 32% responded that they currently do not have an ERM process. Of the respondents who do not currently have an ERM process, 43% cited lack of executive support as the main reason. Additional reasons include a lack of perceived benefits (14%) and not being necessary (14%). Additionally, 7% of those who do not currently have an ERM process said that they are currently in the process of implementing one.

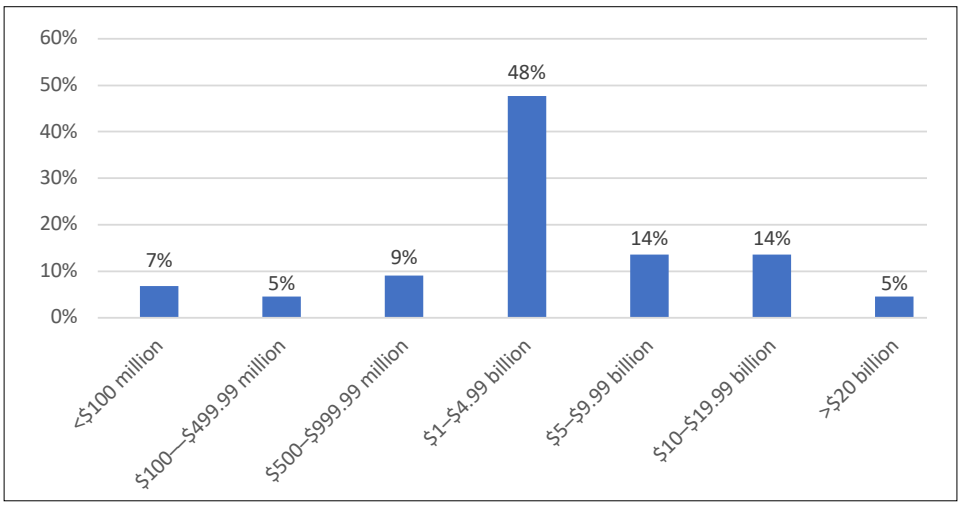
Among the organizations that currently have an ERM process in place, 25% reported that the Chief Risk Officer is responsible for leading this process in their organization, with the remaining organizations indicating responsibility resides with the Chief Audit Executive (15%), Chief Compliance Officer (19%), Chief Executive Officer (11%), General Counsel (4%), and Other (26%).

Respondents that currently have an ERM process in place were also asked to describe the role of internal audit in their organization's ERM process, summarized in Exhibit 17. Multiple responses were permitted for this question.

In Exhibit 17, 59% of the respondents indicate that internal audit's role is facilitating the identification and evaluation of risks. An additional 52% described the role as reviewing the management of key risks. Interestingly, no respondents described their role as setting the risk appetite.

For organizations that have an ERM process, a trend is that internal audit is taking on a larger role in championing the establishment of ERM and facilitating the ongoing evaluation of risk.

Exhibit 19 – Organizational annual gross revenue



Respondent demographics

Additional survey response data is provided in Exhibits 18-21 regarding respondent organization employees, organization annual revenue, respondent position and organization type.

Conclusion

Internal audit functions are at risk of falling behind in the rapidly changing healthcare industry. Ensure that your internal audit function has the staffing, financial resources and other support necessary to advance your capabilities. Build a highly skilled and engaged team while maintaining your focus on meeting stakeholder expectations and complying with professional standards.

Use benchmarks to measure your standing on key metrics to your industry counterparts. Close identified gaps, improve your performance and contribute more value. **NP**

Exhibit 20 – Respondent's position

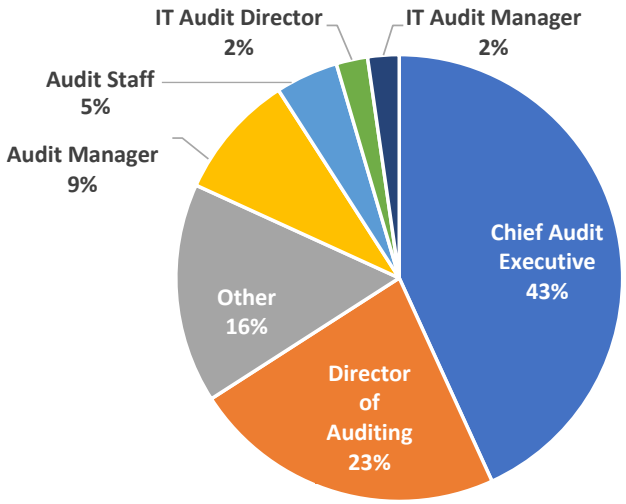
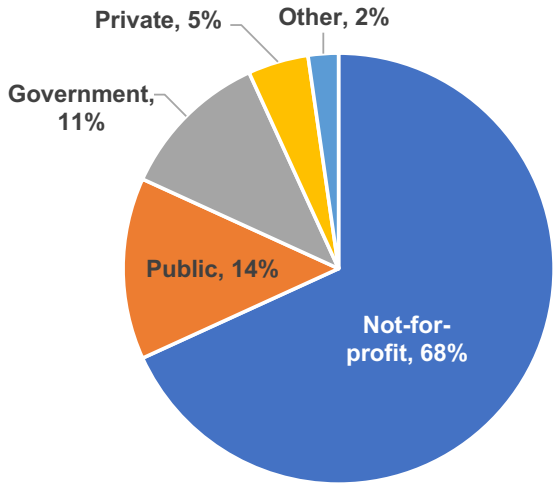


Exhibit 21 – Respondent's organization type



Mike Michalowicz, CIA®, CCSA, CRMA, is a Director of Internal Audit for Bon Secours Mercy Health. He is a member of AHIA's Professional Practices Committee. Mike can be reached at Mike_Michalowicz@bshsi.org and 804-432-7716.

Bryon Neaman, CHIAP®, CIA®, CPA, is a Northeast Region Healthcare Practice Leader with Protiviti. He can be reached at Bryon.Neaman@protiviti.com and 410-375-7946.

Rebecca Nilson, CIA®, CPA, CRMA, is a Director with Protiviti. She can be reached at Rebecca.Nilson@protiviti.com and 773-320-0833.

I can't imagine a person becoming a success who doesn't give this game of life everything he's got. – Walter Cronkite