Dear Colleagues:

Cone Health and its affiliated entities ("CH") are fully committed to compliance with the laws and ethical standards in all we do. This commitment stems from the foundation of our Code of Conduct that encompasses the Cone Health purpose, intent, and values as well as the Cone Health iCARE Commitments that are fundamental to our culture. The Code of Conduct supports the CH enterprise and guides our actions as we strive to transform the health of our patients, and the communities we serve by providing exceptional care with integrity.

In this age of strict government regulation and public scrutiny of business practices, a high level of devotion to compliance and integrity is essential. CH prioritizes compliance and business ethics not only because of increasing enforcement, but because it's the right thing to do. This Compliance and Integrity Program was developed as the framework to drive and sustain a culture of compliance and integrity for CH.

Audit and Compliance Services ("ACS") implements and supports this Compliance and Integrity Program through education and training, program activities, guidance on implementation of policies and regulations, and investigations of non-compliance and fraud, waste, or abuse. Our culture of compliance encourages all individuals to raise compliance concerns directly with their supervisor, and others in the chain of command as well as our Chief Compliance and Privacy Officer, Catharine Fortney, or any member of the ACS team. However, if anyone is not comfortable with this method of reporting, our Compliance and Privacy Helpline (**1-855-809-3042** or www.conehealth.ethicspoint.com) is available to report or raise concerns anonymously.

We encourage asking questions and speaking up to help preserve and strengthen the culture of ethics and integrity throughout the CH system. We do not tolerate retaliation or take adverse action against individuals who make good faith reports, regardless of whether the reports are ultimately substantiated or not.

To ensure a high level of integrity throughout our organization, each of us must be committed to doing the right thing and act consistent with our values, ethics, and standards of conduct. This Compliance and Integrity Program applies to all staff (employed and contracted), including board members, senior leaders, supervisors, medical staff, affiliates, and volunteers. Compliance is everyone's responsibility, and we expect all Cone Health team members to become familiar with this document.

Thank you for all you do.

Mary Jo Cagle, MD
Chief Executive Officer

Mae Douglas
Board Chair, Cone Health Board of Trustees

CONE HEALTH

INTRODUCTION

Cone Health ("CH") began providing care for patients in the North Carolina triad region in 1953. Since then, Cone Health has evolved and grown into one of the state's most comprehensive and trusted health systems with nearly 15,000 employees. Cone Health's non-profit healthcare network contains more than 150 locations including five hospitals, multiple ambulatory care centers, outpatient surgery centers, and urgent care centers, one retirement community and more than 120 physician practices including primary and specialty care through Cone Health Medical Group and Triad Healthcare Network. Cone Health has a fourteen-member Board of Trustees responsible for overseeing and governing Cone Health and its subsidiaries.

As a comprehensive and multi-faceted health system, CH is obligated to manage and operate within a complex set of rules and regulations. To do so, it has a system-wide Compliance and Integrity Program that has established a framework to support compliance with applicable health insurance guidelines, clinical care and research laws, regulations, and policies of CH and its subsidiaries.

Through its Compliance and Integrity Program, CH maintains and enforces a culture of accountability and compliance with state and federal regulatory requirements. These compliance standards, which are set forth in our policies and the Code of Conduct, define Cone Health's commitment to regulatory compliance and ethical business practices.

The Cone Health Compliance and Integrity Program is independent of routine operations and avoids participating in activities that might reasonably be considered to compromise its ability to provide independent and objective services. The Cone Health Audit and Compliance Department is authorized access to any records, facilities, and personnel necessary to ensure that the Compliance and Integrity Program functions as directed by the Board of Trustees.

OVERSIGHT

I. Board of Trustees Oversight

The CH Board of Trustees have responsibility and oversight for compliance and audit activities. The CH Board of Trustees have delegated the duty to provide oversight for the Compliance and Integrity Program to its Resource, Investment, and Risk Committee ("RIR"). The CH Board of Trustees ("Board") is ultimately responsible for supervising the work of the Chief Compliance and Privacy Officer and maintaining the standards of ethics and integrity as outlined in the Code of Conduct and this Compliance and Integrity Program. The Board oversees CH's compliance efforts and takes appropriate and necessary actions to ensure CH conducts its business in compliance with applicable regulations, standards, and ethical practices. The Chief Compliance and Privacy Officer presents compliance matters directly to the Board at least once per year or as necessary.

A. *Resource, Investment, and Risk Committee (RIR).* The Chief Compliance and Privacy Officer provides regular reports to the Board through the RIR about the Compliance and Integrity Program and compliance issues. The RIR provides oversight, exercising reasonable care, to assure that corporate officers, supervisors, and staff carry out their management responsibilities in an ethical manner and in compliance with the law. Committee members are entitled to rely, in good faith, on officers, supervisors, and staff as well as professional experts and advisors in whom committee members believe such confidence is merited. Additionally, in exercising reasonable oversight, each RIR is made aware of any compliance enforcement activities issued to CH, the outcomes of CH compliance activities, and the results of the assessment of Compliance and

Integrity Program performance and effectiveness. The RIR will report compliance matters to the full Board regularly. The RIR reviews and approves the compliance and internal audit work plans.

B. *Meetings.* The Chief Compliance and Privacy Officer provides compliance updates to the Board RIR at least bi-annually and will develop the compliance portion of the agenda for RIR meetings. The Chief Compliance and Privacy Officer will have an executive session with the Board RIR where management is not present at the meeting.

II. Chief Compliance and Privacy Officer

CH has a Chief Compliance and Privacy Officer who oversees the ACS department and serves as the primary supervisor of this Compliance and Integrity Program. The Chief Compliance and Privacy Officer occupies a high-level position within the organization and has authority to carry out all compliance responsibilities described in this Compliance and Integrity Program. The Chief Compliance and Privacy Officer is responsible for assuring that the Compliance and Integrity Program is implemented to ensure that CH maintains business integrity and that all applicable statutes, regulations, sub-regulatory guidance, and policies are followed.

A. *Access.* The Chief Compliance and Privacy Officer reports to the SVP, Chief Legal Counsel, and the CH Board of Trustees with direct access to the CH Chief Executive Officer ("CEO") and immediate access to other executives and senior managers. To further the compliance interests of the organization, the Chief Compliance and Privacy Officer shall regularly communicate and collaborate with the CH CEO and General Counsel regarding compliance concerns, initiatives, and investigations. The Chief Compliance and Privacy Officer shall disclose any compliance investigations or concerns to the CEO and/or the Chief Legal Counsel; except that, the Chief Compliance and Privacy Officer may disclose compliance concerns directly to the CH Board RIR and/or the CH Board of Trustees if, in the opinion of the Chief Compliance and Privacy Officer, disclosure of compliance concerns to the CEO or Chief Legal Counsel would compromise the goals and purposes of the Compliance and Integrity Program. In such cases, the Chief Compliance and Privacy Officer shall disclose the matter through his/her direct reporting relationships with the CH Board RIR and/or the CH Board as a whole. The Chief Compliance and Privacy Officer can retain, as necessary for the performance of his/her responsibilities, consultants and outside legal counsel.

The Chief Compliance and Privacy Officer oversees the compliance and privacy programs for the Triad HealthCare Network (THN). The day-to-day operation of the THN Compliance and Integrity Program is managed by the THN Compliance Officer who reports to the CH systemwide Chief Compliance and Privacy Officer and the THN Board of Managers. The THN Compliance Officer receives support and guidance from the systemwide Audit and Compliance Services department.

B. *Authority.* The Chief Compliance and Privacy Officer has the authority to review all documents and other information relevant to compliance activities, including, but not limited to, patient records, billing records, records concerning marketing efforts and all arrangements with third parties, including without limitation, employees, contract labor, board members, agents, independent contractors, students, vendors, consultants, medical professionals and specialists, volunteers and business partners.

C. *Responsibilities.* The Chief Compliance and Privacy Officer's responsibilities include the following:

- Advising the CEO, Board of Trustees, and other senior leaders on the compliance risks facing the entity, compliance risks related to strategic and operational decisions of the entity, and the operation of the entity's compliance program.

- Oversee and monitor the implementation and maintenance of the CH systemwide and THN Compliance and Integrity Programs.
- Report on a regular basis to the CH RIR of the Board of Trustees (no less than bi-annually) on the progress of implementation and operation of the Compliance and Integrity Program and assisting the CH RIR in establishing methods to reduce CH's risk of fraud, waste, and abuse ("FWA").
- Revise the Compliance and Integrity Program periodically in response to the needs of CH and applicable statutes, regulations, and sub-regulatory guidance.
- Review, at least annually, the implementation and execution of the elements of the Compliance and Integrity Program. The review includes an assessment of each of the basic elements individually, the overall success of the Compliance and Integrity Program, and a comprehensive review of the ACS department.
- Develop, coordinate, and participate in educational and training programs that focus on elements of the Compliance and Integrity Program with the goal of ensuring that all appropriate staff members are knowledgeable about, and act in accordance with the Compliance and Integrity Program.
- Inform independent contractors, agents, vendors of CH about the Compliance and Integrity Program.
- Implement mechanisms that help ensure CH does not employ or contract with any individual who has been convicted of a criminal offense related to health care within the previous five years, or who is listed by a federal or state agency as debarred, excluded, or otherwise ineligible for participation in Medicare, Medicaid, or any other federal or state health care program.
- Coordinate internal compliance review and monitoring activities.
- Independently investigate, or coordinate investigation of compliance matters, including design and coordination of internal investigations and recommending and/or monitoring the implementation of any corrective actions.
- Maintain a good working relationship with other key operational areas, such as coding, billing, and clinical departments.
- Designate work groups or task forces needed to carry out specific missions, such as conducting an investigation or evaluating a proposed enhancement to the Compliance and Integrity Program.

III. CH Executive Compliance Committee

A. *Membership.* CH has established an Executive Compliance Committee ("ECC") to demonstrate senior management's commitment to the Compliance and Integrity Program and promote responsibility and accountability for compliance and ethics throughout the organization. The CH ECC is comprised of CH executive leaders, CH leaders responsible for key operational areas with high compliance risks, and outside representation or ad hoc members when necessary.

B. *Meetings.* The ECC meets quarterly or as necessary to carry out its functions.

C. *Functions.* The ECC's functions include, but are not limited to the following:
- Aiding and supporting the Chief Compliance and Privacy Officer in:
  - Implementing, operating, and monitoring the compliance program.
  - Staying current and evaluating the enterprise's compliance with the requirements of state and federal health care programs.
  - Recommending and monitoring internal systems and controls;
  - Examining organizational compliance with the Health Insurance Portability and Accountability

Act ("HIPAA") and other applicable state and federal laws pertaining to information privacy and information security.
    - Ensuring the implementation of the privacy and information security programs and policies.
- Participate in assessing compliance and integrity risks and help ensure effective mitigation plans are implemented.
- Participate in the creation, review, and approval of the annual compliance and internal audit, privacy, and information security work plans and assess its effectiveness.
- Review and approve the Compliance and Integrity Program, Code of Conduct and compliance, privacy, and information security policies and procedures.
- Review the system-wide compliance training and education and assess its effectiveness.
- Review and propose strategies to promote compliance and detection of potential violations.
- Oversee appropriate and consistent discipline is imposed for violations of the Code of Conduct and policies.
- Oversee steps taken to prevent similar violations from occurring in the future.
- Request the Chief Compliance and Privacy Officer to commission special audits, as necessary, to verify adherence to the Code of Conduct, policies, and/or legal requirements.
- Lead and champion compliance and business ethics for the organization.
- Support the efforts of the Compliance and Integrity Program and promote accountability.

WRITTEN GUIDANCE

I. Code of Conduct

A. *Application.* The CH Code of Conduct applies to all CH staff and endeavors, including patient care, health insurance, research, education, financial management, fundraising, and human resource management.

B. *Approval Process.* The Code of Conduct is reviewed and approved by the CH Board of Trustees' RIR and forwarded to the Board for final approval and adoption.

C. *Awareness and Commitment.* CH staff members, including directors, officers, supervisors, medical staff, affiliates, and volunteers of CH, are committed to ethical behavior and compliance with all applicable federal, state, and local laws and regulations. To effectively carry out these responsibilities, it is essential that everyone associated with CH understand and abide by the contents of the Code of Conduct.

II. Policies and Procedures

A. *Development of intra-departmental ethics and compliance policies.* CH develops policies and processes in support of, and in furtherance of, the Compliance and Integrity Program, including:
    a. Written policies and procedures for any compliance-related activities undertaken by departmental staff members.
    b. Measures to support training and document training attendance.
    c. Periodic internal review of records to determine compliance and to assess any trends, training, or other needs for process improvement.

B. *Implementation of CH institutional policies.* CH implements policies relating to compliance, including, but not limited to, any policies relating to HIPAA and other privacy regulations, HIPAA and other information security regulatory requirements, conflicts of interest, auditing and monitoring, relationships with referral sources, exclusion screening, documentation, charting, training, records maintenance, coding practices, billing practices, research activities, Medicare Conditions of Participation, and Medicare and Medicaid billing requirements.

EDUCATION AND TRAINING

CH will provide training and periodic re-training for all employees and supervisory staff as well as to others to whom the Compliance and Integrity Program applies to familiarize them with all pertinent provisions of the Code of Conduct and CH compliance-related policies, processes, and regulations.

I. Frequency of Training

A. *Employees.* All employees attend new employee orientation and must complete computer-based compliance training as part of new employee orientation, and annually thereafter.

B. *Non-Employees (Affiliates).* Where feasible, outside contractors will be afforded the opportunity to receive, or be encouraged to develop their own, compliance training and education, to complement CH's standards of conduct and compliance policies.

C. *Board of Trustees.* The members of CH's governing bodies are provided training with orientation and periodically thereafter on fraud, waste, and abuse laws, conflicts of interest, and other compliance topics.

II. Training Content

The Chief Compliance and Privacy Officer and ACS department are responsible for developing and/or acquiring the necessary compliance program training materials to provide appropriate levels and types of training for all affected staff. ACS will also determine training content as well as frequency and methods of delivery (e.g., live presentation, video, audio, computer-based, etc.).

III. Training Attendance and Documentation

A. *Training Attendance.* The ACS department will work with the staff education department to identify and notify all persons who are subject to a compliance department training requirement. It is the responsibility of departmental supervisors to be aware of initial and ongoing training requirements and to make employees, affiliates, and volunteers available for such training.

B. *Documentation.* All formal compliance training undertaken as part of the Compliance and Integrity Program is documented. Documentation includes, at a minimum, the identification of the staff participating in the training, the subject matter of the training, the length of the training, the time and date of the training, the training materials used, and any other relevant information.

IV. Expectations

The compliance training described in this Compliance and Integrity Program is in addition to any periodic professional education courses that may be required by statute or regulation for certain staff members. CH expects its staff to comply with applicable professional education requirements; failure to do so may result in disciplinary action.

LINES OF COMMUNICATING AND REPORTING

I. Duty to Report

All members of the CH staff have a duty to report any suspected wrongdoing or violation of applicable laws, regulations, or CH's Code of Conduct and/or policies and procedures. Staff members who fail to fulfill this duty may be subject to disciplinary action up to and including termination.

II. Open Door Policy

CH recognizes that clear and open lines of communication between the Chief Compliance and Privacy Officer and CH staff are important to the success of this Compliance and Integrity Program. All levels of management will maintain an "open-door policy" to encourage staff to report problems and concerns. In the event of any confusion or question about a statute, regulation, policy, or the Code of Conduct, staff members are encouraged to seek clarification from the Chief Compliance and Privacy Officer or designee.

III. Submitting Questions or Complaints

CH staff members are encouraged to submit questions, concerns, and compliance reports to their manager, supervisor, director, executive, Chief Compliance and Privacy Officer, or by reporting to the CH Compliance and Privacy Helpline (**1-855-809-3042** or www.conehealth.ethicspoint.com). The Compliance and Privacy Helpline numbers and the Chief Compliance and Privacy Officer's contact information are posted throughout CH and are available on the organization's intranet.

A. *Compliance and Privacy Helpline.* Reports to the Compliance and Privacy Helpline are answered by an independent contractor, not by CH employees. All calls are treated confidentially and are not traced. The caller need not provide his or her name. The Chief Compliance and Privacy Officer or designee investigates all reports and initiates follow-up actions as appropriate.

B. *Direct Contact.* Reports to the Chief Compliance and Privacy Officer or designees (ACS staff) are treated confidentially. The Chief Compliance and Privacy Officer or designee investigates all reports and initiates follow-up actions as appropriate.

Communications via the Compliance and Privacy Helpline and directly to the Chief Compliance and Privacy Officer or designees (ACS staff) are treated as privileged to the extent permitted by applicable law; however, it is possible that the identity of a person making a report may become known, or that governmental authorities or a court may compel disclosure of the name of the reporting person.

IV. Non-Retaliation Policy

It is CH's policy to prohibit retaliatory action against any person for making a report, anonymous or otherwise, regarding compliance matters. CH applies corrective actions to those who retaliate against a staff member who reports a perceived problem or concern in good faith. However, CH staff cannot use complaints to the Chief Compliance and Privacy Officer to insulate themselves from the consequences of their own wrongdoing or misconduct. False or deceptive reports may be grounds for termination. It will be considered a mitigating factor if a person makes a forthright disclosure of an error or violation of policies, procedures, the Code of Conduct, or the governing statutes and regulations.

RESPONDING TO REPORTED CONCERNS

I. Investigations

- Upon reports or reasonable indications of suspected noncompliance, the Chief Compliance and Privacy Officer or designated investigator will initiate prompt steps to investigate the conduct in question to determine whether a material violation of applicable law or the requirements of the Compliance and Integrity Program has occurred.
- Depending upon the nature of the alleged violations, the Chief Compliance and Privacy Officer's or designated investigator's internal investigation could include interviews with staff members and a review of related documents.
- If the Chief Compliance and Privacy Officer or designated investigator believes the integrity of the investigation may be at risk because of the presence of employees under investigation, those employees will be removed from their current work activity until the investigation is completed.

- The Chief Compliance and Privacy Officer or designated investigator may engage outside legal counsel, external auditors, or health care experts to assist in an investigation where the Chief Compliance and Privacy Officer deems such assistance appropriate.
- Where necessary, the Chief Compliance and Privacy Officer or designated investigator will take appropriate steps to secure or prevent the destruction of documents or other evidence relevant to the investigation.
- The Chief Compliance and Privacy Officer's or designated Investigator will maintain complete records of all investigations which contain documentation of the alleged violations, a description of the investigative process, copies of interview notes and key documents, a log of the witnesses interviewed, and the documents reviewed, results of the investigation, and corrective actions implemented.
- The Chief Compliance and Privacy Officer includes a summary of the information in reports to each Board and the CH CEO.

AUDITING AND MONITORING

Periodic compliance audits are used to promote and test compliance. These audits are performed by internal or external auditors who have the appropriate qualifications and expertise in federal and state health care statutes as well as regulations and federal health care program requirements. The audits focus on specific programs or departments of the organization, including external relationships with third-party contractors. These audits are designed to evaluate CH's compliance with laws and regulations governing health plans (all lines of business), kickback arrangements, physician self-referrals, claims development and submission (including an assessment of CH's billing system), financial or administrative internal controls, reimbursement, marketing, and other topics as identified. All staff members are expected to cooperate fully with auditors during this process by providing information, answering questions, etc. If any employee has concerns regarding audit scope or execution, the employee should discuss this with his or her immediate supervisor.

I. Audit Work Plan

The Chief Compliance and Privacy Officer and ACS shall direct and oversee periodic internal audits of selected facets of CH's operational areas to test and confirm compliance with internal policies and procedures and applicable laws, regulations, and sub-regulatory guidance. The Chief Compliance and Privacy Officer will develop and implement an internal audit and monitoring work plan. The work plan will be reviewed at least quarterly to determine whether it addresses the appropriate areas of concern, considering, for example, findings from previous years' audits, risk areas identified as part of the annual risk assessment and high utilization services.

A. *The Internal Audit Work Plan Design.* The internal audit work plan includes planned auditing, monitoring, and advisory activities identified in the annual risk assessment process. Audit topics may include the following:
   - Revenue cycle compliance with laws governing kickback arrangements, self-referral prohibition, coding claim development and submission, reimbursement, cost reporting, and marketing.
   - Issues identified by regulatory agencies including the Centers for Medicare and Medicaid Services ("CMS"), North Carolina Medicaid, Department of Justice litigation and settlements, Office of Inspector General ("OIG") Work Plan and Special Fraud Alerts, and Medicare and Medicaid Contractor Audits.

B. *Audit Frequency*. It shall be within the discretion of the Chief Compliance and Privacy Officer to determine the frequency that each area will be audited, and which additional areas or subjects will require audit examination.

C. *Audit Resources*. Internal or external staff conducting an audit shall:
- Be independent.
- Have access to existing audit and health care data, relevant staff, and relevant areas of operation.

D. *Audit Documentation and Reporting.*

A. *Maintenance and Content.* Documentation of each audit shall be maintained by ACS and stored in compliance with the CH retention policies and schedules. In all cases necessary, a concise statement of actions undertaken or planned in response to the recommendations and timetable for implementation will be required.

B. Distribution and Reporting. Audit documentation shall be communicated in writing to key stakeholders responsible for the audited area, and the ECC and when necessary. Audit documentation and the auditee's progress towards completion of actions undertaken or planned shall be reported periodically to the CH and Board RIR.

ENFORCING STANDARDS AND POLICIES

It is the policy of CH to hold staff members who fail to comply with the Code of Conduct, policies and procedures, this Compliance and Integrity Program, or any federal or state statutes or regulations, accountable for their actions. CH utilizes accountability-based performance to address behaviors that are non-compliant up to and including termination. Each instance involving disciplinary action shall be thoroughly documented by the staff member's supervisor, Human Resources, and/or the Chief Compliance and Privacy Officer or designee.

I. Compliance as an Element of Performance

Substantial or intentional violations of the Code of Conduct (including intentional failure to report the misconduct of other employees or contractors) will be viewed as a serious infraction. Corrective actions may include termination of employment or contract.

II. Managerial Responsibility

Officers and supervisors will be held accountable as an element of performance for negligence or indifference that results in failing to detect and correct compliance violations that occur. If an executive or manager, due to negligence, indifference, inaction, complicity, or intentional misconduct, facilitates or prolongs misconduct of another, a corrective action commensurate with the seriousness of the violation will be imposed.

III. Nature of Sanctions and Factors Affecting Sanctions

Any formal discipline of persons who violate the Code of Conduct, other policy or any law or regulation will be governed by the policy applicable to that person's employment status (e.g., employee, officer, member of the medical staff, non-employee). In addition, sanctions and/or corrective actions applied may include re-training, suspension of billing activities, limitation of privileges, or limitation of electronic or other access in accordance with the applicable policies and bylaws, including this Compliance and Integrity Program.

A. *Mitigation Factors*. A person whose conduct otherwise would justify more severe punishment may have lesser discipline imposed. This decision will be based upon whether:
   - The person reported his or her own violation;
   - The report constitutes the first awareness of the violation and the person's involvement; and
   - The person has provided full and complete cooperation during the investigation of the violation.

B. *Guidelines for Unintentional Wrongdoing*. In first cases involving unintentional wrongdoing, corrective actions such as re-education and monitoring may be appropriate. Subsequent cases may lead to more serious forms of action, up to and including termination of employment or other CH relationship and, if appropriate, referral for prosecution.

C. *Guidelines in Cases of Financial Loss*. CH will seek reimbursement for losses from wrongfully billed episodes of care or other damages (including attorney fees) in cases involving financial loss to the institution because of intentional or negligent misconduct. Referral for criminal prosecution or civil action will occur in the most serious cases involving intentional wrongdoing, intentional failure to correct known negligent wrongdoing or intentional indifference to the requirements of regulatory compliance.

CORRECTIVE ACTION

Violations of this Compliance and Integrity Program, failure to comply with applicable federal or state laws, regulations, and sub-regulatory guidance, and other types of misconduct threaten CH's status as a reliable and honest provider of health care services. Detected but uncorrected misconduct can seriously endanger CH's business and reputation and can lead to serious sanctions against it.

I. Reporting

If the Chief Compliance and Privacy Officer or a management official discovers credible evidence of misconduct from any source and, after reasonable inquiry, has reason to believe that the misconduct may violate criminal, civil, or administrative law, then the misconduct will promptly be reported as appropriate to the OIG, CMS, or any other appropriate governmental authority or federal and/or state law enforcement agency having jurisdiction over the matter. Such reports will be made by the Chief Compliance and Privacy Officer on a timely basis. All overpayments identified by CH shall be promptly disclosed and/or refunded to the appropriate public or private payer or other entity.

INSTITUTIONAL OBLIGATIONS CONCERNING COMPLIANCE

I. Departmental and Institutional Responsibility

It is the responsibility of each person exercising line management authority to undertake and implement compliance activities, as directed by the Chief Compliance and Privacy Officer and ACS, and to use his or her own best efforts to prevent, detect, investigate, and correct compliance deficiencies within his or her area of responsibility. All CH staff members shall undertake all necessary efforts and implement any necessary policies and structural changes to bring CH into full and ongoing compliance with all applicable federal, state, and local laws and regulations. All compliance activities will be carried out with the coordination and involvement of ACS.

II. Accountability

Ethical behavior and regulatory compliance are elements of job performance expectations of all CH staff,

including employees, contract labor, board members, agents, independent contractors, students, vendors, consultants, medical professionals and specialists, volunteers, business partners and others acting for Cone Health. Each CH staff member is responsible for acting in alignment with this Compliance and Integrity Program along with applicable laws, ethical standards, and CH policies, procedures, and the Code of Conduct.

CH enforces appropriate discipline to ensure consistent and effective corrective actions are implemented for officers, supervisors, medical staff, affiliates, and volunteers within the management and control of each department.

III. Investigations

A. *Full Cooperation, Assistance, and Access to all Records for Internal Audit Investigations.* In order to meet its internal audit and investigations obligations and to assure full compliance with regulations and standards, ACS shall have full and complete access to all necessary records and systems, including, but not limited to, records of episodes of patient care, all billing systems and records, all research records, all grant records, and any other business or patient records, official or unofficial, kept by the department and/or individuals within the department. For HIPAA purposes, compliance oversight is a function of health care operations. Granting such access and full cooperation with compliance activities shall be considered a condition of affiliation or employment with CH.

B. *Staff Response to Government Investigations.* CH and its staff will fully cooperate with any government investigation.

IV. Authority to Promulgate Policies and Procedures in Furtherance of this Compliance and Integrity Program

ACS may develop and promulgate policies and procedures consistent with this Compliance and Integrity Program and in furtherance of its goals and objectives. Additional policies may include departmental compliance plans and committees. Any such policies and procedures are placed in the electronic policy system located on Cone Connects and shall be effective for all CH staff.