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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE COMMISSIONER

Lori A. Shibinette
Commissioner

129 PLEASANT STREET, CONCORD, NH 03301-3857
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June 8, 2020

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Office of the Commissioner, to amend an existing contract with Mary Hitchcock Memorial Hospital (a component of Dartmouth-Hitchcock) (VC#177160), One Medical Center Drive, Lebanon, New Hampshire, 03756 to provide additional Physician, Clinical and Administrative Services to meet the specialized health and related clinical and administrative needs of residents of the State of New Hampshire, by increasing the price limitation by $690,600 from $79,904,111 to $80,594,711 with no change to the contract completion date of June 30, 2022 effective upon Governor and Council approval. The original contract was approved by Governor and Council on September 7, 2016, (Item #6A), amended subsequently amended on January 9, 2019 (Item #5A), and on June 19, 2019, (Item #10. 34% General Funds. 66% Other Funds (Medicare, Medicaid & third party insurance).

SEE ATTACHED FISCAL DETAILS

EXPLANATION

The purpose of this request is two-fold, the first to allow for assistance in the event of a healthcare system emergency and the second to modify the staffing requirements for New Hampshire Hospital.

The first request is to ensure that in the event of a healthcare system emergency, additional staffing or resources are available to assist in a surge of individuals requiring services under this Agreement. In the event of a healthcare system emergency, the total number of psychiatrists or other medical providers provided by the Contractor may be adjusted to include up to three (3) full-time psychiatrist and / or medical provider positions and one part-time psychiatrist and / or medical provider position to serve any or all of the seven (7) Service Areas identified below:

Service Area #1 – New Hampshire Hospital

Service Area #2 – Glencliff Home

Service Area #3 – Medicaid

Service Area #4 – Children, Youth and Families

Service Area #5 – Behavioral Health

Service Area #6 – Elderly and Adult Services

Service Area #7 – Developmental Services

Services provided in the event of a healthcare system emergency are invoiced based on actual time worked to serve any or all of the seven (7) service areas listed above. The budget for those services shall be unencumbered per State Fiscal Year as specified below:

Services Provided	7/1/2019-6/30/2020	7/1/2020-6/30/2021	7/1/2021-6/30/2022	Total Additional Costs
Healthcare Emergency	$230,200	$230,200	$230,200	$690,600

The second request is to modify the staffing requirements in Service Area #1 to account for the increase in adult population and the elimination of children's services at New Hampshire Hospital. This change results in a no cost amendment. The budget of each service area is summarized below.

Budget			
Agreement Period by State Fiscal Year			
Service Area	**7/1/2019-6/30/2020**	**7/1/2020-6/30/2021**	**7/1/2021-6/30/2022**
1: New Hampshire Hospital	$11,640,759	$12,717,827	$13,366,111
2: Glencliff Home	$139,309	$148,447	$156,475
3: Medicaid	$408,628	$432,119	$455,192
4: Children, Youth & Families	$396,688	$392,445	$413,867
5: Behavioral Health	$517,056	$544,803	$572,319
6: Elderly and Adult Services	$39,197	$41,809	$44,110
7: Developmental Services	$284,893	$310,264	$327,751

The Contractor was selected through a competitive bidding process. The Department published a Request for Proposals for Physician Clinical and Administrative Services (RFP-2017-OCOM-01-PHYSI) on the Department of Health and Human Services website on February 25, 2016, and also notified several potentially interested vendors of the release. The Department received one proposal in response. The proposal was evaluated and scored by a team of individuals with comprehensive knowledge of the service areas addressed in the RFP. Based on this evaluation, the Department selected Mary Hitchcock Memorial Hospital to provide these services.

As referenced in the General Provisions in the P-37, Paragraph 18, and Exhibit C-1, Revisions to General Provisions, Paragraph 3, of the original contract, the parties have the option to extend the agreement for up to three (3) additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties and Governor and Council approval. The Department is not exercising its option to renew at this time.

Should the Governor and Executive Council determine to not authorize this request the Department will be limited in its ability to provide essential services in the service areas identified above, thereby putting at risk many of the State's most vulnerable residents.

Area served: Statewide

Source of Funds: 34% General Funds; 66% Other Funds (Medicare, Medicaid & third party insurance).

The Department will request General Funds in the event that Other Funds are no longer available and services are still needed.

Heather M. Moquin

Heather M Moquin
CEO, NHH

Dartmouth Contract Amendment #3

FISCAL DETAIL

Budget			
Agreement Period by State Fiscal Year			
Service Area	7/1/2019-6/30/2020	7/1/2020-6/30/2021	7/1/2021-6/30/2022
1: New Hampshire Hospital	$11,640,759	$12,717,827	$13,366,111
2: Glencliff Home	$139,309	$148,447	$156,475
3: Medicaid	$408,628	$432,119	$455,192
4: Children, Youth & Families	$396,688	$392,445	$413,867
5: Behavioral Health	$517,056	$544,803	$572,319
6: Elderly and Adult Services	$39,197	$41,809	$44,110
7: Developmental Services	$284,893	$310,264	$327,751

Service Area #1
05-95-94-940010-8750 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF, HHS: NEW HAMPSHIRE HOSPITAL, NEW HAMPSHIRE HOSPITAL, ACUTE PSYCHIATRIC SERVICES

Class/ Object	Class Title	Budget FY2020	Budget FY2021	Budget FY2021
102-500731	Contracts for program services	11,640,759	12,717,827	13,366,111

Service Area #2
05-95-91-910010-57100000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: GLENCLIFF, PROFESSIONAL CARE

Class/ Object	Class Title	Budget FY2020	Budget FY2021	Budget FY2021
101-500729	Contracts for program services	139,309	148,447	156,475

Service Area #3
05-95-47-470010-50000000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: COMMISSIONERS OFFICE, OFF. OF MEDICAID & BUS POLICY, MEDICAID

Class/ Object	Class Title	Budget FY2020	Budget FY2021	Budget FY2021
102-500731	Contracts for program services	408,628	432,119	455,193

Service Area #4
05-95-42-421510-79150000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: SUNUNU YOUTH SERVICE CENTER, HEALTH SERVICES.

Class/ Object	Class Title	Budget FY2020	Budget FY2021	Budget FY2021
102-500730	medical payments to providers	396,688	392,445	413,867

Service Area #5

05-95-92-922010-41170000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: BEHAVIORAL HEALTH DIV, BUREAU OF MENTAL HEALTH SERVICES, CMH PROGRAM SUPPORT.

Class/ Object	Class Title	Budget FY2020	Budget FY2021	Budget FY2021
102-500731	Contracts for program services	517,056	544,803	572,319

Service Area #6

05-95-48-481010-78720000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: ELDERLY AND ADULT SERVICES, GRANTS TO LOCALS, ADM ON AGING GRANTS.

Class/ Object	Class Title	Budget FY2020	Budget FY2021	Budget FY2021
540-500382	Social Service Contracts	39,197	41,809	44,110

Service Area #7

05-95-93-930010-51910000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: DEVELOPMENTAL SERV DIV OF, DIV OF DEVELOPMENTAL SVCS, SPECIAL MEDICAL SERVICES.

Class/ Object	Class Title	Budget FY2020	Budget FY2021	Budget FY2021
561-500911	Specialty Services	30,000	30,000	30,000

05-95-93-930010-59470000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: DEVELOPMENTAL SERV DIV OF, DIV OF DEVELOPMENTAL SVCS, PROGRAM SUPPORT.

Class/ Object	Class Title	Budget FY2020	Budget FY2021	Budget FY2021
102-500731	Contracts for program services	254,893	280,264	297,751
Total Service Area #7		284,893	310,264	327,751

State of New Hampshire
Department of Health and Human Services
Amendment #3 to the Physician Clinical and Administrative Services Contract

This 3rd Amendment to the Physician Clinical and Administrative Services contract (hereinafter referred to as "Amendment #3"), is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Mary Hitchcock Memorial Hospital, (hereinafter referred to as "the Contractor"), a nonprofit corporation with a place of business at One Medical Center Drive, Lebanon, New Hampshire 03756.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on August 24, 2016, (Item #6A) as amended on January 9, 2019 (Item #5A), and as amended on June 19, 2019 (Item #10) the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract and in consideration of certain sums specified;

WHEREAS, the State and the Contractor have agreed to increase the price limitation and modify the scope of services to support continued delivery of services;

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 18, and Exhibit C-1, Revisions to General Provisions, Paragraph 3, the parties may amend the contract upon written agreement and approval from the Governor and Executive Council;

WHEREAS, the parties agree to increase the price limitation and modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Form P-37, General Provisions, Block 1.8, Price Limitation, to read:

   $80,594,711.

2. Modify Exhibit A Amendment #2, Scope of Services, by replacing it in its entirety with Exhibit A Amendment #3, which is attached hereto incorporated by reference herein. Modifications are outlined below:

   a. Add subsection 2.2.5 to Section 2.2, General Requirements Applicable to All Service Areas, New Hampshire Hospital, to read:

      In the event of a healthcare system emergency, including but not limited to local epidemic, pandemic, facility closures, or mass-quarantine in which additional staffing or resources are required due to a surge of individuals requiring services under this Agreement, the total number of psychiatrists or other medical providers provided by the Contractor may be adjusted to include up to three (3) full-time staff positions and one part-time staff position to serve any or all of the seven (7) Service Areas.

   b. Modify subsection 2.3.1.1 d., to read:

      To ensure adequate coverage on weekends and holidays to maintain compliance with documentation requirements to justify medical necessity of stay. This may include the need for daily progress notes on patients covered by Medicaid, Medicare or commercial insurance. Notwithstanding the foregoing, the parties acknowledge and agree that clinical care responsibilities may from time to time impede the providers' ability to complete daily progress notes on weekends and holidays. In such an event, the next progress note shall be written as soon thereafter as reasonably possible.

   c. Delete subsection 2.3.4.2 b. Child and Adolescent Fellows in its entirety and adjust the

lettering of the next subsection accordingly.

d. Modify the first sentence of subsection 3.3.3.1 to read:

The Contractor shall provide fourteen (14) General Psychiatrists at NHH:

e. Delete subsection 3.3.4, Child/Adolescent Psychiatrists, in its entirety and adjust the lettering of the following subsections accordingly.

f. Delete subsection 3.3.10.1 b., Child/Adolescent Fellows, in its entirety and adjust the lettering of the remaining subsection accordingly.

g. Modify the first sentence of subsection 3.3.11.1 to read:

The Contractor shall provide eight (8) full-time Psychiatric Advanced Practice Registered Nurses.

h. Modify the chart in subsection 3.3.15 (formerly 3.3.16), Schedule and Allocation of Schedule and Allocation of Positions – Service Area #1 – NHH, to indicate that the Contractor shall provide fourteen (14) General Psychiatrists and eight (8) Psychiatric APRN's, and to delete the Child/Adolescent Psychiatrists and Fellows.

i. Modify subsection 4.2.1.1 to read:

DHHS' expectation is that staffing will be at a level of 100% to ensure in no case shall Contractor staffing impact the number of NHH beds available, and that NHH units will not stop admissions due to the lack of coverage for Contractor staff. All positions allocated in this contract are to be 100% filled or in active recruitment. In the event that a position remains vacant (due to the need to fill the position or recruit for the position) for more than 30 days, the contractor shall reduce the monthly invoice by amount budgeted for that position until the position is filled. The Contractor shall provider DHHS with monthly updates on the recruitment process for all unfilled positions.

j. Modify 4.2.3.1, 1. Psychiatric Progress Notes, (i) to read:

Completion daily on patients who are certified as acute inpatient level of care.

k. Modify 4.2.3.1, 1. Psychiatric Progress Notes, (ii) to read:

Completion of not less than four (4) times per week on patients that are no longer acute level of care.

l. Modify 4.5.3.1, 1. Psychiatric Progress Notes, (i) to read:

Completion daily on patients who are certified as acute inpatient level of care.

m. Modify 4.5.3.1, 1. Psychiatric Progress Notes, (ii) to read:

Completion of not less than four (4) times per week on children and adult patients that are no longer acute level of care.

n. Modify section 6.1, Continuity of Services, to change all references to Exhibit A Amendment #2 to Exhibit A Amendment #3 and to change all references to Exhibit B Amendment #2 to Exhibit B Amendment #3.

3. Modify Exhibit B Amendment #2, Methods and Conditions Precedent to Payment, by replacing it in its entirety with Exhibit B Amendment #3, Method and Conditions Precedent to Payment, which is attached hereto and incorporated by reference herein.

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All terms and conditions of the Contract and prior amendments not inconsistent with this Amendment #3 remain in full force and effect. This amendment shall be effective upon the date of Governor and Executive Council approval.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

6-1-2020
Date

Name: Christie Tappan
Title: Associate Commissioner

Mary Hitchcock Memorial Hospital

5/29/2020
Date

Name: Edward J. Merrens
Title: Edward J. Merrens
Chief Clinical Officer

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Contracts & Procurement
Date
By

The preceding Amendment, having been reviewed by this office, is approved as to form, substance, and execution.

OFFICE OF THE ATTORNEY GENERAL

06/08/20
Date

Catherine Pinos
Name:
Title: Catherine Pinos, Attorney

I hereby certify that the foregoing Amendment was approved by the Governor and Executive Council of the State of New Hampshire at the Meeting on: _____ (date of meeting)

OFFICE OF THE SECRETARY OF STATE

_____
Date

_____
Name:
Title:

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Exhibit A Amendment #3

Scope of Services

1. Provisions Applicable to All Services

1.1. The Contractor will submit a detailed description of the language assistance services they will provide to persons with limited English proficiency to ensure meaningful access to their programs and/or services within ten (10) days of the contract effective date.

1.2. The Contractor agrees that, to the extent future legislative action by the New Hampshire General Court or federal or state court orders may have an impact on the Services described herein, the State has the right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance therewith.

2. Scope of Services

2.1. **Covered Populations and Services**

2.1.1 The Contractor shall provide physician clinical and administrative services to various populations served by DHHS, in all seven (7) Service Areas identified below and as described herein:

2.1.1.1. Service Area #1 – New Hampshire Hospital (NHH)

2.1.1.2. Service Area #2 – Glencliff Home

2.1.1.3. Service Area #3 – Medicaid

2.1.1.4. Service Area #4 – Children, Youth and Families

2.1.1.5. Service Area #5 – Behavioral Health

2.1.1.6. Service Area #6 – Elderly and Adult Services

2.1.1.7. Service Area #7 – Developmental Services

2.2. **General Requirements Applicable to All Service Areas**

2.2.1. The Contractor shall provide psychiatric and other professional services to all service areas through the employment of appropriate Contractor staff described in the following sections, and requiring such staff to perform required services.

2.2.2. The Contractor shall work with DHHS to continue to develop and refine an integrated mental health care system applying principles of managed care for clinical treatment, educational and training programs, and related research.

2.2.3. The Contractor shall work with DHHS to jointly maintain and develop an applied research and evaluation capacity, the general purpose of which shall be to identify and address medical research issues relative to the DHHS mission under RSA 135-E. The activities shall be directed at enhancing applied research

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resources, capacities and activities within the State mental health services system and implementing a program of applied research relative to that system.

2.2.4. All personnel provided by the Contractor under this contract shall be employees or consultants of the Contractor. No personnel provided by the Contractor under this contract shall be considered an employee of the State of New Hampshire.

2.2.5. In the event of a healthcare system emergency, including but not limited to a local epidemic, pandemic, facility closures, or mass-quarantine in which additional staffing or resources are required due to a surge of individuals requiring services under this Agreement, the total number of psychiatrists or other medical providers provided by the Contractor may be adjusted to include up to three (3) full-time staff positions and one part-time staff position to serve any or all of the seven (7) Service Areas.

2.3. **Specific Service Requirements for Service Area #1 – New Hampshire Hospital**

2.3.1. **Chief Medical Officer's Administrative/Clinical Responsibilities**

2.3.1.1. Subject to (1) the statutory authority of the DHHS Commissioner or designee, and (2) the authority of the NHH CEO (NHH CEO) with respect to administrative/clinical matters, the Chief Medical Officer shall be responsible for the following:

a. To coordinate with the NHH CEO all clinical activities in order to accomplish the day-to-day clinical operation of NHH in a manner consistent with RSA Chapter 135-C and the rules adopted pursuant thereto, all NHH policies, and all standards of TJC and CMS;

b. To participate in the formulation, implementation, and supervision of all clinical programs for the diagnosis, assessment, treatment, care, and management of patients of NHH, and all clinical personnel engaged in said programs to participate in the formulation, implementation, and supervision of all clinical educational, clinical research, and clinical training programs within NHH;

c. To supervise all documentation requirements of all staff psychiatrists and other clinical personnel employed by the Contractor and providing services under this contract at NHH;

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d. To ensure adequate coverage on weekends and holidays to maintain compliance with documentation requirements to justify medical necessity of stay. This may include the need for daily progress notes on patients covered by Medicaid, Medicare or commercial insurance. Notwithstanding the foregoing, the parties acknowledge and agree that clinical care responsibilities may from time to time impede the providers' ability to complete daily progress notes on weekends and holidays. In such an event, the next progress note shall be written as soon thereafter as reasonably possible.

e. To perform annual performance evaluations and discipline as necessary for all staff psychiatrists and other clinical personnel employed by the Contractor and providing services under this contract at NHH. In preparing these evaluations, the Chief Medical Officer shall consult with and seek input from the NHH CEO as to the Department's satisfaction with the services provided by any such individual under review;

f. To perform an annual administrative review of all clinical personnel employed by the Contractor and providing services under this contract at NHH to assure compliance with NHH policy, including but not limited to: training, record keeping, matters of medical records, CPR and CMP training/retraining, TJC requirements, customer service responsibilities, and HIPAA compliance and attendance at mandated in-service training. The Chief Medical Officer shall take whatever action necessary to assure compliance with these requirements and take whatever disciplinary action necessary in instances of non- compliance of NHH policy or NHH Medical Staff Organization bylaws;

g. To comply with all applicable performance standards set forth in this contract pertaining to staff psychiatrists;

h. To provide consultation to DHHS relative to the development of the State mental health service system;

i. To support NHH's customer service culture by adhering to and assuring that psychiatrists under his/her direction, adhere to the established Customer Service Guidelines for Physicians;

j. To report to the NHH CEO issues known to him/her regarding all admissions, patient care or any other

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situation that may pose a significant risk to patients or the community or that may result in adverse publicity or in any way undermine public confidence in the clinical care provided by NHH;

k. To participate as a member of the NHH's Administrative Executive Committee;

l. To participate as an ex officio non-voting member of the Executive Committee of the Medical Staff Organization of NHH who represents the NHH CEO;

m. To participate with the NHH CEO in the development of the clinical budget of NHH;

n. To participate in the recruitment of other clinical DHHS personnel, upon the request of the NHH CEO;

o. To establish, subject to the NHH CEO approval, an employment schedule for all clinical personnel employed by the Contractor to provide services at NHH;

p. To assist the NHH Chief Executive Office with the clinical supervision and education of all other clinical staff at NHH; and

q. To provide clinical coverage of Contractor staff as necessary.

2.3.2. **Associate Medical Director Responsibilities**

2.3.2.1. Subject to (1) the statutory authority of the DHHS Commissioner or designee, and (2) the authority of the NHH CEO with respect to administrative/clinical matters, the Associate Medical Director shall be responsible for the following:

a. To coordinate with the NHH Chief Medical Officer and NHH CEO all clinical activities in order to accomplish the day-to-day clinical operation of NHH in a manner consistent with RSA Chapter 135-C and the rules adopted pursuant thereto, all NHH policies, and all standards of TJC and CMS;

b. Serves in the capacity of the chief medical officer during his/her absence;

c. To participate with the Chief Medical Officer in the formulation, implementation, and supervision of all clinical programs for the diagnosis, assessment,

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treatment, care, and management of patients of NHH, and all clinical personnel engaged in said programs to participate in the formulation, implementation, and supervision of all clinical educational, clinical research, and clinical training programs within NHH;

d. To supervise all documentation requirements of all staff psychiatrists and other clinical personnel employed by the Contractor and providing services under this contract at NHH;

e. To participate with the Chief Medical Officer in performing annual performance evaluations and discipline as necessary for all staff psychiatrists and other clinical personnel employed by the Contractor and providing services under this contract at NHH. In preparing these evaluations, the Associate Medical Director shall assist the Chief Medical Officer who shall consult with and seek input from the NHH CEO as to the Department's satisfaction with the services provided by any such individual under review;

f. To work with the CMO to perform an annual administrative review of all clinical personnel employed by the Contractor and providing services under this contract at NHH to assure compliance with NHH policy, including but not limited to: training, record keeping, matters of medical records, CPR and CMP training/retraining, TJC requirements, customer service responsibilities, and HIPAA compliance and attendance at mandated in-service training. The Associate Medical Director shall assist the Chief Medical Officer who shall take whatever action necessary to assure compliance with these requirements

g. To comply with all applicable performance standards set forth in this contract pertaining to staff psychiatrists;

h. To provide consultation to DHHS relative to the development of the state mental health service system;

i. To support NHH's customer service culture by adhering to and assuring that psychiatrists under his/her direction, adhere to the established Customer Service Guidelines for Physicians;

j. To report to the NHH Chief Medical Officer and to the CEO issues known to him/her regarding all admissions,

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patient care or any other situation that may pose a significant risk to patients or the community or that may result in adverse publicity or in any way undermine public confidence in the clinical care provided by NHH;

k. To participate as a member of the NHH's Administrative Executive Committee;

l. In the absence of the Chief Medical Officer, participates as an ex officio non-voting member of the Executive Committee of the Medical Staff Organization of NHH representing the NHH CEO;

m. To participate with the NHH Chief Medical Officer and the NHH CEO in the development of the clinical budget of NHH;

n. To participate in the recruitment of other clinical DHHS personnel, upon the request of the NHH CEO;

o. To assist in establishing, subject to the NHH Chief Medical Officer and NHH CEO approval, an employment schedule for all clinical personnel employed by the Contractor to provide services at NHH; and

p. To assist the NHH Chief Medical Officer and the NHH CEO with the clinical supervision and education of all other clinical staff at NHH; and

q. To provide clinical coverage as necessary and to the extent possible when there are vacancies with the staff psychiatrists or advanced psychiatric nurse practitioners.

2.3.3. **General Psychiatrist Responsibilities**

2.3.3.1. The following responsibilities are applicable to all psychiatrists the Contractor provides to NHH under this contract. Staff psychiatrists shall be responsible for the following:

a. The formulation and implementation of individual treatment plans and clinical services, in cooperation with treatment teams, for the diagnosis, assessment, treatment, care and management of patients of NHH;

b. Maintaining and directing a clinically appropriate treatment plan for assigned cases in concert with the

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multidisciplinary staff consistent with NHH norms;

c. Determination, consistent with RSA 135-C, of the appropriateness of admissions, transfers and discharges;

d. Participation with other staff physicians, the NHH Chief Medical Officer, and the Associate Medical Director to provide on-call afterhours coverage and serve as on-site, after-hours coverage, on a 24-hour a day, 7-day a week, year round basis when necessary as determined by the NHH CEO, the NHH Chief Medical Officer, and/or the Associate Medical Director;

e. Participation in research and education activities consistent with the mission of NHH and subject to the approval of the NHH CEO;

f. Participation in the Medical Staff Organization and other administrative committees of NHH, assigned committees and task forces;

g. Performance of medical/psychiatric consultation on patients from facilities other than NHH, consistent with current NHH policy;

h. Timely completion of all necessary documentation as required by TJC and CMS standards;

i. Responsibility for completing NHH's Incident Reports in compliance with NHH policy;

j. Completion of all medical record documentation in the timeframes required by the NHH's Policy and Procedure "Medical Record Documentation" and other relevant policies and procedures, including ongoing and timely documentation of clinical care regarding medical necessity, including daily progress notes to document and support medical necessity

k. Adherence to all NHH policies, including, but not limited to policies on Medical Records Documentation and Progress Notes;

l. Ensuring that documentation is consistent with normative data collected by the NHH compliance officer and NHH utilization review manager;

m. Provision of other services as required.

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consistent with the mission of NHH and the intent of this contract;

n. Appearing and testifying in all court and administrative hearings as required by the Department;

o. Developing and maintaining positive relationships with NHH staff, patients, families, advocates, community providers and other interest groups vital to the functioning of NHH and the DHHS system of care, including for the purpose of transition planning. In accomplishing this requirement, psychiatrists shall adhere to the standards set forth in NHH's Customer Service Guidelines for Physicians;

p. Meaningfully participating in utilization review processes, including appeals and other processes, as required by the NHH Chief Medical Officer, the Associate Medical Director, and the NHH CEO; and

q. Demonstrating value added achievements with academic and scholarly activities including, but not limited to: teaching (clinical and didactic); attendance and participation in case conferences; engagement with the profession with presentation and/or publication; hospital in-services; and service to the hospital and community through committee work, task force work, community service with advocacy groups; and involvement with the work of DHHS, as well as other public and private agencies that serve the mentally ill, e.g. law enforcement, corrections, the court, the legislature, colleges and universities and other related entities.

r. For a period of twenty-four (24) months commencing on the Amendment #2 Effective Date, one research psychiatrist will contribute 0.15 full-time equivalent (FTE) to serve as a research mentor to the NHH staff and Research Manager and will act as a liaison to trainees pursuing research opportunities at NHH. In addition, this psychiatrist will help to prepare for the work of a research investigator (Ph.D., Psy.D., M.D., or D.O.) who will begin on the thirteenth (13th) month after the Amendment #2 Effective Date. Thus, beginning on the first day of the thirteenth (13th) month after the Amendment #2 Effective Date and continuing for the remainder of the Term specified in Block 1.7 of Amendment #2, a research investigator will be added full-time, or 1.0 full-time

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equivalent (FTE) to serve as a research mentor to the NHH staff and Research Manager, to act as a liaison to trainees pursuing research opportunities at NHH, and to facilitate research projects at NHH

2.3.3.2. All psychiatrists shall provide services on a full-time basis, and limit their practice to treating NHH patients only.

2.3.3.3. Notwithstanding the above, psychiatrists serving under this contract may perform occasional outside practice duties, with the advance written approval of the Chief Medical Officer and the NHH CEO, but only if said duties do not, in the sole judgment of the NHH CEO, interfere with the psychiatrists' duties at the NHH.

2.3.3.4. For subsection 2.3.3.2., the term "full-time" shall mean that each psychiatrist shall be required to account, through appropriate record keeping as specified by NHH, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities, subject to the Contractor's normal and customary employee leave policies.

a. Said minimum hours must be satisfied through hours devoted to clinical activities onsite at NHH.

b. Psychiatrists may be permitted, subject to prior notice and the approval of both the Chief Medical Officer and the NHH CEO; to work up to a maximum of 4 hours per week devoted to educational or research activities so long as those activities further the mission and goals of NHH. Psychiatrists approved for such activities shall provide documentation to the Chief Medical Officer and the NHH CEO that time spent devoted to educational or research activities furthers the mission and goals of NHH.

2.3.3.5. Notwithstanding the foregoing allowance for educational or research activities specified in subsection 2.3.3.4.a., psychiatrists shall be physically present onsite at NHH not less than 36 hours per week, unless otherwise accommodated for through the Contractor's normal and customary employee leave policies.

2.3.4. **Residents/Post Graduate Fellows Responsibilities**

2.3.4.1. The responsibilities of all residents and postgraduate fellows (PGY) shall be outlined, monitored, and reviewed by the Chief Medical Officer or the Associate Medical Director and the appropriate attending psychiatrist.

2.3.4.2. Responsibilities for Residents/Post Graduate Fellows shall

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involve the advancement of the clinical initiatives underway at NHH under the supervision of the Chief Medical Officer.

a. General Psychiatry Residents (PGY II and PGY IV) – The Contractor shall ensure that Residents are an integral part of the Contractor's ACGME approved psychiatric residency program. Additionally, the Contractor shall provide faculty oversight, clinical supervision, didactic education and appropriate research opportunities in the field of public psychiatry.

b. Geropsychiatry Fellow – The Contractor shall ensure that the Fellow is an integral part of an ACGME approved fellowship program in geriatric psychiatry. Additionally, the Contractor shall provide faculty oversight, clinical supervision, didactic education and appropriate research opportunities in the care of the elderly.

2.3.5. **Psychiatric Advanced Practice Registered Nurses (APRN) Responsibilities**

2.3.5.1. Psychiatric Advanced Practice Registered Nurses shall provide clinical services in extended care and admissions areas with patients with severe mental illness and medical co-morbidity morbidity in accordance with the scope of practice described in RSA 326-B:11.

2.3.5.2. The responsibilities for Psychiatric APRNs shall include but not be limited to performing advanced assessments; diagnosing; prescribing; administering and developing treatment regimens; and providing consultation as appropriate.

2.3.5.3. APRNs shall independently prescribe, dispense, and distribute psychopharmacologic drugs within the formulary and act as treatment team leaders in accordance with State law and medical staff by-laws.

2.3.5.4. APRNs shall provide the same level of documentation as required of psychiatrists as outlined in subsection 2.3.3.1.

2.3.6. **NHH Research Manager Responsibilities**

2.3.6.1. The Research Manager working with the research psychiatrist (in years one (1) and two (2) and with the research investigator in years two (2) and three (3) shall be responsible for assisting in the development and management of all research at NHH. The Research Manager shall play a pivotal role in initiating and cultivating research that is efficient and responsive to the needs of the NHH CEO, psychiatrists, nursing staff, clinical investigators, administration, and patient community, and works

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with the Chief Medical Officer to market the research opportunities at NHH while tracking and reporting the growth and development of research activities.

2.3.6.2. The Research Manager shall develop policies and procedures to ensure that research endeavors function effectively and manages and trains support staff in studies as the research program continues to grow and develop.

2.3.6.3. The Research Manager shall serve as the primary contact for all incoming and proposed studies, assesses feasibility and potential use of resources and guides potential projects through the process from initial proposal to planning for staffing, finding resources, reviewing budgets, and providing guidance with hospital, state and federal regulations through to completion of the project.

2.3.7. **After Hours Coverage**

2.3.7.1. The Contractor shall provide on-call after-hours coverage, 24 hours per day, 7 days per week, year round. Coverage shall be provided by no less than one (1) full-time psychiatrist. Additional personnel who are provided for coverage may be either a psychiatrist or a Psychiatric Advanced Practice Registered Nurse. The coverage will be assigned in one-week increments in rotation among the full-time New Hampshire Hospital psychiatric staff. The after-hours coverage will include back-up to the psychiatry residents who provide in-house after-hours coverage and will cover in-house in the event that the assigned in-house physician is not able to provide the service.

2.3.7.2. The Contractor shall provide on-site after-hours coverage, 16 hours per day, Monday through Friday, and 24 hours per day on weekends and holidays, year round.

a. The on-site after-hours coverage on weekdays, weekends and holidays shall be provided by a physician or psychiatric advanced practice registered nurse who is certified or eligible for certification by the American Board of Psychiatry and Neurology, or, is in training in an accredited psychiatry residency program with at least three years of training experience, or is credentialed as a psychiatric APRN through the American Nurse Credentialing Center or equivalent credentialing body.

b. The Contractor shall maintain a pool of psychiatric physicians or resident physicians or psychiatric APRNs,

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or a combination thereof, who are credentialed with New Hampshire Hospital for the after-hours work, and the after-hours physicians will be assigned to in-house after-hours coverage by the Chief Medical Officer or Associate Medical Officer with a six (6) month rolling calendar. The pool shall be of sufficient size and appropriate qualifications to ensure the Contractor's ability to meet 100% staffing level requirements and performance standards specified herein at section 4. Performance Standards and Outcomes.

2.3.8. **Applied Clinical Research**

2.3.8.1 The Contractor, working jointly with DHHS, shall identify and perform applied clinical research for the purpose of advancing the goals of the public mental health services system. All clinical research projects shall be approved by DHHS in advance. This shall include assessing the system's capacity, developing and/or refining clinical strategies, and training clinical staff in emerging treatment technology. The Contractor shall work jointly with DHHS to seek and obtain appropriate financial support (federal, State and foundation) to continue to build on the existing research projects. The Contractor shall, subject to DHHS approval, ensure that publication of the findings of this research shall receive the widest possible dissemination in the services delivery system in New Hampshire and through conferences and special reports nationally and internationally.

2.3.9. **Additional Requirements**

2.3.9.1. The Contractor shall provide clinical personnel to perform the services required for clinical, educational, research, and training programs at NHH. The Contractor shall provide psychiatrists and other clinical personnel with sufficient professional skills and qualifications to provide the educational and research services needed by NHH.

2.3.9.2. At the direction of the NHH CEO, Contractor staff may be assigned to conduct telepsychiatry or offsite consultation not arising from the clinical operation and administration of New Hampshire Hospital or any other public health or clinical service offered by the Department. Contractor staff assigned to telepsychiatry shall have professional malpractice insurance in effect in an amount satisfactory to the Department. The Contractor shall be responsible for ensuring that staff members have malpractice insurance in effect and in amounts satisfactory to DHHS.

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2.4. **Specific Service Requirements for Service Area #2 – Glencliff Home**

2.4.1. **General Requirements**

2.4.1.1. The Contractor shall provide routine or emergency telephone consultation by the Medical Director (described below) or an equally qualified physician at no additional cost, twenty-four (24) hours per day, seven (7) days per week, fifty-two (52) weeks per year, to clinical and administrative staff at the Glencliff Home.

2.4.2. **Medical Director Responsibilities**

2.4.2.1. The Contractor shall provide a geropsychiatrist to serve as the Medical Director. The Medical Director shall be responsible for the following:

a. Coordination of all medical care and direct psychiatric services, treatment and associated follow up to all residents of Glencliff Home;

b. Provide administrative functions, including but not limited to policy review and establishment that reflect current standards of practice; oversight of physicians; attendance at mandatory committee meetings, including but not limited to continuous quality improvement, infection control, and admissions; regularly review the use of psychotropic medications for compliance with the Omnibus Budget Reconciliation Act (OBRA) regulations; and the provision of other assistance in meeting standards for annual State inspections and Federal regulations;

c. Deliver expert testimony in probate court as needed (e.g. guardianship cases, electroconvulsive therapy, do not resuscitate orders). Preparation may include consultation with legal counsel, records review, and travel;

d. Provide written patient evaluations on each patient as frequently as required by the Department but in no case less than once per calendar year;

e. Serve as liaison with other organizations, such as NHH or Dartmouth-Hitchcock Medical Center, when a Glencliff Home resident is receiving services at another healthcare institution; and

f. Provide the applicable services as described herein at subsection 2.3.3.1.and its

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subparagraphs.

2.5. **Specific Service Requirements – Service Area #3 – Medicaid**

2.5.1. **Department of Health and Human Services Chief Medical Officer Responsibilities**

2.5.1.1. The Contractor shall provide for the term of the contract, the full-time services of a designated physician, to serve as the Department's Chief Medical Officer.

2.5.1.2. For the Chief Medical Officer, the term "full-time" shall mean that the Chief Medical Officer shall be required to account, through appropriate record keeping as determined by DHHS, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities, subject to the Contractor's normal and customary employee leave policies.

2.5.1.3. The Chief Medical Officer shall maintain regular office hours consistent with DHHS' regular business hours for senior executive team members. The Contractor shall ensure that the Chief Medical Officer is provided a flexible work schedule that is consistent with the expectations of a senior executive manager at DHHS, subject to the approval of the DHHS Designee.

2.5.1.4. The Chief Medical Officer shall maintain his or her professional calendar electronically, in a format subject to DHHS approval, and make same available to the DHHS Designee as necessary. The Contractor shall ensure the calendar is kept up to date and includes approved leave time, conferences, trainings, etc.

2.5.1.5. The Contractor shall ensure that any out of state travel for conferences and/or trainings for the Chief Medical Officer shall be subject to the prior approval of the DHHS Designee.

2.5.1.6. The Chief Medical Officer's primary workspace shall be located in Concord, New Hampshire, in a DHHS designated facility. DHHS shall provide office space, furniture, a computer with access to DHHS shared network drives as necessary, the usual and customary office supplies, a cell phone for business use and administrative and clerical support. The Contractor shall ensure the Chief Medical Officer utilizes DHHS-provided information and technology resources consistent with applicable State policies.

2.5.1.7. The Chief Medical Officer shall plan and direct all aspects of

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DHHS' medical policies and programs to ensure the provision of integrated primary care services to individuals eligible for the Medicaid program, in collaboration with the DHHS Designee.

2.5.1.8. The responsibilities of the Chief Medical Officer shall include but not be limited to the following:

a. Developing strategic clinical relationships with physicians and in growing public/private partnerships with academic institutions and federal agencies with a focus on quality improvement and the implementation of federal health care reforms, such as but not limited to the Patient Protection Affordable Care Act (ACA), and any amendments thereto;

b. Overseeing the development of the clinical content in marketing and educational materials and ensures all clinical programs are in compliance with state and federal regulations;

c. Participating in the writing of research publications to support clinical service offerings;

d. Providing medical oversight of the state's publicly funded health insurance programs, making key policy decisions, and shaping administrative planning strategies to enhance the operating efficiency of Medicaid and CHIP and related healthcare initiatives across the state;

e. In collaboration with the DHHS Designee, directs the day-to- day operations of the DHHS program area responsible for clinical programs, benefit management, and quality improvement activities. Also serves as chief clinical liaison to other state program units, insurance providers, and professional organizations;

f. Serving as the clinical authority in reviewing and determining requests for covered and uncovered medical services and pharmacy services;

g. Participating in the development of procedural reimbursement policy;

h. Promoting and assures effective and efficient utilization of facilities and services using quality improvement methodologies. Oversees the development of a formal quality assurance and quality improvement function within the NH Medicaid program;

i. Identifying new developments and emerging trends in

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clinical practices and research that would have an impact on medical policy and/or costs, and recommends options and courses of action;

j. Within the context of implementation of federal health care reforms, such as but not limited to the Affordable Care Act and any amendments thereto, provides leadership in the planning, Medicaid program response, development of health care delivery systems, clinical quality initiatives, and related policy issues;

k. Representing the DHHS Designee at meetings and other events and serving as DHHS designee for any committees, boards, and commissions as requested;

l. Analyzing proposed and new federal legislation related to benefits management and recommends options and courses of action;

m. Maintaining and enforces policies, procedures, administrative rules, and State plan provisions that govern Medicaid medical benefits; and

n. Overseeing the implementation of contracted services, maintaining working relationships with contractors, managing contractor deliverables and services, and measuring contractor performance; and

o. Regularly attending Medicaid Management Team meetings.

2.5.1.9. Additionally, the Chief Medical Officer shall assist the DHHS Designee with managing the operations of the clinical and benefits management functions within the Medicaid program. This may include providing to the DHHS Designee input and making recommendations on staffing needs, performance standards, and other matters applicable to DHHS staff.

2.5.1.10. The Chief Medical Officer shall also provide executive team office coverage as needed and requested by the DHHS Designee.

2.6. Specific Service Requirements – Service Area #4 – Children, Youth and Families

2.6.1. DCYF Staff Psychologist Responsibilities

2.6.1.1. The Contractor shall provide, for the term of the contract, the full-time services of a designated psychologist who is a faculty member and/or employee of the Contractor, to provide

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psychological services to the programs within the Children, Youth and Families service area. For purposes of this paragraph, the term "full-time" shall mean that the staff Psychologist shall be required to account, through appropriate record-keeping as determined by the DHHS designee, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities, subject to the Contractor's normal and customary employee leave policies.

2.6.1.2. The staff psychologist is expected to work additional hours, including attending non-business hour meetings as required in order to meet the business needs of DHHS without additional cost to DHHS.

2.6.1.3. The staff psychologist shall maintain regular office hours consistent with those of DHHS senior executive team members.

2.6.1.4. The staff psychologist shall maintain his or her professional calendar electronically, in a form subject to DHHS approval, and make it available to the DHHS designee as necessary, and will keep it up to date to include leave time, conferences and trainings.

2.6.1.5. The Contractor shall ensure that the staff psychologist provided under this contract is subject to the Contractor's normal and customary employee benefits and policies, including leave provisions for a senior executive level position. However, the Contractor and DHHS agree that the continuous provision of services is essential, and in addition to any required approvals by the Contractor for its employees, the staff psychologist shall provide timely, prior notification to the designated DHHS representative of any leave time taken. Absences due to vacation and continuing education shall be planned in advanced, in consideration of the business needs of the DHHS designated program areas.

2.6.1.6. The Contractor shall ensure that any out of state travel for conferences and/or trainings for the staff psychologist shall be subject to the prior approval of the DHHS designee.

2.6.1.7. The Contractor shall ensure that any vacation or continuing education leave time by the staff psychologist shall be planned in advance and consider the business needs of DHHS, including ensuring appropriate coverage for any clinical and/or operational responsibilities or tasks that need oversight.

2.6.1.8. The staff psychologist's primary workspace shall be located in

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Manchester, New Hampshire, in a DHHS designated facility. DHHS shall provide office space, furniture, a computer with access to DHHS shared network drives as necessary, the usual and customary office supplies, a cell phone for business use and administrative and clerical support. The Contractor shall ensure the staff psychologist utilizes DHHS-provided information and technology resources consistent with applicable State policies

2.6.1.9. The Contractor shall work directly with the DHHS designee for the Sununu Youth Services Center (SYSC), and shall ensure the following services are provided by the staff psychologist under the contract:

a. Provide treatment planning oversight, clinical consultations, and assessments to treatment coordinators and Juvenile Probation and Parole Officers. Documents the number of treatment team meetings and clinical consultations attended annually with multi-disciplinary team members at SYSC;

b. Provides program development at SYSC, using a resiliency- building framework, and implementation of evidence-based practices to include interpersonal problem-solving skills, trauma-focused cognitive behavioral therapy, and dialectical behavioral therapy. Documents specific types and numbers of evidence-based treatment interventions implemented annually at SYSC;

c. Oversees implementation of research initiatives on the effectiveness and outcomes of services and programs within and for JJS;

d. Fosters improved interagency collaboration between JJS services, the area mental health agencies, and NHH to enhance mental health services for adjudicated youths, and to improve transitional processes between residential and community-based programs for court-involved youths. Documents the number of youths consulted on annually by Juvenile Probation and Parole Officers and interagency collaborative teams.

2.6.2. **DCYF Staff Psychiatrist Responsibilities**

2.6.2.1. The Contractor shall provide the services of a designated psychiatrist, for no less than .25 FTE, who is a faculty member and/or employee of the Contractor, to provide psychiatric services to the programs within the Children, Youth and

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Families service area. For purposes of this paragraph, the term ".25 FTE" shall mean that the staff psychiatrist shall be required to account, through appropriate record-keeping as determined by the DHHS designee, for a minimum of 10 hours of work per week devoted to his or her psychiatric service duties and responsibilities pursuant to this section, subject to the Contractor's normal and customary employee leave policies.

2.6.2.2. Psychiatric services shall include, but are not limited to:

a. Medical and psychiatric services at SYSC.

b. Documenting the number of comprehensive psychiatric evaluations and units of psychiatric services provided annually in direct care to youths in SYSC and the Juvenile Justice System.

c. Clinical supervision and teaching of child psychiatry residents and fellows at SYSC.

d. Teaching and supervision contacts with interns, residents, and fellows at SYSC

2.6.3. **Psychiatric Consultant**

2.6.3.1. The Contractor shall, provide the services of a designated psychiatrist, who is a faculty member and/or employee of the Contractor, to provide psychiatric consultation services to the programs within the Children, Youth and Families service area. This position shall be a .25 Full-Time Equivalent.

2.6.3.2. The Contractor shall ensure that the psychiatric consultant provides consultation to the Department on psychotropic medication prescriptions for youth who are in out-of-home care at a location other than SYSC. This consultation will typically include a review of the psychotropic medication prescriptions for identified youth and peer-to- peer consultation with prescribers to help ensure the appropriate utilization of psychotropic medications.

2.6.3.3. Notwithstanding the foregoing, the State acknowledges and agrees that the consultation services provided pursuant to this Section 2.6.3 may be limited in scope and nature due to the staffing of this position as a 0.25 Full-Time Equivalent (FTE).

2.7. **Specific Service Requirements – Service Area #5 – Behavioral Health**

2.7.1. **Medical Director Responsibilities**

2.7.1.1. The Contractor shall provide a part-time Medical Director and

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the necessary personnel to fulfill four major service components, in addition to a time study requirement in the area of behavioral health services. The four components are:

a. Medical Director for the Behavioral Health program;
b. Evidence-Based Practices Training and Consultation;
c. Behavioral Health Policy Institute (BHPI); and
d. Committee for the Protection of Human Subjects (CPHS).

2.7.1.2. The Medical Director shall be available on-site, at a DHHS designated location, for twenty (20) hours per week to provide services to the Behavioral Health service area. The Medical Director shall be available via telephone, email, and in person by appointment during that time.

2.7.1.3. The Medical Director shall, in collaboration with the DHHS designee be responsible for the following:

a. Meet weekly with the DHHS designee;
b. Address Behavioral Health clinical issues;
c. Review and inform Behavioral Health policy issues;
d. Enhance housing support capacity planning;
e. Review and inform Medicaid and state rule issues;
f. Assist in developing Telemedicine capacity;
g. Utilizes electronic medical records;
h. Coordinate between NHH and CMHC care;
i. Oversite and consultation of Evidence Based Practices (EBP) implementation;
j. Develop funding and reimbursement strategies;
k. Review and inform the sustainability of behavior change programs.
l. Assess the needs of patients in NHH and Transitional Housing Services who might be served in the community; and
m. Attend meetings between the Behavioral Health program and various community stakeholder groups, such as the Community Behavioral Health Association and the Disabilities Rights Center, to communicate about and also garner support for and input regarding Behavioral Health initiatives.

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n. Serve as the Lead Manager for the ProHealth integration grant, working in collaboration with DHHS and identified programs to implement grant deliverables.

2.7.1.4. The Medical Director shall fulfill the additional following responsibilities:

a. Participate on key departmental and legislative committees, as required by DHHS, including the Mental Health Commission, the Mental Health Council, the Drug Utilization and Review Board, and the DHHS Institutional Review Board;

b. Serve as secretary for the Mental Health Council, to ensure that the work of the council supports the goals of DHHS;

c. Serve as a member of the Drug Utilization and Review Board to ensure that the Medicaid Preferred Drug List and work of the Board addresses the needs of consumers with mental illness disabilities;

d. Attend regular case conferences and sentinel event reviews. Analyze challenging clinical cases or events and recommend improvements in policy or services to address problem areas;

e. Attend monthly Institutional Review Board meetings, review research protocols as needed each month to ensure safety of DHHS research participants;

f. Participate on several Behavioral Health System Transformation Workgroups, including the EBP Steering Committee, Programmatic Workgroup, and Quality Assurance Group;

g. Coordinate and meet with DHHS leadership as required by DHHS;

h. Conduct monthly or more frequent Behavioral Health Medical Director's meeting to coordinate efforts, between Behavioral Health and CMHCs, regarding medical/treatment issues related to both hospital and outpatient care of people with serious mental illness and to consult on other relevant issues or concerns, including: preferred drug list issues, coordination with NHH admissions and treatment, Medicaid interruption during institutionalization, enhancement of community housing supports, use of information technology, medical director administrative issues, use of best practices;

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implementation of EBP's, documentation burden, integration of mental and physical health care, smoking cessation, coordinating local, state and national agendas regarding public mental health care, electronic health records, health information exchange, education and training for CMHC prescribers regarding evidence-based use of antipsychotic medications and monitoring for cardio metabolic side effects;

i. Monitor the effectiveness of the preferred drug list in enhancing cost effective and safe psychotropic medication prescribing in NH including engaging in ongoing discussions with CMHC leaders regarding the Preferred Drug List and direct education and training for CMHC prescribers regarding evidence-based use of antipsychotic medications and monitoring for cardio metabolic side effects;

j. Communicate regularly with, and provide clinical consultation (including potential site visits, conference calls, and written reports) to all Behavioral Health management staff regarding current, challenging clinical issues, including conditional discharges, Medicaid consumer cases, and suicide monitoring;

k. Collaborate with the other DHHS Medical Directors, on a regular basis to monitor medical care and related patient care issues throughout New Hampshire, including drug choice for the Preferred Drug List, performance and impact of the Preferred Drug List on clinical care, Medicaid interruption during hospitalization and incarceration, integration of medical, mental health, and substance abuse services, and enhancement of addiction treatment capacity; and

l. Provide oversight and continuing implementation of Evidence Based Practices, including practices as part of the Medicaid Program for Community Mental Health Services as well as those practices specifically required in the Community Mental Health Agreement.

2.7.2. **Evidence-Based Practices Training and Consultation**

2.7.2.1. The Contractor shall provide Evidence-Based Practices Training and Consultation services as described in Appendix I, of RFP-2017- OCOM-01-PHYSI, for the purpose of sustaining and continuously improving the quality of three (3) Evidence Based Practices (EBP) that are implemented across the New

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Hampshire Community Mental Health Centers (CMHC) system. The EBPs :are Illness Management and Recovery (IMR), Evidence-Based Supported Employment (EBSE), and Assertive Community Treatment Teams (ACT). Additional EBPs may take the place of these based on the availability of federal funding to support the implementation of additional EBPs in New Hampshire.

2.7.2.2. The Contractor shall provide education, training, technical assistance and consultation to the DHHS Behavioral Health service area and the CMH Program and Providers. The deliverables described below shall be provided directly to DHHS-designated Behavioral Health program staff and CMH staff designated by DHHS.

2.7.2.3. DHHS shall designate a specific DHHS Behavioral Health staff member to oversee the deliverables specified herein. The Contractor shall designate a specific representative of the Contractor to work directly with the DHHS designee in the fulfillment of these deliverables.

2.7.2.4. **Training the CMH Workforce:** To sustain and improve the quality of IMR, EBSE, and ACT services, the Contractor shall provide education and training to DHHS designated CMH staff. The contractor shall provide a total of 18 days of training, but schedules and requirements for each EBP as outlined below may be adjusted upon mutual agreement between the DHHS and Contractor in order to meet the needs of the CHM staff.

a. The Contractor shall ensure that the training and education is provided in central locations and in a manner that best facilitates the learning of key skills and strategies that are necessary to provide IMR, EBSE, and ACT in ways that support the most effective outcomes for consumers at each of the CMHCs. The training shall be designed to fulfill the specifications described in He-M 426 for CMHC programs of EBPs in NH.

b. Each training event shall include, at a minimum:

Invitations provided to CMHC staff before the training event;

A description of who should attend the training;

Outcomes for participants attending the training;

Sufficient time to provide instruction and practice for skills;

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Content designed to improve the fidelity of the practice at CMHC's;

Documentation of all participants attending the training; and

Certificates of attendance for all participants completing the training.

c. Each training event shall be staffed by Contractor staff or other qualified professionals; such individuals shall be subject to approval of the DHHS designee.

2.7.2.5. **Illness Management and Recovery (IMR):** The Contractor shall develop, in collaboration with the DHHS designee, specific topic areas for CMH staff providing IMR services. The topic areas shall be subject to the DHHS designee's approval.

a. The Contractor shall provide the IMR trainings in the following formats:

No less than fifteen (15) hours of training, to be presented in one (1) or two (2) training sessions, for new IMR practitioners to fulfill the specifications described in He-M 426 to provide IMR services. The capacity for each of these training events shall be twenty participants and up to thirty participants depending on the availability of the training space;

No less than fifteen (15) hours of training, to be presented in two (2) to six (6) training sessions, for experienced IMR practitioners, of which the combination of attending any two of these events shall fulfill the specifications described in He-M 426 for ongoing providers of IMR services. The capacity for each of these training events shall be at least twenty participants and up to thirty participants depending on the availability of the training space.

No less than eight (8) hours of training, to be presented in one (1) or two (2) training sessions, for IMR supervisors that shall fulfill the specifications in He-M 426 for ongoing providers of IMR services. The content shall include information on supporting the learning of IMR skills for colleagues and improving the quality and outcomes of IMR services through practice-specific supervision. The capacity for this training event shall be twenty participants.

2.7.2.6. **Evidence Based Supported Employment (EBSE):** The

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Contractor shall develop, in collaboration with the DHHS designee, specific topic areas for CMH staff providing EBSE services. The topic areas shall be subject to the DHHS designee's approval.

a. The Contractor shall provide the EBSE trainings in the following formats:

No less than thirty (30) hours of training, to be presented in full-day training sessions, for new EBSE practitioners, to fulfill the specifications described in He-M 426 to provide EBSE services. The capacity for each of these training events shall be twenty participants.

No less than eight (8) hours of training, to be presented in one (1) or two (2) training sessions for experienced EBSE practitioners, the combination of attending these two events shall fulfill the specifications described in He-M 426 for ongoing providers of EBSE services. The capacity for each of these training events shall be twenty participants.

No less than eight (8) hours of training, to be presented in one (1) or two (2) training sessions for experienced EBSE practitioners and EBSE supervisors. The combination of attending these two events shall fulfill the specifications described in He-M 426 for ongoing providers of EBSE services. The content shall include information on developing and improving collaboration with the New Hampshire Department of Vocational Rehabilitation and other important community partners in providing effective EBSE services. The capacity for each of these training events will be twenty participants.

2.7.2.7. **Assertive Community Treatment Teams (ACT):** The Contractor shall develop, in collaboration with the DHHS designee, specific topic areas for CMH Program staff providing ACT services. The topic areas shall be subject to the DHHS designee's approval.

a. The Contractor shall provide the ACT trainings in the following formats:

No less than thirty (30) hours of training, to be presented in full-day training sessions for new ACT practitioners, to fulfill the specifications described in He-M 426 to provide EBSE services. The capacity

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for each of these training events shall be twenty participants.

No less than eight (8) hours of training, to be presented in one (1) or two (2) training sessions for experienced ACT practitioners, the combination of attending these two events shall fulfill the specifications described in He-M 426 for ongoing providers of ACT services. The capacity for each of these training events shall be twenty participants.

No less than eight (8) hours of training, to be presented in one (1) or two (2) training sessions for experienced ACT practitioners and ACT supervisors. The combination of attending these two events shall fulfill the specifications described in He-M 426 for ongoing providers of ACT services. The capacity for each of these training events will be twenty participants.

2.7.2.8. **Assessing Fidelity to Evidence Based Practices (EBPs):** The Contractor shall assess the fidelity (organizational faithfulness to the principles of the practice) of ACT and EBSE for all CMH Programs, as designated by the DHHS designee.

a. Fidelity assessments shall be conducted for the purpose of monitoring the implementation of ACT and EBSE and for providing information about the capacity, strengths and areas in need of improvement in providing the practice at the designated CMH programs.

b. The Contractor shall develop, in collaboration with the DHHS designee, a specific schedule designating specific time periods for each CMH program, ACT and EBSE fidelity or QIP review. The schedule shall be subject to the advanced approval of the DHHS designee.

c. The Contractor shall ensure that each fidelity assessment includes, at a minimum:

Written instructions to the CMH program regarding necessary observations, interviews, data access and other activities for the assessment.

A description of CMH program staff, other community providers, consumers and family members who will need to be interviewed for the assessment.

A specific written assessment schedule is developed by the Contractor and the CMH program.

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Sufficient time to assess and evaluate the CMH program's delivery of ACT or EBSE.

A debriefing at the end of the assessment to review themes from the review with CMH program leadership.

Documentation of the assessment process, findings and scoring of fidelity items for CMH program leadership and the Department no later than four weeks following the assessment.

2.7.2.9. **Consultation to CMH Program Leadership and Workforce Development**: The Contractor shall provide agency-based consultations to all CMH programs as designated by the DHHS designee to assist agencies in sustaining and providing continuous quality improvement for IMR, ACT and EBSE services. The Contractor shall ensure that CMH program leadership has access to consultations at their agencies after they have received the written documentation of the findings of each fidelity assessment described herein at subsection 2.7.2.8. Consultations shall include the development of ideas, strategies and interventions that each individual CMH program may utilize to most effectively sustain and improve IMR, ACT and EBSE services.

a. In cases where CMH programs would benefit from specific agency-based workforce development interventions from the Contractor's staff, the Contractor shall ensure that such further interventions are provided only when collaboratively agreed upon by the DHHS designee, the Contractor and CMH program leadership. These interventions shall be time-limited (customarily one half-day, single events) and specifically tailored to improving designated fidelity areas that are identified as a result of agency-based post fidelity consultations.

2.7.2.10. **NH Behavioral Health Service Area Consultations and Collaboration:** In order to most effectively fulfill the deliverables described in this document for the purposes of sustaining and improving the quality of IMR, ACT and EBSE services in the NH Community Mental Health system, the Contractor shall work in a highly integrated fashion with the DHHS designee and additional DHHS Behavioral Health resources identified by the DHHS designee. This integrated alliance shall also be extended to other state and community agencies as collaboratively agreed upon by the DHHS designee and the Contractor.

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a. In addition to attending designated meeting or events, the Contractor shall prepare research information, specific ideas, interventions, feedback, data and strategies, as collaboratively agreed upon by the DHHS designee and the Contractor. Specific activities for consultation and collaboration shall include:

The Contractor's attendance at the State EBP advisory committee bi-monthly meetings by the Contractor and/or designees;

The Contractor's attendance at weekly meetings with the DHHS designee;

Attendance of Contractor staff at monthly meetings with the DHHS designee and any additional DHHS Behavioral Health resources identified by the DHHS designee;

The Contractor's attendance at quarterly meetings with the DHHS designee, and any additional DHHS Behavioral Health resources identified by the DHHS designee, to review progress of these deliverables and make any necessary resource allocations within the scope based, as collaboratively agreed upon by the DHHS designee and the Contractor;

The Contractor's attendance at DHHS designated meetings with NH Bureau of Vocational Rehabilitation (NHBVR) personnel to improve collaboration between EBSE services and NHBVR at both state-wide and regional levels to better assist CMHC consumers in achieving their vocational goals;

The Contractor's attendance at DHHS designated meetings with Granite State Employment Project (Medicaid Infrastructure Grant) personnel to improve collaboration between EBSE services and the Granite State Employment Project at both state-wide and regional levels to better assist CMHC consumers in achieving their vocational goals;

The Contractor's attendance at DHHS designated meetings with DHHS Behavioral Health personnel regarding Behavioral Health strategies and interventions, including proposed rule or policy and procedure changes, to better facilitate the sustaining and improvement of IMR, ACT and EBSE services

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the NH Community Mental Health system;

The Contractor's attendance at designated meetings with key CMHC personnel, including monthly meetings of CMHC Community Support Program directors, regarding the Contractor's activities and to better facilitate the sustaining and improvement of IMR, ACT and EBSE services; and

The Contractor's attendance at other events, as collaboratively agreed upon by the DHHS designee and the Contractor, for the purposes of sustaining and improving the quality of IMR, ACT and EBSE services.

2.7.3. **Behavioral Health Policy Institute (BHPI)**

2.7.3.1. Under the direction of the DHHS designee and the Behavioral Health Medical Director providing services to the Behavioral Health program, the Contractor shall conduct periodic analyses, the frequency of which shall be determined by DHHS, of Medicaid claims to address policy issues and questions under consideration from the Behavioral Health program. The Contractor shall participate in regular meetings with the DHHS designee and the Behavioral Health Medical Director to review these analyses, and associated policy implications.

2.7.4. **Committee for the Protection of Human Services (CPHS)**

2.7.4.1. The Contractor shall achieve the following CPHS related deliverables for the purpose of sustaining and supporting a committee to oversee research funded by federal agencies and other non-state sources, and conducted in New Hampshire DHHS-funded programs that serve people with mental illness, developmental disabilities, and substance abuse or dependence disorders, in fulfillment of NH RSA 171-A:19-a. Because of federal regulations governing the composition and operation of such committees, a certain number of scientific experts must be present on the committee. The Contractor shall provide research, scientific and human subject's expertise to the CPHS under the contract.

2.7.4.2. The Contractor shall provide staff to support the CPHS who shall:

a. Attend and fully participate in CPHS full committee meetings (once per month);

b. Conduct expedited reviews as requested by the CPHS Administrator (averaging about three per month);

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c. Provide consultation, support, and guidance to the CPHS Administrator, Chairperson, and Committee members regarding the interpretation of federal regulations and human subject's protections (e.g., pre-reviewing materials, reviewing requirements for exempt and expedited determinations, reviewing significant adverse event reports);

d. Serve on the Consent Form Template and Forms sub-committees, or others as requested by the CPHS Chairperson; and

e. Serve as the Co-Vice Chair to the CPHS.

2.7.4.3. Revision of the aforementioned deliverables may be done by mutual agreement of the Contractor and the DHHS designee. The availability of additional federal funds to support the implementation of additional Evidence Based Practices may also necessitate a renegotiation of priorities outlined in this deliverables plan, and a reallocation of the Contractor's time in order to assist with the construction of federal grant applications. Changes agreed upon may be subject to Governor and Executive Council approval.

2.7.5. **Time Studies**

2.7.5.1. The Contractor shall be responsible for performing regular time studies in accordance with CMS and DHHS Medicaid Cost Allocation procedures in order to document activities, relating directly to the administration of the Medicaid program, to draw down federal matching revenues, which will be utilized to support costs associated with the Behavioral Health Medical Director's salary, benefits, and indirect expenses. These studies shall be provided in and documented in a format approved by DHHS.

2.8. **Specific Service Requirements – Service Area #6 – Elderly and Adult Services**

2.8.1. **Medical Director Responsibilities**

2.8.1.1. The Contractor shall provide a part-time Medical Director (.125 FTE) to the Elderly and Adult Services service area. The Medical Director, subject to the FTE allotment, shall provide services for the purposes of consultation and improving the quality of services for older adults and adults with disabilities in NH.

2.8.1.2. The Medical Director shall:

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a. Provide consultation and direction of the organization's clinical components to policies and procedures and administrative rules;

b. Serve as a technical advisor for wellness and prevention initiatives to improve the lives of individuals served by Elderly and Adult Services service area;

c. Perform medical consultation, clinical oversight and authority and guide education instruction, within the Elderly and Adult Services service area;

d. Provide guidance and consultation regarding new developments and emerging trends in clinical practice, research and best practices that would have an impact on service development, service delivery and clinical policy and practice;

e. When requested, participate in the quality initiative, Sentinel Event Reviews and other case consultation and case review convening's as requested;

f. Meet bi-monthly with DHHS designee to review initiatives and check in on consultation services.

2.9. Specific Service Requirements – Service Area #7 – Developmental Services

2.9.1. Medical Director Responsibilities

2.9.1.1. The Contractor shall provide a part-time Medical Director to the Developmental Services service area. The Medical Director shall provide services that includes two days of psychiatric consultation services per week, and is allocated at 0.4 Full-Time Equivalent.

2.9.1.2. The Medical Director must dedicate two (2) days each week to the activities described below:

a. Referrals from the ten (10) Area Agencies, and referrals from Special Medical Services (SMS). These referrals must be prioritized over all other duties, and may include performing evaluations, consultations, and medication reviews by the Medical Director.

b. Based on He-M 1201, the Medical Director will facilitate Developmental Services' Medication Committee meetings as chairperson, and provide will provide expert opinion and leadership to ensure that the committee functions effectively.

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c. Assistance for the DHHS Developmental Services staff in addressing medical issues related to quality assurance activities or Sentinel Event Reviews.

d. Educational training to DHHS Developmental Services staff, Area Agencies, and subcontract agencies and other stakeholders, as identified and directed by Developmental Services.

e. Providing expertise and assistance in efforts to improve New Hampshire's developmental services system.

2.9.2. **Developmental Services Interdisciplinary Clinic Team**

2.9.2.1. The Contractor shall provide an interdisciplinary clinic team for children and adults. The Contractor shall provide the following staffing and fulfill the following responsibilities for the Interdisciplinary Clinic Team for Adults:

a. **Psychiatrist (Child Psychiatrist if applicable)** – the psychiatrist shall serve as the clinic director, coordinating the team / providers involved in this clinic. The psychiatrist shall conduct a comprehensive psychiatric examination; including reviewing the client's entire past psychiatric treatment and medical history. The psychiatrist shall make recommendations as part of the comprehensive report regarding evidence based treatment for optimal care for each client;

b. **Neuropsychologist** – the neuropsychologist shall review all past psychiatric, medical records, neuropsychological testing and behavioral incidents. The neuropsychologist shall document their recommendations as part of the comprehensive report. The neuropsychologist shall supervise the neuropsychology fellow and shall oversee the documentation of historical information regarding the client;

c. **Neuropsychology fellow** – the neuropsychology fellow shall review all past medical, past psychiatric records, neuropsychological testing, behavioral incidents and document pertinent historical information regarding each person as part of the comprehensive report;

d. **Neurologist** – the neurologist shall review past medical records, conduct a physical examination, and document their findings and recommendations as part of the comprehensive report;

e. **Primary Care Physician** – the primary care physician

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shall review past medical records, conduct a physical examination, and document their findings and recommendations as part of the comprehensive report;

f. **Occupational Therapist** – the occupational therapist shall review past medical records, conduct an occupational therapy evaluation, document their findings and recommendations as part of the comprehensive report; and

g. **Administrative Support** – the administrative support will schedule the appointment, review received documents and checklist of requested documents, copy records for providers and fax completed reports.

2.9.2.2. The interdisciplinary clinic team for shall provide the following services:

a. The Contractor shall ensure the team accepts children and adults being referred from the Area Agencies. Should the number of referrals exceed the number of clients able to be seen, then the Contractor shall prioritize clients based on the most immediate need and critical situation;

b. The Contractor shall support the goal of the interdisciplinary clinic team by providing high quality interdisciplinary evaluations to children and adults with developmental disabilities and acquired brain injuries. The Contractor shall provide a comprehensive understanding of the client with a focus on a biological, psychological, social/environmental approach and the interaction of these factors as they relate to the clients' strengths, skills, and interests. The Contractor shall generate one comprehensive report with recommendations that can be utilized by the Systemic – Therapeutic – Assessment – Resources – and Treatment (START) Coordinators, Area Agencies, service providers and medical providers to provide the best quality of care for each person. The Contractor shall serve as one point of access to a team of expert providers which will reduce each client's number of medical appointments and reduce each client's need to travel to multiple appointments.

c. The Contractor shall convene the interdisciplinary clinic team one time per month and shall conduct a face-to-face appointment with two clients per month, for a total of twenty- four (24) clients per year. The interdisciplinary

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clinic team meetings and face-to-face client appointments shall take place at a location designated by DHHS. The Contractor shall review all previous records of each client prior to each face-to-face appointment. The Contractor's interdisciplinary clinic team of providers shall meet with the client and the client's team of caregivers as part of the evaluation to obtain history / concerns and examine the client. After meeting and examining the client, the Interdisciplinary Clinic Team shall meet to discuss recommendations. The interdisciplinary clinic team shall generate a comprehensive report regarding the visit and recommendations. The report shall be made available within 15 business days from the date of the last meeting of the interdisciplinary clinic team.

d. The Contractor shall have the client or the client's authorized representative sign a release form identifying the parties to whom the Contractor may distribute the comprehensive reports.

e. The Contractor shall submit encounter documentation as directed by the Department.

3. Staffing

3.1. General Requirements Applicable to All Service Areas:

3.1.1. The following requirements apply to all personnel provided under the contract:

3.1.1.1. The Contractor shall recruit and retain qualified individuals for the staffing needs specified herein at subsections 3.3 through 3.9, and as otherwise necessary to fulfill the requirements described herein at: Section 2, Scope of Services; Section 4, Performance Standards and Outcomes; and Section 5, Reporting.

3.1.1.2. All such individuals shall be subject to DHHS approval prior to the Contractor notifying candidates of assignment/hire to fulfill a specified staffing role. DHHS shall inform the Contractor of its applicable designee for this purpose per position or service area. The designee, at his or her discretion, shall be entitled to interview any such candidate; the Contractor shall facilitate coordinating such interviews upon the DHHS designee's request.

3.1.1.3. DHHS, at its sole discretion, may rescind, either permanently or temporarily, its approval of any Contractor personnel providing any services under this contract for any of the

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following reasons:

a. Suspension, revocation or other loss of a required license, certification or other contractual requirement to perform such services under the contract;

b. Providing unsatisfactory service based on malfeasance, misfeasance, insubordination or failure to satisfactorily provide required services;

c. Arrest or conviction of any felony, misdemeanor, or drug or alcohol related offense;

d. Abolition of the role due to a change in organizational structure, lack of sufficient funds or like reasons; or

e. Any other reason that includes, but is not limited to: misconduct, violation of DHHS policy, or violation of state or federal laws and regulations pertaining to the applicable DHHS service area, or a determination that the individual presents a risk to the health and safety of any staff member or any individual served by the Department.

In the event of such rescission, the Contractor's applicable staff member shall be prohibited from providing services under the contract for the period of time that DHHS exercises this right. In the event DHHS chooses to exercise this right, DHHS shall provide reasonable advance notice to the Contractor.

3.1.1.4. DHHS shall provide the Contractor with prior notice of exercising its right under subsection 3.1.1.3. and the reason for which DHHS has exercised its right. If DHHS removes Contractor personnel for any reason, no additional payments shall be paid by the State for any staff removed from duty by the Department

3.1.1.5. In the event that DHHS exercises its right under subsection 3.1.1.3.

a. The Contractor shall provide replacement personnel who shall meet all of the applicable requirements under the contract, including but not limited to being subject to the DHHS approval specified in 3.1.1.2.;

b. The Contractor shall be responsible for providing transition services to the applicable DHHS service area to avoid the interruption of services and administrative responsibilities at no additional cost to DHHS;

c. DHHS shall inform the Contractor of the anticipated

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duration for which approval will remain rescinded. If the position is assigned to NHH, and if the duration of a temporarily rescinded approval is greater than seven (7) calendar days, the Contractor shall furnish within ten (10) business days replacement Contractor staff who shall meet all of the requirements for the applicable position under the contract. The Contractor shall be responsible for providing, at no additional cost to the Department, transition services to NHH to avoid service interruption;

d. It shall be at the Contractor's sole discretion whether to initiate any internal personnel actions against its own employees. However, nothing herein shall prohibit the Contractor from seeking information from DHHS regarding DHHS' decision, unless such information is otherwise restricted from disclosure by DHHS based on internal DHHS policies or rules, State of New Hampshire personnel policies, rules, collective bargaining agreements, or other state or federal laws.

3.1.1.6. The Contractor shall ensure that, prior to providing the applicable services for the applicable DHHS service area or facility, all required licenses, certifications, privileges, or other specified minimum qualifications are met for all staff, and where applicable, are maintained throughout the provision of services for the full term of the contract. The Contractor shall provide the applicable DHHS designee with a copy of all such documents. The Contractor acknowledges and agrees that DHHS shall not be held financially liable for any fees or costs for any licenses, certifications or renewal of same, nor for any fees or costs incurred for providing copies of said licenses or certifications.

3.1.1.7. The Contractor shall ensure that all staff provided under this contract are subject to the Contractor's normal and customary employee benefits and policies, including leave provisions. However, whereas the Contractor and DHHS agree that the continuity of operations and continuous provision of the staffing described in this contract is of paramount importance to the State, in addition to any required approvals by the Contractor for its employees, Contractor staff providing services shall provide timely, prior notification to the applicable DHHS designee for any anticipated leave time, unless otherwise stated herein for a specific position or service area. All positions allocated in this contract are to be 100% filled or in active recruitment. In the event that a position remains vacant (due to the need to fill the position or recruit for the position) for

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more than 30 days, the contractor shall reduce the monthly invoice by amount budgeted for that position until the position is filled. The Contractor shall provide DHHS with monthly updates on the recruitment process for all unfilled positions.

3.1.1.8. All personnel provided by the Contractor shall be subject to the identified criminal background, registry, screening and medical examinations, as specified in the table below, for the applicable Service Area to which the individual is assigned contractual service responsibilities. The Contractor shall ensure the successful completion of these requirements for each individual assigned by the Contractor to perform contractual services prior to commencing work and shall ensure that such requirements are kept up to date as required; the Department shall receive copies of all documentation prior to the commencement of services and shall not be responsible for any costs incurred in obtaining the documentation described below:

	Service Area	Required Background, Registry, Screening, and Medical Examinations
1	New Hampshire Hospital	Criminal Background, BEAS State Registry, DCYF Central Registry, Health Assessment (including TB testing and physical capacity examination).
2	Glencliff Home	Criminal Background (including RSO and OIG), BEAS State Registry, DCYF Central Registry, TB Testing
3	Medicaid Program	Criminal Background, BEAS State Registry, DCYF Central Registry
4	Children, Youth & Families	Criminal Background, DCYF Central Registry, TB Testing
5	Behavioral Health	Criminal Background, BEAS State Registry, DCYF Central Registry
6	Elderly and Adult Services	Criminal Background, BEAS State Registry
7	Developmental Services	Criminal Background, BEAS State Registry, DCYF Central Registry

3.2. General Staffing Requirements Applicable to Service Area#1 – New Hampshire Hospital

3.2.1. The following additional requirements shall apply specifically to

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personnel provided to fulfill the contractual requirements applicable to Service Area #1 – NHH, for the duration of the contract:

3.2.1.1. The Contractor shall ensure that the Chief Medical Officer actively participates in the recruitment of all other staffing needs required under the contract for the provision of services at NHH.

3.2.1.2. The Contractor shall ensure that, prior to commencing practice at NHH, all psychiatrists are licensed to practice medicine in the State of New Hampshire, as well as boarded in their particular specialty or are board eligible, and shall commence the privileging process of the Medical Staff Organization of NHH as authorized by its by-laws. Such licenses and clinical privileges must be maintained throughout the term of the contract.

3.2.1.3. The Contractor shall ensure that all clinical personnel maintain appropriate licensure/certification relevant to the practice of their clinical disciplines.

3.2.1.4. DHHS reserves the right to jointly, with the Contractor, or separately, interview, research or otherwise screen and consider candidates the Contractor designates for the Chief Medical Officer role.

3.2.1.5. In addition to the provisions stated herein at subsection 3.1.1.7., staff providing services to NHH shall provide timely, prior notification to the Chief Medical Officer and the NHH CEO for any anticipated leave time. The Contractor shall be solely responsible for providing, at no additional cost to DHHS, qualified, sufficient staff coverage to fill any gap in coverage during any anticipated leave time, including sick leave, lasting more than three (3) consecutive days unless otherwise agreed upon by the NHH CEO on a case-by-case basis, and for providing appropriate transition between staff members covering for those on leave. Qualified sufficient staff coverage shall mean personnel who meet or exceed the qualifications of the vacating staff member.

3.2.1.6. The Contractor acknowledges and understands that DHHS' expectation is that staffing will be at a level that ensures no impact on the number of NHH beds available, and that NHH units will not stop admissions due to the lack of coverage for Contractor staff. All positions allocated in this contract are to be 100% filled or in active recruitment. In the event that a position remains vacant (due to the need to fill the position or recruit for the position) for more than 30 days, the contractor shall reduce the monthly invoice by amount budgeted for that position until

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the position is filled. The Contractor shall provide DHHS with monthly updates on the recruitment process for all unfilled positions.

3.2.2. DHHS reserves the right, through its NHH CEO, or other designee in the absence of the NHH CEO or a vacancy in that position, at its sole discretion to rescind, either temporarily or permanently, its approval of any Contractor staff member providing services at NHH for any of the following reasons:

3.2.2.1. Loss of medical staff privileges at NHH pursuant to medical staff by- laws;

3.2.2.2. Revocation or suspension of the Chief Medical Officer's New Hampshire medical license;

3.2.2.3. Arrest or conviction of a felony, misdemeanor or drug or alcohol related offense; or

3.2.2.4. Any other reason, which includes, but is not limited to: misconduct, violation of NHH or DHHS policy or state or federal laws or regulations, malfeasance, unsatisfactory work performance, or a determination that the individual presents a risk to the health and safety of any staff member or any individual served by the Department.

3.2.3. Should DHHS exercise this right, the applicable staff member shall be prohibited from providing services under the contract for any period of time DHHS chooses.

3.2.4. If the NHH CEO removes Contractor staff assigned to this service area, including the Chief Medical Officer, for any reason, the Contractor shall not be entitled to payment for the staff member during the period of removal.

3.2.5. If approval of the Chief Medical Officer is temporarily rescinded, pursuant to subsection 3.1.1.3., the Contractor shall furnish within ten (10) business days a psychiatrist to serve full-time as interim NHH Chief Medical Officer, until such time as the existing Chief Medical Officer either resumes duty full-time or is replaced by a new Chief Medical Officer. The Interim Chief Medical Officer shall meet all of the requirements for the Chief Medical Officer as set forth under the contract. The Contractor shall be responsible for providing transition services to NHH, at no additional cost, to avoid the interruption of services and administrative responsibilities.

3.2.6. DHHS shall provide Contractor staff at NHH with adequate facilities and DHHS-employed administrative support staff. Facilities shall include, but not be limited to, office space, equipment, and

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furnishings. Sufficient space to accomplish educational, training, and research missions shall also be made available. Administrative support staff shall include, but not be limited to, secretarial assistance, including one full-time executive secretary to support the Chief Medical Officer.

3.2.7. The Contractor, the Chief Medical Officer and all other clinical staff provided by the Contractor shall execute their responsibilities pursuant to this contract consistent with RSA Chapter 135-C, any applicable administrative rules, the by-laws of the NHH's Medical Staff Organization, The Joint Commission (TJC), Centers for Medicare and Medicaid Services (CMS), and in accordance with generally accepted medical standards and practices.

3.3. Specific Staffing Requirements – Service Area #1 – New Hampshire Hospital

3.3.1. Chief Medical Officer

3.3.1.1. The Contractor shall provide for the term of the contract, the full-time services of a qualified physician to serve as the Chief Medical Officer for NHH. The Chief Medical Officer shall possess the following qualifications and meet the following requirements:

a. The Chief Medical Officer shall be a Board Certified Psychiatrist licensed to practice in the State of New Hampshire. The Chief Medical Officer shall, at all times, maintain both a license to practice medicine in the State of New Hampshire and clinical privileges at NHH.

b. The Chief Medical Officer shall be a senior administrative psychiatrist having a minimum of five (5) years of experience in a position of clinical leadership for a major public sector program, psychiatric hospital, governmental authority, state or national medical/psychiatric society organization involved in the delivery of public sector psychiatric services. The Chief Medical Officer shall have completed an ACGME approved residency program with board certification in Psychiatry by the American Board of Psychiatry and Neurology. Additional subspecialty certification in forensic, geriatric or child/adolescent psychiatry may be substituted for 2 years of administrative leadership. Completion of a graduate curriculum in medical administration preferred.

c. For purposes of this paragraph, the term "full-time" shall mean that the Chief Medical Officer shall be required to

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account, through appropriate record-keeping as determined by NHH, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities pursuant to the contract, subject to the Contractor's normal and customary employee leave policies. Said minimum hours must be satisfied through hours devoted to clinical activities onsite at NHH.

3.3.1.2. The Chief Medical Officer may be permitted with prior notice and approval of the NHH CEO to work up to a maximum of 4 hours per week devoted to educational or research activities so long as those activities further the mission and goals of NHH. The Chief Medical Officer shall be responsible for providing documentation to the NHH CEO that time spent devoted to educational or research activities furthers the mission and goals of NHH.

3.3.1.3. Notwithstanding the foregoing allowance for educational or research activities, the Chief Medical Officer shall be physically present onsite at NHH not less than 36 hours per week. The Chief Medical Officer shall also participate with staff psychiatrists in on call, after-hours coverage above the 40-hour week to ensure a 24-hour a day, 7 day per week provision of Psychiatrist-On-Call services without additional compensation to the Contractor or the Chief Medical Officer.

3.3.1.4. In the event the Chief Medical Officer resigns, or is otherwise removed from providing services to NHH under this contract, the Contractor shall furnish within ten (10) business days, not including holidays, a psychiatrist to serve full-time as interim NHH Chief Medical Officer, until such time as the existing Chief Medical Officer either resumes duty full-time or is replaced by a new Chief Medical Officer. The interim Chief Medical Officer shall meet all of the requirements for the Chief Medical Officer as set forth under the contract. The Contractor shall be responsible for providing transition services to NHH, at no additional cost, to avoid the interruption of services and administrative responsibilities.

3.3.1.5. The Chief Medical Officer shall demonstrate:

a. Clear success in the fields of clinical psychiatry and psychiatric education at the graduate or undergraduate level;

b. Development of innovative clinical programs specific to the needs of the severely and persistently mentally ill, (SPMI) population;

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c. Successful collaboration with state government leadership in the areas of program planning, budget, personnel policies, staffing levels, and the legislative process;

d. Cooperation with consumer organizations; and

e. Competence in program evaluation and evidence based outcomes related clinical practice. Research experience; particularly in public sector relevant research as a principal investigator or co-principal investigator is preferred.

3.3.1.6. On an annual basis, the Chief Medical Officer and the NHH CEO shall establish staffing needs for NHH, which shall include psychiatric, research and related clinical personnel. A schedule of personnel shall be developed and written notice shall be provided to the Contractor prior to commencement of the applicable contract year.

3.3.2. **Associate Medical Director**

3.3.2.1. The Contractor shall provide for the term of the contract, the full-time services of a qualified physician to serve as the Associate Medical Director for NHH. The Associate Medical Director shall possess the following qualifications and meet the following requirements:

a. The Associate Medical Director shall be a Board Certified Psychiatrist licensed to practice in the State of New Hampshire. The Associate Medical Director shall, at all times, maintain both a license to practice medicine in the State of New Hampshire and clinical privileges at NHH.

b. The Associate Medical Director shall be a senior administrative psychiatrist having a minimum of five (5) years of experience in a position of clinical leadership for a major public sector program, psychiatric hospital, governmental authority, state or national medical/psychiatric society organization involved in the delivery of public sector psychiatric services. The Associate Medical Director shall have completed an ACGME approved residency program with board certification in Psychiatry by the American Board of Psychiatry and Neurology. Additional subspecialty certification in forensic, addiction, geriatric or child/adolescent psychiatry may be substituted for 2 years of administrative leadership. Completion of a graduate

curriculum in medical administration preferred.

c. For purposes of this paragraph, the term "full-time" shall mean that the Associate Medical Director shall be required to account, through appropriate record-keeping as determined by NHH, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities pursuant to the contract, subject to the Contractor's normal and customary employee leave policies. Said minimum hours must be satisfied through hours devoted to clinical activities onsite at NHH.

3.3.2.2. The Associate Medical Director may be permitted with prior notice and approval of the NHH CEO to work up to a maximum of 4 hours per week devoted to educational or research activities so long as those activities further the mission and goals of NHH. The Associate Medical Director shall be responsible for providing documentation to the NHH CEO that time spent devoted to educational or research activities furthers the mission and goals of NHH.

3.3.2.3. Notwithstanding the foregoing allowance for educational or research activities, the Associate Medical Director shall be physically present onsite at NHH not less than 36 hours per week. The Associate Medical Director shall also participate with staff psychiatrists in on call, after-hours coverage above the 40-hour week to ensure a 24-hour a day, 7 day per week provision of Psychiatrist-On-Call services without additional compensation to the Contractor or the Chief Medical Officer.

3.3.2.4. In the event the Associate Medical Director resigns, or is otherwise removed from providing services to NHH under this contract, the Contractor shall furnish, within 10 business days, not including holidays, a psychiatrist to serve full-time as interim NHH Associate Medical Director, until such time as the existing Associate Medical Director either resumes duty full-time or is replaced by a new Associate Medical Director. The interim Associate Medical Director shall meet all of the requirements for the Chief Medical Officer as set forth under the contract. The Contractor shall be responsible for providing transition services to NHH, at no additional cost, to avoid the interruption of services and administrative responsibilities.

3.3.2.5. The Associate Medical Director shall demonstrate:

a. Clear success in the fields of clinical psychiatry and psychiatric education at the graduate or undergraduate level;

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b. Development of innovative clinical programs specific to the needs of the severely and persistently mentally ill, (SPMI) population;

c. Successful collaboration with state government leadership in the areas of program planning, budget, personnel policies, staffing levels, and the legislative process;

d. Cooperation with consumer organizations; and

e. Competence in program evaluation and evidence based outcomes related clinical practice. Research experience; particularly in public sector relevant research as a principal investigator or co-principal investigator is preferred.

3.3.2.6. On an annual basis, the Associate Medical Director, together with the Chief Medical Officer and the NHH CEO, shall establish staffing needs for NHH, which shall include psychiatric, research and related clinical personnel. A schedule of personnel shall be developed and written notice shall be provided to the Contractor prior to commencement of the applicable contract year.

3.3.3. **Psychiatrists**

3.3.3.1. The Contractor shall provide fourteen (14) General Psychiatrists at NHH:

a. All psychiatrists shall have appropriate experience in the specialty they are boarded or board eligible in;

b. All psychiatrists shall have completed an ACGME approved residency program in psychiatry;

c. At least one psychiatrist shall be dedicated full-time to provide services to the Inpatient Stabilization Unit (ISU); and

d. At least one psychiatrist shall be certified in addiction treatment this psychiatrist shall be a physician who is certified in general psychiatry and has significant clinical experience in addiction medicine. A fellowship training and/or board certification in Addiction Medicine or Addiction Psychiatry is highly desirable.

3.3.4. **Geropsychiatrist**

3.3.4.1. The Contractor shall provide one (1) geropsychiatrist who has:

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a. Completed an ACGME approved residency program in psychiatry, and be board certified by the American Board of Psychiatry and Neurology in Psychiatry; and

b. Completed a 1-year geropsychiatry fellowship and is specialty certified by the American Board of Psychiatry and Neurology in geriatric psychiatry. Two years of additional clinical experience in geriatric psychiatry may be substituted for fellowship training.

3.3.5. **Director of Neuropsychology Laboratory**

3.3.5.1. The Contractor shall provide a senior neuropsychologist who has:

a. Past experience shall include leadership responsibilities in MRI operations and the ability to integrate cognitive test results with data from structural and functional brain imaging;

b. A Ph.D. or Psy.D. in clinical psychology or neuropsychology and shall have completed a neuropsychology postdoctoral fellowship (Houston guidelines); and

c. Evidence of scientific productivity in relation to the SPMI population and the ability to generate proposals for federal and foundation support is preferred.

3.3.6. **Neuropsychologist Trainees**

3.3.6.1. The Contractor shall provide three neuropsychologist trainees who:

a. Shall be clinical psychology graduate students who are obtaining specialty training in neuropsychology; and

b. Shall have three to four years of graduate instruction and training, including training experience in general psychology.

3.3.7. **General Medical Director**

3.3.7.1. The Contractor shall provide one full-time physician to fulfill the role of General Medical Director who shall be a primary care or internal medicine physician who has completed residency with at least three years of experience in supervising primary care clinicians. A board certification in a primary care field is preferred.

3.3.8. **General Medical Physician**

3.3.8.1. The Contractor shall provide one full-time physician who is a

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primary care or internal medicine physician who has completed residency with at least three years of experience. A board certification in a primary care field is preferred.

3.3.9. **Forensic Psychologist**

3.3.9.1. Beginning in SFY 2018, the Contractor shall provide a full-time forensic psychologist. The forensic psychologist shall be a clinical psychologist (PhD or Psy.D.) with significant clinical experience in forensic psychology. A certification in forensic psychology is preferred.

3.3.10. **Residents/Post Graduate Fellows**

3.3.10.1. For all residents or postgraduate fellows the Contractor provides to NHH under this contract, the responsibilities shall be outlined, monitored and reviewed by the Chief Medical Officer and the appropriate, attending psychiatrist.

a. General Psychiatry Residents (PGY II and PGY IV) – The Contractor shall rotate PGY II residents and a PGY IV (chief resident) through NHH.

b. Geropsychiatry Fellow – The Contractor shall rotate a geropsychiatry fellow (PGY V) through the NHH.

3.3.11. **Psychiatric Advanced Practice Registered Nurses (APRN)**

3.3.11.1. The Contractor shall provide eight (8) full-time Psychiatric Advanced Practice Registered Nurses.

a. Psychiatric APRNs shall possess an APRN degree and have board certification as Psychiatric–Mental Health Nurse Practitioner-Board.

b. At least one Psychiatric APRN with specialty in addiction or the requisite number of hours of experience in addiction treatment shall be provided.

c. At least one Psychiatric APRN shall be dedicated full-time to provide services to the ISU.

3.3.12. **NHH Research Manager**

3.3.12.1. The Contractor shall provide a full-time NHH Research Manager, as described below:

a. The Research Manager requires a thorough knowledge and understanding of clinical research, research protocols, and clinical operations, knowledge of GCPs and federal regulations related to human subject research, knowledge of patient privacy and

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confidentiality, ability to manage teams of professionals, maintain meticulous study records, laboratory data and other information related to research protocols, and manage complex schedules and competing priorities.

b. The Research Manager shall meet the following minimum experience and education requirements:

Master's degree in management or health or research related area;

Five or more years of relevant experience in clinical trials research support;

Experience with industry sponsored, federally sponsored and investigator initiated clinical research;

Experience with clinical trial budgets and billing;

Through knowledge of clinical research, research protocols and clinical operations; and

Knowledge of Good Clinical Practices (GCP's) and federal regulations related to research.

3.3.13. **Director of Quality Systems and APRN Services**

3.3.13.1. The Contractor shall provide a full time Director of Quality and APRN Services, as described below:

a. Licensed as an Advance Practice Registered Nurse

b. Two of more years of relevant experience in a psychiatric setting.

c. Experience with quality systems, development and enhancement of organizational systems and processes.

d. Serves as Chair of the Quality Council.

e. Provides clinical standards and provides leadership for all Psychiatric APRNs.

f. Builds community relationships with professional organizations to enhance both the quality programs and APRN programs.

g. Five or more years of experience in leadership of teams.

h. May supervise clinical and non-clinical NHH staff as directed by the Chief Medical Officer and/or the Chief Executive Officer.

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3.3.14. **Director of Health Systems Data and Information Services**

3.3.14.1. The Contractor shall provide a full time Director of Health Systems Data and Information Services, as described below:

a. Five or more years of experience with collecting, analyzing, documenting and reporting hospital and/or health systems data.

b. Five or more years of experience with Electronic Health Records and development of Health Services Data Program.

c. Five or more years of experience in leadership of teams.

d. May supervise clinical and non-clinical NHH staff as directed by the Chief Medical Officer and/or the Chief Executive Officer.

3.3.15. **Schedule and Allocation of Positions – Service Area #1 – NHH**

3.3.15.1 The following schedule shall reflect the full staffing complement for which the Contractor shall provide the required staff, consistent with the requirements described in the Contract for the full term of the contract. All positions allocated in this contract are to be 100% filled or in active recruitment. In the event that a position remains vacant (due to the need to fill the position or recruit for the position) for more than 30 days, the contractor shall reduce the monthly invoice by amount budgeted for that position until the position is filled. The Contractor shall provide DHHS with monthly updates on the recruitment process for all unfilled positions.

Position Title	Full-Time Equivalent
a. Chief Medical Officer	1.0
b. Associate Medical Director	1.0
c. General Psychiatrists	14.0
d. Psychiatric APRNs	8.0
e. Geropsychiatrist	1.0
f. Director of Neuropsychology Laboratory	0.5
g .Director of Quality Systems and APRN Services.	1.0

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h. Neuropsychologist Trainees	3.0
i. General Medical Director	1.0
j. General Medical Physician	1.0
k. Forensic Psychologist	1.0
l. PGY IV Residents	1.0
m. PGY II Residents	1.5
n. Geropsychiatry Fellow	0.5
o. Director of Health System Data and Information Services	1.0
p. Research Manager	1.0
q. Research Mentor/ Investigator (Psychiatrist or Psychologist	0.15 SFY2020, 1.15 SFY 2021, 1.0 SFY 2022

3.4 Specific Staffing Requirements – Service Area #2 – Glencliff HomeMedical Director

3.4.1 The Contractor shall, for the term of the contract, provide the part-time services of one (1) geropsychiatrist to serve at the Glencliff Home as the Medical Director. This position shall be a 0.4 Full-Time Equivalent.

3.5. Specific Staffing Requirements – Service Area #3 – Medicaid Program

3.5.1. Department of Health and Human Services Chief Medical Officer –

3.5.1.1. The Contractor shall, for the term of the contract, provide the full-time services of a designated physician, identified by the Department to serve as the Chief Medical Officer. This position shall be a 1.0 Full- Time Equivalent.

3.5.1.2. The Contractor shall ensure that the Chief Medical Officer provided under this contract is subject to the Contractor's normal and customary employee benefits and policies, including leave provisions for a senior executive level position. However, the Contractor and DHHS agree that the continuous provision of services is essential, and in addition to any required approvals by the Contractor for its employees, the Chief Medical Officer shall provide timely, prior notification to the DHHS Designee of

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any leave time taken. Absences due to vacation and continuing education shall be planned in advance, in consideration of the business needs of the Medicaid program – including ensuring appropriate coverage for any clinical and/or operational responsibilities or tasks that need oversight while the Chief Medical Officer is on leave.

3.5.1.3. The Chief Medical Officer shall possess the following qualifications:

a. Possess a medical degree (MD or DO);

b. Maintain an unrestricted license as a physician by the New Hampshire Board of Medicine;

c. A graduate degree in public health or health care administration with demonstrated experience in public health or healthcare administration systems development;

d. Have a minimum of five years of experience in a position of clinical leadership for a major public sector program, government authority or other organization involved in the delivery of public Medicaid services;

e. Have work experience in managed care settings focused on improved health outcomes;

f. Have fellowship and/or work experience in research in health services, outcomes and/or policy, as well as the ability to work collaboratively with team members and the provider community;

g. Have extensive experience and judgment to plan and accomplish goals working in a team environment;

h. Demonstrate strong verbal and written communication skills;

i. Work collaboratively with Medicaid staff to achieve program goals in an efficient and timely manner;

j. Have Board certification in either Family Medicine, Preventive Medicine/Community Health, Internal Medicine, Pediatrics, or Obstetrics and Gynecology, and with a strong working knowledge of primary care medicine;

k. Must be well versed in the regulations governing the federal Title XIX Medicaid and Title XXI Medicaid and CHIP programs and how those programs are

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administered in New Hampshire;

l. Possess a high degree of creativity and initiative;

m. Have expertise in clinical, policy, or outcomes research; and

n. Have work experience in project management, grant writing, contract management, and program evaluation.

3.6. Specific Staffing Requirements – Service Area #4 – Children, Youth and Families

3.6.1. Staff Psychologist

3.6.1.1. The Staff Psychologist shall possess the following qualifications:

a. Possess a Doctor of Philosophy (Ph.D.) or Doctor of Psychology (Psy.D.) degree from a college or university accredited by the American Psychological Association.

b. Experience and interest in both child psychology and criminal justice;

c. Certification by NH Board of Psychologists.

d. Maintain an unrestricted license to practice Psychology

e. Possess at least five (5) years of experience in community mental health, criminal justice, or similar training.

3.6.2. Staff Psychiatrist

3.6.2.1. The Contractor shall, provide the services of a designated psychiatrist, who is a faculty member and/or employee of the Contractor, to provide psychiatric services to the programs within the Children, Youth and Families service area. This position shall be a .25 Full-Time Equivalent.

3.6.2.2. DHHS reserves the right to jointly, with the Contractor, or separately, interview, research or otherwise screen and consider candidates the Contractor designates for the Staff Psychiatrist.

3.6.2.3. The Staff Psychiatrist shall possess the following qualifications:

a. Possess a medical degree (MD or DO);

b. Specialty in child psychiatry and an interest in criminal justice;

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c. Completion of both an ACGME approved residency program in psychiatry and a 2-year ACGME approved fellowship in child/adolescent psychiatry;

d. Board certification by the American Board of Psychiatry and Neurology in Psychiatry;

e. Maintain an unrestricted license as a physician by the New Hampshire Board of Medicine; and

f. Possess post-fellowship experience in public sector psychiatry, community mental health, criminal justice, or similar training.

3.6.3. Psychiatric Consultant

3.6.3.1. The Contractor shall provide a part-time psychiatric consultant (.25 FTE), to work two (2) days each week for five (5) hours each day, and who meets the following criteria:

3.6.3.2. Has interest and clinical experience in addiction treatment and criminal justice.

3.6.3.3. Has completed a fellowship training and/or board certification in Child Psychiatry.

3.7. Specific Staffing Requirements – Service Area #5 – Behavioral Health

3.7.1. Medical Director

3.7.1.1. The Contractor shall, for the term of the contract, provide a part-time Medical Director to the Behavioral Health service area, as identified by the Department. This position shall be available on-site at a DHHS designated location for twenty (20) hours per week (0.5 FTE).

3.7.1.2. The Medical Director shall possess the following qualifications:

a. Possess a medical degree (MD or DO);

b. Board certification by the American Board of Psychiatry and Neurology in Psychiatry;

c. Maintain an unrestricted license as a physician by the New Hampshire Board of Medicine; and

d. Have at least five (5) years of experience in public mental health and services for people with mental illness.

3.7.2. Support Staff CPHS

3.7.2.1. The Contractor shall, for the term of the contract, provide a part-time Support Staff to support the Committee for the

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Protection of Human Services. This position shall be allocated at 0.15 FTE.

3.7.2.2. The Contractor shall, for the term of the contract, provide a part-time Research Assistant. This position shall be allocated at 0.5 FTE.

3.7.3. Evidence-Based Practice Trainer/Consultant

3.7.3.1. The Contractor shall, for the term of the contract, provide part-time Evidence-Based Practice Trainers/Consultants. These positions shall be allocated, in total, at 2 FTE.

3.7.4. Behavioral Health Policy Institute

3.7.4.1. The Contractor shall, for the term of the contract, provide a part-time Behavioral Health Policy Institute Consultant. This position shall be allocated at 0.1 FTE.

3.8. Specific Staffing Requirements – Service Area #6 – Elderly and Adult Services

3.8.1. Medical Director

3.8.1.1. The Contractor shall, for the term of the contract, provide a part-time Medical Director to the Elderly and Adult Services service area. This position shall be allocated at a 0.03 Full-Time Equivalent.

3.8.1.2. The Medical Director shall possess the following qualifications:

a. Possess a medical degree (MD or DO);

b. Maintain board certification in Gerontology or Preventive Medicine/Community Health;

c. Possess expertise in clinical, policy or outcomes research; and

d. Be well versed in the regulations governing the federal Title XIX Medicaid program, including requirements for the operation of waiver and State Plan services, and Title XX, the Social Service Block Program and services provided under the Older Americans Act.

3.9. Specific Staffing Requirements – Service Area #7 – Developmental Services

3.9.1. Medical Director

3.9.1.1. The Contractor shall, for the term of the contract, provide a part-time Medical Director to the Developmental Services service area. This position shall be allocated at [illegible]

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Equivalent.

3.9.1.2. The Medical Director shall possess the following qualifications:

a. Possess a medical degree (MD or DO);

b. Maintain board certification in Child and Adult Psychiatry; and

c. Possess expertise and experience in developmental disability, including Autism Spectrum Disorders.

3.9.2. Developmental Services Interdisciplinary Clinic Team

3.9.2.1. The Contractor shall, for the term of the contract, provide the following part-time positions to the Adult Developmental Services Interdisciplinary Clinic Team. These positions shall be allocated, as specified below in Full-Time Equivalent (FTE):

3.9.2.2. a. Child Psychiatrist 0.1 FTE

3.9.2.3. b. Psychiatrist 0.1 FTE

3.9.2.4. c. Neuropsychologist 0.1 FTE

3.9.2.5. d. Neuropsychology Fellow 0.1 FTE

3.9.2.6. e. Neurologist 0.05 FTE

3.9.2.7. f. Primary Care Physician 0.05 FTE

3.9.2.8. g. Occupational Therapist 0.05 FTE

3.9.2.9. h. Administrative Support 0.05 FTE

4. Performance Standards and Outcomes

4.1. Service Area #1 – Chief Medical Officer – NHH

4.1.1. Within forty-five (45) days of the assignment of the Chief Medical Officer, and at each contract anniversary thereafter, the Contractor and the NHH CEO, in consultation with the Chief Medical Officer, shall develop a list of performance metrics based upon the deliverables, functions and responsibilities of the Chief Medical Officer. The performance metrics shall be approved by the NHH CEO prior to being effective. The performance metrics shall be reviewed by the NHH CEO on at least a quarterly basis with the Chief Medical Officer.

4.1.2. The Contractor shall ensure the services provided by the Chief Medical Officer at NHH are satisfactory to the Department. As part of this responsibility, the Contractor shall, no less than annually and more frequently if required by DHHS, provide an evaluation tool to solicit input from the NHH CEO regarding the Chief Medical Officer's provision of services under the Contract.

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4.1.3. The Contractor shall develop a corrective action plan to address any concerns raised by the NHH CEO in the evaluation tool, and provide a copy of such plan to the NHH CEO for review. If the NHH CEO disagrees with the Contractor's proposed resolutions within the corrective action plan, the dispute shall be referred to the DHHS Commissioner for resolution with the Contractor.

4.2. **Service Area #1 – Clinical Staff – NHH**

4.2.1. Staffing levels shall be maintained at all times throughout the contract, with the exception of the leave provisions and approval processes described in the subsections applicable to each staffing need.

4.2.1.1. DHHS' expectation is that staffing will be at a level of 100% to ensure in no case shall Contractor staffing impact the number of NHH beds available, and that NHH units will not stop admissions due to the lack of coverage for Contractor staff. All positions allocated in this contract are to be 100% filled or in active recruitment. In the event that a position remains vacant (due to the need to fill the position or recruit for the position) for more than 30 days, the contractor shall reduce the monthly invoice by amount budgeted for that position until the position is filled. The Contractor shall provider DHHS with monthly updates on the recruitment process for all unfilled positions.

4.2.2. The Contractor shall ensure the following performance standards are met by all clinical staff provided by the Contractor to provide services at NHH:

4.2.3. In providing services, DHMC providers shall at all times during the term comply with the Key Performance Indicators (KPI) defined below. Key Performance Indicators may be revised by mutual agreement of the parties. In the event that DHMC providers fail to satisfy any KPI's, in addition to any other rights available to NHH hereunder, DHMC shall cooperate with NHH to remedy such shortfalls and take appropriate action to alleviate the unsatisfactory performance, as determined by the Department.

Key Performance Indicators

4.2.3.1. 1. Psychiatric Progress Notes

(i) Completion daily on patients who are certified as acute inpatient level of care.

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(ii) Completion of not less than four (4) times per week on patients that are no longer acute level of care.

(iii) Content as it pertains to CMS local coverage determinations for NHH and NHH Policy.

2. Patient Length of Stay

(i) Evaluation by through data collection and case review of active treatment during patient stay.

3. CMS Certification Guidelines

(i) Certifications/re-certification conducted in accordance to required CMS and NHH timeframes.

(ii) Assigned certification status is clearly supported in psychiatric progress notes.

4. Standardized Process

(i) Compliance with all existing and future standardized work processes with the goal of reducing variation in care.

(ii) Individual metrics will be developed based on the target outcomes of the standardized work.

5. Treatment Plans

(i) Completed timely and comprehensively.

(ii) Performance measured by random monthly audits which are provided to the Chief Medical Officer and Chief Executive Officer of NHH.

6. Annual Reviews

(i) Annual reviews are documented on all DHMC staff by the Chief Medical Officer or designee. Performance evaluation shall be in compliance with professional standards for evaluations per CMS/Joint Commission guidelines.

4.3. **Service Area #3 – Chief Medical Officer – Medicaid**

4.3.1. Within forty-five (45) days of the assignment of the Chief Medical Officer, and at each contract anniversary thereafter, the Contractor and the DHHS Designee, in consultation with the Chief Medical

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Officer, shall develop a list of performance metrics based upon the deliverables, functions and responsibilities of the Chief Medical Officer. The performance metrics shall be approved by the DHHS Designee prior to being effective. The performance metrics shall be reviewed by the DHHS Designee on at least a quarterly basis with the Chief Medical Officer. These meetings shall be documented with written progress notes by the DHHS Designee.

4.3.2. The Contractor shall ensure the services provided by the Chief Medical Officer are satisfactory to the Department. As part of this responsibility, the Contractor shall, no less than annually and more frequently if required by DHHS, provide an evaluation tool, that is based on the agreed upon performance metrics for the previous year, to solicit input from the DHHS Designee regarding the Chief Medical Officer's provision of services under the contract.

4.3.3. Goals for the upcoming year will be established at the time of the Contractor's evaluation of the Chief Medical Officer, in collaboration with the DHHS Designee. In the case of a newly hired Chief Medical Officer, the evaluation tool shall be completed upon six (6) months of employment and then again at one (1) year, and thereafter on the contract anniversary date.

4.4. **Service Area #4 – Staff Psychiatrist – Children, Youth and Families**

4.4.1. Within forty-five (45) days of the assignment of the Staff Psychiatrist, and at each contract anniversary thereafter, the Contractor and the DHHS designee, in consultation with the Staff Psychiatrist, shall develop a list of performance metrics based upon the deliverables, functions and responsibilities of the Staff Psychiatrist. The performance metrics shall be approved by the DHHS designee prior to being effective. The performance metrics shall be reviewed by the DHHS designee on at least a quarterly basis with the Staff Psychiatrist. These meetings shall be documented with written progress notes by the DHHS designee.

4.4.2. The Contractor shall ensure the services provided by the Staff Psychiatrist are satisfactory to the Department. As part of this responsibility, the Contractor shall, no less than annually and more frequently if needed, provide an evaluation tool, that is based on the agreed upon performance metrics for the previous year, to solicit input from the DHHS designee regarding the Staff Psychiatrist's provision of services under the contract.

Goals for the upcoming year will be established at the time of the Contractor's evaluation of the Staff Psychiatrist, in collaboration with the DHHS designee. In the case of a newly hired Staff Psychiatrist, the evaluation tool shall be completed upon six (6)

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months of employment and then again at one (1) year, and thereafter on the contract anniversary date.

4.5. **Quality Assurance Plan and Monitoring**

The following Quality Assurance Plan and Monitoring shall be provided by the Contractor, subject to modification and/or augmentation as required by DHHS:

4.5.1. **Service Area #1 – New Hampshire Hospital – Chief Medical Officer**

4.5.1.1. The Contractor shall provide oversight of the performance of the Chief Medical Officer toward these Performance Standards and Quality Assurance Monitoring goals.

In addition to performance metrics and in partnership with the NHH CEO, the Chief Medical Officer shall be responsible for the following program outcomes:

a. Ensuring the program is staffed adequately to operate NHH beds at full utilization;

b. Ensuring that Contractor staff receive necessary supervision and training to perform the tasks they are assigned;

c. Assuring that patients receive care consistent with evidence- based care;

d. Creation and implementation of highest standard practices to protect the safety of patients, staff, and visitors; and

e. Other responsibilities detailed herein at subsection 2.3.1.

4.5.1.2. The Chief Medical Officer shall be responsible for monitoring progress toward these goals and providing regular reports, at minimum on a quarterly basis or more frequently if needed, to the NHH CEO and to the Chair of the Department of Psychiatry or his designee. The Chief Medical Officer will meet at minimum on a quarterly basis or more frequently if needed, with the Chair of the Department of Psychiatry (or his or her designee) and the NHH CEO to review progress toward these metrics. The metrics above shall be considered preliminary metrics, subject to refinement, as described herein at subsection 4.2.2., and shall be reviewed and modified by DHHS during the term to assure that they continue to be the best metrics to use to assure contract compliance.

4.5.2. **Monitoring – Service Area #1 – New Hampshire Hospital – Chief Medical Officer:**

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4.5.2.1. The findings from Key Performance Indicators shall be discussed in scheduled meetings between the NHH CEO and the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry (or his or her designee) at meetings that shall take place on a quarterly basis or more frequently if needed.

4.5.2.2. The Key Performance Indicators and feedback solicited from the NHH CEO shall be part of the Chief Medical Officer's annual performance review. The Contractor shall document the annual performance review on the Department's standard annual evaluation tool.

a. If there are performance difficulties that require a corrective action plan, the Contractor shall develop a proposed corrective action plan and shall share and discuss the plan with the NHH CEO prior to issuance to the Chief Medical Officer. If the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry and the NHH CEO disagree on the proposed corrective action plan, the dispute shall be referred to the DHHS Commissioner for resolution.

4.5.2.3. This plan shall be updated and revised at least annually, by the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, working with the NHH CEO and in consultation with the NHH Chief Medical Officer. New goals may be set at any time but shall be set at least annually. New goals may trigger new metrics.

4.5.3. **Service Area #1 – New Hampshire Hospital – Clinical Staff**

4.5.3.1. In providing services, DHMC providers shall at all times during the term comply with the Key Performance Indicators (KPI) defined below. Key Performance Indicators may be revised by mutual agreement of the parties. In the event that DHMC providers fail to satisfy any KPI's, in addition to any other rights available to NHH hereunder, DHMC shall cooperate with NHH to remedy such shortfalls and the parties shall agree on any appropriate action necessary to alleviate the unsatisfactory performance.

Key Performance Indicators

1. Psychiatric Progress Notes

(i) Completion daily on patients who are certified as acute inpatient level of care.

(ii) Completion of not less than four (4) times per week on patients that are no longer acute level of

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care.

(iii) Content as it pertains to CMS local coverage determinations for NHH and NHH Policy.

2. Patient Length of Stay

(i) Evaluation by through data collection and case review of active treatment during patient stay.

3. CMS Certification Guidelines

(i) Certifications/re-certification conducted in accordance to required CMS and NHH timeframes.

(ii) Assigned certification status is clearly supported in psychiatric progress notes.

4. Standardized Process

(i) Compliance with all existing and future standardized work processes with the goal of reducing variation in care.

(ii) Individual metrics will be developed based on the target outcomes of the standardized work.

5. Treatment Plans

(i) Completed timely and comprehensively.

(ii) Performance measured by random monthly audits which are provided to the Chief Medical Officer and Chief Executive Officer of NHH.

6. Annual Reviews

(i) Annual reviews are documented on all DHMC staff by the Chief Medical Officer or designee. Performance evaluation shall be in compliance with professional standards for evaluations per CMS/Joint Commission guidelines.

4.5.4. **Service Area #3 – Medicaid – Chief Medical Officer**

4.5.4.1. Within 45 days of the contract effective date, the Contractor shall work with the DHHS designee overseeing the Medicaid service area to develop a list of performance metrics based on the deliverables, functions, and responsibilities as described herein at subsection 2.5. Together, these metrics shall form an

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evaluation tool. The Chief Medical Officer shall be consulted in this process and the metrics shall be subject to approval by the DHHS Designee overseeing the Medicaid service area. The selection of metrics shall be reviewed over time to assure that they are the best metrics to use to assure contract compliance.

4.5.4.2. The DHHS designee shall review the findings from monitoring of these metrics at least quarterly with the Chief Medical Officer.

4.5.4.3. The Chief Medical Officer role requires initiative, relationship building, and high level leadership. The following metrics are relevant to the Chief Medical Officer's fulfillment of his or her responsibilities and shall be part of the plan for monitoring contract fulfillment:

a. Attendance records of Medicaid Management Team meetings; and

b. A checklist of core duties and expectations, as described herein at subsection 2.5, with feedback solicited on a quarterly or semi-annual basis from the members of the Medicaid Management Team and/or other key informants, designed to monitor performance. The checklist shall rate performance and allow for comments that will help guide improvement.

4.5.5. **Monitoring – Service Area #3 – Medicaid – Chief Medical Officer**

4.5.5.1. Resources for monitoring the performance metrics shall be identified when the performance plan is developed and may require Contractor or State resources to perform such tasks. Performance metric data may include but not be limited to:

a. Checklist feedback from the Medicaid Management Team. Source: Medicaid Management Team members; and

b. Collection and collating of attendance records from the Medicaid Management Team meetings. Source: DHHS administrative support staff.

4.5.5.2. At least twice yearly, or more frequently if needed:

a. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, and the DHHS designee shall review the data collected in the performance metrics, and discuss these with the Chief Medical Officer;

b. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall

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solicit information from the DHHS designee and shall discuss twice yearly with the DHHS designee, or more frequently if needed, the Chief Medical Officer's performance on the metrics.

c. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, and the DHHS designee shall maintain notes of their meetings. The annual performance review shall be documented on the Department's standard annual evaluation tool.

4.5.5.3. The findings collected in the evaluation tool, as well as verbal information solicited from the DHHS designee, shall form the core of the Chief Medical Officer's annual performance review. This review shall be conducted at six months for a new Chief Medical Officer then annually thereafter.

4.5.5.4. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, the DHHS designee, and the Chief Medical Officer shall collaborate to establish goals for the upcoming year as part of the performance evaluation process. New goals may be set at any time but shall be set at least annually.

4.5.5.5. If there are performance difficulties that require a corrective action plan, the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall develop a proposed corrective action plan, and shall discuss and share the plan with the DHHS designee. If the DHHS designee and the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, disagree on the proposed resolutions, the dispute will be referred to the DHHS Commissioner for resolution.

4.5.6. **Service Area #4 – Children, Youth and Families – Staff Psychiatrist**

4.5.6.1. Within 45 days of the contract effective date, the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall work with the DHHS designee overseeing the Children, Youth and Families service area to develop a list of performance metrics based on the deliverables, functions, and responsibilities, as described herein at Subsection 2.6. Together, these metrics shall form an evaluation tool. The Staff Psychologist shall be consulted in this process and the metrics shall be subject to approval by the DHHS Designee overseeing the Children, Youth and Families service area. The selection of metrics shall be reviewed over time to assure that they are the best metrics to use to assure

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Date: 5/29/2020
By: [illegible]

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contract compliance.

4.5.6.2. The content of performance metrics developed shall be such that they assure the Staff Psychologist is fulfilling his or her administrative and clinical responsibilities as described herein at subsection 2.6. The following metrics are relevant to the Staff Psychologist and shall be part of the plan for monitoring contract fulfillment:

a. Monitoring of work hours;

Regular checks of the Staff Psychologist's electronic calendar to be sure it includes proposed leave time, conferences, and trainings;

Clinical documentation monitoring to be sure it meets standards of timeliness and completeness established by Children, Youth, and Families;

Counts of activities such as the number of treatment team meetings and clinical consultations provided, types and numbers of evidence-based practices provided, number of teaching and supervision contacts with interns, residents, and fellows at SYSC; and

Checklist feedback on effectiveness in establishing interagency collaboration between Juvenile Justice Services, area mental health services, and NHH.

4.5.7. **Monitoring – Services Area #4 – Children, Youth & Families – Staff Psychologist**

4.5.7.1. Resources for monitoring the performance metrics shall be identified when the performance plan is developed and may require Contractor or State resources to perform such tasks. Performance metric data may include but not be limited to:

a. Counts of Activities. Source: Staff Psychologist; and

b. Clinical documentation monitoring. Source: DHHS staff.

4.5.7.2. At least twice yearly, or more frequently if needed:

a. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, and the DHHS designee shall review the data collected in the performance metrics, and discuss these with the Staff Psychologist;

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b. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall solicit information from the DHHS designee and shall discuss twice yearly with the DHHS designee, or more frequently if needed, the Staff Psychiatrist's performance on the metrics.

c. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, and the DHHS designee shall maintain notes of their meetings. The annual performance review shall be documented on the Department's standard annual evaluation tool.

4.5.7.3. The findings collected in the evaluation tool, as well as verbal information solicited from the DHHS designee, shall form the core of the Staff Psychologist's annual performance review. This review shall be conducted at six months for a new Staff Psychologist, then annually thereafter.

4.5.7.4. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, the DHHS designee, and the Staff Psychologist shall collaborate to establish goals for the upcoming year as part of the performance evaluation process. New goals may be set at any time but shall be set at least annually.

4.5.7.5. If there are performance difficulties that require a corrective action plan, the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall develop a proposed corrective action plan, and shall discuss and share the plan with the DHHS designee. If the DHHS designee and the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, disagree on the proposed resolutions, the dispute will be referred to the DHHS Commissioner for resolution.

4.5.8. **Service Areas #2, 3, 5, 6 and 7**

4.5.8.1. Upon DHHS request, the Contractor shall identify performance metrics, develop performance goals, establish monitoring processes and engage in collaborative performance evaluation processes, similar to those described herein at subsection 4.5. For Service Areas 2, 3, 5, 6 and 7.

4.5.9. **All Other Positions**

4.5.9.1. All staff provided by the Contractor, not otherwise addressed herein at subsection 4.5, shall have annual performance reviews. The Contractor shall conduct such reviews and first

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obtain feedback from the applicable DHHS designee for the service area in which the staff is assigned to provide services. This feedback shall be a core element of the annual performance review process. The Contractor shall ensure that goal development is responsive to the evolving needs of DHHS over the course of the contract period.

5. Reporting

5.1. Service Area #1 – New Hampshire Hospital

5.1.1 In addition to other reports as agreed to by the parties, on an annual basis, the Contractor shall make a report in writing to DHHS that is descriptive of the Chief Medical Officers' and the clinicians' services provided by the Contractor and the Contractor's performance under this contract during the preceding contract year, the research activities provided during the preceding contract year, and planned research activities for the current contract year.

5.1.2 On an annual basis, DHHS shall submit to the Contractor a report in writing containing DHHS' evaluation of the Contractor's performance pursuant to this contract during the preceding year.

5.1.3 On a quarterly basis, or as otherwise more frequently required by the United States Department of Health and Human Services regulations, DHHS and in a form specified by DHHS, the Contractor shall provide a written report to DHHS documenting the services provided by the Contractor's staff in sufficient form and with sufficient detail to satisfy the reporting requirements of Medicare, Medicaid, and other third-party providers.

5.2 All Service Areas

5.2.2 The Contractor shall maintain and provide the DHHS designee(s) identified by the Department with up-to-date detailed personnel listings for all Contractor staff performing services under this contract. The listings shall include information, including, but not limited to; the names, titles, position costs (including salary and fringe benefit costs, direct and indirect rates), for each position for each service area for each state fiscal year, or more frequently as required by DHHS, to ensure the accuracy of information contained therein and to ensure proper cost allocation. The listings shall be in a format as determined and approved by DHHS.

6 Compliance

6.1 Continuity of Services

6.1.2 The Contractor and the Department agree that:

6.1.2.1 It will be extremely impracticable and difficult to determine

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By:

actual damages that the Department will sustain in the event that the Contractor breaches this Agreement by failing to maintain the required staffing levels or by failing to deliver the required services, as described in this Exhibit A Amendment #3, Sections 2 through 5;

6.1.2.2 Any breach by the Contractor will delay and disrupt the Department's operations and impact its ability to meet its obligations and lead to significant damages of an uncertain amount as well as a reduction of services; The Contractor's failure to provide Required Staffing, Required Services, or meet the Performance Standards and Outcomes and Reporting Requirements, all as specified in this Exhibit A Amendment #3, Sections 2 through 5, shall result in the assessment of liquidated damages as specified in Exhibit B Amendment #3; and

6.1.2.3 The liquidated damages as specified in Exhibit B Amendment #3 are reasonable and fair and not intended as a penalty.

Definitions

CMS – Centers for Medicare and Medicaid Services
CPHS – Committee for the Protection of Human Subjects.
Department – New Hampshire Department of Health and Human Services **DHHS** – New Hampshire Department of Health and Human Services **HIPAA** – Health Insurance Portability and Accountability Act
TJC – The Joint Commission

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Date:

Method and Conditions Precedent to Payment

1. The State shall pay the Contractor an amount not to exceed the Price Limitation, Block 1.8, in consideration for the Contractor's compliance with the terms and conditions of this Agreement and for the services provided by the Contractor pursuant to Exhibit A Amendment #3, Scope of Services.
2. Agreement Period: Effective upon Governor and Executive Council approval through June 30, 2022.
3. Funding Sources:
   - 3.1. The services described in Exhibit A Amendment #3, Scope of Services, are funded with:
     - 3.1.1. 40% Other Funds (Medicare, Medicaid & third party insurance);
     - 3.1.2. 28% Federal Funds from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medical Assistance Program, Code of Federal Domestic Assistance Number (CFDA) 93.778; and
     - 3.1.3. 32% General Funds.
   - 3.2. DHHS reserves the right to adjust funding sources throughout the Agreement Period and will provide the Contractor reasonable notice of any such changes. Adjustments made may require a mutually agreed upon contract amendment.
   - 3.3. Funds must be used in accordance with the provisions of the specified CFDA numbers.
4. This is a firm, fixed price contract. The Contractor shall provide services under this Agreement based on the Budget specified below per applicable Service Area and State Fiscal Year. The Contractor shall be compensated, for providing and delivering the services described in Exhibit A Amendment #3, Scope of Services, on the basis of this Budget.

Budget			
Agreement Period by State Fiscal Year			
Service Area	7/1/2019-6/30/2020	7/1/2020-6/30/2021	7/1/2021-6/30/2022
1: New Hampshire Hospital	$11,640,759	$12,717,827	$13,366,111
2: Glencliff Home	$139,309	$148,447	$156,475
3: Medicaid	$408,628	$432,119	$455,192
4: Children, Youth & Families	$396,688	$392,445	$413,867
5: Behavioral Health	$517,056	$544,803	$572,319
6: Elderly and Adult Services	$39,197	$41,809	$44,110
7: Developmental Services	$284,893	$310,264	$327,751

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4.1. Services provided in the event of a healthcare system emergency as specified in Section 2.2.5 of Exhibit A Amendment #3, Scope of Services, are budgeted to serve any or all of the seven (7) service areas listed above. The Contractor shall invoice the Department at the hourly rate per position, which is inclusive of direct salary and benefits, for the number of hours worked. The budget for these services shall be unencumbered per State Fiscal Year as specified below:

Service	7/1/2019-6/30/2020	7/1/2020-6/30/2021	7/1/2021-6/30/2022
Healthcare Emergency	$230,200	$230,200	$230,200

4.2. Any amendments to this budget will require a written agreement by the parties in the form of a contract amendment, which may be subject to Governor and Executive Council approval and at minimum shall be subject to Attorney General approval.

5. **Invoicing**: The Contractor shall invoice DHHS monthly for services performed in accordance with the contract on invoices the format of which will be identified and approved by DHHS. The Contractor shall ensure that DHHS receives within thirty (30) days following the end of the month in which services were provided, the applicable invoice. The State shall make payment to the Contractor within thirty (30) days of receipt of an accurate invoice for Contractor services provided pursuant to this Agreement. Should a discrepancy in an invoice be identified by DHHS, it shall promptly notify the designated individual identified in Section 7, below, prior to the due date for payment. DHHS shall not be required to pay an invoice until any discrepancy with the invoice is resolved to the satisfaction of DHHS.

5.1. Invoices must be submitted to the attention of the DHHS designee at:

NHHFinancialServices@dhhs.nh.gov
NH Hospital Financial Services
Department of Health and Human Services 36 Clinton St
Concord, NH 03301

5.2. Each monthly invoice shall distinctly identify and differentiate the expenses as charged according to each of the seven (7) Service Areas for which services are provided. The seven (7) Service Areas are as follows:

5.2.1. Service Area #1 – New Hampshire Hospital (NHH)

5.2.2. Service Area #2 – Glencliff Home

5.2.3. Service Area #3 – Medicaid Program

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5.2.4. Service Area #4 – Children, Youth and Families Service Area #5 – Behavioral Health

5.2.5. Service Area #6 – Elderly and Adult Services

5.2.6. Service Area #7 – Developmental Services

5.3. In the event that Healthcare System Emergency services are provided, the Contractor shall separately invoice to distinctly identify and differentiate the expenses as charged according to each of the seven (7) Service Areas for which services are provided. The invoice shall include the dates, the name of the employee and their title, the hourly rate, and the number of hours worked per day.

6. **Payment:** Compensation paid by DHHS shall be accepted by the Contractor as payment in full for the services provided under the Agreement. Notwithstanding anything to the contrary contained in the Agreement or in any other document, contract or understanding, it is expressly understood and agreed by the parties hereto that no payments will be made hereunder to reimburse the Contractor for costs incurred for any purpose or for any services provided to any individual prior to the effective date of the Contract.

7. **Financial Management:** The Contractor shall designate a contact person to resolve any questions or discrepancies regarding invoices. The Contractor shall provide DHHS with the name, title, telephone number, fax number and email address of the contact person. The Contractor shall also notify DHHS in the event of a change of the designated contact person. DHHS shall provide the Contractor with the name, title, mailing address, and telephone number of the corresponding DHHS contact person. DHHS shall notify the Contractor in the event of a change in the designated contact person.

7.1. Contingent upon additional state or federal funding and pursuant to a mutually agreed upon contract amendment, the Contractor may be asked to provide additional services appropriate for inclusion in the contract's scope, if such services are not otherwise detailed in this Agreement.

8. **Liquidated Damages**

8.1. Continuity of Services: As specified and described in Exhibit A Amendment #3, Scope of Services Subsection 6.1, Continuity of Services, the Contractor's failure to provide required staffing, required services, or meet the performance standards and reporting requirements as described in Exhibit A Amendment #3, Scope of Services, Sections 2 through 5, shall result in liquidated damages.

8.2. The Contractor and DHHS agree that:

8.2.1. It will be extremely impracticable and difficult to determine actual damages that DHHS will sustain in the event that the Contractor breaches this Agreement by failing to maintain the required staffing

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levels or by failing to deliver the required services, as described in Exhibit A Amendment #3, Scope of Services, Sections 2 through 5;

8.2.2. Any breach by the Contractor will delay and disrupt DHHS's operations and impact its ability to meet its obligations and lead to significant damages of an uncertain amount as well as a reduction of services;

8.2.3. The Contractor's failure to provide Required Staffing, Required Services, or meet the Performance Standards and Outcomes and Reporting Requirements, all as specified in Exhibit A Amendment #3, Scope of Services, Sections 2 through 5, shall result in the assessment of liquidated damages as specified in this Exhibit B Amendment #3;

8.2.4. The liquidated damages as specified in this Exhibit B Amendment #3 are reasonable and fair and not intended as a penalty; and

8.2.5. Assessment and recovery of liquidated damages by DHHS shall be in addition to, and not exclusive of, any other remedies, including actual damages, as may be available to DHHS for breach of contract, both at law and in equity, and shall not preclude DHHS from recovering damages related to other acts or omissions by the Contractor under this Agreement. Imposition of liquidated damages shall not limit the right of DHHS to terminate the Contract for default as provided in Paragraph 8 of the General Provisions (P-37).

8.3. Notification: DHHS shall make all assessments of liquidated damages. Prior to the imposition of liquidated damages, as described herein, DHHS shall issue a written notice of remedies that will include, as applicable, the following:

8.3.1. A citation of the contract provision violated;

8.3.2. The remedies to be applied, and the date the remedies shall be imposed (cure period);

8.3.3. The basis for DHHS' determination that the remedies shall be imposed;

8.3.4. A request for a Corrective Action Plan from the Contractor; and

8.3.5. The timeframe and procedure for the Contractor to dispute DHHS' determination.

8.4. If the failure to perform by the Contractor is not resolved within the cure period identified by DHHS, liquidated damages may be imposed retroactively to the date of failure to perform and will continue until the failure is cured or any resulting dispute is resolved in the Contractor's favor.

8.5. The Contractor's dispute of liquidated damages or remedies shall not stay the effective date of the proposed liquidated damages or remedies.

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8.6. Corrective Action Plan: The Contractor shall submit a written Corrective Action Plan to DHHS within five (5) business days of receiving notification as specified in subsection 8.3. Notification, for DHHS review. The Corrective Action Plan shall be subject to DHHS approval prior to its implementation.

8.7. **Liquidated Damages:**

8.7.1. Liquidated damages, if assessed, shall be in the amount of $1,000 per day for each day the Contractor fails to meet the general and specific service requirements for each Service Area as identified in Exhibit A Amendment #3, Scope of Services, Section 2, Scope of Services.

8.7.2. Liquidated damages, if assessed, shall be in the amount of $1,000 per day for each day the Contractor fails to meet and maintain the staffing levels identified in Exhibit A Amendment #3, Scope of Services, Section 3, Staffing.

8.7.3. Liquidated damages, if assessed, shall be in the amount of $1,000 per day for each day the Contractor fails to meet the Performance Standards identified in Exhibit A Amendment #3, Scope of Services, Section 4, Performance Standards and Outcomes.

8.7.4. Liquidated damages, if assessed, shall be in the amount of $1,000 per day for each day the Contractor fails to meet the Reporting Requirements identified in Exhibit A Amendment #3, Scope of Services, Section 5, Reporting.

8.7.5. Liquidated damages, if assessed, shall apply until the Contractor cures the failure cited in the Notification described in Subsection 9.3, or until the resulting dispute is resolved in the Contractor's favor.

8.7.6. The amount of liquidated damages assessed by DHHS shall not exceed the price limitation in Form P-37, General Provisions, Block 1.8 – Price Limitation.

8.8. Assessment: DHHS shall be entitled to assess and recover liquidated damages cumulatively under each section applicable to any given incident. Assessment and recovery of liquidated damages by DHHS shall be in addition to, and not exclusive of, any other remedies, including actual damages, as may be available to DHHS for breach of contract, both at law and in equity, and shall not preclude DHHS from recovering damages related to other acts or omissions by the Contractor under this Agreement. Imposition of liquidated damages shall not limit the right of DHHS to terminate the Contract for default as provided in Paragraph 8 of the General Provisions (P-37).

8.9. Damages Related to Failure to Document Medical Necessity: The Contractor shall be liable to DHHS for any losses incurred by DHHS which arise out of the failure of Contractor staff to provide the required documentation to support

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medical necessity as identified in Exhibit A Amendment #3, Scope of Services, Section 2.3.3.1. (j) and Section 2.3.5.4.

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Date
By

State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that MARY HITCHCOCK MEMORIAL HOSPITAL is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on August 07, 1889. I further certify that all fees and documents required by the Secretary of State's office have been received and is in good standing as far as this office is concerned.

Business ID: **68517**

Certificate Number: **0004905338**

IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 1st day of May A.D. 2020.

William M. Gardner

Secretary of State

Dartmouth-Hitchcock

Dartmouth-Hitchcock
Dartmouth-Hitchcock Medical Center
1 Medical Center Drive
Lebanon, NH 03756
Dartmouth-Hitchcock.org

CERTIFICATE OF VOTE/AUTHORITY

I, Charles G. Plimpton, of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital, do hereby certify that:

1. I am the duly elected Treasurer and Secretary of the Board of Trustees of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital;
2. The following is a true and accurate excerpt from the December 7th, 2012 Bylaws of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital:

   ARTICLE I – Section A. Fiduciary Duty. Stewardship over Corporate Assets

   "In exercising this [fiduciary] duty, the Board may, consistent with the Corporation's Articles of Agreement and these Bylaws, delegate authority to the Board of Governors, Board Committees and various officers the right to give input with respect to issues and strategies, incur indebtedness, make expenditures, enter into contracts and agreements and take such other binding actions on behalf of the Corporation as may be necessary or desirable."
3. Article I – Section A, as referenced above, provides authority for the chief officers, including the Chief Executive Officer, the Chief Clinical Officer, and other officers, of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital to sign and deliver, either individually or collectively, on behalf of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital.
4. Edward J. Merrens, MD is the Chief Clinical Officer of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital and therefore has the authority to enter into contracts and agreements on behalf of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital.

IN WITNESS WHEREOF, I have hereunto set my hand as the Treasurer and Secretary of the Board of Trustees of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital this 6th day of May, 2020.

Charles G. Plimpton, Board Treasurer and Secretary

STATE OF NH

COUNTY OF GRAFTON

The foregoing instrument was acknowledged before me this 6th day of May, 2020, by Charles G. Plimpton.

LAURA K. RONDEAU
STATE OF
- MY -
COMMISSION
EXPIRES
APRIL 19,
2022
NEW HAMPSHIRE
NOTARY PUBLIC

Notary Public
My Commission Expires: April 19, 2022

CERTIFICATE OF INSURANCE

DATE: 02/18/2020

COMPANY AFFORDING COVERAGE
Hamden Assurance Risk Retention Group, Inc.
P.O. Box 1687
30 Main Street, Suite 330
Burlington, VT 05401

INSURED
Mary Hitchcock Memorial Hospital – DH-H
One Medical Center Drive
Lebanon, NH 03756
(603)653-6850

This certificate is issued as a matter of information only and confers no rights upon the Certificate Holder. This Certificate does not amend, extend or alter the coverage afforded by the policies below.

COVERAGES

The Policy listed below has been issued to the Named Insured above for the Policy Period notwithstanding any requirement, term or condition of any contract or other document with respect to which this certificate may be issued. The insurance afforded by the policy is subject to all the terms, exclusions and conditions of the policy. Limits shown may have been reduced by paid claims.

TYPE OF INSURANCE		POLICY NUMBER	POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	LIMITS	
GENERAL LIABILITY		0002019-A	07/01/2019	07/01/2020	EACH OCCURRENCE	$1,000,000
					DAMAGE TO RENTED PREMISES	$100,000
X	CLAIMS MADE				MEDICAL EXPENSES	N/A
					PERSONAL & ADV INJURY	$1,000,000
	OCCURRENCE				GENERAL AGGREGATE	$2,000,000
OTHER					PRODUCTS-COMP/OP AGG	$1,000,000
PROFESSIONAL LIABILITY					EACH CLAIM	
	CLAIMS MADE				ANNUAL AGGREGATE	
	OCCURENCE					
OTHER						

DESCRIPTION OF OPERATIONS/ LOCATIONS/ VEHICLES/ SPECIAL ITEMS (LIMITS MAY BE SUBJECT TO RETENTIONS)

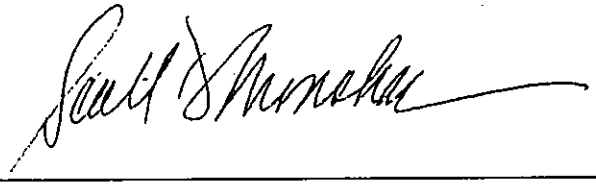
Certificate of Insurance issued as evidence of insurance for services provided as part of the DHHS Injury Prevention Program.

CERTIFICATE HOLDER

NH Dept of Health & Human Services
129 Pleasant Street
Concord, NH 03301

CANCELLATION
Should any of the above described policies be cancelled before the expiration date thereof, the issuing company will endeavor to mail 30 DAYS written notice to the certificate holder named below, but failure to mail such notice shall impose no obligation or liability of any kind upon the company, its agents or representatives.

AUTHORIZED REPRESENTATIVES



DARTHIT-01 ASTOBERT

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 2/18/2020

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER License # 1780862 HUB International New England 100 Central Street, Suite 201 Holliston, MA 01746	CONTACT NAME: Rita Durgin PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS: rita.durgin@hubinternational.com
	INSURER(S) AFFORDING COVERAGE — NAIC #
INSURED Dartmouth-Hitchcock Health 1 Medical Center Dr. Lebanon, NH 03756	INSURER A : Safety National Casualty Corporation — 15105 INSURER B : INSURER C : INSURER D : INSURER E : INSURER F :

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	☐ OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) ☐ Y/N If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		AG4061049	7/1/2019	7/1/2020	X PER STATUTE ☐ OTH-ER	
							E.L. EACH ACCIDENT	$ 1,000,000
							E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Evidence of Workers Compensation coverage for Dartmouth-Hitchcock Health

CERTIFICATE HOLDER

NH DHHS
129 Pleasant Street
Concord, NH 03301

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

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Dartmouth-Hitchcock

Mission, Vision, & Values

Our Mission

We advance health through research, education, clinical practice, and community partnerships, providing each person the best care, in the right place, at the right time, every time.

Our Vision

Achieve the healthiest population possible, leading the transformation of health care in our region and setting the standard for our nation.

Values

- Respect
- Integrity
- Commitment
- Transparency
- Trust
- Teamwork
- Stewardship
- Community

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Dartmouth-Hitchcock Health and Subsidiaries

Report on Federal Awards in Accordance With the Uniform Guidance
June 30, 2019
EIN #02–0222140

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Part I

Financial Statements and Schedule of Expenditures of Federal Awards

Report of Independent Auditors

To the Board of Trustees of
Dartmouth-Hitchcock Health and subsidiaries

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Dartmouth-Hitchcock Health and its subsidiaries (the "Health System"), which comprise the consolidated balance sheets as of June 30, 2019 and 2018, and the related consolidated statements of operations and changes in net assets and of cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on the consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Health System's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health System's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Dartmouth-Hitchcock Health and its subsidiaries as of June 30, 2019 and 2018, and the results of their operations, changes in net assets and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

As discussed in Note 2 to the consolidated financial statements, the Health System changed the manner in which it accounts for revenue recognition from contracts with customers and the manner in which it presents net assets and reports certain aspects of its financial statements as a not-for-profit entity in 2019. Our opinion is not modified with respect to this matter.

Other Matters

Other Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The consolidating information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The consolidating information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves and other additional procedures, in accordance with auditing standards generally accepted in the United States of America. In our opinion, the consolidating information is fairly stated, in all material respects, in relation to the consolidated financial statements taken as a whole. The consolidating information is presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position, results of its operations, changes in net assets and cash flows of the individual companies and is not a required part of the consolidated financial statements. Accordingly, we do not express an opinion on the financial position, results of operations, changes in net assets and cash flows of the individual companies.

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying schedule of expenditures of federal awards for the year ended June 30, 2019 is presented for purposes of additional analysis as required by Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) and is not a required part of the consolidated financial statements. The information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures, in accordance with auditing standards generally accepted in the United States of America. In

our opinion, the schedule of expenditures of federal awards is fairly stated, in all material respects, in relation to the consolidated financial statements taken as a whole.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated November 26, 2019 on our consideration of the Health System's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements and other matters for the year ended June 30, 2019. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing and not to provide an opinion on the effectiveness of internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Health System's internal control over financial reporting and compliance.

PricewaterhouseCoopers LLP

Boston, Massachusetts
November 26, 2019

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Balance Sheets
June 30, 2019 and 2018

(in thousands of dollars)	2019	2018
Assets		
Current assets		
Cash and cash equivalents	$ 143,587	$ 200,169
Patient accounts receivable, net of estimated uncollectible of $132,228 at June 30, 2018 (Note 4)	221,125	219,228
Prepaid expenses and other current assets	95,495	97,502
Total current assets	460,207	516,899
Assets limited as to use (Notes 5 and 7)	876,249	706,124
Other investments for restricted activities (Notes 5 and 7)	134,119	130,896
Property, plant, and equipment, net (Note 6)	621,256	607,321
Other assets	124,471	108,785
Total assets	$ 2,216,302	$ 2,070,025
Liabilities and Net Assets		
Current liabilities		
Current portion of long-term debt (Note 10)	$ 10,914	$ 3,464
Current portion of liability for pension and other postretirement plan benefits (Note 11)	3,468	3,311
Accounts payable and accrued expenses (Note 13)	113,817	95,753
Accrued compensation and related benefits	128,408	125,576
Estimated third-party settlements (Note 4)	41,570	41,141
Total current liabilities	298,177	269,245
Long-term debt, excluding current portion (Note 10)	752,180	752,975
Insurance deposits and related liabilities (Note 12)	58,407	55,516
Liability for pension and other postretirement plan benefits, excluding current portion (Note 11)	281,009	242,227
Other liabilities	124,136	88,127
Total liabilities	1,513,909	1,408,090
Commitments and contingencies (Notes 4, 6, 7, 10, and 13)		
Net assets		
Net assets without donor restrictions (Note 9)	559,933	524,102
Net assets with donor restrictions (Notes 8 and 9)	142,460	137,833
Total net assets	702,393	661,935
Total liabilities and net assets	$ 2,216,302	$ 2,070,025

The accompanying notes are an integral part of these consolidated financial statements.

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Statements of Operations and Changes in Net Assets
Years Ended June 30, 2019 and 2018

(in thousands of dollars)	2019	2018
Operating revenue and other support		
Patient service revenue	$ 1,999,323	$ 1,899,095
Provision for bad debts (Notes 2 and 4)	-	47,367
Net patient service revenue	1,999,323	1,851,728
Contracted revenue (Note 2)	75,017	54,969
Other operating revenue (Notes 2 and 5)	210,698	148,946
Net assets released from restrictions	14,105	13,461
Total operating revenue and other support	2,299,143	2,069,104
Operating expenses		
Salaries	1,062,551	989,263
Employee benefits	251,591	229,683
Medical supplies and medications	407,875	340,031
Purchased services and other	323,435	291,372
Medicaid enhancement tax (Note 4)	70,061	67,692
Depreciation and amortization	88,414	84,778
Interest (Note 10)	25,514	18,822
Total operating expenses	2,229,441	2,021,641
Operating income (loss)	69,702	47,463
Nonoperating gains (losses)		
Investment income, net (Note 5)	40,052	40,387
Other losses, net (Note 10)	(3,562)	(2,908)
Loss on early extinguishment of debt	(87)	(14,214)
Loss due to swap termination	-	(14,247)
Total nonoperating gains, net	36,403	9,018
Excess of revenue over expenses	$ 106,105	$ 56,481

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Statements of Operations and Changes in Net Assets
Years Ended June 30, 2019 and 2018

(in thousands of dollars)	2019	2018
Net assets without donor restrictions		
Excess of revenue over expenses	$ 106,105	$ 56,481
Net assets released from restrictions	1,769	16,313
Change in funded status of pension and other postretirement benefits (Note 11)	(72,043)	8,254
Other changes in net assets	-	(185)
Change in fair value of interest rate swaps (Note 10)	-	4,190
Change in interest rate swap effectiveness	-	14,102
Increase in net assets without donor restrictions	35,831	99,155
Net assets with donor restrictions		
Gifts, bequests, sponsored activities	17,436	14,171
Investment income, net	2,682	4,354
Net assets released from restrictions	(15,874)	(29,774)
Contribution of assets with donor restrictions from acquisition	383	-
Increase (decrease) in net assets with donor restrictions	4,627	(11,249)
Change in net assets	40,458	87,906
Net assets		
Beginning of year	661,935	574,029
End of year	$ 702,393	$ 661,935

The accompanying notes are an integral part of these consolidated financial statements.

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Statements of Cash Flows
Years Ended June 30, 2019 and 2018

(in thousands of dollars)	2019	2018
Cash flows from operating activities		
Change in net assets	$ 40,458	$ 87,906
Adjustments to reconcile change in net assets to net cash provided by operating and nonoperating activities		
Change in fair value of interest rate swaps	-	(4,897)
Provision for bad debt	-	47,367
Depreciation and amortization	88,770	84,947
Change in funded status of pension and other postretirement benefits	72,043	(8,254)
(Gain) on disposal of fixed assets	(1,101)	(125)
Net realized gains and change in net unrealized gains on investments	(31,397)	(45,701)
Restricted contributions and investment earnings	(2,292)	(5,460)
Proceeds from sales of securities	1,167	1,531
Loss from debt defeasance	-	14,214
Changes in assets and liabilities		
Patient accounts receivable, net	(1,803)	(29,335)
Prepaid expenses and other current assets	2,149	(8,299)
Other assets, net	(9,052)	(11,665)
Accounts payable and accrued expenses	17,898	19,693
Accrued compensation and related benefits	2,335	10,665
Estimated third-party settlements	429	13,708
Insurance deposits and related liabilities	2,378	4,556
Liability for pension and other postretirement benefits	(33,104)	(32,399)
Other liabilities	12,267	(2,421)
Net cash provided by operating and nonoperating activities	161,145	136,031
Cash flows from investing activities		
Purchase of property, plant, and equipment	(82,279)	(77,598)
Proceeds from sale of property, plant, and equipment	2,188	-
Purchases of investments	(361,407)	(279,407)
Proceeds from maturities and sales of investments	219,996	273,409
Cash received through acquisition	4,863	-
Net cash used in investing activities	(216,639)	(83,596)
Cash flows from financing activities		
Proceeds from line of credit	30,000	50,000
Payments on line of credit	(30,000)	(50,000)
Repayment of long-term debt	(29,490)	(413,104)
Proceeds from issuance of debt	26,338	507,791
Repayment of interest rate swap	-	(16,019)
Payment of debt issuance costs	(228)	(4,892)
Restricted contributions and investment earnings	2,292	5,460
Net cash (used in) provided by financing activities	(1,088)	79,236
(Decrease) increase in cash and cash equivalents	(56,582)	131,671
Cash and cash equivalents		
Beginning of year	200,169	68,498
End of year	$ 143,587	$ 200,169
Supplemental cash flow information		
Interest paid	$ 23,977	$ 18,029
Net assets acquired as part of acquisition, net of cash aquired	(4,863)	-
Noncash proceeds from issuance of debt	-	137,281
Use of noncash proceeds to refinance debt	-	137,281
Construction in progress included in accounts payable and accrued expenses	1,546	1,569
Equipment acquired through issuance of capital lease obligations	-	17,670
Donated securities	1,167	1,531

The accompanying notes are an integral part of these consolidated financial statements.

1. Organization and Community Benefit Commitments

Dartmouth-Hitchcock Health (D-HH) serves as the sole corporate member of the following entities: Dartmouth-Hitchcock Clinic and Subsidiaries (DHC), Mary Hitchcock Memorial Hospital and Subsidiaries (MHMH), (DHC and MHMH together are referred to as D-H), The New London Hospital Association and Subsidiaries (NLH), Windsor Hospital Corporation (d/b/a Mt. Ascutney Hospital and Health Center) and Subsidiaries (MAHHC), Cheshire Medical Center and Subsidiaries (Cheshire), Alice Peck Day Memorial Hospital and, effective July 1, 2018, Subsidiary (APD), and the Visiting Nurse and Hospice for Vermont and New Hampshire and Subsidiaries (VNH). The "Health System" consists of D-HH, its members and their subsidiaries.

The Health System currently operates one tertiary, one community and three acute care (critical access) hospitals in New Hampshire (NH) and Vermont (VT). One facility provides inpatient and outpatient rehabilitation medicine and long-term care. The Health System also operates multiple physician practices, a nursing home, a continuing care retirement community, and a home health and hospice service. The Health System operates a graduate level program for health professions and is the principal teaching affiliate of the Geisel School of Medicine (Geisel), a component of Dartmouth College.

D-HH, Dartmouth-Hitchcock Clinic, Mary Hitchcock Memorial Hospital, The New London Hospital Association, Cheshire Medical Center, and Alice Peck Day Memorial Hospital are NH not-for-profit corporations exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code (IRC). Windsor Hospital Corporation and the Visiting Nurse and Hospice of VT and NH are VT not-for-profit corporations exempt from federal income taxes under Section 501(c)(3) of the IRC.

Community Benefits
The mission of the Health System is to advance health through clinical practice and community partnerships, research and education, providing each person the best care, in the right place, at the right time, every time.

Consistent with this mission, the Health System provides high quality, cost effective, comprehensive, and integrated healthcare to individuals, families, and the communities it serves regardless of a patient's ability to pay. The Health System actively supports community-based healthcare and promotes the coordination of services among healthcare providers and social services organizations. In addition, the Health System also seeks to work collaboratively with other area healthcare providers to improve the health status of the region. As a component of an integrated academic medical center, the Health System provides significant support for academic and research programs.

Certain member hospitals of the Health System file annual Community Benefits Reports with the State of NH which outline the community and charitable benefits each provides. VT hospitals are not required by law to file a state community benefit report. The categories used in the Community Benefit Reports to summarize these benefits are as follows:

- *Community Health Services* include activities carried out to improve community health and could include community health education (such as classes, programs, support groups, and materials that promote wellness and prevent illness), community-based clinical services (such as free clinics and health screenings), and healthcare support services (enrollment assistance in public programs, assistance in obtaining free or reduced costs medications, telephone information services, or transportation programs to enhance access to care, etc.).

- *Health Professions Education* includes uncompensated costs of training medical students, Residents, nurses, and other health care professionals.

- *Subsidized health services* are services provided by the Health System, resulting in financial losses that meet the needs of the community and would not otherwise be available unless the responsibility was assumed by the government.

- *Research support and other grants* represent costs in excess of awards for numerous health research and service initiatives awarded to the organizations within the Health System.

- *Financial Contributions* include financial contributions of cash, as well as in-kind contributions such as time, supplies, and expertise to local organizations to address community health needs.

- *Community-Building Activities* include expenses incurred to support the development of programs and partnerships intended to address public health challenges as well as social and economic determinants of health. Examples include physical improvements and housing, economic development, support system enhancements, environmental improvements, leadership development and training for community members, community health improvement advocacy, and workforce enhancement.

- *Community Benefit Operations* includes costs associated with staff dedicated to administering benefit programs, community health needs assessment costs, and other costs associated with community benefit planning and operations.

- *Charity Care and Costs of Government Sponsored Health Care* includes losses, at-cost, incurred by providing health care services to persons qualifying for hospital financial assistance programs, and uncompensated costs of providing health care services to patients who are Medicaid Beneficiaries.

- *The uncompensated cost of care for Medicaid* patients reported in the unaudited Community Benefits Reports for 2018 was approximately $139,683,000. The 2019 Community Benefits Reports are expected to be filed in February 2020.

The following table summarizes the value of the community benefit initiatives outlined in the Health System's most recently filed Community Benefit Reports for the year ended June 30, 2018:

(in thousands of dollars)

Government-sponsored healthcare services	$	246,064
Health professional education		33,067
Charity care		13,243
Subsidized health services		11,993
Community health services		6,570
Research		5,969
Community building activities		2,540
Financial contributions		2,360
Community benefit operations		1,153
Total community benefit value	$	322,959

2. Summary of Significant Accounting Policies

Basis of Presentation

The consolidated financial statements are prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America, and have been prepared consistent with the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 954, *Healthcare Entities*, which addresses the accounting for healthcare entities. The net assets, revenue, expenses, and gains and losses of healthcare entities are classified based on the existence or absence of donor-imposed restrictions. Accordingly, net assets without donor restrictions are amounts not subject to donor-imposed stipulations and are available for operations. Net assets with donor restrictions are those whose use has been limited by donors to a specific time period or purpose, or whose use has been restricted by donors to be maintained in perpetuity. All significant intercompany transactions have been eliminated upon consolidation.

Use of Estimates

The preparation of the consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the dates of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting periods. The most significant areas that are affected by the use of estimates include implicit and explicit pricing concessions, valuation of certain investments, estimated third-party settlements, insurance reserves, and pension obligations. Actual results may differ from those estimates.

Excess of Revenue Over Expenses

The consolidated statements of operations and changes in net assets include the excess of revenue over expenses. Operating revenues consist of those items attributable to the care of patients, including contributions and investment income on investments of net assets without donor restrictions, which are utilized to provide charity and other operational support. Peripheral activities, including contribution of net assets without donor restrictions from acquisitions, loss on early extinguishment of debt, loss due to swap termination, realized gains/losses on sales of investment securities and changes in unrealized gains/losses in investments are reported as nonoperating gains (losses).

Changes in net assets without donor restrictions which are excluded from the excess of revenue over expenses, consistent with industry practice, include contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purpose of acquiring such assets), change in funded status of pension and other postretirement benefit plans, and the effective portion of the change in fair value of interest rate swaps.

Charity Care

The Health System provides care to patients who meet certain criteria under their financial assistance policies without charge or at amounts less than their established rates. Because the Health System does not anticipate collection of amounts determined to qualify as charity care, they are not reported as revenue.

The Health System grants credit without collateral to patients. Most are local residents and are insured under third-party arrangements. The amount of charges for implicit price concessions is based upon management's assessment of historical and expected net collections, business and economic conditions, trends in federal and state governmental healthcare coverage, and other collection indicators (Notes 1 and 4).

Patient Service Revenue
The Health System applies the accounting provisions of ASC 606, *Revenue from Contracts with Customers* (ASC 606). Patient service revenue is reported at the amount of consideration to which the Health System expects to be entitled from patients, third party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors and implicit pricing concessions. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as estimates change or final settlements are determined (Note 4).

Contracted Revenue
The Health System has various Professional Service Agreements (PSAs), pursuant to which certain organizations purchase services of personnel employed by the Health System and also lease space and equipment. Revenue pursuant to these PSAs and certain facility and equipment leases and other professional service contracts have been classified as contracted revenue in the accompanying consolidated statements of operations and changes in net assets.

Other Revenue
The Health System recognizes other revenue which is not related to patient medical care but is central to the day-to-day operations of the Health System. Other revenue primarily consists of revenue from retail pharmacy, which the Health System records as customer revenues in the amounts that reflect the consideration to which it expects to be entitled in exchange for the prescription. Other revenue also includes joint operating agreements, grant revenue, cafeteria sales and other support service revenue.

Cash Equivalents
Cash equivalents include investments in highly liquid investments with maturities of three months or less when purchased, excluding amounts where use is limited by internal designation or other arrangements under trust agreements or by donors.

Investments and Investment Income
Investments in equity securities with readily determinable fair values, mutual funds and pooled/commingled funds, and all investments in debt securities are considered to be trading securities reported at fair value with changes in fair value included in the excess of revenues over expenses. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date (Note 7).

Investments in pooled/commingled investment funds, private equity funds and hedge funds that represent investments where the Health System owns shares or units of funds rather than the underlying securities in that fund are valued using the equity method of accounting with changes in value recorded in the excess of revenues over expenses. All investments, whether held at fair value or under the equity method of accounting, are reported at what the Health System believes to be the amount they would expect to receive if it liquidated its investments at the balance sheet dates on a nondistressed basis.

Certain members of the Health System are partners in a NH general partnership established for the purpose of operating a master investment program of pooled investment accounts. Substantially all of the Health System's board-designated and assets with donor restrictions, such as endowment funds, were invested in these pooled funds by purchasing units based on the market value of the pooled funds at the end of the month prior to receipt of any new additions to the funds. Interest, dividends, and realized and unrealized gains and losses earned on pooled funds are allocated monthly based on the weighted average units outstanding at the prior month-end.

Investment income or losses (including change in unrealized and realized gains and losses on investments, change in value of equity method investments, interest, and dividends) are included in the excess of revenue over expenses and classified as nonoperating gains and losses, unless the income or loss is restricted by donor or law (Note 9).

Fair Value Measurement of Financial Instruments
The Health System estimates fair value based on a valuation framework that uses a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of fair value hierarchy, as defined by ASC 820, *Fair Value Measurements and Disclosures*, are described below:

Level 1 — Unadjusted quoted prices in active markets that are accessible at the measurement date for assets or liabilities.

Level 2 — Prices other than quoted prices in active markets that are either directly or indirectly observable as of the date of measurement.

Level 3 — Prices or valuation techniques that are both significant to the fair value measurement and unobservable.

The Health System applies the accounting provisions of Accounting Standards Update (ASU) 2009-12, *Investments in Certain Entities That Calculate Net Asset Value per Share (or its Equivalent)* (ASU 2009-12). ASU 2009-12 allows for the estimation of fair value of investments for which the investment does not have a readily determinable fair value, to use net asset value (NAV) per share or its equivalent as a practical expedient, subject to the Health System's ability to redeem its investment.

The carrying amount of patient accounts receivable, prepaid and other current assets, accounts payable and accrued expenses approximates fair value due to the short maturity of these instruments.

Property, Plant, and Equipment
Property, plant, and equipment, and other real estate are stated at cost at the time of purchase or fair value at the time of donation, less accumulated depreciation. The Health System's policy is to capitalize expenditures for major improvements and to charge expense for maintenance and repair expenditures which do not extend the lives of the related assets. The provision for depreciation has been determined using the straight-line method at rates which are intended to amortize the cost of assets over their estimated useful lives which range from 10 to 40 years for buildings and improvements, 2 to 20 years for equipment, and the shorter of the lease term, or 5 to 12 years, for leasehold improvements. Certain software development costs are amortized using the straight-line method over a period of up to 10 years. Net interest cost incurred on borrowed funds during the

period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

The fair value of a liability for legal obligations associated with asset retirements is recognized in the period in which it is incurred, if a reasonable estimate of the fair value of the obligation can be made. When a liability is initially recorded, the cost of the asset retirement obligation is capitalized by increasing the carrying amount of the related long-lived asset. Over time, the liability is accreted to its present value each period and the capitalized cost associated with the retirement is depreciated over the useful life of the related asset. Upon settlement of the obligation, any difference between the actual cost to settle the asset retirement obligation and the liability recorded is recognized as a gain or loss in the consolidated statements of operations and changes in net assets.

Gifts of capital assets such as land, buildings, or equipment are reported as support, and excluded from the excess of revenue over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of capital assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire capital assets are reported as restricted support. Absent explicit donor stipulations about how long those capital assets must be maintained, expirations of donor restrictions are reported when the donated or acquired capital assets are placed in service.

Bond Issuance Costs
Bond issuance costs, classified on the consolidated balance sheets within long-term debt, are amortized over the term of the related bonds. Amortization is recorded within interest expense in the consolidated statements of operations and changes in net assets using the straight-line method which approximates the effective interest method.

Intangible Assets and Goodwill
The Health System records within other assets on the consolidated balance sheets goodwill and intangible assets such as trade names and leases-in-place. The Health System considers trade names and goodwill to be indefinite-lived assets, assesses them at least annually for impairment or more frequently if certain events or circumstances warrant and recognizes impairment charges for amounts by which the carrying values exceed their fair values. The Health System has recorded $10,524,000 and $2,462,000 as intangible assets associated with its affiliations as of June 30, 2019 and 2018, respectively.

Derivative Instruments and Hedging Activities
The Health System applies the provisions of ASC 815, *Derivatives and Hedging*, to its derivative instruments, which require that all derivative instruments be recorded at their respective fair values in the consolidated balance sheets.

On the date a derivative contract is entered into, the Health System designates the derivative as a cash-flow hedge of a forecasted transaction or the variability of cash flows to be received or paid related to a recognized asset or liability. For all hedge relationships, the Health System formally documents the hedging relationship and its risk-management objective and strategy for undertaking the hedge, the hedging instrument, the nature of the risk being hedged, how the hedging instrument's effectiveness in offsetting the hedged risk will be assessed, and a description of the method of measuring ineffectiveness. This process includes linking cash-flow hedges to specific assets and liabilities on the consolidated balance sheets, specific firm commitments or forecasted transactions. The Health System also formally assesses, both at the hedge's inception and on an ongoing basis, whether the derivatives that are used in hedging transactions are highly

effective in offsetting changes in variability of cash flows of hedged items. Changes in the fair value of a derivative that is highly effective and that is designated and qualifies as a cash-flow hedge are recorded in net assets without donor restrictions until earnings are affected by the variability in cash flows of the designated hedged item. The ineffective portion of the change in fair value of a cash flow hedge is reported in excess of revenue over expenses in the consolidated statements of operations and changes in net assets.

The Health System discontinues hedge accounting prospectively when it is determined: (a) the derivative is no longer effective in offsetting changes in the cash flows of the hedged item; (b) the derivative expires or is sold, terminated, or exercised; (c) the derivative is undesignated as a hedging instrument because it is unlikely that a forecasted transaction will occur; (d) a hedged firm commitment no longer meets the definition of a firm commitment; and (e) management determines that designation of the derivative as a hedging instrument is no longer appropriate.

In all situations in which hedge accounting is discontinued, the Health System continues to carry the derivative at its fair value on the consolidated balance sheets and recognizes any subsequent changes in its fair value in excess of revenue over expenses.

Gifts
Gifts without donor restrictions are recorded net of related expenses as nonoperating gains. Conditional promises to give and indications of intentions to give to the Health System are reported at fair value at the date the gift is received. Gifts are reported with donor restrictions if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, net assets with donor restrictions are reclassified as net assets without donor restrictions and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions.

Recently Issued Accounting Pronouncements
In May 2014, the FASB issued ASU 2014-09 - *Revenue from Contracts with Customers (ASC 606)* and in August 2015, the FASB amended the guidance to defer the effective date of this standard by one year. ASU 2014-09 affects any entity that either enters into contracts with customers to transfer goods or services or enters into contracts for the transfer of nonfinancial assets unless those contracts are within the scope of other standards. The core principle of the guidance in ASU 2014-09 is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The Health System adopted ASU 2014-09 effective July 1, 2018 under the modified retrospective method, and has provided the new disclosures required post implementation. For example, patient accounts receivable are shown net of the allowance for doubtful accounts of approximately $132,228,000 as of June 30, 2018 on the consolidated balance sheet. If an allowance for doubtful accounts had been presented as of June 30, 2019, it would have been approximately $121,544,000. While the adoption of ASU 2014-09 has had a material effect on the presentation of revenues in the Health System's consolidated statements of operations and changes in net assets, and has had an impact on certain disclosures, it has not materially impacted the financial position, results of operations or cash flows. Refer to Note 4, Patient Service Revenue and Accounts Receivable, for further details.

In February 2016, the FASB issued ASU 2016-02 – *Leases (Topic 842)*, which requires a lessee to recognize a right-of-use asset and a lease liability, initially measured at the present value of the lease payments, on its balance sheet. The standard also requires a lessee to recognize a single lease cost, calculated so that the cost of the lease is allocated over the lease term, on a generally straight-line basis. The guidance also expands the required quantitative and qualitative disclosures surrounding leases. The ASU is effective for fiscal years beginning after December 15, 2018, or fiscal year 2020 for the Health System. The Health System is evaluating the impact of the new guidance on the consolidated financial statements.

In January 2016, the FASB issued ASU 2016-01- *Recognition and Measurement of Financial Assets and Financial Liabilities*, which address certain aspects of recognition, measurement, presentation and disclosure of financial instruments. This guidance allows an entity to choose, investment-by-investment, to report an equity investment that neither has a readily determinable fair value, nor qualifies for the practical expedient for fair value estimation using NAV, at its cost minus impairment (if any), plus or minus changes resulting from observable price changes in orderly transactions for the identical or similar investment of the same issue. Impairment of such investments must be assessed qualitatively at each reporting period. Entities must disclose their financial assets and liabilities by measurement category and form of asset either on the face of the balance sheet or in the accompanying notes. The ASU is effective for annual reporting periods beginning after December 15, 2018 or fiscal year 2020 for the Health System. The provision to eliminate the requirement to disclose the fair value of financial instruments measured at cost (such as the fair value of debt) was early adopted during the year ended June 30, 2017.

In August 2016, the FASB issued ASU 2016-14 - *Presentation of Financial Statements for Not-for-Profit Entities*. The new pronouncement amends certain financial reporting requirements for not-for-profit entities. It reduces the number of classes of net assets from three to two: net assets with donor restrictions includes amount previously disclosed as both temporarily and permanently restricted net assets, net assets without donor restrictions includes amounts previously disclosed as unrestricted net assets. It expands the disclosure of expenses by both natural and functional classification. It adds quantitative and qualitative disclosures about liquidity and availability of resources. The ASU is effective for the Health System for the year ending June 30, 2019. The Health System has adopted this ASU on a retrospective basis, except for the presentation of expenses based on natural and functional classification and the discussion of liquidity, as permitted in the ASU. Please refer to Note 14, Functional Expenses, and Note 15, Liquidity.

In June 2018, the FASB issued ASU 2018-08, Not–for-Profit Entities (Topic 958), Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made. The new pronouncement was intended to assist entities in evaluating whether transactions should be accounted for as contributions or exchange transactions and whether a contribution is conditional. This ASU was effective for the Health System on July 1, 2018 on a modified prospective basis and did not have a significant impact on the consolidated financial statements of the Health System.

3. Acquisitions

Effective July 1, 2018, Alice Peck Day Memorial Hospital became the sole corporate member of APD LifeCare Center Inc. (LifeCare). LifeCare owns and operates Harvest Hill, an assisted living facility, the Woodlands, a residential living community and the Elizabeth S. Hughes Care Unit, which provides hospice care.

In accordance with applicable accounting guidance on not-for-profit mergers and acquisitions, Alice Peck Day Memorial Hospital recorded goodwill related to the acquisition of LifeCare of approximately $5,131,000. Restricted contribution income of $383,000 was recorded within net assets with donor restrictions in the accompanying consolidated statement of changes in net assets. Included in the transaction was LifeCare's cash balance of $4,863,000. No consideration was exchanged for the net assets assumed and acquisition costs were expensed as incurred. LifeCare's financial position, results of operations and changes in net assets are included in the consolidated financial statements as of and for the year ended June 30, 2019.

4. Patient Service Revenue and Accounts Receivable

The Health System reports patient service revenue at amounts that reflect the consideration to which it expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payers (including managed care payers and government programs), and others; and they include variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations. Generally, the Health System bills patients and third-party payers several days after the services were performed or shortly after discharge. Revenue is recognized as performance obligations are satisfied under contracts by providing healthcare services to patients.

The Health System determines performance obligations based on the nature of the services provided. Revenues for performance obligations satisfied over time are recognized based on actual charges incurred in relation to total expected charges as this method provides a reasonable estimate of the transfer of services over the term of performance obligations based on inputs needed to satisfy the obligations. Generally, performance obligations satisfied over time relate to patients receiving inpatient acute care services. For inpatient services, performance obligations are measured from admission to the point when there are no further services required for the patient, which is generally the time of discharge. For outpatient services and physician services, performance obligations are recognized at a point in time when the services are provided and no further patient services are deemed necessary.

Generally, the Health System's patient service performance obligations relate to contracts with a duration of less than one year, therefore the Health System has elected to apply the optional exemption provided in ASC 606-10-50-14a and, therefore, we are not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. This generally refers to inpatient services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period.

Established charges represent gross charges. They are not the same as actual pricing, and they generally do not reflect what a hospital is ultimately entitled to for services it provides. Therefore, they are not displayed in the Health System's consolidated statements of operations and changes in net assets.

Hospitals are paid amounts negotiated with insurance companies or set by government entities, which are typically less than established or standard charges. Gross charges are used to calculate Medicare outlier payments and to determine certain elements of payment under managed care contracts. Gross charges are what hospitals charge all patients prior to the application of contractual adjustments and implicit price concessions.

Explicit Pricing Concessions
Revenues for the Health System under the traditional fee-for service Medicare and Medicaid programs are based on prospectively determined rates per discharge or visit, reasonable (allowable) cost, or prospective rates per episodic period, depending on the type of provider.

- Inpatient acute care services provided to Medicare program beneficiaries are paid using the prospective payment system ("PPS") to determine rates-per-discharge. These rates vary according to a patient classification system ("DRG"), based on diagnostic, clinical and other factors. In addition, inpatient capital costs (depreciation and interest) are reimbursed by Medicare on the basis of a prospectively determined rate per discharge. Medicare outpatient services are paid on a prospective payment system, based on a pre-determined amount for each outpatient procedure (APC), subject to various mandated modifications. Retrospectively determined cost-based revenues under these programs, such as indirect medical education, direct graduate medical education, disproportionate share hospital, transplant services, and bad debt reimbursement are based on the hospital's cost reports and are estimated using historical trends and current factors. The Health System's payments for inpatient services rendered to New Hampshire ("NH") and Vermont ("VT") Medicaid beneficiaries are based on PPS, while outpatient services are reimbursed on a retrospective cost basis or fee schedules for NH beneficiaries. VT outpatient beneficiaries are paid on a prospective basis per outpatient procedure.

- Inpatient acute, swing, and outpatient services furnished by critical access hospitals ("CAH") are reimbursed by Medicare at 101% of reasonable costs, subject to 2% sequestration, excluding ambulance services and inpatient hospice care.

- Providers of home health services to patients eligible for Medicare home health benefits are paid on a prospective basis, with no retrospective settlement. The prospective payment is based on the scoring attributed to the acuity level of the patient at a rate determined by federal guidelines.

- Hospice services to patients eligible for Medicare hospice benefits are paid on a per diem basis, with no retrospective settlement, provided the aggregate annual Medicare reimbursement is below a predetermined aggregate capitated rate.

- The Health System's cost based services to Medicare and Medicaid are reimbursed during the year based on varying interim payment methodologies. Final settlement is determined after the submission of an annual cost report and subject to audit of this report by Medicare and Medicaid auditors, as well as administrative and judicial review. Because the laws, regulations, and rule interpretations, governing Medicare and Medicaid reimbursement are complex and change frequently, the estimates recorded could change over time by material amounts.

- Revenues under Managed Care Plans (Plans) consist primarily of payment terms involving mutually agreed upon rates per diagnosis, discounted fee-for service rates, or similar contractual arrangements. These revenues are also subject to review and possible audit. The Plans are billed for patient services on an individual patient basis. An individual patient's bill is subject to adjustments in accordance with contractual terms in place with the Plans following their review and adjudication of each bill.

The Health System is not aware of any claims, disputes, or unsettled matters with any payer that would materially affect its revenues for which it has not adequately provided in the accompanying Health System's consolidated financial statements.

The Health System provides charity care to patients who are unable to pay for healthcare services they receive as determined by financial conditions. Patients who qualify receive partial or full adjustments to charges for services rendered. The Health System's policy is to treat amounts qualified as charity care as explicit price concessions and as such are not reported in net patient service revenue.

During fiscal year 2016, Vermont state legislation passed changes to the tax base for home health providers from 19.30% of core home health care services (primarily Medicaid services) with a cap of 6% of net patient service revenue to 3.63% of net patient revenue for fiscal year 2017 and fiscal year 2018. Home health provider tax paid, which is included in other operating expenses, was $628,000 and $737,000 in 2019 and 2018, respectively.

On June 30, 2014, the NH Governor signed into law a bi-partisan legislation reflecting an agreement between the State of NH and 25 NH hospitals on the Medicaid Enhancement Tax (MET) Senate Bill 369. As part of the agreement, the parties have agreed to resolve all pending litigation related to MET and Medicaid Rates, including the Catholic Medical Center Litigation, the Northeast Rehabilitation Litigation, 2014 DRA Refund Requests, and the State Rate Litigation. As part of the MET Agreement Effective July 1, 2014, a "Trust / Lock Box" dedicated funding mechanism will be established for receipt and distribution of all MET proceeds with all monies used exclusively to support Medicaid services.

On May 22, 2018, the State of New Hampshire and all New Hampshire hospitals (NH Hospitals) signed a new settlement agreement and multi-year plan for Disproportionate Share Hospital (DSH) payments, with provisions to create alternative payments should there be federal changes to the DSH program by the United States Congress. The agreement may change or limit federal matching funds for MET when used to support DSH payments to hospitals and the Medicaid program, or change the definition of Uncompensated Care (UCC) for purposes of calculating DSH or other allowable uncompensated care payments. The term of the agreement is through state fiscal year (SFY) 2024. Under the agreement, the NH Hospitals forgo approximately $28,000,000 of DSH payment for SFY 2018 and 2019, in consideration of the State agreeing to form a pool of funds to make directed payments or otherwise increase rates to hospitals for SFY 2020 through 2024. The Federal share of payments to NH Hospitals are contingent upon the receipt of matching funds from Centers for Medicare & Medicaid Services (CMS) in the covered years. In the event that, due to changes in federal law, the State is unable to make payments in a way that ensures the federal matching funds are available, the Parties will meet and confer to negotiate in good faith an appropriate amendment to this agreement consistent with the intent of this agreement. The State is required to maintain the UCC Dedicated Fund pursuant to earlier agreements. The agreement prioritizes payments of funds to critical access hospitals at 75% of allowable UCC, the remainder thereafter is distributed to other NH Hospitals in proportion to their allowable uncompensated care amounts. During the term of this agreement, the NH Hospitals are barred from bringing a new claim in federal or state court or at Department of Revenue Administration (DRA) related to the constitutionality of MET.

During the years ended June 30, 2019 and 2018, the Health System received DSH payments of approximately, $69,179,000 and $66,383,000, respectively. DSH payments are subject to audit pursuant to the agreement with the state and therefore, for the years ended June 30, 2019 and 2018, the Health System recognized as revenue DSH receipts of approximately $64,864,000 and approximately $54,469,000, respectively.

During the years ended June 30, 2019 and 2018, the Health System recorded State of NH Medicaid Enhancement Tax ("MET") and State of VT Provider tax of $70,061,000 and $67,692,000, respectively. The taxes are calculated at 5.5% for NH and 6% for VT of certain net patient service revenues in accordance with instructions received from the States. The Provider taxes are included in operating expenses in the consolidated statements of operations and changes in net assets.

Implicit Price Concessions

Generally, patients who are covered by third-party payer contracts are responsible for related co-pays, co-insurance and deductibles, which vary depending on the contractual obligations of patients. The Health System also provides services to uninsured patients and offers those patients a discount from standard charges. The Health System estimates the transaction price for patients with co-pays, co-insurance, and deductibles and for those who are uninsured based on historical collection experience and current market conditions. The discount offered to uninsured patients reduces the transaction price at the time of billing. The uninsured and patient responsible accounts, net of discounts recorded, are further reduced through implicit price concessions based on historical collection trends for similar accounts and other known factors that impact the estimation process. Subsequent changes to the estimate of transaction price are generally recorded as adjustments to net patient service revenue in the period of change.

The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amounts the Health System expects to collect based on collection history with similar patients. Although outcomes vary, the Health System's policy is to attempt to collect amounts due from patients, including co-pays, co-insurance and deductibles due from insurance at the time of service while complying with all federal and state statutes and regulations, including but not limited to, the Emergency Medical Treatment and Active Labor Act (EMTALA). Through various systems and processes the Health System estimates Medicare and Medicaid net patient service revenue and cost report settlements and accrues final expected settlements. For filed cost reports, the accrual is recorded based on those filings, subsequent activity, and on historical trends and other relevant evidence. For periods in which a cost report is yet to be filed, accruals are based on estimates of what is expected to be reported, and any trends and relevant evidence. Cost reports generally must be filed within five months of the closing period.

Settlements with third-party payers for retroactive revenue adjustments due to audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care using the most likely amount. These settlements are estimated based on the terms of the payment agreement with the payer, correspondence from the payer and historical settlement activity, including assessments to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known, or as years are settled or are no longer subject to such audits, reviews or investigations. As of June 30, 2019 and 2018, the Health System had $52,470,000 and $52,041,000, respectively, reserved for estimated third-party settlements.

For the years ended June 30, 2019 and 2018, additional increases (decreases) in revenue of $1,800,000 and ($5,604,000), respectively, was recognized due to changes in its prior years related to estimated third-party settlements.

Net operating revenues for the hospital operations of the PPS and CAH, and other business segments consist primarily of patient service revenues, principally for patients covered by Medicare, Medicaid, managed care and other health plans as well as patients covered under the Health System's uninsured discount and charity care programs.

The table below shows the Health System's sources of net operating revenues presented at the net transaction price for the years ended June 30, 2019 and 2018.

	2019		
(in thousands of dollars)	PPS	CAH	Total
Hospital			
Medicare	$ 456,197	$ 72,193	$ 528,390
Medicaid	134,727	12,794	147,521
Commercial	746,647	64,981	811,628
Self pay	8,811	2,313	11,124
	1,346,382	152,281	1,498,663
Professional			
Professional	454,425	23,707	478,132
VNH			22,528
Other revenue			285,715
Total operating revenue and other support	$ 1,800,807	$ 175,988	$ 2,285,038

	2018		
(in thousands of dollars)	PPS	CAH	Total
Hospital			
Medicare	$ 432,251	$ 76,522	$ 508,773
Medicaid	117,019	10,017	127,036
Commercial	677,162	65,916	743,078
Self pay	10,687	2,127	12,814
	1,237,119	154,582	1,391,701
Professional			
Professional	412,605	24,703	437,308
VNH			22,719
Other revenue			203,915
Total operating revenue and other support	$ 1,649,724	$ 179,285	$ 2,055,643

Accounts Receivable

The principal components of patient accounts receivable as of June 30, 2019 and 2018 are as follows:

(in thousands of dollars)	2019	2018
Patient accounts recivable	$ 221,125	$ 351,456
Less: Allowance for doubtful accounts	-	(132,228)
Patient accounts receivable	$ 221,125	$ 219,228

The following table categorizes payors into four groups based on their respective percentages of gross patient accounts receivable as of June 30, 2019 and 2018:

	2019	2018
Medicare	34 %	34 %
Medicaid	12	14
Commercial	41	40
Self pay	13	12
Patient accounts receivable	100 %	100 %

5. Investments

The composition of investments at June 30, 2019 and 2018 is set forth in the following table:

(in thousands of dollars)	2019	2018
Assets limited as to use		
Internally designated by board		
Cash and short-term investments	$ 21,890	$ 8,558
U.S. government securities	91,492	50,484
Domestic corporate debt securities	196,132	109,240
Global debt securities	83,580	110,944
Domestic equities	167,384	142,796
International equities	128,909	106,668
Emerging markets equities	23,086	23,562
Real estate investment trust	213	816
Private equity funds	64,563	50,415
Hedge funds	32,287	32,831
	809,536	636,314
Investments held by captive insurance companies (Note 12)		
U.S. government securities	23,241	30,581
Domestic corporate debt securities	11,378	16,764
Global debt securities	10,080	4,513
Domestic equities	14,617	8,109
International equities	6,766	7,971
	66,082	67,938
Held by trustee under indenture agreement (Note 10)		
Cash and short-term investments	631	1,872
Total assets limited as to use	876,249	706,124
Other investments for restricted activities		
Cash and short-term investments	6,113	4,952
U.S. government securities	32,479	28,220
Domestic corporate debt securities	29,089	29,031
Global debt securities	11,263	14,641
Domestic equities	20,981	20,509
International equities	15,531	17,521
Emerging markets equities	2,578	2,155
Real estate investment trust	-	954
Private equity funds	7,638	4,878
Hedge funds	8,414	8,004
Other	33	31
Total other investments for restricted activities	134,119	130,896
Total investments	$ 1,010,368	$ 837,020

Investments are accounted for using either the fair value method or equity method of accounting, as appropriate on a case by case basis. The fair value method is used for all debt securities and equity securities that are traded on active markets and are valued at prices that are readily available in those markets. The equity method is used when investments are made in pooled/commingled investment funds that represent investments where shares or units are owned of pooled funds rather than the underlying securities in that fund. These pooled/commingled funds make underlying investments in securities from the asset classes listed above. All investments, whether the fair value or equity method of accounting is used, are reported at what the Health System believes to be the amount that the Health System would expect to receive if it liquidated its investments at the balance sheets date on a nondistressed basis.

The following tables summarize the investments by the accounting method utilized, as of June 30, 2019 and 2018. Accounting standards require disclosure of additional information for those securities accounted for using the fair value method, as shown in Note 7.

	2019		
(in thousands of dollars)	**Fair Value**	**Equity**	**Total**
Cash and short-term investments	$ 28,634	$ -	$ 28,634
U.S. government securities	147,212	-	147,212
Domestic corporate debt securities	164,996	71,603	236,599
Global debt securities	55,520	49,403	104,923
Domestic equities	178,720	24,262	202,982
International equities	76,328	74,878	151,206
Emerging markets equities	1,295	24,369	25,664
Real estate investment trust	213	-	213
Private equity funds	-	72,201	72,201
Hedge funds	-	40,701	40,701
Other	33	-	33
	$ 652,951	$ 357,417	$ 1,010,368

	2018		
(in thousands of dollars)	**Fair Value**	**Equity**	**Total**
Cash and short-term investments	$ 15,382	$ -	$ 15,382
U.S. government securities	109,285	-	109,285
Domestic corporate debt securities	95,481	59,554	155,035
Global debt securities	49,104	80,994	130,098
Domestic equities	157,011	14,403	171,414
International equities	60,002	72,158	132,160
Emerging markets equities	1,296	24,421	25,717
Real estate investment trust	222	1,548	1,770
Private equity funds	-	55,293	55,293
Hedge funds	-	40,835	40,835
Other	31	-	31
	$ 487,814	$ 349,206	$ 837,020

Investment income is comprised of the following for the years ended June 30, 2019 and 2018:

(in thousands of dollars)	2019	2018
Net assets without donor restrictions		
Interest and dividend income, net	$ 11,333	$ 12,324
Net realized gains on sales of securities	17,419	24,411
Change in net unrealized gains on investments	12,283	4,612
	41,035	41,347
Net assets with donor restrictions		
Interest and dividend income, net	987	1,526
Net realized gains on sales of securities	2,603	1,438
Change in net unrealized gains on investments	(908)	1,390
	2,682	4,354
	$ 43,717	$ 45,701

For the years ended June 30, 2019 and 2018 investment income is reflected in the accompanying consolidated statements of operations and changes in net assets as operating revenue of approximately $983,000 and $960,000 and as nonoperating gains of approximately $40,052,000 and $40,387,000, respectively.

Private equity limited partnership shares are not eligible for redemption from the fund or general partner, but can be sold to third party buyers in private transactions that typically can be completed in approximately 90 days. It is the intent of the Health System to hold these investments until the fund has fully distributed all proceeds to the limited partners and the term of the partnership agreement expires. Under the terms of these agreements, the Health System has committed to contribute a specified level of capital over a defined period of time. Through June 30, 2019 and 2018, the Health System has committed to contribute approximately $164,319,000 and $137,219,000 to such funds, of which the Health System has contributed approximately $109,584,000 and $91,942,000 and has outstanding commitments of $54,735,000 and $45,277,000, respectively.

6. Property, Plant, and Equipment

Property, plant, and equipment are summarized as follows at June 30, 2019 and 2018:

(in thousands of dollars)	2019	2018
Land	$ 38,232	$ 38,058
Land improvements	42,607	42,295
Buildings and improvements	898,050	876,537
Equipment	888,138	818,902
Equipment under capital leases	15,809	20,966
	1,882,836	1,796,758
Less: Accumulated depreciation and amortization	1,276,746	1,200,549
Total depreciable assets, net	606,090	596,209
Construction in progress	15,166	11,112
	$ 621,256	$ 607,321

As of June 30, 2019, construction in progress primarily consists of an addition to the ambulatory surgical center located in Manchester, NH as well as renovations taking place at the various pharmacy locations to bring their facilities compliant with Regulation USP800. The estimated cost to complete the ambulatory surgical center at June 30, 2019 is approximately $59,000,000 over the next two fiscal years while the pharmacy renovation is estimated to cost approximately $6,300,000 over the next fiscal year.

The construction in progress reported as of June 30, 2018 for the building renovations taking place at the birthing pavilion in Lebanon, NH was completed during the first quarter of fiscal year 2019 and the information systems PeopleSoft project for Alice Peck Day Memorial Hospital and Cheshire was completed in the fourth quarter of fiscal year 2019.

Depreciation and amortization expense included in operating and nonoperating activities was approximately $88,496,000 and $84,729,000 for 2019 and 2018, respectively.

7. Fair Value Measurements

The following is a description of the valuation methodologies for assets and liabilities measured at fair value on a recurring basis:

Cash and Short-Term Investments
Consists of money market funds and are valued at net asset value (NAV) reported by the financial institution.

Domestic, Emerging Markets and International Equities
Consists of actively traded equity securities and mutual funds which are valued at the closing price reported on an active market on which the individual securities are traded (Level 1 measurements).

U.S. Government Securities, Domestic Corporate and Global Debt Securities
Consists of U.S. government securities, domestic corporate and global debt securities, mutual funds and pooled/commingled funds that invest in U.S. government securities, domestic corporate and global debt securities. Securities are valued based on quoted market prices or dealer quotes where available (Level 1 measurement). If quoted market prices are not available, fair values are based on quoted market prices of comparable instruments or, if necessary, matrix pricing from a third party pricing vendor to determine fair value (Level 2 measurements). Matrix prices are based on quoted prices for securities with similar coupons, ratings and maturities, rather than on specific bids and offers for a designated security. Investments in mutual funds are measured based on the quoted NAV as of the close of business in the respective active market (Level 1 measurements).

The preceding methods may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Health System believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

Investments are classified in their entirety based on the lowest level of input that is significant to the fair value measurement. The following tables set forth the consolidated financial assets and liabilities that were accounted for at fair value on a recurring basis as of June 30, 2019 and 2018:

	2019					
(in thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Assets						
Investments						
Cash and short term investments	$ 28,634	$ -	$ -	$ 28,634	Daily	1
U.S. government securities	147,212	-	-	147,212	Daily	1
Domestic corporate debt securities	34,723	130,273	-	164,996	Daily–Monthly	1–15
Global debt securities	28,412	27,108	-	55,520	Daily–Monthly	1–15
Domestic equities	171,318	7,402	-	178,720	Daily–Monthly	1–10
International equities	76,295	33	-	76,328	Daily–Monthly	1–11
Emerging market equities	1,295	-	-	1,295	Daily–Monthly	1–7
Real estate investment trust	213	-	-	213	Daily–Monthly	1–7
Other	-	33	-	33	Not applicable	Not applicable
Total investments	488,102	164,849	-	652,951		
Deferred compensation plan assets						
Cash and short-term investments	2,952	-	-	2,952		
U.S. government securities	45	-	-	45		
Domestic corporate debt securities	4,932	-	-	4,932		
Global debt securities	1,300	-	-	1,300		
Domestic equities	22,403	-	-	22,403		
International equities	3,576	-	-	3,576		
Emerging market equities	27	-	-	27		
Real estate	11	-	-	11		
Multi strategy fund	48,941	-	-	48,941		
Guaranteed contract	-	-	89	89		
Total deferred compensation plan assets	84,187	-	89	84,276	Not applicable	Not applicable
Beneficial interest in trusts	-	-	9,301	9,301	Not applicable	Not applicable
Total assets	$ 572,289	$ 164,849	$ 9,390	$ 746,528		

	2018					
(in thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Assets						
Investments						
Cash and short term investments	$ 15,382	$ -	$ -	$ 15,382	Daily	1
U.S. government securities	109,285	-	-	109,285	Daily	1
Domestic corporate debt securities	41,488	53,993	-	95,481	Daily–Monthly	1–15
Global debt securities	32,874	16,230	-	49,104	Daily–Monthly	1–15
Domestic equities	157,011	-	-	157,011	Daily–Monthly	1–10
International equities	59,924	78	-	60,002	Daily–Monthly	1–11
Emerging market equities	1,296	-	-	1,296	Daily–Monthly	1–7
Real estate investment trust	222	-	-	222	Daily–Monthly	1–7
Other	-	31	-	31	Not applicable	Not applicable
Total investments	417,482	70,332	-	487,814		
Deferred compensation plan assets						
Cash and short-term investments	2,637	-	-	2,637		
U.S. government securities	38	-	-	38		
Domestic corporate debt securities	3,749	-	-	3,749		
Global debt securities	1,089	-	-	1,089		
Domestic equities	18,470	-	-	18,470		
International equities	3,584	-	-	3,584		
Emerging market equities	28	-	-	28		
Real estate	9	-	-	9		
Multi strategy fund	46,680	-	-	46,680		
Guaranteed contract	-	-	86	86		
Total deferred compensation plan assets	76,284	-	86	76,370	Not applicable	Not applicable
Beneficial interest in trusts	-	-	9,374	9,374	Not applicable	Not applicable
Total assets	$ 493,766	$ 70,332	$ 9,460	$ 573,558		

The following table is a rollforward of financial instruments classified by the Health System within Level 3 of the fair value hierarchy defined above.

	2019		
(in thousands of dollars)	Beneficial Interest in Perpetual Trust	Guaranteed Contract	Total
Balances at beginning of year	$ 9,374	$ 86	$ 9,460
Net unrealized gains (losses)	(73)	3	(70)
Balances at end of year	$ 9,301	$ 89	$ 9,390

	2018		
(in thousands of dollars)	Beneficial Interest in Perpetual Trust	Guaranteed Contract	Total
Balances at beginning of year	$ 9,244	$ 83	$ 9,327
Net unrealized gains	130	3	133
Balances at end of year	$ 9,374	$ 86	$ 9,460

There were no transfers into and out of Level 1 and 2 measurements due to changes in valuation methodologies during the years ended June 30, 2019 and 2018.

8. Net Assets With Donor Restrictions

Net assets with donor restrictions are available for the following purposes at June 30, 2019 and 2018:

(in thousands of dollars)	2019	2018
Healthcare services	$ 20,140	$ 19,570
Research	26,496	24,732
Purchase of equipment	3,273	3,068
Charity care	12,494	13,667
Health education	19,833	18,429
Other	3,841	2,973
Investments held in perpetuity	56,383	55,394
	$ 142,460	$ 137,833

Income earned on donor restricted net assets held in perpetuity is available for these purposes.

9. Board Designated and Endowment Funds

Net assets include numerous funds established for a variety of purposes including both donor-restricted endowment funds and funds designated by the Board of Trustees to function as endowments. Net assets associated with endowment funds, including funds designated by the Board of Trustees to function as endowments, are classified and reported based on the existence or absence of donor-imposed restrictions.

The Board of Trustees has interpreted the NH and VT Uniform Prudent Management of Institutional Funds Acts (UPMIFA or Act) for donor-restricted endowment funds as requiring the preservation of the original value of gifts, as of the gift date, to donor-restricted endowment funds, absent explicit donor stipulations to the contrary. The Health System's net assets with donor restrictions which are to be held in perpetuity consist of (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to be held in perpetuity, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund, if any. Collectively these amounts are referred to as the historic dollar value of the fund.

Net assets without donor restrictions include funds designated by the Board of Trustees to function as endowments and the income from certain donor-restricted endowment funds, and any accumulated investment return thereon, which pursuant to donor intent may be expended based on trustee or management designation. Net assets with donor restrictions that are temporary in nature, either restricted by time or purpose, include funds appropriated for expenditure pursuant to endowment and investment spending policies, certain expendable endowment gifts from donors, and any retained income and appreciation on donor-restricted endowment funds, which are restricted by the donor to a specific purpose or by law. When the restrictions on these funds have been met, the funds are reclassified to net assets without donor restrictions.

In accordance with the Act, the Health System considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: the duration and preservation of the fund; the purposes of the donor-restricted endowment fund; general economic conditions; the possible effect of inflation and deflation; the expected total return from income and the appreciation of investments; other resources available; and investment policies.

The Health System has endowment investment and spending policies that attempt to provide a predictable stream of funding for programs supported by its endowment while ensuring that the purchasing power does not decline over time. The Health System targets a diversified asset allocation that places emphasis on investments in domestic and international equities, fixed income, private equity, and hedge fund strategies to achieve its long-term return objectives within prudent risk constraints. The Health System's Investment Committee reviews the policy portfolio asset allocations, exposures, and risk profile on an ongoing basis.

The Health System, as a policy, may appropriate for expenditure or accumulate so much of an endowment fund as the institution determines is prudent for the uses, benefits, purposes, and duration for which the endowment is established, subject to donor intent expressed in the gift instrument and the standard of prudence prescribed by the Act.

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below their original contributed value. Such market losses were not material as of June 30, 2019 and 2018.

Endowment net asset composition by type of fund consists of the following at June 30, 2019 and 2018:

	2019		
(in thousands of dollars)	Without Donor Restrictions	With Donor Restrictions	Total
Donor-restricted endowment funds	$ -	$ 78,268	$ 78,268
Board-designated endowment funds	31,421	-	31,421
Total endowed net assets	$ 31,421	$ 78,268	$ 109,689

	2018		
(in thousands of dollars)	Without Donor Restrictions	With Donor Restrictions	Total
Donor-restricted endowment funds	$ -	$ 78,197	$ 78,197
Board-designated endowment funds	29,506	-	29,506
Total endowed net assets	$ 29,506	$ 78,197	$ 107,703

Changes in endowment net assets for the years ended June 30, 2019 and 2018 are as follows:

	2019		
(in thousands of dollars)	Without Donor Restrictions	With Donor Restrictions	Total
Balances at beginning of year	$ 29,506	$ 78,197	$ 107,703
Net investment return	1,184	2,491	3,675
Contributions	804	1,222	2,026
Transfers	(73)	(1,287)	(1,360)
Release of appropriated funds	-	(2,355)	(2,355)
Balances at end of year	$ 31,421	$ 78,268	$ 109,689

	2018		
(in thousands of dollars)	Without Donor Restrictions	With Donor Restrictions	Total
Balances at beginning of year	$ 26,389	$ 75,457	$ 101,846
Net investment return	3,112	4,246	7,358
Contributions	-	1,121	1,121
Transfers	5	(35)	(30)
Release of appropriated funds	-	(2,592)	(2,592)
Balances at end of year	$ 29,506	$ 78,197	$ 107,703

10. Long-Term Debt

A summary of long-term debt at June 30, 2019 and 2018 is as follows:

(in thousands of dollars)	2019	2018
Variable rate issues		
New Hampshire Health and Education facilities Authority (NHHEFA) revenue bonds		
Series 2018A, principal maturing in varying annual amounts, through August 2037 (1)	$ 83,355	$ 83,355
Fixed rate issues		
New Hampshire Health and Education facilities Authority revenue bonds		
Series 2018B, principal maturing in varying annual amounts, through August 2048 (1)	303,102	303,102
Series 2017A, principal maturing in varying annual amounts, through August 2040 (2)	122,435	122,435
Series 2017B, principal maturing in varying annual amounts, through August 2031 (2)	109,800	109,800
Series 2014A, principal maturing in varying annual amounts, through August 2022 (3)	26,960	26,960
Series 2018C, principal maturing in varying annual amounts, through August 2030 (4)	25,865	-
Series 2012, principal maturing in varying annual amounts, through July 2039 (5)	25,145	25,955
Series 2014B, principal maturing in varying annual amounts, through August 2033 (3)	14,530	14,530
Series 2016B, principal maturing in varying annual amounts, through August 2045 (6)	10,970	10,970
Total variable and fixed rate debt	$ 722,162	$ 697,107

A summary of long-term debt at June 30, 2019 and 2018 is as follows:

(in thousands of dollars)	2019	2018
Other		
Series 2010, principal maturing in varying annual amounts, through August 2040 (7)*	$ -	$ 15,498
Note payable to a financial institution payable in interest free monthly installments through July 2015; collateralized by associated equipment*	445	646
Note payable to a financial institution with entire principal due June 2029 that is collateralized by land and building. The note payable is interest free*	323	380
Mortgage note payable to the US Dept of Agriculture; monthly payments of $10,892 include interest of 2.375% through November 2046*	2,629	2,697
Obligations under capital leases	17,526	18,965
Total other debt	20,923	38,186
Total variable and fixed rate debt	722,162	697,107
Total long-term debt	743,085	735,293
Less: Original issue discounts and premiums, net	(25,542)	(26,862)
Bond issuance costs, net	5,533	5,716
Current portion	10,914	3,464
	$ 752,180	$ 752,975

* Represents nonobligated group bonds

Aggregate annual principal payments required under revenue bond agreements and capital lease obligations for the next five years ending June 30 and thereafter are as follows:

(in thousands of dollars)	
2020	$ 10,914
2021	10,693
2022	10,843
2023	7,980
2024	3,016
Thereafter	699,639
	$ 743,085

Dartmouth-Hitchcock Obligated Group (DHOG) Bonds
MHMH established the DHOG in 1993 for the original purpose of issuing bonds financed through NHHEFA or the "Authority". The members of the obligated group consist of D-HH, MHMH, DHC, Cheshire, NLH, MAHHC, and, effective August 15, 2018, APD. D-HH is designated as the obligated group agent.

Revenue Bonds issued by members of the DHOG are administered through notes registered in the name of the Bond Trustee and in accordance with the terms of a Master Trust Indenture. The Master Trust Indenture contains provisions permitting the addition, withdrawal, or consolidation of members of the DHOG under certain conditions. The notes constitute a joint and several obligation of the members of the DHOG (and any other future members of the DHOG) and are equally and ratably collateralized by a pledge of the members' gross receipts. The DHOG is also subject to certain annual covenants under the Master Trust Indenture, the most restrictive is the Annual Debt Service Coverage Ratio (1.10x).

(1) Series 2018A and Series 2018B Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds, Series 2018A and Series 2018B in February 2018. The Series 2018A Revenue Bonds were primarily used to refund a portion of Series 2015A and Series 2016A. The Series 2018B were primarily used to refund a portion of Series 2015A and Series 2016A, Revolving Line of Credit, Series 2012 Bank Loan and the Series 2015A and Series 2016A Swap terminations. A loss on the extinguishment of debt of approximately $578,000 was recognized in nonoperating gains (losses) on the statement of operations and changes in net assets, as a result of the refinancing. The interest on the Series 2018A Revenue Bonds is variable with a current interest rate of 5.00% and matures in variable amounts through 2037. The interest on the Series 2018B Revenue Bonds is fixed with an interest rate of 4.18% and matures in variable amounts through 2048.

(2) Series 2017A and Series 2017B Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds, Series 2017A and Series 2017B in December, 2017. The Series 2017A Revenue Bonds were primarily used to refund Series 2009 and Series 2010 and the Series 2017B Revenue Bonds were used to refund Series 2012A and Series 2012B. The interest on the Series 2017A Revenue Bonds is fixed with an interest rate of 5.00% and matures in variable amounts through 2040. The interest on the Series 2017B Revenue Bonds is fixed with an interest rate of 2.54% and matures in variable amounts through 2031.

(3) Series 2014A and Series 2014B Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds, Series 2014A and Series 2014B in August 2014. The proceeds from the Series 2014A and 2014B Revenue Bonds were used to partially refund the Series 2009 Revenue Bonds and to cover cost of issuance. Interest on the 2014A Revenue Bonds is fixed with an interest rate of 2.63% and matures at various dates through 2022. Interest on the Series 2014B Revenue Bonds is fixed with an interest rate of 4.00% and matures at various dates through 2033.

(4) Series 2018C Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds, Series 2018C in August, 2018. The Series 2018C Revenue Bonds were used primarily to refinance the Series 2010 Revenue Bonds. The interest on the series 2018C Revenue Bonds is fixed with an interest rate of 3.22% and matures in variable amounts through 2030.

(5) Series 2012 Revenue Bonds

The NHHEFA issued $29,650,000 of tax-exempt Revenue Bonds, Series 2012. The proceeds of these bonds were used to refund 1998 and 2009 Series Bonds, to finance the settlement cost of the interest rate swap, and to finance the purchase of certain equipment and renovations. The bonds have fixed interest coupon rates ranging from 2.0% to 5.0% (a net interest cost of 3.96%), and matures in variable amounts through 2039.

(6) Series 2016B Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds, Series 2016B in July 2016 through a private placement with a financial institution. The Series 2016B Revenue Bonds were used to finance 2016 projects. The Series 2016B is fixed with an interest rate of 1.78% and matures at various dates through 2045.

Outstanding joint and several indebtedness of the DHOG at June 30, 2019 and 2018 approximates $722,162,000 and $697,107,000, respectively.

Non Obligated Group Bonds
(1) Series 2010 Revenue Bonds

The Business Finance Authority (BFA) of the State of NH issued Revenue Bonds, Series 2010. Interest is based on an annual percentage rate equal to the sum of (a) 69% of the 1-Month LIBOR rate plus (b) 1.8975/5. The Health System redeemed these bonds in August 2018.

The Health System Indenture agreements require establishment and maintenance of debt service reserves and other trustee held funds. Trustee held funds of approximately $631,000 and $1,872,000 at June 30, 2019 and 2018, respectively, are classified as assets limited as to use in the accompanying consolidated balance sheets (Note 5). The debt service reserves are mainly comprised of escrowed funds held for future principal and interest payments.

For the years ended June 30, 2019 and 2018 interest expense on the Health System's long term debt is reflected in the accompanying consolidated statements of operations and changes in net assets as operating expense of approximately $25,514,000 and $18,822,000 and other nonoperating losses of $3,784,000 and $2,793,000, respectively.

Swap Agreements
The Health System is subject to market risks such as changes in interest rates that arise from normal business operation. The Health System regularly assesses these risks and has established business strategies to provide natural offsets, supplemented by the use of derivative financial instruments to protect against the adverse effect of these and other market risks. The Health System has established clear policies, procedures, and internal controls governing the use of derivatives and does not use them for trading, investment, or other speculative purposes.

As of June 30, 2019 and 2018, there was no liability for interest rate swaps as all remaining swaps were terminated in February 2018. For the year ended June 30, 2018, the Health System recognized a nonoperating loss due to swap termination of $14,247,000 relating to the swap termination. The change in fair value during the year ended June 30, 2018 was a decrease of $4,897,000. For the year ended June 30, 2018 the Health System recognized a nonoperating gain of $145,000 resulting from hedge ineffectiveness and amortization of frozen swaps.

11. Employee Benefits

All eligible employees of the Health System are covered under various defined benefit and/or define contribution plans. In addition, certain members provide postretirement medical and life benefit plans to certain of its active and former employees who meet eligibility requirements. The postretirement medical and life plans are not funded.

All of the defined benefit plans within the Health System have been frozen and therefore there are no remaining participants earning benefits in any of the Health System's defined benefit plans.

The Health System continued to execute the settlement of obligations due to retirees in the defined benefit plans through bulk lump sum offerings or purchases of annuity contracts. The annuity purchases follow guidelines established by the Department of Labor (DOL). The Health System anticipates continued consideration and/or implementation of additional settlements over the next several years.

Defined Benefit Plans

Net periodic pension expense included in employee benefits in the consolidated statements of operations and changes in net assets is comprised of the components listed below for the years ended June 30, 2019 and 2018:

(in thousands of dollars)	2019	2018
Service cost for benefits earned during the year	$ 150	$ 150
Interest cost on projected benefit obligation	47,814	47,190
Expected return on plan assets	(65,270)	(64,561)
Net loss amortization	10,357	10,593
Total net periodic pension expense	$ (6,949)	$ (6,628)

The following assumptions were used to determine net periodic pension expense as of June 30, 2019 and 2018:

	2019	2018
Discount rate	3.90 % – 4.60%	4.00 % – 4.30 %
Rate of increase in compensation	N/A	N/A
Expected long-term rate of return on plan assets	7.50%	7.50 % – 7.75 %

The following table sets forth the funded status and amounts recognized in the Health System's consolidated financial statements for the defined benefit pension plans at June 30, 2019 and 2018:

(in thousands of dollars)	2019	2018
Change in benefit obligation		
Benefit obligation at beginning of year	$ 1,087,940	$ 1,122,615
Service cost	150	150
Interest cost	47,814	47,190
Benefits paid	(51,263)	(47,550)
Expenses paid	(170)	(172)
Actuarial (gain) loss	93,358	(34,293)
Settlements	(42,306)	-
Benefit obligation at end of year	1,135,523	1,087,940
Change in plan assets		
Fair value of plan assets at beginning of year	884,983	878,701
Actual return on plan assets	85,842	33,291
Benefits paid	(51,263)	(47,550)
Expenses paid	(170)	(172)
Employer contributions	20,631	20,713
Settlements	(42,306)	-
Fair value of plan assets at end of year	897,717	884,983
Funded status of the plans	(237,806)	(202,957)
Less: Current portion of liability for pension	(46)	(45)
Long term portion of liability for pension	(237,760)	(202,912)
Liability for pension	$ (237,760)	$ (202,912)

As of June 30, 2019 and 2018 the liability, for pension is included in the liability for pension and other postretirement plan benefits in the accompanying consolidated balance sheets.

Amounts not yet reflected in net periodic pension expense and included in the change in net assets without donor restrictions include approximately $478,394,000 and $418,971,000 of net actuarial loss as of June 30, 2019 and 2018, respectively.

The estimated amounts to be amortized from net assets without donor restrictions into net periodic pension expense in fiscal year 2020 for net actuarial losses is $12,032,000.

The accumulated benefit obligation for the defined benefit pension plans was approximately $1,135,770,000 and $1,087,991,000 at June 30, 2019 and 2018, respectively.

The following table sets forth the assumptions used to determine the benefit obligation at June 30, 2019 and 2018:

	2019	2018
Discount rate	4.20% - 4.50%	4.20 % – 4.50 %
Rate of increase in compensation	N/A	N/A

The primary investment objective for the Plan's assets is to support the Pension liabilities of the Pension Plans for Employees of the Health System, by providing long-term capital appreciation and by also using a Liability Driven Investing ("LDI") strategy to partially hedge the impact fluctuating interest rates have on the value of the Plan's liabilities. As of both June 30, 2019 and 2018, it is expected that the LDI strategy will hedge approximately 60% of the interest rate risk associated with pension liabilities. To achieve the appreciation and hedging objectives, the Plans utilize a diversified structure of asset classes designed to achieve stated performance objectives measured on a total return basis, which includes income plus realized and unrealized gains and losses.

The range of target allocation percentages and the target allocations for the various investments are as follows:

	Range of Target Allocations	Target Allocations
Cash and short-term investments	0–5%	3 %
U.S. government securities	0–10	5
Domestic debt securities	20–58	38
Global debt securities	6–26	8
Domestic equities	5–35	19
International equities	5–15	11
Emerging market equities	3–13	5
Real estate investment trust funds	0–5	0
Private equity funds	0–5	0
Hedge funds	5–18	11

To the extent an asset class falls outside of its target range on a quarterly basis, the Health System shall determine appropriate steps, as it deems necessary, to rebalance the asset class.

The Boards of Trustees of the Health System, as Plan Sponsors, oversee the design, structure, and prudent professional management of the Health System's Plans' assets, in accordance with Board approved investment policies, roles, responsibilities and authorities and more specifically the following:

- Establishing and modifying asset class targets with Board approved policy ranges,
- Approving the asset class rebalancing procedures,
- Hiring and terminating investment managers, and
- Monitoring performance of the investment managers, custodians and investment consultants.

The hierarchy and inputs to valuation techniques to measure fair value of the Plans' assets are the same as outlined in Note 7. In addition, the estimation of fair value of investments in private equity and hedge funds for which the underlying securities do not have a readily determinable value is made using the NAV per share or its equivalent as a practical expedient. The Health System's Plans own interests in these funds rather than in securities underlying each fund and, therefore, are generally required to consider such investments as Level 2 or 3, even though the underlying securities may not be difficult to value or may be readily marketable.

The following table sets forth the Health System's Plans' investments and deferred compensation plan assets that were accounted for at fair value as of June 30, 2019 and 2018:

	2019					
(in thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Investments						
Cash and short-term investments	$ 166	$ 18,232	$ -	$ 18,398	Daily	1
U.S. government securities	48,580	-	-	48,580	Daily–Monthly	1–15
Domestic debt securities	122,178	273,424	-	395,602	Daily–Monthly	1–15
Global debt securities	428	75,146	-	75,574	Daily–Monthly	1–15
Domestic equities	159,259	18,316	-	177,575	Daily–Monthly	1–10
International equities	17,232	77,146	-	94,378	Daily–Monthly	1–11
Emerging market equities	321	39,902	-	40,223	Daily–Monthly	1–17
REIT funds	357	2,883	-	3,240	Daily–Monthly	1–17
Private equity funds	-	-	21	21	See Note 7	See Note 7
Hedge funds	-	-	44,126	44,126	Quarterly–Annual	60–96
Total investments	$ 348,521	$ 505,049	$ 44,147	$ 897,717		

	2018					
(in thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Investments						
Cash and short-term investments	$ 142	$ 35,817	$ -	$ 35,959	Daily	1
U.S. government securities	46,265	-	-	46,265	Daily–Monthly	1–15
Domestic debt securities	144,131	220,202	-	364,333	Daily–Monthly	1–15
Global debt securities	470	74,676	-	75,146	Daily–Monthly	1–15
Domestic equities	158,634	17,594	-	176,228	Daily–Monthly	1–10
International equities	18,656	80,803	-	99,459	Daily–Monthly	1–11
Emerging market equities	382	39,881	-	40,263	Daily–Monthly	1–17
REIT funds	371	2,686	-	3,057	Daily–Monthly	1–17
Private equity funds	-	-	23	23	See Note 7	See Note 7
Hedge funds	-	-	44,250	44,250	Quarterly–Annual	60–96
Total investments	$ 369,051	$ 471,659	$ 44,273	$ 884,983		

The following table presents additional information about the changes in Level 3 assets measured at fair value for the years ended June 30, 2019 and 2018:

	2019		
(in thousands of dollars)	Hedge Funds	Private Equity Funds	Total
Balances at beginning of year	$ 44,250	$ 23	$ 44,273
Net unrealized losses	(124)	(2)	(126)
Balances at end of year	$ 44,126	$ 21	$ 44,147

	2018		
(in thousands of dollars)	Hedge Funds	Private Equity Funds	Total
Balances at beginning of year	$ 40,507	$ 96	$ 40,603
Sales	-	(51)	(51)
Net realized losses	-	(51)	(51)
Net unrealized gains	3,743	29	3,772
Balances at end of year	$ 44,250	$ 23	$ 44,273

The total aggregate net unrealized gains (losses) included in the fair value of the Level 3 investments as of June 30, 2019 and 2018 were approximately $14,617,000 and $14,743,000, respectively. There were no transfers into and out of Level 3 measurements during the years ended June 30, 2019 and 2018.

There were no transfers into and out of Level 1 and 2 measurements due to changes in valuation methodologies during the years ended June 30, 2019 and 2018.

The weighted average asset allocation for the Health System's Plans at June 30, 2019 and 2018 by asset category is as follows:

	2019	2018
Cash and short-term investments	2 %	4 %
U.S. government securities	5	5
Domestic debt securities	44	41
Global debt securities	9	9
Domestic equities	20	20
International equities	11	11
Emerging market equities	4	5
Hedge funds	5	5
	100 %	100 %

The expected long-term rate of return on plan assets is reviewed annually, taking into consideration the asset allocation, historical returns on the types of assets held, and the current economic environment. Based on these factors, it is expected that the pension assets will earn an average of 7.50% per annum.

The Health System is expected to contribute approximately $20,426,000 to the Plans in 2020 however actual contributions may vary from expected amounts.

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid for the years ending June 30 and thereafter:

(in thousands of dollars)

2020	$ 50,743
2021	52,938
2022	55,199
2023	57,562
2024	59,843
2025 – 2028	326,737

Defined Contribution Plans
The Health System has an employer-sponsored 401(a) plan for certain of its members, under which the employer makes base, transition and discretionary match contributions based on specified percentages of compensation and employee deferral amounts. Total employer contributions to the plan of approximately $40,537,000 and $38,563,000 in 2019 and 2018, respectively, are included in employee benefits in the accompanying consolidated statements of operations and changes in net assets.

Various 403(b) and tax- sheltered annuity plans are available to employees of the Health System. Plan specifications vary by member and plan. No employer contributions were made to any of these plans in 2019 and 2018, respectively.

Postretirement Medical and Life Benefits
The Health System has postretirement medical and life benefit plans covering certain of its active and former employees. The plans generally provide medical or medical and life insurance benefits to certain retired employees who meet eligibility requirements. The plans are not funded.

Net periodic postretirement medical and life benefit (income) cost is comprised of the components listed below for the years ended June 30, 2019 and 2018:

(in thousands of dollars)	2019	2018
Service cost	$ 384	$ 533
Interest cost	1,842	1,712
Net prior service income	(5,974)	(5,974)
Net loss amortization	10	10
	$ (3,738)	$ (3,719)

The following table sets forth the accumulated postretirement medical and life benefit obligation and amounts recognized in the Health System's consolidated financial statements at June 30, 2019 and 2018:

(in thousands of dollars)	2019	2018
Change in benefit obligation		
Benefit obligation at beginning of year	$ 42,581	$ 42,277
Service cost	384	533
Interest cost	1,842	1,712
Benefits paid	(3,149)	(3,174)
Actuarial loss	5,013	1,233
Employer contributions	-	-
Benefit obligation at end of year	46,671	42,581
Funded status of the plans	$ (46,671)	$ (42,581)
Current portion of liability for postretirement medical and life benefits	$ (3,422)	$ (3,266)
Long term portion of liability for postretirement medical and life benefits	(43,249)	(39,315)
Liability for postretirement medical and life benefits	$ (46,671)	$ (42,581)

As of June 30, 2019 and 2018, the liability for postretirement medical and life benefits is included in the liability for pension and other postretirement plan benefits in the accompanying consolidated balance sheets.

Amounts not yet reflected in net periodic postretirement medical and life benefit income and included in the change in net assets without donor restrictions are as follows:

(in thousands of dollars)	2019	2018
Net prior service income	$ (9,556)	$ (15,530)
Net actuarial loss	8,386	3,336
	$ (1,170)	$ (12,194)

The estimated amounts that will be amortized from net assets without donor restrictions into net periodic postretirement income in fiscal year 2020 for net prior service cost is $5,974,000.

The following future benefit payments, which reflect expected future service, as appropriate, are expected to be paid for the year ending June 30, 2020 and thereafter:

(in thousands of dollars)	
2020	$ 3,468
2021	3,436
2022	3,394
2023	3,802
2024	3,811
2025-2028	17,253

In determining the accumulated postretirement medical and life benefit obligation, the Health System used a discount rate of 3.70% in 2019 and an assumed healthcare cost trend rate of 6.50%, trending down to 5.00% in 2024 and thereafter. Increasing the assumed healthcare cost trend rates by one percentage point in each year would increase the accumulated postretirement medical benefit obligation as of June 30, 2019 and 2018 by $1,601,000 and $1,088,000 and the net periodic postretirement medical benefit cost for the years then ended by $77,000 and $81,000, respectively. Decreasing the assumed healthcare cost trend rates by one percentage point in each year would decrease the accumulated postretirement medical benefit obligation as of June 30, 2019 and 2018 by $1,452,000 and $996,000 and the net periodic postretirement medical benefit cost for the years then ended by $71,000 and $72,000, respectively.

12. Professional and General Liability Insurance Coverage

Mary Hitchcock Memorial Hospital and Dartmouth-Hitchcock Clinic, along with Dartmouth College, Cheshire Medical Center, The New London Hospital Association, Mt. Ascutney Hospital and Health Center, and the Visiting Nurse and Hospice for VT and NH are provided professional and general liability insurance on a claims-made basis through Hamden Assurance Risk Retention Group, Inc. (RRG), a VT captive insurance company. Effective November 1, 2018 Alice Peck Day Memorial Hospital is provided professional and general liability insurance coverage through RRG. RRG reinsures the majority of this risk to Hamden Assurance Company Limited (HAC), a captive insurance company domiciled in Bermuda and to a variety of commercial reinsurers. Mary Hitchcock Memorial Hospital, Dartmouth-Hitchcock Clinic, and Dartmouth College have ownership interests in both HAC and RRG. The insurance program provides coverage to the covered institutions and named insureds on a modified claims-made basis which means coverage is triggered when claims are made. Premiums and related insurance deposits are actuarially determined based on asserted liability claims adjusted for future development. The reserves for outstanding losses are recorded on an undiscounted basis.

Selected financial data of HAC and RRG, taken from the latest available financial statements at June 30, 2019 and 2018, are summarized as follows:

	2019		
(in thousands of dollars)	HAC	RRG	Total
Assets	$ 75,867	$ 2,201	$ 78,068
Shareholders' equity	13,620	50	13,670

	2018		
(in thousands of dollars)	HAC	RRG	Total
Assets	$ 72,753	$ 2,068	$ 74,821
Shareholders' equity	13,620	50	13,670

13. Commitments and Contingencies

Litigation
The Health System is involved in various malpractice claims and legal proceedings of a nature considered normal to its business. The claims are in various stages and some may ultimately be brought to trial. While it is not feasible to predict or determine the outcome of any of these claims, it is the opinion of management that the final outcome of these claims will not have a material effect on the consolidated financial position of the Health System.

Operating Leases and Other Commitments
The Health System leases certain facilities and equipment under operating leases with varying expiration dates. The Health System's rental expense totaled approximately $12,707,000 and $14,096,000 for the years ended June 30, 2019 and 2018, respectively.

Minimum future lease payments under noncancelable operating leases at June 30, 2019 were as follows:

(in thousands of dollars)

2020	$ 11,342
2021	10,469
2022	7,488
2023	6,303
2024	4,127
Thereafter	5,752
	$ 45,481

Lines of Credit

The Health System has entered into Loan Agreements with financial institutions establishing access to revolving loans ranging from $2,000,000 up to $30,000,000. Interest is variable and determined using LIBOR or the Wall Street Journal Prime Rate. The Loan Agreements are due to expire March 27, 2020. There was no outstanding balance under the lines of credit as of June 30, 2019 and 2018. Interest expense was approximately $95,000 and $232,000, respectively, and is included in the consolidated statements of operations and changes in net assets.

14. Functional Expenses

Operating expenses are presented by functional classification in accordance with the overall service missions of the Health System. Each functional classification displays all expenses related to the underlying operations by natural classification. Salaries, employee benefits, medical supplies and medications, and purchased services and other expenses are generally considered variable and are allocated to the mission that best aligns to the type of service provided. Medicaid enhancement tax is allocated to program services. Interest expense is allocated based on usage of debt-financed space. Depreciation and amortization is allocated based on square footage and specific identification of equipment used by department.

Operating expenses of the Health System by functional and natural basis are as follows for the year ended June 30, 2019:

	2019			
(in thousands of dollars)	Program Services	Management and General	Fundraising	Total
Operating expenses				
Salaries	$ 922,902	$ 138,123	$ 1,526	$ 1,062,551
Employee benefits	178,983	72,289	319	251,591
Medical supplies and medications	406,782	1,093	-	407,875
Purchased services and other	212,209	108,783	2,443	323,435
Medicaid enhancement tax	70,061	-	-	70,061
Depreciation and amortization	37,528	50,785	101	88,414
Interest	3,360	22,135	19	25,514
Total operating expenses	$ 1,831,825	$ 393,208	$ 4,408	$ 2,229,441

Operating expenses of the Health System by functional classification are as follows for the year ended June 30, 2018:

(in thousands of dollars)

Program services	$ 1,715,760
Management and general	303,527
Fundraising	2,354
	$ 2,021,641

15. Liquidity

The Health System is substantially supported by cash generated from operations. In addition, the Health System holds financial assets for specific purposes which are limited as to use. Thus, certain financial assets reported on the accompanying consolidated balance sheet may not be available for general expenditure within one year of the balance sheet date.

The Health System's financial assets available at June 30, 2019 to meet cash needs for general expenditures within one year of June 30, 2019 are as follows:

(in thousands of dollars)

Cash and cash equivalents	$ 143,587
Patient accounts receivable	221,125
Assets limited as to use	876,249
Other investments for restricted activities	134,119
Total financial assets	1,375,080
Less: Those unavailable for general expenditure within one year:	
Investments held by captive insurance companies	66,082
Investments for restricted activities	134,119
Other investments with liquidity horizons greater than one year	97,063
Total financial assets available within one year	$ 1,077,816

For the years ending June 30, 2019 and June 30, 2018, the Health System generated positive cash flow from operations of approximately $161,853,000 and $136,031,000, respectively. In addition, the Health System's liquidity management plan includes investing excess daily cash in intermediate or long term investments based on anticipated liquidity needs. The Health System has an available line of credit of up to $30,000,000 which it can draw upon as needed to meet its liquidity needs. See Note 13 for further details on the line of credit.

16. Subsequent Events

The Health System has assessed the impact of subsequent events through November 26, 2019, the date the audited consolidated financial statements were issued, and has concluded that there were no such events that require adjustment to the audited consolidated financial statements or disclosure in the notes to the audited consolidated financial statements other than as noted below.

Effective September 30, 2019, the Boards of Trustees of D-HH, GraniteOne Health, Catholic Medical Center Health Services, and their respective member organizations approved a Combination Agreement to combine their healthcare systems. If regulatory approval of the

transaction is obtained, the name of the new system will be Dartmouth-Hitchcock Health GraniteOne.

The GraniteOne Health system is comprised of Catholic Medical Center (CMC), a community hospital located in Manchester NH, Huggins Hospital located in Wolfeboro NH, and Monadnock Community Hospital located in Peterborough NH. Both Huggins Hospital and Monadnock Community Hospital are designated as Critical Access Hospitals. GraniteOne is a non-profit, community based health care system.

On September 13, 2019, the Board of Trustees of D-HH approved the issuance of up to $100,000,000 par of new debt. On October 17, 2019, D-HH closed on the direct placement tax-exempt borrowing of $99,165,000 on behalf of the DHOG acting through the New Hampshire Health and Education Facilities Authority and issued its DHOG Issue, Series 2019A Bonds.

On January 29, 2020, D-HH closed on a tax-exempt borrowing of $125,000,000 on behalf of the DHOG acting through the New Hampshire Health and Education Facilities Authority and issued its DHOG Issue, Series 2020A Bonds.

17. Subsequent Events - Unaudited

Subsequent to the issuance of the audited financial statements on November 26, 2019, the novel strain of coronavirus emerged and in January 2020 the World Health Organization has declared the novel coronavirus a Public Health Emergency of International Concern. Beginning in March 2020, the State of New Hampshire and Vermont have adopted various measures to address the spread of this pandemic, including supporting social distancing, requests to stay home unless necessary (i.e., groceries or medications) and work from home recommendations. Such restrictions and the perception that such orders or restrictions could occur, have resulted in business closures, work stoppages, slowdowns and delays, work-from-home policies, travel restrictions and cancellation of events, including the rescheduling of elective or non-critical procedures (which management believes is temporary and such procedures will be performed at a later date) and redeployment of resources to address the novel coronavirus needs, among other effects. The outbreak has also negatively impacted the financial markets and has and may continue to materially affect the returns on and value of our investments. While we expect that the novel coronavirus may negatively impact our 2020 results, we believe we have sufficient liquidity to meet our operating and financing needs; however, given the difficulty in predicting the ultimate duration and severity of the impact of the novel coronavirus on our organization, the economy and the financial markets, the ultimate impact may be material.

Consolidating Supplemental Information – Unaudited

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2019

(in thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	Alice Peck Day Memorial	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Assets											
Current assets											
Cash and cash equivalents	$ 42,456	$ 47,465	$ 9,411	$ 7,066	$ 10,462	$ 8,372	$ -	$ 125,232	$ 18,355	$ -	$ 143,587
Patient accounts receivable, net	-	180,938	15,880	7,279	8,960	5,010	-	218,067	3,058	-	221,125
Prepaid expenses and other current assets	14,178	139,034	8,563	2,401	5,567	1,423	(74,083)	97,083	1,421	(3,009)	95,495
Total current assets	56,634	367,437	33,854	16,746	24,989	14,805	(74,083)	440,382	22,834	(3,009)	460,207
Assets limited as to use	92,602	688,485	18,759	12,684	12,427	11,619	-	836,576	39,673	-	876,249
Notes receivable, related party	553,484	752	-	1,406	-	-	(554,236)	1,406	(1,406)	-	-
Other investments for restricted activities	-	91,882	6,970	31	2,973	6,323	-	108,179	25,940	-	134,119
Property, plant, and equipment, net	22	432,277	67,147	30,945	41,946	17,797	-	590,134	31,122	-	621,256
Other assets	24,864	108,208	1,279	15,019	6,042	4,388	(10,970)	148,830	(3,013)	(21,346)	124,471
Total assets	$ 727,606	$ 1,689,041	$ 128,009	$ 76,831	$ 88,377	$ 54,932	$ (639,289)	$ 2,125,507	$ 115,150	$ (24,355)	$ 2,216,302
Liabilities and Net Assets											
Current liabilities											
Current portion of long-term debt	$ -	$ 8,226	$ 830	$ 954	$ 547	$ 262	$ -	$ 10,819	$ 95	$ -	$ 10,914
Current portion of liability for pension and other postretirement plan benefits	-	3,468	-	-	-	-	-	3,468	-	-	3,468
Accounts payable and accrued expenses	55,499	99,884	15,620	6,299	3,878	2,776	(74,083)	109,873	6,953	(3,009)	113,817
Accrued compensation and related benefits	-	110,639	5,851	3,694	2,313	4,270	-	126,767	1,641	-	128,408
Estimated third-party settlements	-	26,405	103	1,290	10,851	2,921	-	41,570	-	-	41,570
Total current liabilities	55,499	248,622	22,404	12,237	17,589	10,229	(74,083)	292,497	8,689	(3,009)	298,177
Notes payable, related party	-	526,202	-	-	28,034	-	(554,236)	-	-	-	-
Long-term debt, excluding current portion	643,257	44,820	24,503	35,604	643	11,465	(10,970)	749,322	2,858	-	752,180
Insurance deposits and related liabilities	-	56,786	440	513	388	240	-	58,367	40	-	58,407
Liability for pension and other postretirement plan benefits, excluding current portion	-	266,427	10,262	-	-	4,320	-	281,009	-	-	281,009
Other liabilities	-	98,201	1,104	28	1,585	-	-	100,918	23,218	-	124,136
Total liabilities	698,756	1,241,058	58,713	48,382	48,239	26,254	(639,289)	1,482,113	34,805	(3,009)	1,513,909
Commitments and contingencies											
Net assets											
Net assets without donor restrictions	28,832	356,880	63,051	27,653	35,518	21,242	-	533,176	48,063	(21,306)	559,933
Net assets with donor restrictions	18	91,103	6,245	796	4,620	7,436	-	110,218	32,282	(40)	142,460
Total net assets	28,850	447,983	69,296	28,449	40,138	28,678	-	643,394	80,345	(21,346)	702,393
Total liabilities and net assets	$ 727,606	$ 1,689,041	$ 128,009	$ 76,831	$ 88,377	$ 54,932	$ (639,289)	$ 2,125,507	$ 115,150	$ (24,355)	$ 2,216,302

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2019

(in thousands of dollars)	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD and Subsidiaries	VNH and Subsidiaries	Eliminations	Health System Consolidated
Assets									
Current assets									
Cash and cash equivalents	$ 42,456	$ 48,052	$ 11,952	$ 11,120	$ 8,549	$ 15,772	$ 5,686	$ -	$ 143,587
Patient accounts receivable, net	-	180,938	15,880	8,960	5,060	7,280	3,007	-	221,125
Prepaid expenses and other current assets	14,178	139,832	9,460	5,567	1,401	1,678	471	(77,092)	95,495
Total current assets	56,634	368,822	37,292	25,647	15,010	24,730	9,164	(77,092)	460,207
Assets limited as to use	92,602	707,597	17,383	12,427	12,738	12,685	20,817	-	876,249
Notes receivable, related party	553,484	752	-	-	-	-	-	(554,236)	-
Other investments for restricted activities	-	99,807	24,985	2,973	6,323	31	-	-	134,119
Property, plant, and equipment, net	22	434,953	70,846	42,423	19,435	50,338	3,239	-	621,256
Other assets	24,864	108,366	7,388	5,476	1,931	8,688	74	(32,316)	124,471
Total assets	$ 727,606	$ 1,720,297	$ 157,894	$ 88,946	$ 55,437	$ 96,472	$ 33,294	$ (663,644)	$ 2,216,302
Liabilities and Net Assets									
Current liabilities									
Current portion of long-term debt	$ -	$ 8,226	$ 830	$ 547	$ 288	$ 954	$ 69	$ -	$ 10,914
Current portion of liability for pension and other postretirement plan benefits	-	3,468	-	-	-	-	-	-	3,468
Accounts payable and accrued expenses	55,499	100,441	19,356	3,879	2,856	6,704	2,174	(77,092)	113,817
Accrued compensation and related benefits	-	110,639	5,851	2,313	4,314	4,192	1,099	-	128,408
Estimated third-party settlements	-	26,405	103	10,851	2,921	1,290	-	-	41,570
Total current liabilities	55,499	249,179	26,140	17,590	10,379	13,140	3,342	(77,092)	298,177
Notes payable, related party	-	526,202	-	28,034	-	-	-	(554,236)	-
Long-term debt, excluding current portion	643,257	44,820	24,503	643	11,763	35,604	2,560	(10,970)	752,180
Insurance deposits and related liabilities	-	56,786	440	388	240	513	40	-	58,407
Liability for pension and other postretirement plan benefits, excluding current portion	-	266,427	10,262	-	4,320	-	-	-	281,009
Other liabilities	-	98,201	1,115	1,585	-	23,235	-	-	124,136
Total liabilities	698,756	1,241,615	62,460	48,240	26,702	72,492	5,942	(642,298)	1,513,909
Commitments and contingencies									
Net assets									
Net assets without donor restrictions	28,832	379,498	65,873	36,087	21,300	22,327	27,322	(21,306)	559,933
Net assets with donor restrictions	18	99,184	29,561	4,619	7,435	1,653	30	(40)	142,460
Total net assets	28,850	478,682	95,434	40,706	28,735	23,980	27,352	(21,346)	702,393
Total liabilities and net assets	$ 727,606	$ 1,720,297	$ 157,894	$ 88,946	$ 55,437	$ 96,472	$ 33,294	$ (663,644)	$ 2,216,302

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2018

(in thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Assets										
Current assets										
Cash and cash equivalents	$ 134,634	$ 22,544	$ 6,688	$ 9,419	$ 6,604	$ -	$ 179,889	$ 20,280	$ -	$ 200,169
Patient accounts receivable, net	-	176,981	17,183	8,302	5,055	-	207,521	11,707	-	219,228
Prepaid expenses and other current assets	11,964	143,893	6,551	5,253	2,313	(72,361)	97,613	4,766	(4,877)	97,502
Total current assets	146,598	343,418	30,422	22,974	13,972	(72,361)	485,023	36,753	(4,877)	516,899
Assets limited as to use	8	616,929	17,438	12,821	10,829	-	658,025	48,099	-	706,124
Notes receivable, related party	554,771	-	-	-	-	(554,771)	-	-	-	-
Other investments for restricted activities	-	87,613	8,591	2,981	6,238	-	105,423	25,473	-	130,896
Property, plant, and equipment, net	36	443,154	66,759	42,438	17,356	-	569,743	37,578	-	607,321
Other assets	24,863	101,078	1,370	5,906	4,280	(10,970)	126,527	3,604	(21,346)	108,785
Total assets	$ 726,276	$ 1,592,192	$ 124,580	$ 87,120	$ 52,675	$ (638,102)	$ 1,944,741	$ 151,507	$ (26,223)	$ 2,070,025
Liabilities and Net Assets										
Current liabilities										
Current portion of long-term debt	$ -	$ 1,031	$ 810	$ 572	$ 187	$ -	$ 2,600	$ 864	$ -	$ 3,464
Current portion of liability for pension and other postretirement plan benefits	-	3,311	-	-	-	-	3,311	-	-	3,311
Accounts payable and accrued expenses	54,995	82,061	20,107	6,705	3,029	(72,361)	94,536	6,094	(4,877)	95,753
Accrued compensation and related benefits	-	106,485	5,730	2,487	3,796	-	118,498	7,078	-	125,576
Estimated third-party settlements	3,002	24,411	-	9,655	1,625	-	38,693	2,448	-	41,141
Total current liabilities	57,997	217,299	26,647	19,419	8,637	(72,361)	257,638	16,484	(4,877)	269,245
Notes payable, related party	-	527,346	-	27,425	-	(554,771)	-	-	-	-
Long-term debt, excluding current portion	644,520	52,878	25,354	1,179	11,270	(10,970)	724,231	28,744	-	752,975
Insurance deposits and related liabilities	-	54,616	465	155	240	-	55,476	40	-	55,516
Liability for pension and other postretirement plan benefits, excluding current portion	-	232,696	4,215	-	5,316	-	242,227	-	-	242,227
Other liabilities	-	85,577	1,107	1,405	-	-	88,089	38	-	88,127
Total liabilities	702,517	1,170,412	57,788	49,583	25,463	(638,102)	1,367,661	45,306	(4,877)	1,408,090
Commitments and contingencies										
Net assets										
Net assets without donor restrictions	23,759	334,882	61,828	32,897	19,812	-	473,178	72,230	(21,306)	524,102
Net assets with donor restrictions	-	86,898	4,964	4,640	7,400	-	103,902	33,971	(40)	137,833
Total net assets	23,759	421,780	66,792	37,537	27,212	-	577,080	106,201	(21,346)	661,935
Total liabilities and net assets	$ 726,276	$ 1,592,192	$ 124,580	$ 87,120	$ 52,675	$ (638,102)	$ 1,944,741	$ 151,507	$ (26,223)	$ 2,070,025

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2018

(in thousands of dollars)	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD	VNH and Subsidiaries	Eliminations	Health System Consolidated
Assets									
Current assets									
Cash and cash equivalents	$ 134,634	$ 23,094	$ 8,621	$ 9,982	$ 6,654	$ 12,144	$ 5,040	$ -	$ 200,169
Patient accounts receivable, net	-	176,981	17,183	8,302	5,109	7,996	3,657	-	219,228
Prepaid expenses and other current assets	11,964	144,755	5,520	5,276	2,294	4,443	488	(77,238)	97,502
Total current assets	146,598	344,830	31,324	23,560	14,057	24,583	9,185	(77,238)	516,899
Assets limited as to use	8	635,028	17,438	12,821	11,862	9,612	19,355	-	706,124
Notes receivable, related party	554,771	-	-	-	-	-	-	(554,771)	-
Other investments for restricted activities	-	95,772	25,873	2,981	6,238	32	-	-	130,896
Property, plant, and equipment, net	36	445,829	70,607	42,920	19,065	25,725	3,139	-	607,321
Other assets	24,863	101,235	7,526	5,333	1,886	130	128	(32,316)	108,785
Total assets	$ 726,276	$ 1,622,694	$ 152,768	$ 87,615	$ 53,108	$ 60,082	$ 31,807	$ (664,325)	$ 2,070,025
Liabilities and Net Assets									
Current liabilities									
Current portion of long-term debt	$ -	$ 1,031	$ 810	$ 572	$ 245	$ 739	$ 67	$ -	$ 3,464
Current portion of liability for pension and other postretirement plan benefits	-	3,311	-	-	-	-	-	-	3,311
Accounts payable and accrued expenses	54,995	82,613	20,052	6,714	3,092	3,596	1,929	(77,238)	95,753
Accrued compensation and related benefits	-	106,485	5,730	2,487	3,831	5,814	1,229	-	125,576
Estimated third-party settlements	3,002	24,411	-	9,655	1,625	2,448	-	-	41,141
Total current liabilities	57,997	217,851	26,592	19,428	8,793	12,597	3,225	(77,238)	269,245
Notes payable, related party	-	527,346	-	27,425	-	-	-	(554,771)	-
Long-term debt, excluding current portion	644,520	52,878	25,354	1,179	11,593	25,792	2,629	(10,970)	752,975
Insurance deposits and related liabilities	-	54,616	465	155	241	-	39	-	55,516
Liability for pension and other postretirement plan benefits, excluding current portion	-	232,696	4,215	-	5,316	-	-	-	242,227
Other liabilities	-	85,577	1,117	1,405	-	28	-	-	88,127
Total liabilities	702,517	1,170,964	57,743	49,592	25,943	38,417	5,893	(642,979)	1,408,090
Commitments and contingencies									
Net assets									
Net assets without donor restrictions	23,759	356,518	65,069	33,383	19,764	21,031	25,884	(21,306)	524,102
Net assets with donor restrictions	-	95,212	29,956	4,640	7,401	634	30	(40)	137,833
Total net assets	23,759	451,730	95,025	38,023	27,165	21,665	25,914	(21,346)	661,935
Total liabilities and net assets	$ 726,276	$ 1,622,694	$ 152,768	$ 87,615	$ 53,108	$ 60,082	$ 31,807	$ (664,325)	$ 2,070,025

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Net Assets without Donor Restrictions
Year Ended June 30, 2019

(in thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	Alice Peck Day Memorial	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Operating revenue and other support											
Patient service revenue	$ -	$ 1,580,552	$ 220,255	$ 69,794	$ 60,166	$ 46,029	$ -	$ 1,976,796	$ 22,527	$ -	$ 1,999,323
Contracted revenue	5,011	109,051	355	-	-	5,902	(46,100)	74,219	790	8	75,017
Other operating revenue	21,128	186,852	3,407	1,748	4,261	2,289	(22,076)	197,609	13,386	(297)	210,698
Net assets released from restrictions	369	11,556	732	137	177	24	-	12,995	1,110	-	14,105
Total operating revenue and other support	26,508	1,888,011	224,749	71,679	64,604	54,244	(68,176)	2,261,619	37,813	(289)	2,299,143
Operating expenses											
Salaries	-	868,311	107,671	37,297	30,549	26,514	(24,682)	1,045,660	15,785	1,106	1,062,551
Employee benefits	-	208,348	24,225	8,454	5,434	6,966	(3,763)	247,662	3,642	287	251,591
Medical supplies and medications	-	354,201	34,331	8,834	6,298	3,032	-	406,496	1,379	-	407,875
Purchased services and other	11,366	242,106	35,088	15,308	13,528	13,950	(21,176)	310,170	14,887	(1,622)	323,435
Medicaid enhancement tax	-	54,954	8,005	3,062	2,264	1,776	-	70,061	-	-	70,061
Depreciation and amortization	14	69,343	7,977	2,305	3,915	2,360	-	85,914	2,500	-	88,414
Interest	20,677	21,585	1,053	1,169	1,119	228	(20,850)	24,981	533	-	25,514
Total operating expenses	32,057	1,818,846	218,350	74,229	63,107	54,826	(70,471)	2,190,944	38,726	(229)	2,229,441
Operating (loss) margin	(5,549)	69,165	6,399	(2,550)	1,497	(582)	2,295	70,675	(913)	(60)	69,702
Nonoperating gains (losses)											
Investment income (losses), net	3,929	32,193	227	469	834	623	(198)	38,077	1,975	-	40,052
Other (losses) income, net	(3,784)	1,586	(187)	30	(240)	279	(2,097)	(4,413)	791	60	(3,562)
Loss on early extinguishment of debt	-	-	-	(87)	-	-	-	(87)	-	-	(87)
Loss on swap termination	-	-	-	-	-	-	-	-	-	-	-
Total non-operating gains (losses), net	145	33,779	40	412	594	902	(2,295)	33,577	2,766	60	36,403
(Deficiency) excess of revenue over expenses	(5,404)	102,944	6,439	(2,138)	2,091	320	-	104,252	1,853	-	106,105
Net assets without donor restrictions											
Net assets released from restrictions	-	419	565	-	402	318	-	1,704	65	-	1,769
Change in funded status of pension and other postretirement benefits	-	(65,005)	(7,720)	-	-	682	-	(72,043)	-	-	(72,043)
Net assets transferred to (from) affiliates	10,477	(16,360)	1,939	8,760	128	110	-	5,054	(5,054)	-	-
Additional paid in capital	-	-	-	-	-	-	-	-	-	-	-
Other changes in net assets	-	-	-	-	-	-	-	-	-	-	-
Change in fair value on interest rate swaps	-	-	-	-	-	-	-	-	-	-	-
Change in funded status of interest rate swaps	-	-	-	-	-	-	-	-	-	-	-
Increase in net assets without donor restrictions	$ 5,073	$ 21,998	$ 1,223	$ 6,622	$ 2,621	$ 1,430	$ -	$ 38,967	$ (3,136)	$ -	$ 35,831

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Net Assets without Donor Restrictions
Year Ended June 30, 2019

(in thousands of dollars)	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD and Subsidiaries	VNH and Subsidiaries	Eliminations	Health System Consolidated
Operating revenue and other support									
Patient service revenue	$ -	$ 1,580,552	$ 220,254	$ 60,166	$ 46,029	$ 69,794	$ 22,528	$ -	$ 1,999,323
Contracted revenue	5,010	109,842	355	-	5,902	-	-	(46,092)	75,017
Other operating revenue	21,128	188,775	3,549	4,260	3,868	10,951	540	(22,373)	210,698
Net assets released from restrictions	371	12,637	732	177	26	162	-	-	14,105
Total operating revenue and other support	26,509	1,891,806	224,890	64,603	55,825	80,907	23,068	(68,465)	2,299,143
Operating expenses									
Salaries	-	868,311	107,706	30,549	27,319	40,731	11,511	(23,576)	1,062,551
Employee benefits	-	208,346	24,235	5,434	7,133	7,218	2,701	(3,476)	251,591
Medical supplies and medications	-	354,201	34,331	6,298	3,035	8,639	1,371	-	407,875
Purchased services and other	11,366	246,101	35,396	13,390	14,371	18,172	7,437	(22,798)	323,435
Medicaid enhancement tax	-	54,954	8,005	2,264	1,776	3,062	-	-	70,061
Depreciation and amortization	14	69,343	8,125	3,920	2,478	4,194	340	-	88,414
Interest	20,678	21,585	1,054	1,119	228	1,637	63	(20,850)	25,514
Total operating expenses	32,058	1,822,841	218,852	62,974	56,340	83,653	23,423	(70,700)	2,229,441
Operating (loss) margin	(5,549)	68,965	6,038	1,629	(515)	(2,746)	(355)	2,235	69,702
Non-operating gains (losses)									
Investment income (losses), net	3,929	33,310	129	785	645	469	983	(198)	40,052
Other (losses) income, net	(3,784)	1,586	(171)	(240)	288	31	765	(2,037)	(3,562)
Loss on early extinguishment of debt	-	-	-	-	-	(87)	-	-	(87)
Loss on swap termination	-	-	-	-	-	-	-	-	-
Total nonoperating gains (losses), net	145	34,896	(42)	545	933	413	1,748	(2,235)	36,403
(Deficiency) excess of revenue over expenses	(5,404)	103,861	5,996	2,174	418	(2,333)	1,393	-	106,105
Net assets without donor restrictions									
Net assets released from restrictions	-	484	565	402	318	-	-	-	1,769
Change in funded status of pension and other postretirement benefits	-	(65,005)	(7,720)	-	682	-	-	-	(72,043)
Net assets transferred to (from) affiliates	10,477	(16,360)	1,963	128	118	3,629	45	-	-
Additional paid in capital	-	-	-	-	-	-	-	-	-
Other changes in net assets	-	-	-	-	-	-	-	-	-
Change in fair value on interest rate swaps	-	-	-	-	-	-	-	-	-
Change in funded status of interest rate swaps	-	-	-	-	-	-	-	-	-
Increase in net assets without donor restrictions	$ 5,073	$ 22,980	$ 804	$ 2,704	$ 1,536	$ 1,296	$ 1,438	$ -	$ 35,831

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Net Assets Without Donor Restrictions
Year Ended June 30, 2018

(in thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non Oblig Group Affiliates	Eliminations	Health System Consolidated
Operating revenue and other support										
Patient service revenue	$ -	$ 1,475,314	$ 216,736	$ 60,486	$ 52,014	$ -	$ 1,804,550	$ 94,545	$ -	$ 1,899,095
Provision for bad debts	-	31,358	10,967	1,554	1,440	-	45,319	2,048	-	47,367
Net patient service revenue	-	1,443,956	205,769	58,932	50,574	-	1,759,231	92,497	-	1,851,728
Contracted revenue	(2,305)	97,291	-	-	2,169	(42,870)	54,285	716	(32)	54,969
Other operating revenue	9,799	134,461	3,365	4,169	1,814	(10,554)	143,054	6,978	(1,086)	148,946
Net assets released from restrictions	658	11,605	620	52	44	-	12,979	482	-	13,461
Total operating revenue and other support	8,152	1,687,313	209,754	63,153	54,601	(53,424)	1,969,549	100,673	(1,118)	2,069,104
Operating expenses										
Salaries	-	806,344	105,607	30,360	24,854	(21,542)	945,623	42,035	1,605	989,263
Employee benefits	-	181,833	28,343	7,252	7,000	(5,385)	219,043	10,221	419	229,683
Medical supplies and medications	-	289,327	31,293	6,161	3,055	-	329,836	10,195	-	340,031
Purchased services and other	8,509	215,073	33,065	13,587	13,960	(19,394)	264,800	29,390	(2,818)	291,372
Medicaid enhancement tax	-	53,044	8,070	2,659	1,744	-	65,517	2,175	-	67,692
Depreciation and amortization	23	66,073	10,217	3,934	2,030	-	82,277	2,501	-	84,778
Interest	8,684	15,772	1,004	981	224	(8,882)	17,783	1,039	-	18,822
Total operating expenses	17,216	1,627,466	217,599	64,934	52,867	(55,203)	1,924,879	97,556	(794)	2,021,641
Operating margin (loss)	(9,064)	59,847	(7,845)	(1,781)	1,734	1,779	44,670	3,117	(324)	47,463
Non-operating gains (losses)										
Investment income (losses), net	(26)	33,628	1,408	1,151	858	(198)	36,821	3,566	-	40,387
Other (losses) income, net	(1,364)	(2,599)	-	1,276	266	(1,581)	(4,002)	733	361	(2,908)
Loss on early extinguishment of debt	-	(13,909)	-	(305)	-	-	(14,214)	-	-	(14,214)
Loss on swap termination	-	(14,247)	-	-	-	-	(14,247)	-	-	(14,247)
Total non-operating gains (losses), net	(1,390)	2,873	1,408	2,122	1,124	(1,779)	4,358	4,299	361	9,018
(Deficiency) excess of revenue over expenses	(10,454)	62,720	(6,437)	341	2,858	-	49,028	7,416	37	56,481
Net assets without donor restrictions										
Net assets released from restrictions	-	16,038	-	4	252	-	16,294	19	-	16,313
Change in funded status of pension and other postretirement benefits	-	4,300	2,827	-	1,127	-	8,254	-	-	8,254
Net assets transferred to (from) affiliates	17,791	(25,355)	7,188	48	328	-	-	-	-	-
Additional paid in capital	-	-	-	-	-	-	-	58	(58)	-
Other changes in net assets	-	-	-	-	-	-	-	(185)	-	(185)
Change in fair value on interest rate swaps	-	4,190	-	-	-	-	4,190	-	-	4,190
Change in funded status of interest rate swaps	-	14,102	-	-	-	-	14,102	-	-	14,102
Increase in net assets without donor restrictions	$ 7,337	$ 75,995	$ 3,578	$ 393	$ 4,565	$ -	$ 91,868	$ 7,308	$ (21)	$ 99,155

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Net Assets Without Donor Restrictions
Year Ended June 30, 2018

(in thousands of dollars)	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD	VNH and Subsidiaries	Eliminations	Health System Consolidated
Operating revenue and other support									
Patient service revenue	$ -	$ 1,475,314	$ 216,736	$ 60,486	$ 52,014	$ 71,458	$ 23,087	$ -	$ 1,899,095
Provision for bad debts	-	31,358	10,967	1,554	1,440	1,680	368	-	47,367
Net patient service revenue	-	1,443,956	205,769	58,932	50,574	69,778	22,719	-	1,851,728
Contracted revenue	(2,305)	98,007	-	-	2,169	-	-	(42,902)	54,969
Other operating revenue	9,799	137,242	4,061	4,166	3,168	1,697	453	(11,640)	148,946
Net assets released from restrictions	658	11,984	620	52	44	103	-	-	13,461
Total operating revenue and other support	8,152	1,691,189	210,450	63,150	55,955	71,578	23,172	(54,542)	2,069,104
Operating expenses									
Salaries	-	806,344	105,607	30,360	25,592	29,215	12,082	(19,937)	989,263
Employee benefits	-	181,833	28,343	7,252	7,162	7,408	2,653	(4,966)	229,683
Medical supplies and medications	-	289,327	31,293	6,161	3,057	8,484	1,709	-	340,031
Purchased services and other	8,512	218,690	33,431	13,432	14,354	19,220	5,945	(22,212)	291,372
Medicaid enhancement tax	-	53,044	8,070	2,659	1,743	2,176	-	-	67,692
Depreciation and amortization	23	66,073	10,357	3,939	2,145	1,831	410	-	84,778
Interest	8,684	15,772	1,004	981	223	975	65	(8,882)	18,822
Total operating expenses	17,219	1,631,083	218,105	64,784	54,276	69,307	22,864	(55,997)	2,021,641
Operating (loss) margin	(9,067)	60,106	(7,655)	(1,634)	1,679	2,271	308	1,455	47,463
Nonoperating gains (losses)									
Investment income (losses), net	(26)	35,177	1,954	1,097	787	203	1,393	(198)	40,387
Other (losses) income, net	(1,364)	(2,599)	(3)	1,276	273	(223)	952	(1,220)	(2,908)
Loss on early extinguishment of debt	-	(13,909)	-	(305)	-	-	-	-	(14,214)
Loss on swap termination	-	(14,247)	-	-	-	-	-	-	(14,247)
Total non-operating gains (losses), net	(1,390)	4,422	1,951	2,068	1,060	(20)	2,345	(1,418)	9,018
(Deficiency) excess of revenue over expenses	(10,457)	64,528	(5,704)	434	2,739	2,251	2,653	37	56,481
Net assets without donor restrictions									
Net assets released from restrictions	-	16,058	-	4	251	-	-	-	16,313
Change in funded status of pension and other postretirement benefits	-	4,300	2,827	-	1,127	-	-	-	8,254
Net assets transferred to (from) affiliates	17,791	(25,355)	7,188	48	328	-	-	-	-
Additional paid in capital	58	-	-	-	-	-	-	(58)	-
Other changes in net assets	-	-	-	-	-	(185)	-	-	(185)
Change in fair value on interest rate swaps	-	4,190	-	-	-	-	-	-	4,190
Change in funded status of interest rate swaps	-	14,102	-	-	-	-	-	-	14,102
Increase (decrease) in net assets without donor restrictions	$ 7,392	$ 77,823	$ 4,311	$ 486	$ 4,445	$ 2,066	$ 2,653	$ (21)	$ 99,155

Dartmouth-Hitchcock Health and Subsidiaries
Notes to Supplemental Consolidating Information
June 30, 2019 and 2018

1. Basis of Presentation

The accompanying supplemental consolidating information includes the consolidating balance sheet and the consolidating statement of operations and changes in net assets without donor restrictions of D-HH and its subsidiaries. All intercompany accounts and transactions between D-HH and its subsidiaries have been eliminated. The consolidating information presented is prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America consistent with the consolidated financial statements. The consolidating information is presented for purposes of additional analysis of the consolidated financial statements and is not required as part of the basic financial statements.

Schedule of Expenditures of Federal Awards

Dartmouth-Hitchcock Health and Subsidiaries
Schedule of Expenditures of Federal Awards
Year Ended June 30, 2019

Federal Program	CFDA	Award Number/pass-through Identification Number	Funding Source	Pass-Through Entity	Total Expenditures	Amount Passed Through to Subrecipients
Research and Development Cluster						
Department of Defense						
National Guard Military Operations and Maintenance (O&M) Projects	12.401	W81XWH1820076	Direct		$ 234,630	$ -
Military Medical Research and Development	12.420	W81XWH1810712	Direct		131,525	-
Military Medical Research and Development	12.420	R1143	Pass-Through	Trustees of Dartmouth College	2,055	-
					133,580	-
Department of Defense	12.RD	80232	Pass-Through	Creare, Inc.	46,275	-
					414,485	-
Environmental Protection Agency						
Science To Achieve Results (STAR) Research Program	66.509	31220SUB52965	Pass-Through	University of Vermont	1,031	-
					1,031	-
Department of Health and Human Services						
Innovations in Applied Public Health Research	93.061	1 R01 TS000288	Direct		84,957	8,367
Environmental Health	93.113	6K23ES025781-06	Direct		111,125	-
Environmental Health	93.113	R1118	Pass-Through	Trustees of Dartmouth College	5,087	-
					116,212	-
NIEHS Superfund Hazardous Substances	93.143	R1099	Pass-Through	Trustees of Dartmouth College	6,457	-
Health Program for Toxic Substances and Disease Registry	93.161	AWD00010523	Direct		61,180	-
Research Related to Deafness and Communication Disorders	93.173	6R21DC015133-03	Direct		119,896	61,908
National Research Service Award in Primary Care Medicine	93.188	T32HP32520	Direct		309,112	-
Research and Training in Complementary and Integrative Health	93.213	R1112	Pass-Through	Trustees of Dartmouth College	21,197	-
Research and Training in Complementary and Integrative Health	93.213	R1187	Pass-Through	Trustees of Dartmouth College	446	-
Research and Training in Complementary and Integrative Health	93.213	12272	Pass-Through	Palmer College of Chiropractic	30,748	-
Research and Training in Complementary and Integrative Health	93.213	Not Provided	Pass-Through	Southern California University of Health	12,030	-
					64,421	-
Research on Healthcare Costs, Quality and Outcomes	93.226	5P30HS024403	Direct		641,114	-
Research on Healthcare Costs, Quality and Outcomes	93.226	R1128	Pass-Through	Trustees of Dartmouth College	6,003	-
Research on Healthcare Costs, Quality and Outcomes	93.226	R1146	Pass-Through	Trustees of Dartmouth College	4,696	-
					651,813	-
Mental Health Research Grants	93.242	1K08MH117347-01A1	Direct		54,211	-
Mental Health Research Grants	93.242	5K23MH116367-02	Direct		109,228	-
Mental Health Research Grants	93.242	6R01MH110965	Direct		220,076	84,823
Mental Health Research Grants	93.242	6T32MH073553-15	Direct		130,340	-
Mental Health Research Grants	93.242	6R25MH068502-17	Direct		157,599	-
Mental Health Research Grants	93.242	6R01MH107625-05	Direct		200,805	27,964
Mental Health Research Grants	93.242	R1082	Pass-Through	Trustees of Dartmouth College	11,740	-
Mental Health Research Grants	93.242	R1144	Pass-Through	Trustees of Dartmouth College	5,897	-
Mental Health Research Grants	93.242	R1156	Pass-Through	Trustees of Dartmouth College	4,721	-
					894,617	112,787

Dartmouth-Hitchcock Health and Subsidiaries
Schedule of Expenditures of Federal Awards
Year Ended June 30, 2019

	CFDA	Award Number/pass-through Identification Number	Funding Source	Pass-Through Entity	Total Expenditures	Amount Passed Through to Subrecipients
Drug Abuse and Addiction Research Programs	93.279	6R01DA034699-05	Direct		390,647	90,985
Drug Abuse and Addiction Research Programs	93.279	6R21DA044501-03	Direct		118,741	-
Drug Abuse and Addiction Research Programs	93.279	6R01DA041416-04	Direct		135,687	62,277
Drug Abuse and Addiction Research Programs	93.279	R1105	Pass-Through	Trustees of Dartmouth College	11,957	-
Drug Abuse and Addiction Research Programs	93.279	R1104	Pass-Through	Trustees of Dartmouth College	4,109	-
Drug Abuse and Addiction Research Programs	93.279	R1192	Pass-Through	Trustees of Dartmouth College	5,059	-
					666,200	153,262
Discovery and Applied Research for Technological Innovations to Improve Human Health	93.286	6K23EB026507-02	Direct		98,499	9,582
Discovery and Applied Research for Technological Innovations to Improve Human Health	93.286	6R21EB021456-03	Direct		23,293	-
Discovery and Applied Research for Technological Innovations to Improve Human Health	93.286	R1103	Pass-Through	Trustees of Dartmouth College	16,635	-
Discovery and Applied Research for Technological Innovations to Improve Human Health	93.286	5R21EB024771-02	Pass-Through	Trustees of Dartmouth College	5,938	-
					144,365	9,582
National Center for Advancing Translational Sciences	93.350	R1113	Pass-Through	Trustees of Dartmouth College	342,790	-
21st Century Cures Act - Beau Biden Cancer Moonshot	93.353	1204501	Pass-Through	Dana Farber Cancer Institute	166,421	-
Cancer Cause and Prevention Research	93.393	1R01CA225792	Direct		54,351	-
Cancer Cause and Prevention Research	93.393	R21CA227776A	Direct		28,640	-
Cancer Cause and Prevention Research	93.393	R01CA229197	Direct		65,701	-
Cancer Cause and Prevention Research	93.393	R1127	Pass-Through	Trustees of Dartmouth College	6,035	-
Cancer Cause and Prevention Research	93.393	R1097	Pass-Through	Trustees of Dartmouth College	5,870	-
Cancer Cause and Prevention Research	93.393	R1109	Pass-Through	Trustees of Dartmouth College	1,984	-
Cancer Cause and Prevention Research	93.393	DHMCCA222648	Pass-Through	The Pennsylvania State University	3,173	-
Cancer Cause and Prevention Research	93.393	R44CA210810	Pass-Through	Cairn Surgical, LLC	38,241	-
					203,995	-
Cancer Detection and Diagnosis Research	93.394	4R00CA190890-03	Direct		1,717	-
Cancer Detection and Diagnosis Research	93.394	6R37CA212187-03	Direct		106,110	2,907
Cancer Detection and Diagnosis Research	93.394	6R03CA219445-03	Direct		18,880	-
Cancer Detection and Diagnosis Research	93.394	R1079	Pass-Through	Trustees of Dartmouth College	23,031	-
Cancer Detection and Diagnosis Research	93.394	R1080	Pass-Through	Trustees of Dartmouth College	23,031	-
Cancer Detection and Diagnosis Research	93.394	R1086	Pass-Through	Trustees of Dartmouth College	6,772	-
Cancer Detection and Diagnosis Research	93.394	R1096	Pass-Through	Trustees of Dartmouth College	1,174	-
Cancer Detection and Diagnosis Research	93.394	R1124	Pass-Through	Trustees of Dartmouth College	83,174	-
					263,889	2,907
Cancer Treatment Research	93.395	1UG1CA233323-01	Direct		14,875	-
Cancer Treatment Research	93.395	6U10CA180854-06	Direct		27,790	-
Cancer Treatment Research	93.395	DAC-194321	Pass-Through	Mayo Clinic	36,708	-

Dartmouth-Hitchcock Health and Subsidiaries
Schedule of Expenditures of Federal Awards
Year Ended June 30, 2019

	CFDA	Award Number/pass-through Identification Number	Funding Source	Pass-Through Entity	Total Expenditures	Amount Passed Through to Subrecipients
Cancer Treatment Research	93.395	R1087	Pass-Through	Trustees of Dartmouth College	2,630	-
Cancer Treatment Research	93.395	110408	Pass-Through	Brigham and Women's Hospital	20,430	-
					102,233	-
Cancer Centers Support Grants	93.397	R1126	Pass-Through	Trustees of Dartmouth College	95,624	-
Cardiovascular Diseases Research	93.837	1UM1HL147371-01	Direct		11,774	-
Cardiovascular Diseases Research	93.837	7K23HL142835-02	Direct		65,544	-
					77,318	-
Lung Diseases Research	93.838	6R01HL122372-05	Direct		205,920	8,664
Arthritis, Musculoskeletal and Skin Diseases Research	93.846	6T32AR049710-16	Direct		73,049	-
Diabetes, Digestive, and Kidney Diseases Extramural Research	93.847	R1098	Pass-Through	Trustees of Dartmouth College	70,736	704
Extramural Research Programs in the Neurosciences and Neurological Disorders	93.853	6R01NS052274-11	Direct		50,412	-
Extramural Research Programs in the Neurosciences and Neurological Disorders	93.853	16-210950-04	Direct		18,016	-
					68,428	-
Allergy and Infectious Diseases Research	93.855	R1081	Pass-Through	Trustees of Dartmouth College	3,787	-
Allergy and Infectious Diseases Research	93.855	RES513934	Pass-Through	Case Western Reserve University	4,170	-
Allergy and Infectious Diseases Research	93.855	R1155	Pass-Through	Trustees of Dartmouth College	14,582	-
					22,539	-
Biomedical Research and Research Training	93.859	R1100	Pass-Through	Trustees of Dartmouth College	14,901	-
Biomedical Research and Research Training	93.859	R1141	Pass-Through	Trustees of Dartmouth College	587	-
Biomedical Research and Research Training	93.859	R1145	Pass-Through	Trustees of Dartmouth College	241	-
					15,729	-
Child Health and Human Development Extramural Research	93.865	5P2CHD086841-04	Direct		127,400	10,132
Child Health and Human Development Extramural Research	93.865	6UG1OD024946-03	Direct		260,914	-
Child Health and Human Development Extramural Research	93.865	6R01HD067270	Direct		314,058	223,885
Child Health and Human Development Extramural Research	93.865	R1119	Pass-Through	Trustees of Dartmouth College	13,264	-
Child Health and Human Development Extramural Research	93.865	51460	Pass-Through	Univ of Arkansas for Medical Sciences	4,696	-
					720,332	234,017
Aging Research	93.866	6K23AG051681-04	Direct		76,377	2,883
Aging Research	93.866	R1102	Pass-Through	Trustees of Dartmouth College	8,285	-
					84,662	2,883
Vision Research	93.867	6R21EY028677-02	Direct		28,751	3,149
Medical Library Assistance	93.879	R1107	Pass-Through	Trustees of Dartmouth College	4,273	-
Medical Library Assistance	93.879	R1190	Pass-Through	Trustees of Dartmouth College	1,244	-
					5,517	-
International Research and Research Training	93.989	R1123	Pass-Through	Trustees of Dartmouth College	5,936	-
International Research and Research Training	93.989	6R25TW007693-09	Pass-Through	Fogarty International Center	96,327	65,097
					102,263	65,097

Dartmouth-Hitchcock Health and Subsidiaries
Schedule of Expenditures of Federal Awards
Year Ended June 30, 2019

	CFDA	Award Number/pass-through Identification Number	Funding Source	Pass-Through Entity	Total Expenditures	Amount Passed Through to Subrecipients
Department of Health and Human Services	93.RD		Pass-Through	Leidos Biomedical Research, Inc.	201,551	-
Total Department of Health and Human Services					5,970,977	663,327
Total Research and Development Cluster					6,386,493	663,327
Medicaid Cluster						
Medical Assistance Program	93.778	SNHH 2-18-19	Pass-Through	Southern New Hampshire Health	131,775	-
Medical Assistance Program	93.778	Not Provided	Pass-Through	NH Dept of Health and Human Services	1,453,796	-
Medical Assistance Program	93.778	RFP-2017-OCOM-01-PHYSI-01	Pass-Through	NH Dept of Health and Human Services	3,106,149	-
Medical Assistance Program	93.778	03420-7235S	Pass-Through	Vermont Department of Health	59,391	
Medical Assistance Program	93.778	03410-2020-19	Pass-Through	Vermont Department of Health	118,786	
Total Medicaid Cluster					4,869,897	-
Highway Safety Cluster						
State and Community Highway Safety	20.600	19-266 Youth Operator	Pass-Through	NH Highway Safety Agency	66,660	-
State and Community Highway Safety	20.600	19-266 BUNH	Pass-Through	NH Highway Safety Agency	76,915	-
State and Community Highway Safety	20.600	19-266 Statewide CPS	Pass-Through	NH Highway Safety Agency	82,202	-
Total Highway Safety Cluster					225,777	-
Other Sponsored Programs						
Department of Justice						
Crime Victim Assistance	16.575	2015-VA-GX0007	Pass-Through	New Hampshire Department of Justice	237,692	-
Improving the Investigation and Prosecution of Child Abuse and the Regional and Local Children's Advocacy Centers	16.758	1-CLAR-NH-SA17	Pass-Through	National Children's Alliance	1,448	-
					239,140	-
Department of Education						
Race to the Top	84.412	03440-34119-18-ELCG24	Pass-Through	Vermont Dept for Children and Families	115,094	-
					115,094	-
Department of Health and Human Services						
Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Aligned Cooperative Agreements	93.074	Not Provided	Pass-Through	NH Dept of Health and Human Services	69,945	-
Blood Disorder Program: Prevention, Surveillance, and Research	93.080	GENFD0001568485	Pass-Through	Boston Children's Hospital	18,263	
Maternal and Child Health Federal Consolidated Programs	93.110	6 T73MC323930101	Direct		652,997	591,411
Maternal and Child Health Federal Consolidated Programs	93.110	0253-6545-4609	Pass-Through	Icahn School of Medicine at Mount Sinai	19,548	
					672,545	591,411
Emergency Medical Services for Children	93.127	7 H33MC323950100	Direct		137,067	
Centers for Research and Demonstration for Health Promotion and Disease Prevention	93.135	R1140	Pass-Through	Trustees of Dartmouth College	449,757	-
HIV-Related Training and Technical Assistance	93.145	Not Provided	Pass-Through	University of Massachusetts Med School	3,242	
Coordinated Services and Access to Research for Women, Infants, Children	93.153	H12HA31112	Direct		391,829	-
Substance Abuse and Mental Health Services Projects of Regional and National Significance	93.243	7H79SM063584-01	Direct		24,313	-
Substance Abuse and Mental Health Services Projects of Regional and National Significance	93.243	RFP-2018-DPHS-01-REGION-1	Pass-Through	NH Dept of Health and Human Services	55,361	-
Substance Abuse and Mental Health Services Projects of Regional and National Significance	93.243	Not Provided	Pass-Through	Vermont Department of Health	227,437	-
Substance Abuse and Mental Health Services Projects of Regional and National Significance	93.243	03420-A19006S	Pass-Through	Vermont Department of Health	126,764	
					433,875	-
Drug Free Communities Support Program Grants	93.276	5H79SP020382	Direct		126,464	-
Department of Health and Human Services	93.628	RFP-2018-DPHS-01-REGION-1	Pass-Through	NH Dept of Health and Human Services	29,838	-

Dartmouth-Hitchcock Health and Subsidiaries
Schedule of Expenditures of Federal Awards
Year Ended June 30, 2019

	CFDA	Award Number/pass-through Identification Number	Funding Source	Pass-Through Entity	Total Expenditures	Amount Passed Through to Subrecipients
University Centers for Excellence in Developmental Disabilities Education, Research, and Service	93.632	19-029	Pass-Through	University of New Hampshire	2,811	-
Adoption Opportunities	93.652	AWD00009303	Direct		32,384	-
Adoption Opportunities	93.652	RFP-2018-DPHS-01-REGION-1	Pass-Through	NH Dept of Health and Human Services	110,524	-
					142,908	-
Preventive Health and Health Services Block Grant funded solely with Prevention and Public Health Funds (PPHF)	93.758	RFP-2018-DPHS-01-REGION-1	Pass-Through	NH Dept of Health and Human Services	343,297	-
University Centers for Excellence in Developmental Disabilities Education, Research, and Service	93.761	90FPSG0019	Direct		134,524	-
Opioid STR	93.788	RFP-2018-BDAS-05-INTEG	Pass-Through	NH Dept of Health and Human Services	954,356	61,208
Opioid STR	93.788	2019-BDAS-05-ACCES-04	Pass-Through	NH Dept of Health and Human Services	161,184	-
Opioid STR	93.788	SS-2019-BDAS-05-ACCES-02	Pass-Through	NH Dept of Health and Human Services	243,747	
					1,359,287	61,208
Organized Approaches to Increase Colorectal Cancer Screening	93.800	5 NU58DP006086	Direct		912,937	-
Hospital Preparedness Program (HPP) Ebola Preparedness	93.817	03420-6755S	Pass-Through	Vermont Department of Health	2,347	-
Maternal, Infant and Early Childhood Home Visiting Grant	93.870	03420-6951S	Pass-Through	Vermont Department of Health	99,841	-
Maternal, Infant and Early Childhood Home Visiting Grant	93.870	03420-07623	Pass-Through	Vermont Department of Health	178,907	-
					278,748	-
National Bioterrorism Hospital Preparedness Program	93.889	03420-7272S	Pass-Through	Vermont Department of Health	2,786	-
Rural Health Care Services Outreach, Rural Health Network Develop and Small Health Care Provider Quality Improvement	93.912	6 D06RH31057-02-03	Direct		138,959	-
Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease	93.918	1 H76HA31654-01-00	Direct		273,866	-
Block Grants for Community Mental Health Services	93.958	9224120	Pass-Through	NH Dept of Health and Human Services	2,498	-
Block Grants for Community Mental Health Services	93.958	RFP-2017-DBH-05-FIRSTE	Pass-Through	NH Dept of Health and Human Services	32,625	-
					35,123	-
Block Grants for Prevention and Treatment of Substance Abuse	93.959	05-95-49-491510-2990	Pass-Through	NH Dept of Health and Human Services	69,278	-
Block Grants for Prevention and Treatment of Substance Abuse	93.959	Not Provided	Pass-Through	Foundation for Healthy Communities	54,356	-
Block Grants for Prevention and Treatment of Substance Abuse	93.959	05-95-49-491510-2990	Pass-Through	Foundation for Healthy Communities	1,695	-
Block Grants for Prevention and Treatment of Substance Abuse	93.959	03420-A18033S	Pass-Through	Vermont Department of Health	59,204	-
					184,531	-
PPHF Geriatric Education Centers	93.969	U1QHP32519	Direct		728,055	-
Department of Health and Human Services	93.U01	RFP-2018-DPHS-05-INJUR	Pass-Through	NH Highway Safety Agency	80,107	-
Department of Health and Human Services	93.U02	Not Provided	Pass-Through	NH Dept of Health and Human Services	48,489	-
Department of Health and Human Services	93.U03	Not Provided	Pass-Through	NH Dept of Health and Human Services	56,419	-
Department of Health and Human Services	93.U04	Not Provided	Pass-Through	NH Dept of Health and Human Services	37,009	-
Department of Health and Human Services	93.U05	Not Provided	Pass-Through	NH Dept of Health and Human Services	39,653	-
Department of Health and Human Services	93.U06	Not Provided	Pass-Through	County of Cheshire	213,301	-
					474,978	-
Corporation for National and Community Service AmeriCorps	94.006	17ACHNH0010001	Pass-Through	Volunteer NH	72,297	-
					72,297	-
Total Other Programs					7,774,313	652,619
Total Federal Awards and Expenditures					$ 19,256,480	$ 1,315,946

Dartmouth-Hitchcock Health and Subsidiaries
Notes to Schedule of Expenditures of Federal Awards
June 30, 2019

1. Basis of Presentation

The accompanying schedule of expenditures of federal awards (the "Schedule") presents the activity of federal award programs administered by Dartmouth-Hitchcock Health and Subsidiaries (the "Health System") as defined in the notes to the consolidated financial statements and is presented on an accrual basis. The purpose of this Schedule is to present a summary of those activities of the Health System for the year ended June 30, 2019 which have been financed by the United States government ("federal awards"). For purposes of this Schedule, federal awards include all federal assistance entered into directly between the Health System and the federal government and subawards from nonfederal organizations made under federally sponsored agreements. The information in this Schedule in presented in accordance with the requirements of the Uniform Guidance. Pass-through entity identification numbers and CFDA numbers have been provided where available.

Visiting Nurse and Hospice of NH and VT ("VNH") received a Community Facilities Loan, CFDA #10.766, of which the proceeds were expended in the prior fiscal year. The VNH had an outstanding balance of $2,696,512 as of June 30, 2019. As this loan was related to a project that was completed in the prior audit period and the terms and conditions do not impose continued compliance requirements other than to repay the loan, we have properly excluded the outstanding loan balance from the Schedule.

2. Indirect Expenses

Indirect costs are charged to certain federal grants and contracts at a federally approved predetermined indirect rate, negotiated with the Division of Cost Allocation and therefore we do not use the de minimus 10% rate. The predetermined rate provided for the year ended June 30, 2019 was 29.3%. Indirect costs are included in the reported federal expenditures.

3. Related Party Transactions

The Health System has an affiliation agreement with Dartmouth College dated June 4, 1996 in which the Health System and the Geisel School of Medicine at Dartmouth College affirm their mutual commitment to providing high quality medical care, medical education and medical research at both organizations. Pursuant to this affiliation agreement, certain clinical faculty of the Health System participate in federal research programs administered by Dartmouth College. During the fiscal year ended June 30, 2019, Health System expenditures, which Dartmouth College reimbursed, totaled $3,979,033. Based on the nature of these transactions, the Health System and Dartmouth College do not view these arrangements to be subrecipient transactions but rather view them as Dartmouth College activity. Accordingly, this activity does not appear in the Health System's schedule of expenditures of federal awards for the year ended June 30, 2019.

Part II
Reports on Internal Control and Compliance

Report of Independent Auditors on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

To the Board of Trustees of
Dartmouth-Hitchcock Health and subsidiaries

We have audited, in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, the consolidated financial statements of Dartmouth-Hitchcock Health and its subsidiaries (the "Health System"), which comprise the consolidated balance sheet as of June 30, 2019, and the related consolidated statements of operations and changes in net assets and of cash flows for the year then ended, and the related notes to the financial statements, and have issued our report thereon dated November 26, 2019, which included an emphasis of a matter paragraph related to the Health System changing the manner in which it accounts for revenue recognition from contracts with customers and the manner in which it presents net assets and reports certain aspects of its financial statements as a not-for-profit entity in 2019 as discussed in note 2 of the consolidated financial statements.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the Health System's internal control over financial reporting ("internal control") to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Health System's internal control. Accordingly, we do not express an opinion on the effectiveness of the Health System's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Health System's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

PricewaterhouseCoopers LLP

Boston, Massachusetts
November 26, 2019

Report of Independent Auditors on Compliance with Requirements That Could Have a Direct and Material Effect on Each Major Program and on Internal Control Over Compliance in Accordance with the Uniform Guidance

To the Board of Trustees of
Dartmouth-Hitchcock Health and subsidiaries

Report on Compliance for Each Major Federal Program

We have audited Dartmouth-Hitchcock Health and its subsidiaries' (the "Health System") compliance with the types of compliance requirements described in the *OMB Compliance Supplement* that could have a direct and material effect on each of the Health System's major federal programs for the year ended June 30, 2019. The Health System's major federal programs are identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with federal statutes, regulations and the terms and conditions of its federal awards applicable to its federal programs.

Auditors' Responsibility

Our responsibility is to express an opinion on compliance for each of the Health System's major federal programs based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and the audit requirements of Title 2 U.S. *Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Those standards and the Uniform Guidance require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about the Health System's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for each major federal program. However, our audit does not provide a legal determination of Dartmouth-Hitchcock Health and its subsidiaries compliance.

Opinion on Each Major Federal Program

In our opinion, Dartmouth-Hitchcock Health and its subsidiaries complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended June 30, 2019.

Report on Internal Control Over Compliance

Management of the Health System are responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered the Health System's internal control over compliance with the types of requirements that could have a direct and material effect on each major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for each major federal program and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the Health System's internal control over compliance.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

PricewaterhouseCoopers LLP

Boston, Massachusetts
March 31, 2020

Part III
Findings and Questioned Costs

Dartmouth-Hitchcock and Subsidiaries
Schedule of Findings and Questioned Costs
Year Ended June 30, 2019

I. Summary of Auditor's Results

Financial Statements

Type of auditor's report issued	Unmodified opinion
Internal control over financial reporting	
Material weakness (es) identified?	No
Significant deficiency (ies) identified that are not considered to be material weakness (es)?	None reported
Noncompliance material to financial statements	No

Federal Awards

Internal control over major programs	
Material weakness (es) identified?	No
Significant deficiency (ies) identified that are not considered to be material weakness (es)?	None reported
Type of auditor's report issued on compliance for major programs	Unmodified opinion
Audit findings disclosed that are required to be reported in accordance with 2 CFR 200.516(a)?	No

Identification of major programs

CFDA Number	Name of Federal Program or Cluster
Various CFDA Numbers	Research and Development
93.800	Organized Approaches to Increase Colorectal Cancer Screening
93.788	Opiod STR
93.110	Maternal and Child Health Federal Consolidated Programs
Dollar threshold used to distinguish between Type A and Type B programs	$750,000
Auditee qualified as low-risk auditee?	Yes

Dartmouth-Hitchcock and Subsidiaries
Schedule of Findings and Questioned Costs
Year Ended June 30, 2019

II. **Financial Statement Findings**

None Noted

III. **Federal Award Findings and Questioned Costs**

None Noted

Dartmouth-Hitchcock and Subsidiaries
Summary Schedule of Prior Audit Findings and Status
Year Ended June 30, 2019

There are no findings from prior years that require an update in this report.

DARTMOUTH-HITCHCOCK (D-H) | DARTMOUTH-HITCHCOCK HEALTH (D-HH)
BOARDS OF TRUSTEES AND OFFICERS

Effective: January 1, 2020

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Jocelyn D. Chertoff, MD, MS, FACR MHMH/DHC (Clinical Chair/Center Director) Trustee *Chair, Dept. of Radiology*	**Robert A. Oden, Jr., PhD** MHMH/DHC/D-HH Trustee *Retired President, Carleton College*
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William J. Conaty MHMH/DHC/D-HH Trustee *President, Conaty Consulting, LLC*	**Charles G. Plimpton, MBA** MHMH/DHC/D-HH Boards' Treasurer & Secretary *Retired Investment Banker*
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Senator Judd A. Gregg MHMH/DHC Trustee *Senior Advisor to SIFMA*	**Edward Howe Stansfield, III, MA** MHMH/DHC/D-HH Boards' Chair *Senior VP, Resident Director for the Hanover, NH Bank of America/Merrill Lynch Office*
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Cherie A. Holmes, MD, MSc MHMH/DHC/(Community Group Practice) Trustee *Medical Director, Acute Care Services, D-H Keene/Cheshire Medical Center*	**Jon W. Wahrenberger, MD, FAHA, FACC** MHMH/DHC (Lebanon Physician) Trustee *Clinical Cardiologist, Cardiovascular Medicine*
Jonathan T. Huntington, MD, PhD, MPH MHMH/DHC (Lebanon Physician) Trustee *Acting Chief Medical Officer, DHMC*	**Marc B. Wolpow, JD, MBA** MHMH/DHC/D-HH Trustee *Co-Chief Executive Officer of Audax Group*
Laura K. Landy, MBA MHMH/DHC/D-HH Trustee *President and CEO of the Fannie E. Rippel Foundation*	

Jeffrey C. Fetter, MD
[redacted]

Education

August 1993-May 1997	Johns Hopkins University, Baltimore MD	BA
August 1997-May 2001	Case Western Reserve University, Cleveland OH	MD

Postdoctoral Training

June 2001-June 2006	Combined Internal Medicine and Psychiatry Residency Dartmouth-Hitchcock Medical Center, Lebanon NH
June 2005-June 2006	Chief Med-Psych Resident Dartmouth-Hitchcock Medical Center, Lebanon NH
Sept 2019- Sept 2021	Physician Leadership Program University of NH Paul College of Business and Economics

Licensure/Certification

April 5, 2006-Jun 30, 2018	New Hampshire Medical License #13042
May 2019-May 2021	Basic Life Support
Jan 2018- Dec 31, 2028	Board Certified in Internal Medicine, Diplomate #255543
May 2010-May 2020	Board Certified in Psychiatry, Diplomate #60814
April 2010-present	Certified in Transcranial Magnetic Stimulation (Neurostar, Inc.)
Nov 2016-present	DEA Buprenorphine X-Waiver

Hospital Appointments and Clinical Responsibilities

Aug 2018 – Present
Chief Medical Officer
Riverbend Community Mental Health Center
Concord, NH

- Supervision of 18 providers
- Assertive Community Treatment Team Psychiatrist
- Program Development
- Integrated Delivery Network (IDN2) Medical Director
    - Medication Assisted Treatment for Substance Use Disorders
    - Psychopharmacology Services and Re-Entry initiatives for county inmates
    - Integrated Primary Care and Behavioral Health Program

Jan 2013-Sept 2018
Chief Medical Officer
NH Department of Corrections
MHM Services, Inc.
Concord, NH

- Supervision of Correctional Health Services
- Utilization Management
- Program Development
- Psychiatrist, Special Housing Unit, Residential Treatment Unit

Feb 2015 to present
Expert Witness

- Independent Psychiatric Examiner; RSA 135-C Physician Certifications
  - Cheshire, Merrimack, Rockingham, and Hillsborough Counties Probate Courts
- Correctional Malpractice/Section 1983 Cases

March 2013-July 2016
EKG Interpretation Consultant
Dartmouth Psychopharmacology Research Group

Feb 2010- Dec 2012
Director of Consultation Psychiatry

- Inpatient Psychiatry
- Consultation to Hospitalists and Emergency Room
- ECT, rTMS

Concord Hospital, Concord NH

July 2010-Dec 2012
Cardiometabolic Psychiatry Clinic
Riverbend Community Mental Health Center
Concord NH

July 2006-Jan 2010
Attending Physician with Privileges in Psychiatry and Internal Medicine
New Hampshire Hospital, Concord NH

August 2006-Jan 2013
Consulting Physician with Privileges in Electroconvulsive Therapy
Concord Hospital, Concord NH

Mar 2009-Feb 2010
Cardiometabolic Psychiatry Consult Service
New Hampshire Hospital, Concord NH

Professional Leadership Positions

Dec 2017-Present
Fellowship Committee, American College of Correctional Physicians

May 2016-Present
Psychiatry Representative, NH Medical Society

May 2014-May 2016
Legislative Liaison, NH Psychiatric Society

May 2011-May 2015
President, NH Psychiatric Society

Nov 2013-May 2016
Executive Councilor, NH Medical Society

Mar 2009-Jan 2011
Inpatient Psychiatry Liaison, NH Psychiatric Society

July 2007-Feb 2010
Chair, Pharmacy and Therapeutics Committee, NH Hospital

July 2007-Feb 2010
Chair, Metabolic Syndrome Work Group, NH Hospital

Committee Assignments

June 2003-2006	DHMC Graduate Medical Education Accreditation Committee
Apr-June 2004	Chair, DHMC Psychiatry Resident Curriculum Project
July-Dec 2005	DHMC Resident Work Hours Task Force
Aug 2006-Jan 2007	Pharmacy and Therapeutics Committee, NHH
October 2006-June 2007	Metabolic Syndrome Work Group, New Hampshire Hospital
January 2007-2010	New Hampshire State Institutional Review Board
March 2007-2010	Medical Emergencies Committee, NHH
Sept 2007-2010	Adverse Medication Events Review Committee, NHH
June 2009-Aug 2009	Defensive Measures Task Force, NHH
March 2010-Dec 2012	Pharmacy and Therapeutics Committee, Concord Hospital
July-October 2016	Special Legislative Commission on Syringe Service Programs
October 2013-Sept 2018	MHM Inc. Credentialing Committee

Memberships

American College of Correctional Physicians
Association of Medicine and Psychiatry
American Psychiatric Association
New Hampshire Psychiatric Society
New Hampshire Medical Society

Awards and Honors

April 2001	Case Western Reserve University Health Policy Competition, Honorable Mention
June 2003	Abraham Lenzner, MD Award for Excellence in Consultation Psychiatry
April 2005	Association of Medicine and Psychiatry Martin Fenton, MD Award Med-Psych Resident of the Year
April 2006	Dartmouth Medical School Department of Medicine Excellence in Teaching Award Nominee
May 2006	Dartmouth Medical School Students' Excellence in Teaching Award for Medicine Clerkship
May 2007	Emory University Future Leaders in Psychiatry
April 2017	NH Public Health Association, Friend of Public Health

Research Experience

Site Investigator for Riverbend: "Cannabis, Schizophrenia and Reward: Self Medication and Agonist Treatment" NIDA D14016, Dartmouth Psychopharmacology Research Group (A. Green, PI)

Principal Investigator: "N-3 Fatty Acids for hypertriglyceridemia in patients with schizophrenia taking atypical antipsychotics." Dartmouth Psychiatry Department Junior Clinical Investigator Research Award.

Site Investigator for New Hampshire Hospital: "Clozapine vs. Risperidone for People with First Episode Schizophrenia and Co-Occurring Substance Use Disorder," Dartmouth Psychopharmacology Research Group (A. Green, PI)

Collaborating Investigator: "Management of Risk of Relapse in Schizophrenia III," NIMH #MH41573 (S. Marder, PI)

Site Investigator for New Hampshire Hospital: "Pilot study for treatment of persistent psychotic symptoms in schizophrenia," feasibility study to prepare for NIMH funded randomized antipsychotic trial. Dartmouth Psychopharmacology Research Group (D. Noordsy, PI)

Teaching Experience

May 2004	Conceived and Organized Psychotherapy Roundtable for Residents
June 2004 and 2005	Taught "Medical Emergencies for Psychiatry Interns" Lecture Series
June 2005-2006	Initiated and Facilitated Med-Psych Residents' Report
June 2006	"Inflammatory Bowel Disease and Mental Illness," Crohn's and Colitis Foundation Symposium at Dartmouth-Hitchcock Medical Center
2006-2010	Supervision of 3rd year medical students on psychiatry clerkship Supervision of 2nd year psychiatry residents Initiated and Organized Weekly Unit "Doc Talk" Seminar
Nov 2007	Internal Medicine Morbidity and Mortality Conference, White River Junction VA Medical Center

Sept 2008	NH Hospital Grand Rounds: "Cardiometabolic Risk and Mental Illness"
May 2009	Dartmouth PRC Seminar: "N-3 Fatty Acids for High Triglycerides in Patients Taking Atypical Antipsychotics"
May 2010	CH Grand Rounds: "Consultation Psychiatry"
May 2010	"Severe Depression and Cardiovascular Disease" New England ECT Annual Meeting
Oct 2011-2013	CH Simulation Center Course "Psychiatric Emergencies: De-escalation"; Conceived and Executed Course; Filmed Video Training, Moderated Simulations
May 2012	NH Hospital Grand Rounds: "Inpatient Violence"
Oct 2012	NH Medical Society Annual Scientific Meeting: "Obesity and Mental Health"
Feb 2012	Concord Hospital Grand Rounds: "Psychiatric Perspectives on Obesity"
Nov 2013	NH Medical Society Annual Scientific Meeting: "Mental Illness: Skills Every Physician Should Have"
Nov 2013	Concord Hospital Symposium: "Inpatient Violence"
Jan 2015	NH Hospital Grand Rounds: "Correctional Medicine Update"
Feb 2017	NH DOC Grand Rounds: "SHU and Analogue Environments"
March 2017	Psychiatric Consultant: Northern NH SWAT Team Hostage Negotiation Training Exercise
Oct 2018	Association of Medicine and Psychiatry National Meeting, Chicago IL: "Correctional Medicine"
April 2019	Kansas University Department of Psychiatry Grand Rounds "Correctional Medicine"
Dec 2019	"Psychiatric Diagnosis and the Law" NH Circuit Court Judge Conference (Scheduled)
June 2019	TBA NH Trauma Conference (Scheduled)

Original Articles:

Fetter, JC. Implementing a Correctional Electronic Medical Record. CorDocs: Newsletter of the American College of Correctional Physicians. 2017;20(2)

Fetter, JC. Chronic Pain in Corrections. CorDocs: Newsletter of the American College of Correctional Physicians. 2016;19(2)

Fetter JC, Brunette M, Green A. N3 Fatty Acids for Hypertriglyceridemia in Patients Taking Second Generation Antipsychotics. Clinical Schizophrenia and Related Psychoses. Summer 2013 73-77A

Fetter JC, Bartels SJ, Parker C. A cardiometabolic psychiatry consultation service in a state psychiatric hospital. Prim Care Companion of CNS Disorders 2011; 13(2)

Fetter JC. Diagnosing and Managing Violence. Prim Care Companion J of CNS Disorders. 2011;13(5)

Shagoury P, Currier M, Bemis R, Fetter JC. A motivational interviewing group to manage cardiometabolic risk on an inpatient psychiatry unit: A chart review. Prim Care Companion to J Clin Psych; 2010; 12(6)

Shagoury P, Currier M, Fetter JC. A motivational interviewing group to manage cardiometabolic risk on an inpatient psychiatry unit: A case study. Prim Care Companion to J Clin Psych 2010; 12(3)e1

Fetter JC. Mirtazapine for MDMA-Induced Depression. Am J Addict. 2005 May-Jun;14(3):300-1

Denard PJ, Fetter JC, Zacharski LR. Rectus sheath hematoma complicating low-molecular weight heparin therapy. Int J Lab Hematol. 2007 Jun;29(3):190-4.

Fetter JC. Psychosocial Response to Mass Casualty Terrorism: Guidelines for Physicians. Primary Care Companion to J Clin Psychiatry 2005; 7(2): 49-52

Fetter JC, Askland KD. Antidepressants for Bipolar Depression. Am J Psychiatry 2005 Aug; 162(8): 1546

Fetter JC. Letter: Weight gain and quality of life among patients taking antipsychotics. Psychiatr Serv. 2003 Jul;54(7):1041

Fetter JC. The Gift of Therapy: A Letter to a New Generation of Therapists and their Patients. Prim Care Companion J Clin Psychiatry. 2006; 8(3): 181

Poster Presentations:

Fetter JC, Barton E, Grattan V. Englander C. Hepatitis C Treatment in a Correctional System: 10 Years' Experience.
Presented at National Committee for Correctional Health Care National Conference, Oct. 2014

Fetter JC, Bartels S. Developing a Medication Algorithm for Second Generation Antipsychotic-Induced Metabolic Effects.
Presented at Future Leaders in Psychiatry, Atlanta GA 2007

Fetter JC, Gillock KL, Friedman M, Howard J. Adiposity and Chronic Traumatic Stress.
Presented at Association for Medicine and Psychiatry Annual Meeting, Los Angeles CA, 2006

Scientific Sessions:
Chair, "Weight Gain and Mental Illness"
American Psychiatric Association General Meeting, New Orleans, 2010

CURRICULUM VITAE
GARY S. MOAK, M.D.

I. EDUCATION

University of Pennsylvania	BA	1974-1978
Robert Wood Johnson Rutgers Medical School	MD	1978-1982

II. POSTDOCTORAL TRAINING

University of Pittsburg	Psychiatry Residency	1982-1986
University of Pittsburg	Geriatric Psychiatry Fellowship	1985-1986

III. ACADEMIC APPOINTMENTS

Geisel Medical School at Dartmouth	Assistant Professor of Psychiatry	2015-present
University of Massachusetts Medical School	Associate Professor of Clinical Psychiatry	1996-2015
College of the Holy Cross	Lecturer	1993-1994
University of Massachusetts Medical School	Assistant Professor of Psychiatry	1986-1996

IV. INSTITUTIONAL LEADERSHIP ROLES

Clinical Director of Psychogeriatrics, Worcester State Hospital	1986-1989
Medical Director, Geriatric Medical Psychiatry Unit, UMassMemorial~Clinton Hospital	1990-1997
Chief of Psychiatry, UMassMemorial~Clinton Hospital	1991-1997
Director of Geriatric Services, Boston Road Clinic/Capstan, Inc./Fallon Community Health Plan	1997-1999
Director, Geriatric Division, Department of Psychiatry Saint Vincent Hospital, Worcester, MA	1997-1999
Owner and Medical Director, Moak Center for Healthy Aging, LLC.	1999-2015
Medical Director, Geriatric Psychiatry Consultation Project, University of Massachusetts Medical School	2009-2011
Chief of Geriatric Psychiatry, New Hampshire Hospital	2015-present
Associate Medical Director, New Hampshire Hospital	2017-present
Director, Geriatric Psychiatry Fellowship Program, Dartmouth-Hitchcock Medical Center	2017-present

V. LICENSURE AND CERTIFICATION

Commonwealth of Massachusetts	Medical License	1986-2018
American Board of Psychiatry and Neurology	Certified in Psychiatry	1987
State of New Hampshire	Medical License	1989-present
American Board of Psychiatry and Neurology	Certified in Geriatric Psychiatry	1991-2001
	Recertified	2001-2011
	Recertified	2011-2021

VI. HOSPITAL OR HEALTH SYSTEM APPOINTMENTS

Worcester State Hospital, Clinical Director of Psychogeriatrics	1986-1989

UMassMemorial Healthcare, Worcester, MA Staff psychiatrist	1986-1989
Nashua Brookside Hospital, Nashua, New Hampshire Staff psychiatrist	1989-1990
UMassMemorial~Clinton Hospital, Clinton, Massachusetts Medical Director, Geriatric Medical Psychiatry Unit	1990-1997
UMassMemorial Healthcare, Worcester, MA	
Consultant, Geriatric Medicine Clinic	1994-1996
Consultant, Geriatric Medical Psychiatry Unit	2004-2006
Medical director, Geriatric Psychiatry Consultation Project	2009-2011
Saint Vincent Hospital, Worcester, Massachusetts Director, Geriatric Division	1997-1999
Whittier Rehabilitation Hospital, Westborough, Massachusetts Consultant	1999-2015
New Hampshire Hospital, Concord, New Hampshire, Member, Active medical staff	2015-present
Dartmouth-Hitchcock Medical Center, Lebanon, New Hampshire, Member, active medical staff	2015-present

VII. OTHER PROFESSIONAL POSITIONS

VIII. PROFESSIONAL DEVELOPMENT ACTIVITIES

IX. TEACHING ACTIVITIES

A. Undergraduate teaching

Aging and Health. College of the Holy Cross, Senior Undergraduate Seminar	1993-1994

B. Undergraduate Classroom Medical Education

Scientific Basis of Medicine, Geisel Medical School: Lectures on dementia and normal aging for this second-year medical student lecture course	2017-present

C. Undergraduate Clerkship

Geriatric Psychiatry Teaching Rounds: 2017-present
New Hampshire Hospital.
As chief of geriatric psychiatry, I see all new geriatric patients with the faculty and medical students. Time with students averages 60 hours per year.

D. Graduate Medical Education

Health Aging Brain Care Clinic: 2015-present
Dartmouth-Hitchcock Medical Center.
I supervise geriatric psychiatry fellows and two to four PGY-3 psychiatry residents, and precept PGY-3 internal medicine residents in this outpatient clinic, which includes monthly teaching rounds at an affiliated nursing facility.
Teaching activities includes clinical supervision and group discussion of cases and clinical topics or selected readings from the literature.
The clinic requires about 172 hours per year

Geriatric Medicine Consultation Clinic: 2018-present
Dartmouth-Hitchcock Medical Center.
I supervise geriatric psychiatry fellows in the provision of consultation to geriatricians on difficult cases. Requires up to 150 hours per year.

Geriatric Psychiatry Teaching Rounds: 2017-present
New Hampshire Hospital.
As chief of geriatric psychiatry, I see all new geriatric patients with the faculty and residents or fellows. Requires about 120 hours per year.

Geriatric Psychiatry Didactic Supervision: 2018-present
Dartmouth-Hitchcock Medical Center. Discussion with fellows of weekly assigned readings from the literatures of geriatric psychiatry, aging, geriatric medicine, neurology, and gerontology. 40 hours per year.

Geriatric Psychiatry Core Curriculum: 2017-present
Dartmouth-Hitchcock Medical Center
Didactic teaching of the geriatric segment of the core curriculum for the PGY-2 and PGY-4 residents. Four hours per year.

Transition to Practice Seminar: 2017-2018
Dartmouth-Hitchcock Medical Center.
monthly seminar covering transition from fellowship to early career practice, focusing on practice roles and professional identity of practicing geriatric psychiatrists. Twelve hours total.

Required PGY-3 Geriatric Psychiatry Rotation: 2011-2014
University of Massachusetts Medical School.
My private practice served as the geriatric psychiatry training site for the psychiatry residency. Residents learned to treat geriatric patients under my supervision. Required about 400 hours per year.

Geriatric Psychiatry Rotation, Geriatric Medicine Fellowship: 2011-2014
University of Massachusetts Medical School.
My private practice served as the training site for geriatric medicine fellows to satisfy their geriatric psychiatry requirement. Required 80 hours per year.

Geriatric Psychiatry Core Curriculum: 1992-1999,
University of Massachusetts Medical School. 2004-2015
I coordinated the didactic curriculum in geriatric psychiatry For the psychiatry residency, personally delivering two to four seminars per year.

X. PRIMARY RESEARCH ADVISING

Athari Alyazidi, M.D. Academic year 2017-2018. Dartmouth-Hitchcock Medical Center Geriatric Psychiatry Fellowship Program.
I mentored a geriatric psychiatry fellow on the conceptualization and execution of a small research project conducted at New Hampshire Hospital on frailty among older adult state hospital patients. She was able to present the study at an early-career poster session at the 40th Annual Scientific Meeting of the American Association for Geriatric Psychiatry, March 16, 2018, Honolulu

Carol Lim, M.D. Academic year 2019-2021
Dartmouth-Hitchcock Medical Center Psychiatry Residency Program.
I presently mentor a PGY-IV psychiatry resident on a qualitative research project looking at knowledge, beliefs, and attitudes about aging among middle-age patients with severe and persistent mental disorders.

XI. ADVISING/OTHER MENTORING

Carol Lim, M.D. Academic year 2018-2019
Dartmouth-Hitchcock Medical Center Psychiatry Residency Program.
I mentored a PGY-III psychiatry resident who applied for, and was awarded, an American Association for Geriatric Psychiatry Geriatric Mental Health Foundation Scholarship. This award funds residents to attend two annual meetings of the AAGP, during which they participate in leadership development programs.

XII. ENGAGEMENT, COMMUNITY SERVICE

Assabet Valley Home Health Association
1991-1998
I served on the Board of Directors of this home health (VNA) organization located in Marlborough Massachusetts. It required about fifty hours per year. I also served on the Executive Search Committee for nearly one year, spanning 1994-1995, and this required 48 additional hours.

Jewish Family Services of Worcester, MA
2000-2006
I served as a member of the Guardianship Advisory Committee. Jewish Family Services Was the largest provider of public guardian services in Central Massachusetts, and this committee required thirty-six hours per year.

Beat Depression to Stay Healthier and Live Longer: A Guide for Older Adults and Their Families. Rowman & Littlefield, Lanham, MD, 2016. I wrote this book for a lay audience to educate the public about the negative impact depression has on health, aging, and lifespan. It included a bibliography with over 200 references from the research literature to support the claims I made. It was released in hardcover in 2016 and paperback in 2018.

XIII. RESEARCH ACTIVITIES

XIV. PROGRAM DEVELOPMENT

Geriatric Mental Health Consultation Program
New Hampshire Hospital, 2018 – present.
This program, based at New Hampshire Hospital, offers real-time telephone-based clinical consultation, on-site educational in-service training, and academic detailing to healthcare professionals all over New Hampshire to assist in the management of older adults with mental disorders. It utilizes the geriatric psychiatry expertise at New Hampshire Hospital, consisting of Geisel Medical School faculty geriatric psychiatrists.

New Hampshire Hospital I-Unit
New Hampshire Hospital, 2018 -present
I have been working with a team to develop a 12-bed unit to address the unique psychosocial and biomedical needs of middle-aged patients with severe and persistent mental disorders. The program design will support measurement-based treatment, and the clinical data collected will be available for studies to understand the impact of chronic mental illness on aging.

XV. ENTREPRENEURIAL ACTIVITIES

Moak Associates
Westborough, Massachusetts, 2001-2018
My wife and I built a medical billing company specializing in geriatric mental health services. My role was to provide Medicare compliance and practice management consultant to the company's clients.

XVI. MAJOR COMMITTEE ASSIGNMENTS

A. National/International

B. Regional

Member, Task Force on Mental Health Services for the Elderly, Massachusetts Department of Mental Health	1987-1989
Medicare Carrier Advisory Committee, Representative for the Massachusetts Psychiatric Society	1994-2012

C. Institutional

Associate Member, Center on Aging, UMassMemorial Healthcare	1988-1990
Peer Review Committee, Nashua Brookside Hospital	1989-1990
Credentials Committee, UMassMemorial~Clinton Hospital	1990-1997
Member (non-voting), Board of Directors, UMassMemorial~Clinton Hospital	1992-1997
Chair, Grand Rounds Committee, New Hampshire Hospital	2016-present
Chair, Medical Records Committee, New Hampshire Hospital	2017-2019
Electronic Health Record Committee, New Hampshire Hospital	2017-present
Chair, Treatment Plan Work Group, New Hampshire Hospital	2016-2017
Research Administration Committee, New Hampshire Hospital	2017-present
Chair, Pain Management Committee, New Hampshire Hospital	2018-present
Graduate Medical Education Committee, Dartmouth-Hitchcock	2018-present

XVII. MEMBERSHIPS, OFFICE AND COMMITTEE ASSIGNMENTS IN PROFESSIONAL SOCIETIES

Member, American Medical Association	1979-present
Member, American Psychiatric Association	1983-present
American Psychiatric Association Council on Aging	
Burroughs Wellcome Fellow	1984-1986
Council Member	1986-1991
Corresponding Member	2006-2007
American Psychiatric Association Task Force on Public Mental Health Systems and the Elderly, member	1988-1991
Member, American Geriatrics Society	1989-present
Member, Gerontologic Society of America	1990-present
Massachusetts Psychiatric Society, Chair, Committee on Geriatric Psychiatry	1992-1999
American Psychiatric Association, Member, Medicare Carrier Advisory Network	1994-2012
American Association for Geriatric Psychiatry	
Chair, Clinical Practice Committee	1996-1999
Member, Public Policy Committee	1996-1999
Member, Board of Directors	1999-2002
Member, Long-Term Care Initiative	1999-2001
Member, Scientific Program Committee	2001-2002
Secretary-Treasurer	2004-2005
Member, Reimbursement Task Force	2005-2009
President	2007-2008
Member, International Psychogeriatric Association	2003-present
Member, New Hampshire Psychiatric Society	2015-present

XVIII. INSTITUTIONAL CENTER OR PROGRAM AFFILIATIONS

XIX. EDITORIAL BOARDS

XX. JOURNAL REFEREE ACTIVITY

XXI. AWARDS AND HONORS

Phi Beta Kappa - Pennsylvania Chapter – Member	1978
American Psychiatric Association Burroughs Wellcome Fellow	1984-1986
American Association for Geriatric Psychiatry Clinician-of-the-Year Award	2011
Distinguished Life Fellow, American Psychiatric Association	2016
Distinguished Fellow, American Association for Geriatric Psychiatry	2019

XXII. INVITED PRESENTATIONS

A. International

*^Reichman, WE, Aupperle PM, Moak GS, Sultzer DL: Practical Management of Behavioral Disturbances in Dementia, A Hands-On, Case-Based Approach. Presented at the 16th Annual Meeting of the American Association for Geriatric Psychiatry, Honolulu, March 1-4, 2003.

*^Moak GS: Will There Be Any Geriatric Psychiatrists in the Future Healthcare Delivery System? Presidential Keynote Address, 20th Annual Meeting of the American Association for Geriatric Psychiatry, New Orleans, March 1-4, 2007.

B. National

#^Moak GS, Merowitz M: Geriatric Psychiatry in the State Hospital: Current Status and Future Directions. Workshop presented at the 39th Institute on Hospital and Community Psychiatry, Boston, 1987

*^Introduction to Geriatric Practice: Roundtable discussion presented at the Tenth Annual Meeting of the American Association for Geriatric Psychiatry, Orlando, Florida, March 3, 1997

*^Moak GS, Siegal A, Stein EM, et. al.: Successful Management of a Geriatric Psychiatry Practice: Workshop presented at the Tenth Annual Meeting of the American Association for Geriatric Psychiatry, Orlando, FLorida, March 6, 1997.

*^Elderly Persons with Psychosis in the Community. Symposium discussant, presented at the 150th Annual Meeting of the American Psychiatric Association, San Diego, May 20, 1997.

#^Moak GS, Jackson J, Steinberg A: Managing a Successful Nursing Home Practice: Presented at the 11th Annual Meeting of the American Association for Geriatric Psychiatry, San Diego, March 12, 1998.

*^Moak GS: What You Need To Know About the OBRA Regs. In Dyck G and Moak GS. Component Workshop Number 24, Successful Practice in Long-Term Care. Presented at the 151st Annual Meeting of the American Psychiatric Association, Toronto, June 2, 1998.

#^Moak GS, Siegal AP: Emerging Opportunities for Geriatric Practice – Managed Care Workshop. Presented at the 12th Annual Meeting of the American Association for Geriatric Psychiatry, New Orleans, March 15, 1999.

#^Moak GS, Stein EM: Medicare Coding Workshop. Presented at the 12th Annual Meeting of the American Association for Geriatric Psychiatry, New Orleans, March 17, 1999.

*^Moak GS, Reichman W, Siegal AP, Steinberg A: Advanced Practice Management: Strategies for Building a Dementia Practice in Diverse Settings. Presented at the 12th Annual Meeting of the American Association for Geriatric Psychiatry, New Orleans, March 18, 1999.

*^Moak GS, Greenspan D: How to Set Up a Geropsychiatry Unit. Presented at the 13th Annual Meeting of the American Association for Geriatric Psychiatry, Miami, March15, 2000.

*^Moak GS: Depression in the Elderly, in Steinberg AL: Review and Update of Geriatric Psychiatry. Presented at the 13th Annual Meeting of the American Association for Geriatric Psychiatry, Miami, March 11, 2000.

#^Moak GS, Stein EM, Shellow RA: Coding/Reimbursement Controversies: How to Maintain a viable Practice in Geriatric Psychiatry. Presented at the 13th Annual Meeting of the American Association for Geriatric Psychiatry, Miami, March 13, 2000.

*^Moak GS: Providers of Nursing Home Mental Health Services-Patterns of Practice. Providing Optimal Mental Health Services in Long Term Care. American Association for Geriatric Psychiatry, Washington, D.C., June 23-24, 2000.

#^Moak GS, Stein EM: Medicare Coding and Reimbursement: Presented at the 14th Annual Meeting of the American Association for Geriatric Psychiatry, San Francisco, February 24, 2001.

*^Moak GS: Reimbursement Issues for Geriatric Psychiatrists. Presented at the 15th Annual Meeting of the American Association for Geriatric Psychiatry, Orlando, February 24-27, 2002.

*^Stein, E, Moak G, Liptzin B: Everything You Every Wanted to Know About Coding, Documentation, and Reimbursement. Presented at the 16th Annual Meeting of the American Association for Geriatric Psychiatry, Honolulu, March 1-4, 2003.

*^Bruce M, Vogel-Scibilia S, Hansen JC, Moak GS: Aging Well, The Successful Integration of Mental, Medical, and Social Services. Presented at the 20th Annual Meeting of the American Association for Geriatric Psychiatry, New Orleans, March 1-4, 2007.

*^Moak GS: New Developments in Medicare. In Proper Billing and Fair Reimbursement for Elder Care. AAGP's 2009 Clinical Practice Management Symposium. Presented at the 22nd Annual Meeting of the American Association for Geriatric Psychiatry. March 5, 2009, Honolulu.

*^Moak GS: Geriatric Psychiatry Workforce Issues Across the Pacific. Symposium Discussant. 22nd Annual Meeting of the American Association for Geriatric Psychiatry. March 6, 2009, Honolulu.

*^Kirwin P, Lyness J, Moak GS, Reynolds C, Forester B: The 2008 Institute of Medicine Report: Implications and Opportunities for Education, Public Policy/Access to Care and Research. 23rd Annual Meeting of the American Association for Geriatric Psychiatry. March 7, 2010, Savannah.

*^Moak GS: Provision of Services – How Can Healthcare Organizations Incentivize Geriatric Mental Health Practitioners to Provide the Expertise They Need?. Presentation in symposium "Evolving Roles for Geriatric Mental Health Providers in the 21st Century Health Care System. Annual Meeting of the American Association for Geriatric Psychiatry, Los Angeles, March 14-17, 2012.

*^Moak, G., "New Codes", in "Engaging in the Business of Geriatric Psychiatry: Making a Career and a Living in Geriatric Psychiatry", Symposium presented at the 40th Annual Meeting of the American Association for Geriatric Psychiatry, March 15, 2018, Honolulu.

*^Moak G., "The Best of Times and the Worst of Times: Opening and Closing Private Practices" in "Engaging in the Business of Geriatric Psychiatry: Making a Career and a Living in Geriatric Psychiatry", Symposium presented at the 40th Annual Meeting of the American Association for Geriatric Psychiatry, March 15, 2018, Honolulu.

*^Moak, G, "Collect Your Fees if You Want to Pay Your Office Rent: Billing, Collections and Appeals" in "Engaging in the Business of Geriatric Psychiatry: Making a Career and a Living in Geriatric Psychiatry", Symposium presented at the 40th Annual Meeting of the American Association for Geriatric Psychiatry, March 15, 2018, Honolulu.

C. Regional/Institutional

*^Poststroke Depression: Evaluation and Treatment. Workshop presented at the Second Annual Stroke Rehabilitation Conference sponsored by The National Stroke Association, The Medical Center of Central Massachusetts, and Education
Resources, Inc., Boston, October 19, 1990

*Aging, Mental Health, and Mental Illness. Briefing presented to the Legislative Caucus on Older Citizens' Concerns, Massachusetts State House, March 27, 1997.

*Moak GS: Geriatric Issues: Lecture presented at the Massachusetts Probate and Family Court Judicial Conference. Plymouth, October 23, 1998.

*Freedman D, Moak GS: Defining, Diagnosing, Medicating and Treating Persons of Questionable Competency. Presented at the 5th Elder Law Institute, Suffolk University Law School and the Massachusetts Chapter of the National Academy of
Elder Law Attorneys, Waltham, March 19, 1999.

*^Moak GS: Neuropsychiatric Complications of Stroke. Stroke Management: A Paradigm for the New Millennium. Whittier Rehabilitation Hospital-UMassMemorial Healthcare Stroke Rehabilitation Conference, October 27, 1999, Westboro, MA.

*^Moak GS: CATIE-AD: A Clinician's Perspective. Massachusetts Psychiatric Society 18th Annual Psychopharmacology Update. November 17, 2007, Waltham.

*Moak GS: Collaborative Care and Management of Late-Life Health Problems: Presentation given in symposium Models of Care & Coverage in a Full Risk World. Coordinated Care and coverage Conference, Fallon Community Health Plan, Westborough, MA, October 11, 2012.

*Moak GS: Challenges to Wellness. Keynote address presented at the 21st Annual Gerontological Nurses Conference, Saint Anselm College, Manchester, NH, August 21, 2015

*^Moak GS: Depression is a Risk Factor for Cardiovascular Disease Throughout the Lifespan. Grand rounds lecture presented at New Hampshire Hospital, Concord, NH, September 17, 2015.

*^Moak GS: Navigating the Treacherous Straits of Behavioral Health Documentation, Coding, Billing in the Era of ICD-10. Symposium presented at the Beth Israel Deaconess Hospital-Plymouth, Plymouth, MA, November 17, 2016.

*Moak GS: Safe and Effective Geriatric Psychopharmacology. Keynote lecture presented at the 21st Annual Northeast Psychiatric Nursing conference, St. Anselm College, Beford, NH, April 6, 2017

*^ Moak GS: Depression and Anxiety in the Elderly: A Framework for Primary Care. Annual Meeting of the New Hampshire Osteopathic Association, North Conway, NH, January 25, 2019.

*Ross D, Norton S, Moak GS: Aging Well in New Hampshire's Behavioral Healthcare System. Panel Presentation at the New Hampshire Behavioral Health Summit, Manchester, NH, December 16, 2019

XXIII. BIBLIOGRAPHY

A. Peer-reviewed publications in print or other media

1. Most Significant Publications:
   (These papers deal with the psychiatric services older adults receive in various healthcare settings and barriers they face to quality of care)

   Fisher WH, Moak GS: Psychogeriatric Specialization in State Mental Hospitals: Data from a Nationwide Survey. Administration and Policy in Mental Health; 1990: 101-110.

   Moak GS, Fisher WH: Alzheimer's Disease and Related Disorders in State Mental Hospitals: Data from a Nationwide Survey. The Gerontologist 1990; 30(6): 798-799.

Moak GS, Fisher WH: Geriatric Patients and Services in State Mental Hospitals: Data from a National Survey. Hospital & Community Psychiatry 1991; 42: 273-276.

Bartels SJ, Moak GS, Dums AR: Models of Mental Health Services in Nursing Homes: A Review of the Literature and Provider Surveys. Psychiatric Services 2002; 53: 1390-1396.

Moak GS: Treatment of Late-Life Mental Disorders In Primary Care: Can We Do A Better Job? J Aging & Social Policy 2011; 23: 274-285.

2. All Other Publications:

Wapnir RA, Moak GS: Beta-2-Thienyl-DL-Alanine as an Inhibitor of Phenylalanine Hydroxylase and Phenylalanine Intestinal Transport. Biochemical Journal 1979; 177: 347-352.

Moak GS, Harris H: Lack of Homology Between Dog and Human Placental Alkaline Phophatases. Proceedings of the National Academy of Sciences, USA 1979; 76: 1948-1951.

Moak GS: Treating the Chronic Mentally Ill Elderly State Hospital Patient. Hospital and Community Psychiatry 1988; 39:119-120.

Moak GS, Zimmer B, Stein EM: Clinical Perspectives on Elderly First-Offender Shoplifters. Hospital and Community Psychiatry1988; 39: 648-651.

Tonkonogy J, Moak GS: Alois Alzheimer on Presenile Dementia. Journal of Geriatric Psychiatry and Neurology 1988; 1: 199-206.

Moak GS: Discharge and Retention of Psychogeriatric Long-Stay Patients in a State Mental Hospital. Hospital and Community Psychiatry 1990; 41: 445-447.

Moak GS: Improving Quality in Psychogeriatric Treatment. Psychiatric Clinics of North America 1990; 13: 99-111.

Moak GS: Characteristics of Demented and Non-demented Geriatric Admissions to a State Hospital. Hospital and Community Psychiatry 1990; 41: 799-801.

Fisher WH, Moak GS: Psychogeriatric Specialization in State Mental Hospitals: Data From a Nationwide Survey. Administration and Policy in Mental Health; 1990: 101-110.

Moak GS, Fisher WH: Alzheimer's Disease and Related Disorders in State Mental Hospitals: Data From a Nationwide Survey. The Gerontologist 1990; 30(6): 798-799.

Moak GS, Fisher WH: Geriatric Patients and Services in State Mental Hospitals: Data from a National Survey. Hospital & Community Psychiatry 1991; 42: 273-276.

Porello PT, Madsen L, Futterman A, Moak GS: Description of a Geriatric Medical/Psychiatry Unit in a Small Community General Hospital. The Journal of Mental Health Administration 1995; 22: 38- 48.

Moak GS: Geriatric Psychiatry and Managed Care. Psychiatric Clinics of North America, 2000; 23: 437-451.

Moak GS, Borson S: Mental Health Services in Long-Term Care – Still an Unmet Need. Guest Editorial, Am J Geriatr Psychiatry 2000; 8:96-100.

3. Book Chapters

Moak GS: Disturbances of Higher Intellectual Functioning. in Outpatient Psychiatry, Diagnosis and Treatment, Second Edition, Lazare A, ed., Williams and Wilkins, Baltimore, 1989

Moak GS: Wandering Behavior in Dementing Illness. in Disorders of Movement in Psychiatry and Neurology, Joseph A, Young RR, eds., Blackwell Scientific Publications, Inc., Boston, 1992

Moak, GS: Geriatric Psychiatry Evaluation. in Documentation Survival Handbook for Psychiatrists and other Mental Health Professionals, Soreff S, McDuffee MA, eds., Hogrefe & Huber, Publishers, Seattle, 1993

Moak, GS: When the Seriously Mentally Ill Patient Grows Old. in Handbook for the Treatment of the Seriously Mentally Ill, Soreff S, ed, Hogrefe & Huber Publishers, Seattle, 1996.

Stein EM, Moak GS: The North American Model of the Organisation of Services. In Principles and Practice of Geriatric Psychiatry, 2nd Edition. Wiley Publications, London, 2002.

Moak GS: Psychiatric Consultation and Liaison. In Psychiatry in Long-Term Care, Reichman WE, Katz PR, eds. Oxford University Press, Oxford, 2009.

B. Other Scholarly Work in Print of Other Media:

Moak, GS, Stein EM, Rubin JEV: The Over-50 Guide to Psychiatric Medications, A Task Force Report of the Council on Aging. American Psychiatric Association, Washington, D.C., 1989. This work is a book, written for a lay readership, about the benefits and risks of psychiatric medications in the treatment of mental disorders in older adults. It was published by the American Psychiatric Press, Inc., and subsequently translated into Japanese.

Fogel BS, Colenda C, deFigeurido JM, Larson D, Luchins D, Moak GS, Olympia J, Pfeiffer E, Waxman H: State Mental Hospitals and the Elderly: A Report of the American Psychiatric Association Task Force on Geriatric Psychiatry in the Public Mental Health Sector, American Psychiatric Association, Washington, D.C., 1993.

Siegal AP and Jackson JM: Geriatric Psychiatry Practice Management Handbook. Moak, GS Content Editor. American Association for Geriatric Psychiatry, Bethesda, 1997.

New Approaches for the Diagnosis and Management of Alzheimer's Disease. Symposium discussant. The American Journal of Managed Care 2000; 6(22), Supplement.

Moak GS: Beat Depression to Stay Healthier and Live Longer: A Guide for Older Adults and Their Families. Rowman & Littlefield, Lanham, MD, 2016.

C. Abstracts

Moak GS: Alzheimer Patients Admitted to a State Hospital: Who Are They and What Are Their Needs. Poster presented at the 39th Institute on Hospital and Community Psychiatry, Boston, October, 1987

Fisher WH, Moak GS: Prevalence of Alzheimer's Disease and Related Disorders in State Mental Hospitals: Correlation with Nursing Home Bed Undersupply. Poster presented at the 116th annual meeting of the American Public Health Association, Boston, November, 1988

Athari Alyazidi, Andrew P. Huang, Alexander C. Bender, Aliaksandr Shakhau, and Gary S. Moak, "Frailty Among Older Adult State Hospital Patients", poster presented at the 40th Annual Scientific Meeting of the American Association for Geriatric Psychiatry, March 16, 2018, Honolulu.

XXIV. PERSONAL STATEMENT

I did not follow a traditional academic path. I left academia to develop geriatric services in various sectors of the healthcare system, eventually settling in my own private practice. No matter where I found myself, however, I maintained ties with the University of Massachusetts Medical School and remained aligned with the mission of academic medicine. I accomplished this through teaching and training activities, education of the public, and political advocacy.

From my diverse experience in healthcare, I gained a broad perspective on the field of geriatric psychiatry, and I drew upon this to inform my work in the American Association for Geriatric Psychiatry. As a leader of AAGP, I worked to advance a national agenda in the areas of Medicare mental health payment policy, the geriatric psychiatry workforce, and the pipeline for clinician educators and researchers. A crowning accomplishment was successfully lobbying the Centers for Medicare and Medicaid Services to add a unique provider designator for geriatric psychiatry, on par with those for geriatric medicine and child psychiatry.

Early in my career I realized that consumer knowledge gaps pose a greater barrier to geriatric mental healthcare services than do provider or system barriers, and so I committed myself to educating the public. Over the years, I have given countless talks to patient and family groups, legislators, judges, and healthcare policymakers and have appeared in radio, television, and podcast venues always to speak about various aspects of mental health and aging. Hoping to reach a broader audience I wrote my book "Beat Depression to Stay Healthier and Live Longer: A Guide for Older Adults and Their Families."

In 2015 I decided to return to academia seeking new opportunities to thrive as a geriatric psychiatrist. When I joined the faculty of the Geisel Medical School at Dartmouth, the geriatric psychiatry programs at both New Hampshire Hospital and Dartmouth-Hitchcock Medical Center were well established, and I looked forward to academic collaboration with colleagues. This was not to be. The transition of the Department of Psychiatry from Dartmouth College to DHMC, in 2016, triggered unexpected departures of faculty and staff that jeopardized the geriatric programs in both institutions. In response to this crisis, I stepped forward to sustain and revitalize both programs. At NHH I assumed additional clinical responsibilities to ensure that geriatric patients continued to receive high quality of care. I demonstrated leadership by encouraging colleagues to support the transition to DHMC. When the chief medical officer of NHH also resigned, I again assumed additional responsibility as associate medical director, while continuing as chief of geriatric psychiatry.

During this period, successive Geriatric Psychiatry Fellowship Program directors also resigned, leaving DHMC without a full-time geriatric psychiatrist, and placing the Geriatric Psychiatry Fellowship Program at risk. Having spent my career teaching and training geriatric psychiatry and advocating for the workforce and pipeline upon which it depends, I again accepted additional responsibility as program director, preventing Dartmouth's geriatric psychiatry fellowship program from failing.

My first priority as program director was to mentor the fellow, who had yet to fulfill the ACGME-required scholarly project. I helped her initiate and complete a project on frailty among older adult state hospital patients. Two medical students assisted with literature review, data collection, and analysis of the results. The fellow completed her project and she presented it at an early-career poster session of the 2018 Annual Meeting of the American Association for Geriatric Psychiatry.

Next I needed to redesign the fellowship program to both update its orientation and to preserve high quality training rotations with fewer geriatric psychiatry core faculty. I collaborated with faculty in neurology, geriatric medicine, and community-based primary care to create new clinical rotations reflective of the field's expanding knowledge base and evolving service delivery models. I replaced a textbook-based reading curriculum with a curated syllabus of primary source articles from the literatures of geriatric psychiatry, neurology, geriatric medicine, gerontology, and aging. As a result, despite the loss of key faculty members, I was able to demonstrate to the GME Committee and ACGME that Dartmouth still could field a credible fellowship, and I was able to recruit not one but two new fellows. Both graduating fellows accepted staff positions in Dartmouth-affiliated teaching hospitals, and received faculty appointments, fulfilling a critical need of the Department of Psychiatry.

In addition to becoming fellowship program director, I met other geriatric teaching and training needs in the Department of Psychiatry. I took responsibility for the geriatric didactic core curriculum in the psychiatry residency program and for geriatric psychiatry lectures in the Geisel Medical School.

Going forward, my goal is to set geriatric psychiatry at Dartmouth back on solid footing. In working to develop I-Unit at NHH I plan to create a clinical data base that will support a modest research program. Already I am mentoring a PGY-IV resident on a qualitative research project on attitudes, knowledge, and beliefs about aging among the middle-aged patients with severe and persistent mental disorders whom I-Unit will serve. I launched a geriatric psychiatry telephonic consultation program at NHH to support New Hampshire healthcare providers. Within the coming year, I expect to present and publish pilot data from this program. And, finally, I initiated an annual, statewide conference on geriatric psychiatry at NHH. The first installment addressed psychiatric challenges in nursing home care. The format included a half-day CME/CEU program for nursing home professionals, and a half-day program for family caregivers, open to the lay public, a first-ever for NHH, but consistent with my long-term goal of public education.

Ultimately, I hope these efforts will attract future fellows and faculty members and set Dartmouth geriatric psychiatry on a path to re-establish its academic vigor.

CURRICULUM VITAE

[redacted]

NAME: Lisa A. Mistler, MS MD

[redacted]

[redacted]

I. EDUCATION

DATES	INSTITUTION	DEGREE
2006 – 2008	The Dartmouth Institute	M.S.
1991 – 1996	University of Vermont College of Medicine	M.D.
1984 – 1989	Massachusetts Institute of Technology	M.S.
1982 – 1984	University of California, San Francisco	none
1978 – 1982	Massachusetts Institute of Technology	B.S.

II. POSTDOCTORAL TRAINING

DATES	INSTITUTION	SPECIALTY
2006 – 2008	VT VAMC	VA National Quality Scholar Fellowship
1996 – 2000	Dartmouth-Hitchcock	Resident, General Adult Psychiatry
1999 – 2000	Dartmouth-Hitchcock	Chief Resident, Psychiatry

III. PROFESSIONAL DEVELOPMENT ACTIVITIES

DATES	INSTITUTION	TITLE	CREDITS
2017	American Society of Addiction Medicine Review Course	Dallas TX	CME
2014	Geisel/Dartmouth	SYNERGY Certificate Program	CME
2013	Geisel/Dartmouth	The Science and Practice of Leadership	CME
2013	Motivational Interviewing Skill Code Training	Albuquerque NM	CME
2013	Mindfulness-Based Stress Reduction	Mt Madonna, San Jose CA	CME

	Intensive Teacher Workshop		
2011	Motivational Interviewing Treatment Integrity Coding Training	online	CME
2011	Mind and Life Institute	Summer Research Institute Fellow	CME
2010	Motivational Interviewing Treatment Integrity Coding Training	Silver Spring MD	CME
2009	Motivational Interviewing Treatment Integrity Coding Training	Minneapolis MN	CME
2009	Dartmouth College	Dartmouth Summer Institute Shared Decision Making Fellowship	CME
2007	Motivational Interviewing Supervisor Training	Albuquerque NM	CME
2004	Motivational Interviewing Network Trainer (MINT)	Portland ME	CME
1994-1995	University of Vermont	Pathology Student Fellowship	

IV. ACADEMIC APPOINTMENTS

DATES	**INSTITUTION**	**TITLE**
2013 – present	Geisel School of Medicine	Assistant Professor
2008 – 2013	University of Massachusetts	Assistant Professor
2000 – 2008	Dartmouth Medical School	Assistant Professor
2004 – 2005	University of New Hampshire	Adjunct Faculty

V. INSTITUTIONAL LEADERSHIP ROLES:

DATES	**INSTITUTION**	**TITLE**
2018 – present	New Hampshire Hospital	Patient Experience Committee Member
2016 – present	New Hampshire Hospital	President, Medical Staff Organization
2015	New Hampshire Hospital	Violence and Safety Task Force Chair
2015 – 2016	New Hampshire Hospital	Secretary, Medical Staff Organization
2014-present	New Hampshire Hospital	Medical Records Committee Member
2014-present	New Hampshire Hospital	Pharmaceuticals and Therapeutics Committee Member
2013	Worcester Recovery Center and Hospital	Complaint Review Committee Member
2012	University of Massachusetts	Women's Faculty Committee Member

VI. LICENSURE AND CERTIFICATION:

DATE	LICENSURE/CERTIFICATION
2011 – 2021	Diplomate, American Board of Psychiatry and Neurology
2008 – present	MA State Medical license
2000 – present	NH State Medical license

VII. HOSPITAL APPOINTMENTS:

DATES **INSTITUTION** **POSITION/TITLE**

2016 – present Dartmouth-Hitchcock Medical Center Attending Psychiatrist and Assistant Professor of Psychiatry at Geisel School of Medicine

2010 – 2013 University of Massachusetts Memorial Hospital, Worcester MA Attending Psychiatrist and Assistant Professor of Psychiatry at UMass Medical School

2010 Westboro State Hospital, Westboro MA Attending Psychiatrist

2008 – 2013 Worcester Recovery Center and Hospital, Worcester MA
Attending Psychiatrist

2006 – 2008 Catholic Medical Center, Manchester NH Attending Psychiatrist (on-call)

2006 – 2008 VAMC, White River Junction VT Attending Psychiatrist

2000 – present New Hampshire Hospital, Concord NH Attending Psychiatrist and Assistant Professor of Psychiatry at Dartmouth Medical School (2000-2012) and Geisel School of Medicine 2012-present

VIII. OTHER PROFESSIONAL POSITIONS (NON-DARTMOUTH): n/a

DATES **INSTITUTION** **POSITION/TITLE**

IX. TEACHING ACTIVITIES:

A. UNDERGRADUATE (COLLEGE) EDUCATION n/a

B. GRADUATE EDUCATION n/a

C. UNDERGRADUATE MEDICAL EDUCATION:

i. CLASSROOM TEACHING:

Fall 2009 University of Massachusetts Medical School, Worcester
"Shared decision-making in psychiatry," small group of medical students, 1 hour

Spring 2009 University of Massachusetts Medical School, Worcester
Mind Brain and Behavior leader of small group section for medical students

30 hours

ii. CLERKSHIP OR OTHER CLINICAL UME TEACHING (e.g., ON-DOCTORING)

D. GRADUATE MEDICAL EDUCATION

Winter 2013 New Hampshire Hospital Addiction Psychiatry Seminar, "Motivational Interviewing and MET," speaker, 1.5 hours

Spring 2012 University of Massachusetts Medical School, Worcester Biological Psychiatry Seminar faculty supervisor, 10 hours

Fall 2011 University of Massachusetts Medical School, Worcester Biological Psychiatry Seminar Critical Reading and Research seminar leader, 10 hours

Spring 2010 University of Massachusetts Medical School, Worcester
"Life after residency," speaker for Psychiatry residents, 1.5 hours

Summer 2009 University of Massachusetts Medical School, Worcester
"Life after residency," speaker for Psychiatry residents, 1.5 hours

Summer 2009 University of Massachusetts Medical School, Worcester "Motivational Interviewing," speaker for Psychiatry residents, 1.5 hours

E. OTHER CLINICAL EDUCATION (e.g., PA programs)

X. ADVISING/MENTORING

A. UNDERGRADUATE STUDENTS

DATES	STUDENT'S NAME	PROGRAM (e.g., WISP, Presidential Scholar)

B. GRADUATE STUDENTS

DATES	STUDENT'S NAME	PROGRAM NAME	DEGREE
2016	Valerie Rice RN	Vanderbilt University APRN Program	APRN
2015	Kate Folkins RN	Rivier College APRN Program	APRN

2001-2006 Massachusetts College of Pharmacy Physician Assistant Program Supervisor at NHH

C. NON-DEGREE PROGRAM STUDENTS (e.g., certificate programs, post-baccalaureate programs)

D. MEDICAL STUDENTS

DATES	STUDENT'S NAME	PROGRAM NAME (if applicable)
1/8/18 – 2/9/18	Emily Johnson	Geisel School of Medicine

5/15/17 – 6/16/17	Alex Bender	Geisel School of Medicine
4/4/17 – 5/5/17	Claire Hogue	Geisel School of Medicine
2/21/17 – 3/24/17	Thomas Wilcoxon	Geisel School of Medicine
1/9/17 – 2/10/17	Ana Rodriguez-Villa	Geisel School of Medicine
4/4/16 – 5/6/16	Andrew Pintea	Geisel School of Medicine
2/22/16 – 3/25/16	Chelsea Modlin	Geisel School of Medicine
1/11/16 – 2/12/16	Xing Li	Geisel School of Medicine
9/21/15 – 10/23/15	Megan Rose Laporte	Geisel School of Medicine
8/10/15 – 9/11/15	Shawn Li	Geisel School of Medicine
5/18/15 – 6/15/15	Charis Ripley-Hager	Geisel School of Medicine
4/16/15 – 5/8/15	Bianca Williams	Geisel School of Medicine
1/12/15 – 2/3/15	Katerina Byanova	Geisel School of Medicine
11/3/14 – 12/12/14	Keshia Torres-Shafer	Geisel School of Medicine
8/11/14 – 9/12/14	Huy Le	Geisel School of Medicine
6/27/05 – 8/19/05	Joan Hier	Dartmouth Medical School
3/28/05 – 4/22/05	Jody Rutz	Dartmouth Medical School
1/10/05 – 2/11/05	Eric Horton	Dartmouth Medical School
10/25/04 – 12/17/04	Jodi Leverone	Dartmouth Medical School
10/28/03 – 12/10/03	Rebekah Kim	Dartmouth Medical School
6/30/03 – 7/25/03	Malinda Danforth	Dartmouth Medical School
3/1/03 – 4/24/03	David Holznagel	Dartmouth Medical School
10/28/02 – 12/20/02	David Wartman	Dartmouth Medical School
8/26/02 – 10/18/02	Victoria Martin	Dartmouth Medical School
7/2/02 – 8/23/02	Christine Haughey	Dartmouth Medical School
5/2/02 – 6/21/02	David Gibbons	Dartmouth Medical School
3/4/02 – 3/29/02	Sanjoy Bhattacharya	Dartmouth Medical School
1/10/02 – 3/1/02	Megan Jenkins	Dartmouth Medical School
8/30/01 – 10/19/01	Timothy Burdick	Dartmouth Medical School

E. RESIDENTS/FELLOWS

DATES	**MENTEE'S NAME**	**SPECIALTY**

Dartmouth-Hitchcock Medical Center Psychiatry Residency Program, 2016-present

2/5/18 – 4/1/18	Bryan Hybki MD
12/11/17 – 1/7/18	Samuel Kohrman MD
8/21/17 – 10/15/17	Nikhil Teja MD
5/31/17 – 6/25/17	Amanda Silverio MD
02/06/17 – 4/12/17	Leonardo Cubillos MD
11/14/16 – 12/11/16	Joseph Bond MD
6/27/16 – 8/21/16	Nicole Smith MD

University of Massachusetts Medical School Psychiatry Residency Program, Worcester, 2008-2013

Clara Kim MD
Kathryn Sikorez MD
Shirley Rajan MD
Erik Istre MD

Dartmouth-Hitchcock Medical Center Psychiatry Residency Program, 2000-2006

Madhavi Kamireddi MD
Duke Fisher MD
Bernard Kim MD

Evan Eyler MD MPh
Jodi Marshall MD
Pat Daly MD
Eve Wolinski MD
Steven James MD
Jonathan Schwartz MD
Lorna Mayo MD

F. FACULTY

DATES MENTEE'S NAME SPECIALTY

G. ADDITIONAL INFORMATION

XI. RESEARCH TEACHING/MENTORING

A. UNDERGRADUATE STUDENTS

DATES STUDENT'S NAME PROGRAM (e.g., WISP, Presidential Scholar)

B. GRADUATE STUDENTS

DATES STUDENT'S NAME PROGRAM NAME DEGREE

C. MEDICAL STUDENTS

DATES STUDENT'S NAME PROGRAM NAME (if applicable
D. RESIDENTS/FELLOWS/RESEARCH ASSOCIATES

DATES STUDENT'S NAME SPECIALTY

E. FACULTY

DATES MENTEE'S NAME SPECIALTY

XII. COMMUNITY SERVICE, EDUCATION, AND ENGAGEMENT:

2009-2011	Co-chair of MI-MED Workgroup, Motivational Interviewing Network of Trainers
2007-present	Board of Advisors, New England Center for Children, Southboro MA
2005-2008	Leadership Committee, Governor's Commission on Transforming Mental Health in New Hampshire

XIII. RESEARCH FUNDING:

A. CURRENT SUPPORT
none

B. PAST SUPPORT

(PI MISTLER) Dates: 7/1/15-6/30/16 $20,000
Title: Feasibility and Acceptability of a Mobile Mindfulness Intervention on an Acute Psychiatric Unit
Funded by Department of Psychiatry Gary Tucker Junior Investigator Research Award

The goal of this project was to study implementation of a brief existing mindfulness application for mobile devices on acute psychiatric inpatient units.
Role: PI responsible for overseeing all aspects of the project, collaborating with research study coordinator and research assistant.

(PI BEN ZE'EV) Dates: 12/2013-12/2014 $20,000
Title: Deploying Mobile Technologies to Identify Predictors of Violence in Hospitalized Patients with Co-Occurring Substance Use and Psychiatric Disorders
Funded by Center for Technology and Behavioral Health Pilot Program
Role: Unfunded on-site Investigator responsible for overseeing all on-site aspects of the project, collaborating with research study coordinator and research **assistants.**

(PI GELLER) Dates: 8/2012-9/2013
Title: Assessing Major Mental Health System Change: A Proposed Evaluation of Process and Outcomes in the Worcester Recovery Center & Hospital
Unfunded
The goal of this project is to study the transformation during the move from Worcester State Hospital to the Worcester Recovery Center and Hospital in 2012. Qualitative and quantitative studies ongoing of patients, staff and administration. Pre-post study.
Role: Unfunded co-Investigator, designing the study, creating questionnaires, analyzing data and writing papers.

(PI BIEBEL) Dates: 2010-2013 $221,000
Title: Transformation Transfer Initiative (TTI) Shared Decision Making
Funded by NASMHPD, SAMHSA, CMHS
The goal of this project is to develop a polypharmacy reduction team in a community mental health center in Massachusetts.
Role: Unfunded consultant, developer of polypharmacy reduction algorithm and evaluation methods.

(PI ZIEDONIS) Dates: 9/15/12-9/14/13 $100,000
Title: Adapting the Open Dialogue Model in the United States: Developing Organizational Change Approach & Behavioral Therapy Materials
Funded by Foundation for Excellence in Mental Health Care
The objectives for this grant include (a) enhancing grantees' fluency with the existing Open Dialogue model, (b) fleshing out content for fidelity scale measures and manual development to inform further evaluation and program implementation of the model, and (c) sharing thoughts/reactions, in a dialogical format, on current practices/techniques/approaches in U.S. that may or may not be congruent with the Open Dialogue model, as well as perceived strengths and anticipated challenges that will influence the implementation of this model in the U.S.
Role: Unfunded consultant, developing questions for and running focus groups of providers that have been trained to date, analysis of focus group data, writing manuscripts. Writing introductory material for US adaptation regarding shared decision making, motivational interviewing, and health care financing.

(PI DAVIS) Dates: 9/20/09-3/2/12
Title: Treatment Retention in Transition Age Youth
Funded by NIMH
The goal of this grant is to develop an age-tailored transitional age youth therapeutic retention (TAY TR) intervention using motivational enhancement techniques (MET) and conduct a pilot study.
Role: Consultant. Create protocol for intervention, train therapists in Motivational Interviewing, ensure therapist fidelity to model, create MET TAY manual.
Support: 13% time as UMass faculty

(PI: MISTLER) Dates: 5/03-5/05 $5,000
Title: An Algorithm to Reduce Polypharmacy in People with Mental Illness
Funded by Dartmouth Quality Research Grant Program
The goal of this study was to evaluate an innovative algorithm designed to reduce the number of psychotropic medications taken by acutely hospitalized psychiatric inpatients at the New Hampshire State Hospital.
Role: Principal Investigator.

(PI: ROSENBERG) Dates: 2001-2007
Title: The Tolerability, Management and Neuropsychiatric Side Effects of Antiviral Treatment of Chronic Hepatitis C in Persons with Severe Mental Illness.
Funded by NIMH
The goal of this study was to treat state hospital psychiatric inpatients for hepatitis C with pegylated interferon and ribavirin.
Role: Unfunded clinical consultant, on-site study coordinator.

C. PENDING SUPPORT

XIV. PROGRAM DEVELOPMENT

XV. ENTREPRENEURIAL ACTIVITIES
n/a

XVI. MAJOR COMMITTEE ASSIGNMENTS:

National/international

DATES	COMMITTEE	ROLE	INSTITUTION

Regional

DATES	COMMITTEE	ROLE	INSTITUTION
2014 – present	NH Committee for the Protection of Human Subjects	Alternate	
2008	New Hampshire Drug Utilization Review Board	Chairman	
2005 – 2008	NH Governor's Commission on the Transformation of Services for Mental Illness Information technology workgroup leader		
2005 – 2008	NH Governor's Commission on the Transformation of Services for Mental Illness Executive Leadership Committee	Member	
2005 – 2008	New Hampshire Drug Utilization Review Board	Member	
2005 – 2007	New Hampshire Mental Health Coalition	Member	
2004 – 2006	NH Committee for the Protection of Human Subjects	Member	

Institutional

DATES	COMMITTEE	ROLE	INSTITUTION
2018-present	Patient Experience Committee,		NHH
2018-present	Quality Council,		NHH
2017	Discharge Planning Committee,		NHH
2016-present	Research Innovation Steering Committee,		NHH
2016-present	Medical Staff Organization	President,	NHH

2015	Violence and Safety Task Force, NHH
2015-2016	Medical Staff Organization Secretary, NHH
2014-present	Medical Records Committee, NHH
2014-present	Pharmaceuticals and Therapeutics Committee, NHH
2013	Complaint Review Committee, Worcester Recovery Center and Hospital
2012	Women's Faculty Committee, University of Massachusetts

XVII. MEMBERSHIPS, OFFICE AND COMMITTEE ASSIGNMENTS IN PROFESSIONAL SOCIETIES:

DATES	SOCIETY	ROLE
2017	American Society of Addiction Medicine	General Member
2015-2018	New Hampshire Psychiatric Society	President
2014-present	American Psychiatric Association	Fellow
2001-2006	New Hampshire Psychiatric Society	Deputy Representative to APA Assembly
2004-present	Motivational Interviewing Network of Trainers	Member
2008-present	Society for Medical Decision Making	General Member
2010-present	American Association for Community Psychiatrists	General Member
2015-present	European Violence Prevention Group	General Member

XVIII. EDITORIAL BOARDS: n/a

DATES	SOCIETY/JOURNAL	ROLE

XIX. JOURNAL REFEREE ACTIVITY:

DATES	JOURNAL NAME	ANNUAL FREQUENCY OF REVIEW
2017-present	Psychiatric Services	Once per year
2013-2017	Administration and Policy in Mental Health and Mental Health Services Research	Four times per year
2017-present	Journal of Medical Internet Research	Once per year
2014-2017	Medical Decision Making	Once per year
2013-2014	Community Mental Health Journal	Once per year
2017	Schizophrenia Research	Once per year
2012	Journal of Dual Diagnosis	Once per year
2010-present	Shared Medical Decision Making Annual Meeting Abstracts	Once per year

XX. AWARDS AND HONORS:

DATE	AWARD
2008	NCDEU New Investigators' Award, Phoenix AZ
2006	Academy of Psychosomatic Medicine Dorfman Award for Best Research Paper of the Year
2005	APA Early Career Psychiatrist Legislative Advocacy Fellow, Spring
2004	NAMI Psychiatrist of the Year in NH
2004	Early Career Psychiatry Fellowship, Institute for Psychiatric Services, Atlanta GA
2001	AAMC Early Career Women Faculty Professional Development Seminar
2000	Resident of the Year, Janssen Fellowship
1998	Emory University Residency Fellowship

1997 Eli Lilly Mental Health Congress Residency Fellowship

XXI. INVITED PRESENTATIONS:

A. International:

10/26/17 "What you don't know can hurt you: a comprehensive approach to aggression and violence." 10th European Congress on Violence in Clinical Psychiatry. Dublin Ireland.

10/7/16 "What you don't know can hurt you." Institute for Psychiatric Services, Washington DC.

11/1/12 The 28th Annual Rosalynn Carter Symposium on Mental Health Policy Nov. 1-2, 2012. Beyond Stigma: Advancing the Social Inclusion of People with Mental Illness. Workshop leader. Atlanta GA.

9/20/12 "Shared Decision Making in Mental Health." Symposium speaker. 2nd World Congress on Shared Decision Making. Newton MA.

5/8/2012 "Overview of Shared Decision Making." Symposium speaker, "Is there such a thing as a med check?" American Psychiatric Association Annual Meeting, Philadelphia PA.

10/30/11 "Overview of Shared Decision Making." Symposium speaker, "Is there such a thing as a med check?" Institute on Psychiatric Services. San Francisco CA.

10/28/11 Symposium speaker, Developing Evidence Based Treatments for Emerging Adults with Mental Health Conditions. "Treatment retention for transition age youth in outpatient psychotherapy." 5th Conference on Emerging Adulthood. Providence RI.

6/2011 "What is right for me? An interactive decision aid on antipsychotic medications." 6th Annual International Shared Decision Making Conference, Maastricht, The Netherlands.

3/2011 Symposium speaker, 24th Annual Children's Mental Health Research Policy Conference: "Treatment Retention Intervention for Transition Age Youth in Outpatient Psychotherapy." Tampa FL.

6/2010 Symposium speaker, Motivational Interviewing in Medical Schools. International Conference on Motivational Interviewing, Stockholm Sweden.

5/2005 APA Presidential Symposium presentation, Treatment of individuals with hepatitis C and severe mental illness. Atlanta GA.

B. National:

10/19/16 "Managing aggression and violence on inpatient psychiatric units." American Psychiatric Nurses Association, Hartford CT.

6/2008 Keynote Address: "Using Motivational Interviewing as a Global Positioning System (GPS) for Supported Employment," and "Introduction to Motivational Interviewing Skills Development and Application," Mental Health Services Training Center, University of Maryland, Baltimore Annual MHA/DORS conference.

C. Regional/Institutional:

2/15/18 "A comprehensive approach to aggression and violence." Co-presented with D. Allen, A. de Nesnera, F. Harris, New Hampshire Hospital Grand Rounds, Concord NH.

9/12/17 "What you don't know can hurt you." New Hampshire Hospital Association Annual Meeting. Bretton Woods NH.

7/25/17 "Psychopharmacology of co-occurring disorders." NH DHHS ACT team leader training. Concord NH.

5/3/17 "A New Perspective on Violence." Co-presented with Shannon Bader PhD. New Hampshire Psychiatric Society Annual Meeting. New London NH.

1/5/17 "Project PAUSE." Co-presented with Dror Ben Zeev, NHH Grand Rounds, Concord NH.

10/15/15 "Project MoMINT." NHH Grand Rounds, Concord NH.

8/27/14 "A taste of Motivational Interviewing." NHH Brown Bag Series, Concord NH.

3/20/14 "Using Mobile Technology to Improve the Care of People with Severe Mental Illness." Co-presented with Dror Ben Zeev. New Hampshire Hospital Grand Rounds, Concord NH.

5/10/12 "Using Mindfulness to Reduce Stress." Symposium speaker, Managing Stress Conference, Office of Consumer Affairs, Concord NH.

9/6/11 "Introduction to Motivational Interviewing." Worcester State Hospital Grand Rounds and Patient Open Forum. Worcester MA.

4/2006 "Psychopharmacology of dual diagnosis," National Association of Social Workers, Concord NH.

7/2005 "Physiology and psychopharmacology of dual diagnosis" at the New England Addictions Best Practices School, New Hampshire.

2005 "Hepatitis C treatment of individuals with severe mental illness," Gastroenterology Department Dartmouth-Hitchcock Medical Center, Lebanon NH.

2001 "Hepatitis C treatment of individuals with severe mental illness," Nursing Grand Rounds, New Hampshire Hospital, Concord NH.

INVITED MOTIVATIONAL INTERVIEWING TRAINING:
DATE
11/2017 NH Bureau of Behavioral Health Assertive Community Treatment Team Co-Occurring Disorders Series, Concord NH

11/2011 University of Massachusetts Worcester 2 day training in motivational interviewing for retention of transitional age youth in treatment research project, Worcester MA

3/2011 Riverbend Mental Health Center 2 day training in motivational interviewing for supported employment February 25 and March 4 2011, Concord NH

2/2011 The Bridge of Central Massachusetts 1 day training in motivational interviewing Westboro MA, February 11, 2011

9/2010 University of Massachusetts Worcester 2 day training in motivational interviewing for retention of transitional age youth in treatment research project, Worcester MA

12/2009 University of New Hampshire 2 day training in motivational interviewing for money coaches December 7-8 2009, Milwaukee WI

12/2009 University of New Hampshire 2 day training in motivational interviewing for money coaches November 30 and December 2 2009, Manchester NH

6/2009 NH Bureau of Behavioral Health 2 day motivational interviewing training June 15 and 29 2009, Concord NH

6/2009 Worcester State Hospital motivational interviewing training June 24 2009, Worcester MA

5/2009 Institute for Community Inclusion, University of Massachusetts Boston NERCEP training Motivational Interviewing and Supported Employment Shrewsbury MA, May 21, 2009

6/2007 Institute for Community Inclusion, University of Massachusetts Boston NERCEP training Motivational Interviewing and Supported Employment Montpelier Vermont, June 28, 2007

3/2007 NH Bureau of Behavioral Health Foundation Skills Training in Motivational Interviewing, Plymouth NH, March 21, 2007

3/2007 NH Bureau of Behavioral Health Foundation Skills Training in Motivational Interviewing, Concord NH, March 20, 2007

2006-2007 Motivational Interviewing Teaching Series at West Central Behavioral Health Center, Claremont NH, monthly from October 2006-May 2007

8/2005 Motivational interviewing and supported employment, Department of Mental Health VT, Waterbury VT

XXII. BIBLIOGRAPHY:

A. Peer-reviewed publications in print or other media

Original articles:

1. Knapp AG, **Mistler LA.** Response properties of cells in rabbit's lateral geniculate nucleus during reversible blockade of retinal on-center channel. J Neurophysiol. 1983 Nov;50(5):1236-45. PubMed PMID: 6644369.

2. Grzywacz NM, Amthor FR, **Mistler LA.** Applicability of quadratic and threshold models to motion discrimination in the rabbit retina. Biol Cybern. 1990;64(1):41-9. PubMed PMID: 2285760.

3. **Mistler LA,** Brunette MF, Marsh BJ, Vidaver RM, Luckoor R, Rosenberg SD. Hepatitis C treatment for people with severe mental illness. Psychosomatics. 2006 Mar-Apr;47(2):93-107. Review. PubMed PMID: 16508020.

4. **Mistler LA,** Brunette MF, Rosenberg SD, Vidaver RM, Luckoor R, Iber M. Case report of 3 patients with severe mental illness and chronic hepatitis C virus infection treated with interferon-alpha. **Int J Psychiatry Med. 2006;36(4):449-55. PubMed PMID: 17407998.**

5. **Mistler LA,** Drake RE. Shared decision making in antipsychotic management. J Psychiatr Pract. 2008 Nov;14(6):333-44. doi: 10.1097/01.pra.0000341889.97759.54. PubMed PMID: 19057236.

6. **Mistler LA,** Mellman TA, Drake RE. A pilot study testing a medication algorithm to reduce polypharmacy. Qual Saf Health Care. 2009 Feb;18(1):55-8. doi: 10.1136/qshc.2007.024471. PubMed PMID: 19204133.

7. Morden NE, **Mistler LA,** Weeks WB, Bartels SJ. Health care for patients with serious mental illness: family medicine's role. J Am Board Fam Med. 2009 Mar-Apr;22(2):187-95. doi: 10.3122/jabfm.2009.02.080059. PubMed PMID: 19264942; PubMed Central PMCID: PMC3766978.

8. Curtis LC, Wells SM, Penney DJ, Ghose SS, **Mistler LA,** Mahone IH, Delphin-Rittmon M, del Vecchio P, Lesko S. Pushing the envelope: shared decision making in mental health. Psychiatr Rehabil J. 2010 Summer;34(1):14-22. doi: 10.2975/34.1.2010.14.22. Review. PubMed PMID: 20615840.

9. **Mistler LA,** Brunette MF, Ferron J, Ziedonis D. Shared decision making and behavioral support interventions for people with severe mental illness and tobacco dependence. Journal of Dual Diagnosis. 2012. 8(2): 99-103.

10. Shuler GK, **Mistler LA,** Torrey K, Depukat R. Bridging communication gaps with the deaf. Nursing. 2013 Nov;43(11):24-30; quiz 30-1. doi: 10.1097/01.NURSE.0000435197.65529.cd. Review. PubMed PMID: 24096599.

11. Shuler GK, **Mistler LA,** Torrey K, Depukat R. More than signing: communicating with the deaf. Nurs Manage. 2014 Mar;45(3):20-7; quiz 27-8. doi: 10.1097/01.NUMA.0000444299.04190.94. PubMed PMID: 24503552.

12. Anderson ML, Glickman NS, **Mistler LA,** Gonzalez M. Working therapeutically with deaf people recovering from trauma and addiction. Psychiatr Rehabil J. 2016 Mar;39(1):27-32. doi: 10.1037/prj0000146. Epub 2015 May 18. Review. PubMed PMID: 25984736; PubMed Central PMCID: PMC4651859.

13. **Mistler LA,** Sheidow A, Davis M. "Trans-Diagnostic Motivational Enhancement Therapy Protocol to Reduce Treatment Attrition: Use in Emerging Adults." Cognitive and Behavioral Practice. 2016. 23(3): 368-384.

14. Ben-Zeev D, Wang R, Abdullah S, Brian R, Scherer EA, **Mistler LA,** Hauser M, Kane JM, Campbell A, Choudhury T. Mobile Behavioral Sensing for Outpatients and Inpatients With Schizophrenia. Psychiatr Serv. 2016 May 1;67(5):558-61. doi: 10.1176/appi.ps.201500130. Epub 2015 Dec 15. PubMed PMID: 26695497;

15. Ben-Zeev D, Scherer EA, Brian RM, **Mistler LA,** Campbell AT, Wang R. Use of Multimodal Technology to Identify Digital Correlates of Violence Among Inpatients With Serious Mental Illness: A Pilot Study. Psychiatr Serv. 2017 Oct 1;68(10):1088-1092. doi: 10.1176/appi.ps.201700077. Epub 2017 Jul 3. PubMed PMID: 28669285.

16. **Mistler LA,** Ben-Zeev D, Carpenter-Song E, Brunette MF, Friedman MJ. Mobile Mindfulness Intervention on an Acute Psychiatric Unit: Feasibility and Acceptability Study. JMIR Ment Health. 2017 Aug 21;4(3):e34. doi: 10.2196/mental.7717. PubMed PMID: 28827214; PubMed Central PMCID: PMC5583505.

Reviews:

Book chapters:

1. Ellison, ML., Drebing; C., Mueller, L., Delman, J., **Mistler,L. (2011).** Vocational and Educational Supports for Veterans. In D. Smelson, L. Sawh, D. Zeidonis (Eds.) *The MISSION-VET Treatment Manual.* Veterans Health Administration, Bedford: MA

2. Ziedonis, Kalman, Johnson, **Mistler.** Nicotine Dependence Management. Chapter 36 in Lowinson and Ruiz's Substance Abuse: A Comprehensive Textbook. 5th Edition. Editors: Pedro Ruiz MD, Eric C. Strain. 2011. Lippincott Williams and Wilkins. Philadelphia.

B. Other scholarly work in print or other media

SHARED DECISION MAKING TOOLS DEVELOPED:
1) Lead content developer of unique web-based client-centered SAMHSA Decision aid for antipsychotic medications: Substance Abuse and Mental Health Services Administration. *What is Right for Me? Considering the role of antipsychotic medications in my recovery plan* [Electronic Decision Aid] (HHS Pub No. SMA-XX-XXXX), 2011. Available from:
http://archive.samhsa.gov/BRSS-TACS-Decision-Tool

This tool compares the currently marketed antipsychotic medications on key side effects. It offers information about treatment and service options – including complementary approaches. And, it provides people with an opportunity to consider and create a personalized report about their preferences on the role of antipsychotic medications in their recovery plan.

2) Content developer for SAMHSA Web-based Medication-Assisted Treatment Decision Support Tool for Opiate Dependence, 2012. "Decisions in Recovery: Medication Assisted Treatment for Opioid Addiction." This interactive, multimedia tool compares three medications used for the treatment of opioid addiction. It helps people consider whether using medication-assisted treatment is the right approach for them and if so, which approach would best fit their situation. It also provides information on recovery supports. Available from:
http://archive.samhsa.gov/MAT-Decisions-in-Recovery/Default.aspx

GOVERNMENT PUBLICATIONS:
Delman, Foti, **Mistler,** Skolnick. Shared Decision Making White Paper, State of Massachusetts DMH. September 2010.

Fulfilling the Promise: Transforming New Hampshire's Mental Health System. Report of the Governor's Commission on Mental Health. January, 2008. HYPERLINK "http://www.endowmentforhealth.org/uploads/documents/resource-center/MHC_Report-volume1.pdf" http://www.endowmentforhealth.org/uploads/documents/resource-center/MHC_Report-volume1.pdf

TREATMENT MANUALS:
Mistler, Fortuna, Sheidow. Motivational Enhancement Therapy for Treatment Retention of Transitional Age Youth; 2010, unpublished manuscript

PODCASTS:
SAMHSA. Why should prescribers be interested in shared decision making? October 2010. HYPERLINK "http://www.samhsa.gov/ConsumerSurvivor/podcasts/sdm-podcast1-transcript.doc" www.samhsa.gov/ConsumerSurvivor/podcasts/sdm-podcast1-transcript.doc

RADIO PRESENTATIONS:

NH Public Radio interview on Hepatitis C and People with Severe Mental Illness, Spring 2006

C. Abstracts: Include both oral, exhibit and poster presentations.

Conway, Schiller, and **Mistler.** "Functional Organization of tree Shrew Lateral Geniculate Nucleus." Society for Neuroscience Abstracts. 1980.

Lecas, **Mistler**, and Requin. "Anticipatory Neuronal Activity in Monkey Cortex During Reaction Time Foreperiod." Society for Neuroscience Abstracts. 1981.

Knapp and **Mistler.** "2-APB Reveals the Independence of ON and OFF Channels in Rabbit Lateral Geniculate Nucleus."Society for Neuroscience Abstracts. 1982.

Mistler, Amthor, and Koch. "Modelling HRP-injected, Physiologically-Characterized Direction-Selective Cells in the Rabbit's Retina." Investigative Ophthalmology and Visual Science. 26 March 1985.

Grzywacz, Koch, and **Mistler.** "A Comparison of the Nonlinear Properties of the Shunting Inhibition and Threshold Models for Direction Selectivity in the Retina." Society for Neuroscience Abstracts. 1986.

Amthor, **Mistler,** and Grzywacz. "Experimental Analysis of the Nonlinear Mechanisms of Direction Selectivity in Rabbit Retinal Ganglion Cells." Investigative Ophthalmology and Visual Science. March 1987.

Mistler, Rosenberg, Luckoor, Iber et al. "Treatment of individuals with hepatitis C and severe mental illness with interferon", Schering Hepatitis Meeting, 10/2001.

Mistler and Mellman. "Reduction of psychotropic medication using a collaborative algorithm at NH Hospital", 6/2006. San Antonio TX

Mistler, Mahone, Curtis et al. "Decision Aid for Antipsychotic Medications" at International Shared Medical Decision Making, 6/2009. Boston MA

Mistler, Mahone and Curtis. "Shared decision making and antipsychotic medications" at Society for Medical Decision Making, 10/2009, Hollywood CA

Mistler, Curtis, Mahone. "Decision aid for antipsychotic medication." European Psychiatry, 2010 25 Supp.1:1216.

Mistler, Mahone, Curtis et al. "A decision aid for antipsychotic medication" at European Congress of Psychiatry, February 27-March 2, 2010, Munich Germany

Mahone, **Mistler,** Curtis et al. "Shared decision making in mental health: an emerging best practice." European Congress of Psychiatry, February 27-March 2, 2010, Munich Germany

Mistler, Curtis, Mahone et al. "Evaluation of a decision aid for antipsychotics" at Society for Medical Decision Making meeting October 22-26 2011, Chicago IL.

Mistler, Davis, Sheidow. "Treatment retention intervention for emerging adults in outpatient psychotherapy" at 25th Annual Children's Mental Health Research and Policy Conference, March 4-7, 2012, Tampa FL. Systems and Psychosocial Advances Research Center Publications and Presentations. Paper 636.

Anderson, Glickman, **Mistler** et al. "Supporting Recovery in the Deaf Community: Creating a Continuum of Behavioral Health Care in Central Massachusetts." Annual University of Massachusetts Medical School Department of Psychiatry Research Day, Worcester MA. 4/2013.

[redacted]

Name: Erika Ebert

CURRICULUM VITAE

Date prepared: 2/14/18

NAME: Erika Ebert

ADDRESS: [redacted]

I. EDUCATION

DATES	INSTITUTION	DEGREE
9/2002-6/2006	UCLA	BS (Neuroscience)
8/2002-6/2010	Albany Medical College	MD

II. POSTDOCTORAL TRAINING

DATES	INSTITUTION	SPECIALTY
7/2010-6/2013	Dartmouth Hitchcock Medical Center	Psychiatry Residency
7/2013-6/2015	Dartmouth Hitchcock Medical Center	Child and Adolescent Psychiatry Resident

III. PROFESSIONAL DEVELOPMENT ACTIVITIES

DATES	INSTITUTION	TITLE	CREDITS
5/2017	Dartmouth Hitchcock Value Institute	Greenbelt Training	33.0
11/2017	Harvard School of Medicine	Career Advancement and Leadership Skills for Women in Healthcare	20.0

IV. ACADEMIC APPOINTMENTS

DATES	INSTITUTION	TITLE
7/2015-current	Geisel School of Medicine at Dartmouth College	Instructor of Psychiatry

V. INSTITUTIONAL LEADERSHIP ROLES:

DATES	INSTITUTION	TITLE
7/2014-6/2015	Dartmouth Hitchcock Medical Center	Chief Resident

VI. LICENSURE AND CERTIFICATION (IF APPLICABLE):

DATE	LICENSURE/CERTIFICATION
6/2013-current	New Hampshire Medical License
9/2014-current	ABPN Psychiatry Board Certification
9/2016-current	ABPN Child and Adolescent Psychiatry Board Certification

VII. HOSPITAL APPOINTMENTS (IF APPLICABLE):

DATES	INSTITUTION	POSITION/TITLE
7/2015-current	New Hampshire Hospital	Child and Adolescent Psychiatrist
7/2016-current	Dartmouth Hitchcock Medical Center	

IX. TEACHING ACTIVITIES:

C. UNDERGRADUATE MEDICAL EDUCATION:

i. CLASSROOM TEACHING:

2013, Geisel School of Medicine, Scientific Basis of Medicine Psychiatry Course, Lecturer (Adolescent Development), 1 hr/year

D. GRADUATE MEDICAL EDUCATION

2015-Current, Dartmouth Hitchcock Medical Center, Inpatient Child and Adolescent Psychiatry Rotation at New Hampshire Hospital, Supervision and instruction of 1st year CAP residents in clinical work, 240hrs/year

2015-Current, Dartmouth Hitchcock Medical Center, Inpatient Child and Adolescent Psychiatry Rotation at New Hampshire Hospital, Supervision and instruction of 2nd year psychiatry residents in clinical work, 40 hrs/year

2016-Current, Dartmouth Hitchcock Medical Center, Child and Adolescent Psychiatry Residency/3rd year Psychiatry Resident Psychopharmacology Course, Lecturer on antipsychotic medications, 1 hr/year

2016-current, Dartmouth Hitchcock Medical Center, Child and Adolescent Psychiatry Residency/3rd Year psychiatry Resident Psychopathology Course, Lecturer on Psychotic Spectrum Disorders, 1hr/year

XVI. MAJOR COMMITTEE ASSIGNMENTS:

Institutional

DATES	COMMITTEE	ROLE	INSTITUTION
2012	Call Committee for Psychiatry Residency	Member	Dartmouth Hitchcock Medical Center
2017-current	Medical Records Committee	Member	New Hampshire Hospital
2/2018-current	Provider Burnout, Engagement and Wellness Comittee	Chair/Project Leader	New Hampshire Hospital

XVII. MEMBERSHIPS, OFFICE AND COMMITTEE ASSIGNMENTS IN PROFESSIONAL SOCIETIES:

DATES	SOCIETY	ROLE
Current	American Academy of Child and Adolescent Psychiatrists	Member
Current	American Psychiatric Association	Member
Current	New Hampshire Psychiatric Society	Member
Current	New England Council of Child and Adolescent Psychiatry	Member
Current	American Medical Association	Member
Current	Alpha Omega Alpha Honor Medical Society	Member

XX. AWARDS AND HONORS:

DATE	AWARD
2003	Alpha Lambda Delta National Honor Society
2003	Phi Eta Sigma National Honor Society
2007	Commendation for Scholastic Excellence
2008	Commendation for Scholastic Excellence
2010	Alpha Omega Alpha Honor Medical Society
2011	Excellence in Teaching Award, Department of Medicine at DHMC

XXII. BIBLIOGRAPHY:

C. Abstracts: Include both oral, exhibit and poster presentations. Indicate with (#) abstracts that were reviewed (e.g., by a professional society) prior to being accepted for presentation.

Ebert, E. Interdisciplinary Handoff Project. Poster session presented at: Dartmouth Hitchcock Value Institute Patient Safety Week. 2018 March 12; Lebanon, NH.

XXIII. Personal Statement:

As an early career psychiatrist, I have recently found that I am passionate about quality improvement work. To this end I pursued Greenbelt training in the Lean/six sigma model through the Dartmouth Hitchcock Value institute and led a team at NHH in a greenbelt project using the DMAIC process to establish a standardized handoff process between nursing shifts. This allowed me to complete my Greenbelt certification and was also the first project of this type at NHH. It has led to a poster presentation at the Value Institute's patient safety poster day as well as an invitation to present at NHH research journal club later this year to educate and inspire further quality improvement work. In fact, two of our team members who were yellow belt trained are starting their own projects based on their training and the work our team accomplished. As this project wrapped up I have started a workgroup to respond to the Dartmouth Hitchcock Engagement Survey results at NHH by measuring and addressing provider burnout in our MSO. While these two projects are important to me as I gain skills both using quality improvement tools and at project management, I am most passionate about improving the care that we deliver to our pediatric psychiatric patients using the quality improvement tools I have been learning. This quality improvement spills into true research as it is contributing to an area where there is little in the literature, thus I am excited to be embarking on my first research endeavor around behavioral management strategies in our hospital milieu with hopes for publication and presentations to a wider audience. This is the first of many quality improvement and research projects that will impact patient care and the work of our clinicians and direct care staff. Someday I hope to be in a position to lead our pediatric inpatient unit in evidence based practices,

data driven decision making and make significant contributions to the literature and collective knowledge on these practices.

PERSONAL INFORMATION [redacted]

Name: John Anthony Hinck MD
Present Position: Attending Psychiatrist at New Hampshire Hospital

Medical School Name: Cornell University Medical College
Primary Degree Awarded: MD
Year Completed: 1989

GRADUATE MEDICAL EDUCATION

Graduate Medical Education Program Name: Dartmouth Medical School
Specialty/Field: Residency in Psychiatry
Date From: 6/1989
Date To: 6/1993

Graduate Medical Education Program Name: Dartmouth Medical School
Specialty/Field: Fellowship in Geriatric Psychiatry
Date From: 6/1993
Date To: 6/1995

CERTIFICATION INFORMATION

American Board of Psychiatry and Neurology, Psychiatry 11-1994, #40081
Recertified 12-2004; Recertified 2-2014.

Specialty: Geriatric Psychiatry
ABMS Board-Certified: Yes
Original Certification Year: October 1995; #1412
Certification Status: expired 2005

Specialty: Adolescent Psychiatry
ABMS Board-Certified: No. (Certified by American Board of Adolescent Psychiatry)
Original Certification Year: 1999
Certification Status: expired 2009

LICENSURE

State: NH
Date of Expiration: 6/30/21

ACADEMIC APPOINTMENTS

Description of Position: Instructor in Clinical Psychiatry

Date of Appointment: June 1993
Date of Appointment Ended: April 1995

Description of Position: Assistant Professor of Psychiatry

Date of Appointment: April 1995
Date of Appointment Ended: present

ADDITIONAL INFORMATION

CONCISE SUMMARY OF ROLE/RESPONSIBILITIES IN PROGRAM:

1) TEACHING THE 3RD YEAR DARTMOUTH MEDICAL STUDENTS AT NEW HAMPSHIRE HOSPITAL FROM 1995 THROUGH 2012 (ADMISSION UNIT)

2) TEACHING THE 3RD YEAR DARTMOUTH MEDICAL STUDENTS AT DHMC 8/2015 TO 6/2016

3) TEACHING 4TH YEAR MEDICAL STUDENTS FROM GEISEL SCHOOL OF MEDICINE AND OTHER MEDICAL SCHOOLS (INCLUDING JEFFERSON, NEW ENGLAND MEDICAL, QUINNIPIAC AND WAKE FORREST) AT NEW HAMPSHIRE HOSPITAL JULY 2013 TO PRESENT (SUB-INTERNSHIP ELECTIVE ON CONTINUING CARE UNIT)

4) SUPERVISION OF 1ST YEAR PSYCHIATRY RESIDENTS AT DARTMOUTH HITCHCOCCK MEDICAL CENTER 8/2012 TO PRESENT

5) SUPERVISION OF 2ND YEAR DARTMOUTH PSYCHIATRY RESIDENTS ON AN INPATIENT UNIT AT NEW HAMPSHIRE STATE HOSPITAL: 2010 TO 2012.

6) TEACHING 4TH YEAR PSYCHIATRY RESIDENTS FROM GEISEL SCHOOL OF MEDICINE AT DARTMOUTH: JULY 2013 TO PRESENT (ELECTIVE ON CONTINUING CARE UNIT)

AWARDS:

GEISEL SCHOOL OF MEDICINE AT DARTMOUTH
DEPARTMENT OF PSYCHIATRY
2014 TEACHER OF THE YEAR AWARD

EXCELLENCE IN TEACHING AWARD
NOMINATED FOR 2005 TO 2006 ACADEMIC YEAR

CURRENT PROFESSIONAL ACTIVITIES / COMMITTEES (LIMIT OF 10)

- Vice President of the Medical Staff Organization of New Hampshire Hospital 2016 to present
- Member of the Medical Staff Organization Executive Committee 2016 to present
- Chairman of the New Hampshire Hospital Ethics Committee 2014 to present
- Member of the Schwartz Center Rounds 2011 to present
- Member of the NH Bureau of Behavioral Health's Committee for the Protection of Human Subjects 2012 to present
- Member of the DHMC Psychiatry Residency Selection Committee. 2013 to present
- Member of the Suicide Prevention Task Force. January 2017 to present
- Project BE Well, member of Task Force to Assess Physician Burnout, 2018
- Treasurer, New Hampshire Psychiatric Society, May 2019 to present

SELECTED BIBLIOGRAPHY (LIMIT OF 10)

Most representative Peer Reviewed Publications / Journal Articles from the last 5 years:

- Chen JJ "JJ",Dahle D, Hinck J, deNesnera A (2015) A Cautionary Tale: The Process of Mental Health Treatment and Restoration to Sanity of Individuals who are found Not Guilty by Reason of Insanity in New Hampshire. Ann Psychiatry Ment Health 3(5):1042

PARTICIPATION IN LOCAL, REGIONAL AND NATIONAL ACTIVITIES / PRESENTATIONS / ABSTRACTS / GRANTS FROM THE LAST FIVE YEARS: (LIMIT OF 10)

- "It Takes a Village." Compassionate Care and Benefits from a Lifestyle Change Intervention. New Hampshire Hospital Schwartz Rounds 9-22-16

- "History of Psychiatry: The State Hospitals." Presented at DHMC on 2-28-2017, and on-2-27-18 to the 4th Year Psychiatry Residents.

- "History of Forensic Psychiatry: Four Important Cases." Presented at DHMC on 2-27-18 to the 4th Year Psychiatry Residents.

- Management of Weight Gain in a Patient Associated with Psychiatric Medication. CME Case Conference 11-18-2018. Presented at NHH.

- "When will this end?" A case of a patient with periodic catatonia. Presented at New Hampshire Hospital. Schwartz Center Rounds. 1-31-19.

- "The STRIDE Weight Loss and Lifestyle Intervention: The New Hampshire Hospital Experience."
  The New Hampshire Hospital Grand Rounds.
  December 19. 2019

Patrick RJ Hattan, MD

[redacted]

Licenses:

Massachusetts State Medical License, 2016-17

Educational Background:

Cambridge Health Alliance/Harvard Medical School — July 2012-June 17
Cambridge, MA
Internship in General Internal Medicine
Residency in Adult Psychiatry

Areas of special focus:

PGY4 focus on junior resident supervision and medical student teaching (see below)
PGY4 focus on Emergency Psychiatry
- Spent a half day/week supervising junior residents and allied healthcare professionals on Emergency Psychiatric Service

Ambulatory Community Service, Outpatient Psychiatry Dept
- I was one of two PGY3 residents to work in this specialty clinic serving the severe and persistently mentally ill.

Co-facilitated a weekly psychodynamic group psychotherapy for five patients with chronic psychotic disorders. This experience lasted for 1 year.
Center for Mindfulness and Compassion, Outpatient Psychiatry Dept
- As a founding member, I was one of about 20 healthcare providers to help conceptualize this center at its founding in 2014.

Geisel School of Medicine at Dartmouth, Hanover, NH — Aug 2008-June 12
MD

McGill University, Montreal, QC, Canada — Sep 2003-June 08
Bachelor of Arts and Science, major concentrations in Biomedical Studies and History
Graduated with *Great Distinction* (*Magna Cum Laude* equivalent)

New Hampshire Technical Institute, Concord, NH — Sep 2001-Dec 02
Part-time post-secondary studies, undeclared concentration

Peer-reviewed Publications:

Barnes N, Hattan P, Black DS, Schuman-Olivier Z. *An Examination of Mindfulness-Based Programs in US Medical Schools*. Mindfulness. Published online: 2016 Oct 6. DOI 10.1007/s12671-016-0623-8.

Bambico FR, Lacoste B, Hattan PR, Gobbi G. *Father absence in the monogamous California mouse impairs social behavior and modifies dopamine and glutamate*

synapses in the medial prefrontal cortex. Cerebral Cortex. 2015 May; 25(5): 1163-75. DOI 10.1093/cercor/bht310.

Bambico FR, Hattan PR, Garant JP, Gobbi G. *Effect of delta-9-tetrahydrocannabinol on behavioral despair and on pre- and postsynaptic serotonergic transmission.* Progress in neuro-psychopharmacology and biological psychiatry. 2012 Jul 2; 38(1): 88-98. DOI 10.1016/j.pnpbp.2012.02.006.

Poster Presentations:

Barnes N, Black DS, Hattan P, Schuman-Olivier Z. *The Emergence of Academic Mindfulness Centers Associated with Medical Schools (AMCAMS).* Poster presentation at the Mind and Life International Symposium on Contemplative Studies. Oct 2014.

Bambico F, Hattan P. *Cannabinoids elicit antidepressant-like behaviour and activate serotonergic neurons through the medial prefrontal cortex*. Poster presentation at Programs and Abstracts of the 17th Annual Symposium on the Cannabinoids. June 2007.

Supervisory/Teaching Experience:

Individual psychotherapy supervision Jul 2016-June 17
Cambridge Health Alliance/Harvard Medical School
Supervised a PGY2 resident for 4 individual psychotherapy cases and 1 group therapy

Medical student teaching Nov-Dec 2016
Harvard Medical School
Instructed, observed, and evaluated medical students doing psychiatric evaluations, presentations, and formulations

Chiefship for the PGY1 psychiatry intern class Jul 2016-June 17
Cambridge Health Alliance/Harvard Medical School

- Liaise with Dept of Medicine regarding psychiatry intern performance and wellbeing while working on medical services.
- Develop comprehensive curriculum (24 instructional hours in April, May 2017) orienting psychiatry interns to their various roles and responsibilities as psychiatry residents, as they approach their PGY2 year.

Individual psychopharmacology supervision Jan 2015-July 17
Cambridge Health Alliance/Harvard Medical School
Supervised three PGY3 residents in the Transitions Clinic, which provides short-term care for patients who are between providers

Small group facilitator for The Profession of Medicine Mar-June 2012
Geisel School of Medicine at Dartmouth, MS4 year
Facilitated small groups of 1st year medical students, as they processed the deeper meanings of the career paths on which they were embarking.

Neuroanatomy Teaching Assistant, 300-level anatomy course — Sep-Dec 2007
Department of Anatomy and Cell Biology, McGill University

Lectures/Presentations:

Hattan P, *Introduction to Psychopharmacology, parts 1 and 2* — Nov 2016
Post-doctoral Psychology seminar
Cambridge Health Alliance/Harvard Medical School

Hattan P, *De-escalating the Agitated Patient* — June 2016
PGY1 intern orientation for internal medicine, psychiatry, and transitional residents
Cambridge Health Alliance/Harvard Medical School

Hattan P, *Fundamentals of Neuroanatomy* — Jan 2016
Brain & Behavior: PGY3 psychiatry seminar
Cambridge Health Alliance/Harvard Medical School

Hattan P, *Depression in Animals and Animal Models* — Mar 2015
Brain & Behavior: PGY3 psychiatry seminar
Cambridge Health Alliance/Harvard Medical School

Hattan P, *Antipsychotic Medications for the Treatment of Psychosis* — Oct 2014
Psychopharmacology: PGY3 psychiatry seminar
Cambridge Health Alliance/Harvard Medical School

Hattan P. *Antipsychotic Medications, QTc Prolongation, and Sudden Cardiac Death*
Consult/Liaison Psychiatry: PGY2 psychiatry seminar — June 2014
Cambridge Health Alliance/Harvard Medical School

Metastatic Struma Ovarii — June 2011
CME-accredited grand rounds; Dept of Obstetrics & Gynecology, California Pacific Medical Center, San Francisco, CA

Employment Experience:

Research Assistant — Sep 2007-Aug 08
Department of Neurobiology and Psychiatry, McGill University
- Obtained proficiency in single-cell electrophysiology and behavioral modeling in experimental animals. Researched novel antidepressants and animal bonding.

House staff — Jan-July 2003
Killarney International Youth Hostel, Ireland

Teaching Assistant, grades kindergarten – 5 — Sep 2000-Dec 02
Salisbury Elementary School, Salisbury, NH

Extracurricular/Honors:

Patient Care Award, Cambridge Hospital — May 2014

- Recognized by the hospital for compassionate patient care, based on patient feedback

Gold Humanism Honors Society — June 2012
Geisel School of Medicine at Dartmouth
- Elected by classmates for representing the values humanism in medicine

Psychiatry Department Award — June 2012
Geisel School of Medicine at Dartmouth
- Recipient from the graduating class of 2012

Partners in Health Education — Sep 2008-May 10
Geisel School of Medicine at Dartmouth
- Educated local elementary school children about health and the human body
- Club president Sep 2009-May 10

American Medical Student Association — Sep 2008-Aug 11
Geisel School of Medicine at Dartmouth
- Organized extra-curricular lectures and retreats for the medical student body, as well as general and health-related service projects for the local community
- Chapter president Aug 2009-Aug 11

Adult Mentor — Sep 2006-June 2007
Big Brothers Big Sisters of Greater Montreal

Personal Information:

[redacted]
Interests: American history, classic film, outdoor sports (hiking, running), cooking

References:

Marshall Forstein, MD
Adult Psychiatry Residency Training Director
Interim Chair of the Dept of Psychiatry
Cambridge Health Alliance/Harvard Medical School
mforstein@challiance.org, 617.665.1189

Lior Givon, MD PhD
Director of Psychiatric Emergency Services, Cambridge Hospital
lgivon@challiance.org, 617.665.1934

Robert Joseph, MD
Director of Psychosomatic Medicine Service, Cambridge Health Alliance
rjoseph@challianc.org, 617.665.1544

Reji Attupurath, MD
Attending psychiatrist on the Psychosomatic Medicine Service, Cambridge Health Alliance
PGY4 psychopharmacology supervisor
rattupurath@challiance.org

Cathy Schen, MD
PGY4 psychotherapy supervisor
cathy-schen@hms.harvard.edu, 978.287.0104

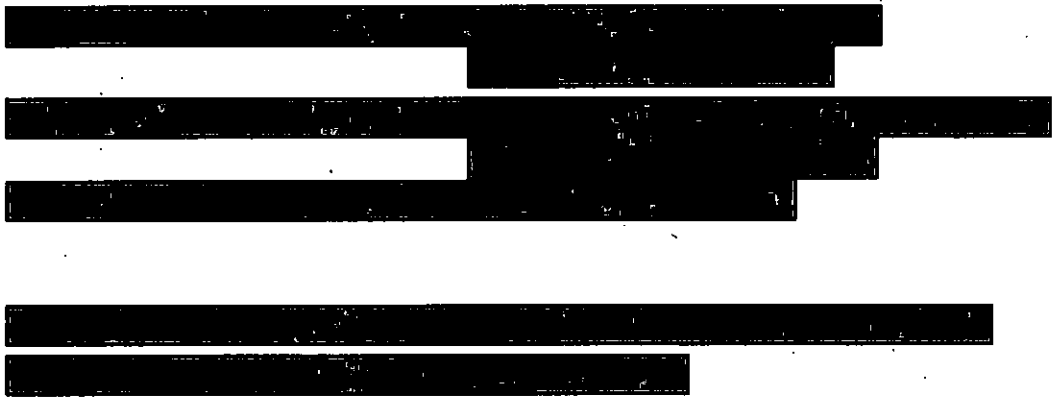
Letters will be provided upon request.

CURRICULUM VITAE

Cornel Natanael Stanciu

Bachelor of Sciences, Honors, Immunology Specialist
M.D., Psychiatric Medicine – Addiction Psychiatry Trainee

Current Position: *Fellow, post-graduate year 5*
Department of Psychiatric Medicine
Geisel School of Medicine
Dartmouth-Hitchcock Medical Center, Lebanon, NH



References: Available upon request

CORNEL N. STANCIU, M.D.

EDUCATION & TRAINING

Dartmouth-Hitchcock Medical Center, Geisel School of Medicine — Lebanon, NH
Addiction Psychiatry Fellowship — July 2017– June 2018

East Carolina University, Brody School of Medicine
Vidant Medical Center — Greenville, NC
Psychiatric Residency — July 2013– June 2017

SABA University School of Medicine — Saba, Netherlands-Antilles
Doctorate of Medicine — September 2008 - May 2013

University of Toronto — Toronto, ON
Honors Bachelor of Science, Immunology Specialist — September 2004 – May 2008

LICENSES/CERTIFICATIONS

North Carolina Medical License -- active
New Hampshire Medical License -- active
Buprenorphine and Office-based Treatment of Opioid Dependence License -- active
USMLE Steps 1-3
BLS, ACLS certified
Lean Six Sigma Yellow Belt trained
Crisis Prevention Institute certified
Basic Certificate in Quality and Safe-Institute for Healthcare Improvement
CISCO Java Programming Certificate

CLINICAL EXPERIENCE

Moonlighting Outpatient: Child, Adult, Geriatric, ID and Substance Abuse experience
Moonlighting Inpatient Dual Diagnosis: Adult, Geriatric, ID experience
Moonlighting Consult Liaison and Emergency Department experience
Moonlighting Tele psychiatry experience
Outpatient and Inpatient Adult, Geriatric, Child, College, ID and Dual diagnosis experience
Outpatient Substance Abuse treatment including Suboxone training and Methadone exposure
Inpatient Substance Abuse detoxification
Residential Substance Abuse treatment experience
Consult Liaison and Emergency psychiatry
Experience in the Veterans' Affairs system at outpatient, inpatient and substance abuse level
Proficient in the practice of Electroconvulsive therapy (ECT)
Experience with Transcranial Magnetic Stimulation (TMS)
Trained in Crisis prevention, de-escalation and nonviolent intervention
Practices various forms of psychotherapy

CORNEL N. STANCIU, M.D.

HONORS/AWARDS

East Carolina University, Department of Psychiatry Academic Resident Award	2017
American Society of Addiction Medicine Ruth Fox Scholar	2017
Best Resident Paper in Administrative Psychiatry Award	2017
Governor's Institute on Substance Abuse Scholarship	2017
American Psychiatric Association MindGames Jeopardy Competition Award	2017, 2015, 2014
North Carolina Psychiatric Association Poster Presentation Award	2016, 2015, 2014
Vidant Medical Center EHR Excellent Clinical Documentation Award	2014
Dofasco Technology and Ingenuity Award	2004
Canadian Nuclear Society Innovative Research Award	2004
Manulife Financial Award for Creative Solutions to Health-related Issues	2004

RESEARCH LEADERSHIP

American Journal of Psychiatry Residents' Journal, Special Section Editor	2017
Journal of Depression and Anxiety, Editorial board	2017-present
Journal of Alcoholism and Drug Dependence, Editorial board	2017-present
International Journal of Mental Health and Addiction, Ad hoc Reviewer	2017-present

LEADERSHIP, APPOINTMENTS & COMMITTEES

American Association of Addiction Psychiatry, Scientific Program Committee member	2016-present
East Carolina University Senior Academic Resident	2016-2017
North Carolina Psychiatric Association Executive Committee ECU representative	2015-2016
East Carolina University Medical Student Education Committee resident representative	2014-2016
North Carolina Addiction Committee	2014-2017
North Carolina Psychiatry and the Law Committee	2013-2017
North Carolina Clinical Committee	2013-2017
East Carolina University Christian Medical and Dental Association	2013-2017

PROFESSIONAL MEMBERSHIPS

American Association of Psychiatric Administrators (AAPA)	2017 – present
American Society of Addiction Medicine (ASAM)	2016 – present
American Association of Addiction Psychiatry (AAAP)	2014 – present
North Carolina Medical Society (NCMS)	2014 – present
North Carolina Psychiatric Association (NCPA)	2013 – present
American Psychiatric Association (APA)	2012 – present
University of Toronto Pre-Medical Society	2006
University of Toronto Immunology Association	2005

CORNEL N. STANCIU, M.D.

PUBLICATIONS

Journal

Stanciu, CN; Gnanasegaram SA. "Strategies for Mitigating Risk in those with Substance Use Disorders " Journal of Psychiatric Administration and Management. 2017. 6(2).

Stanciu, CN; Glass, M. et al. ""Meth Mouth' - An Interdisciplinary Review of a Neglected Dental and Psychiatric Condition" Journal of Addiction Medicine. 2017

Stanciu, CN; Penders TM. Et al. "Behavioral profile of Flakka and Bath salts" Current Drug Abuse Reviews. 2017. 9:1-5.

Stanciu, CN; Gnanasegaram SA. "Loperamide, The "Poor Man's Methadone" – Brief Review" Journal of Psychoactive Drugs. 2017; 49:1

Broszko, M; Stanciu, CN. "Survey of EKG monitoring practices: A necessity of prolonged nuisance?" American Journal of Psychiatry, Residents' Journal. 2017

Stanciu, CN; Glass, OM; Penders, TM. "Use of Buprenorphine in Treatment of refractory depression – review of current literature" Asian Journal of Psychiatry, 2017; (26) 94-98

Stanciu, CN; Penders TM; Rouse EM. "Recreational Use of Dextromethorphan, "Robotripping" – A Brief Review" The American Journal on Addictions, 2016

Penders, TM; Stanciu, CN et al. "Bright Light Therapy as Augmentation of Pharmacotherapy for Treatment of Depression – A MetaAnalysis" The Primary Care Companion to the Journal of Clinical Psychiatry, 2016

Stanciu, CN; Glass, OM; Penders, TM. "Gabapentin (Neurontin): An Adjunct for Benzodiazepine Withdrawal – Case Series" Journal of Addiction and Dependence 2015; 1:2.

Stanciu, CN; Penders, TM. "Hallucinogen Persistent Perception Disorder Induced by New Psychoactive Substituted Phenethylmines - Review with Illustrative Case" Current Psychiatry Reviews 2015.

Stanciu, CN; Glass, OM. "Pain Killers that Cause Pain – Addressing a Rising, Poorly Recognized Complication" American Journal of Psychiatry Residents' Journal 2015.

Stanciu, CN; Penders TM; Rouse EM. "Mania Following Misuse of Dextromethorphan - A Case Report and Brief Review of "Robotripping"" Journal of Addiction Medicine 2015.

Penders, TM; Stanciu, CN et al. "Psychogenic Polydisia, Hyponatremia and Osmotic Myelinolysis – A case report and brief review" BMJ Case Reports 2015.

Stanciu, CN; Oxentine HN; Penders, TM. "Delusional Infestation Following Misuse of Prescription Stimulants" Psychosomatics 2014, 10:04

Penders, TM; Stanciu, CN. "New Psychoactive Substances in the Internet Age" Journal of Policy Analysis and Management 2014, 03:01.

Rossetti, S; Hoogeveen, AT; Liang, P; Stanciu, CN. et al. "A Distinct Epigenetic Signature at Targets of a Leukemia Protein" BMC Genomics 2007, 8:38

Other

Stanciu, CN; Rolley, J. "Summary of AAAP Symposium on Medical Update – The State of The Art of Evidence- Based Non-opioid Pain management" The American Journal on Addictions, 2017. 26:239-240.

Stanciu, CN; Gnanasegaram, SA. "Don't Balk at Using Medical Therapy to Manage Alcohol Use Disorder" Current Psychiatry (Residents' Voices), Vol 12 No 2, February 2017; 50-52

Stanciu, CN. "New Substances and New Means of Acquisition Deserve New Monitoring Strategies" AAAP quarterly newsletter, Trainee's column, Fall 2016; 32:3.

Penders, TM; Stanciu, CN. "Prescribing for Those with Substance Use Disorders" North Carolina Psychiatry Association newsletter July 2016

Saeed, SA; Anand, V; Stanciu, CN. "Top Research That May Change How You Treat Patients With Substance Use Disorders" Psychiatric Times 2015, 32:4.

Stanciu, CN. "Online Drug Marketplaces – Digital Drug Dealers" AAAP quarterly newsletter, Trainee's column, Winter 2015; 31:1.

Position Statements

Stanciu, CN; Gnanasegaram, SA. "Let's Talk About Your Tobacco use" Psychiatric News Residents' Forum Apr. 2017

Stanciu, CN; Gnanasegaram, SA. "Don't Balk at Using Medical Therapy to Manage Alcohol Use Disorder" Current Psychiatry (Residents' Voices), Vol 15 No 9, Sept. 2016

Stanciu, CN; Gnanasegaram, SA. "An Underutilized , Evidence-based, Treatment for Alcohol Use Disorder" Psychiatric News Residents' Forum Oct. 2015

In progress:

"Survey of Alcohol Dependence Pharmacotherapy Practices Among Mental Health Providers in NC"
Status: submitted to CDAR

"Survey of Alcohol Dependence Screening Practices Among Mental Health Providers in NC"
Status: submitted to CDAR

"Second hand Cannabis use"
Status: pending publication

"Evidence for TB Screening in Cannabis Users"
Status: in progress

"Treating Addictive Disorders, The New Norm" Commentary
Status: submitted to American Journal of Psychiatry, Residents' Journal

"Methamphetamine Induced Delusional Parasitosis"
Status: submitted to American Journal of Psychiatry, Residents' Journal

TEACHING ACTIVITIES

Substance Abuse (resident lecture) 2017
East Carolina University, Greenville, NC

Trauma and Stressor-related Disorders (resident lecture) 2017
Fayetteville Veteran's Affairs, Fayetteville, NC

Identification and Management of Withdrawals (resident lecture) 2016
East Carolina University, Greenville, NC

Introduction to Schizophrenia (resident lecture) East Carolina University, Greenville, NC	2016
Electroconvulsive Therapy Introduction (resident lecture) East Carolina University, Greenville, NC	2016
Tobacco and Tobacco Products Awareness, Peach.Love.Pirates.Cure 8th Annual Cancer Awareness Event East Carolina University, Greenville, NC	2016
Psychiatry Shelf Exam Review (medical student lecture) East Carolina University, Greenville, NC	2014-2016
Teaching and mentoring 3rd and 4th year medical students East Carolina University, Greenville, NC	2013-2017
SABA University Physiology Teacher's Assistant SABA University, Netherlands-Antilles	2009
SABA University Anatomy Teacher's Assistant SABA University, Netherlands-Antilles	2008

PRESENTATIONS

Poster Presentation	"Integrating Psychiatry and Dentistry When Treating Patients With 'Meth Mouth'" East Carolina University GME Research Day Greenville, North Carolina	2017
	"Digital Epidemiology of New Drugs of Abuse" American Academy of Addiction Psychiatry conference Bonita Springs, Florida	2016
	"There's a pill for that, but I am not comfortable prescribing it" North Carolina Psychiatric Association conference Asheville, North Carolina	2016
	"Ouch it Still Hurts – Pain Killers that Cause Pain, A Review of a Rising and Poorly Recognized Complication" North Carolina Psychiatric Association conference Winston Salem, North Carolina	2015
	"Survey of Electroconvulsive Therapy practices" North Carolina Psychiatric Association conference Winston Salem, North Carolina	2015
	"Outpatient QTc monitoring: A necessity or prolonged nuisance?" North Carolina Psychiatric Association conference Winston Salem, North Carolina	2015
	"Bright Light Therapy as Augmentation of Pharmacotherapy for Treatment of Depression – A Meta-Analysis" American Psychiatric Association conference Toronto, Ontario	2015

"Survey of Electroconvulsive Therapy Practices"
International Society for ECT and Neurostimulation 2015
Toronto, Ontario

"Bright Light Therapy as Augmentation of Pharmacotherapy for Treatment of Depression – A Meta-Analysis"
North Carolina Psychiatric Association conference 2014
Asheville, North Carolina

"Psychogenic Polydipsia, Hyponatremia, and Osmotic Myelinolysis – A Case Report"
East Carolina University Neuroscience symposium 2014
Greenville, North Carolina

"Psychogenic Polydipsia, Hyponatremia, and Osmotic Myelinolysis – A Case Report"
North Carolina Medical Society conference 2014
Greensboro, North Carolina

"Delusional Infestation Following Misuse of Prescription Stimulants – A Case Report"
American Academy of Addiction Psychiatry conference 2014
Aventura, Florida

"Cavitation:Cancer of the Hydraulic Machinery"
Bay Area Science and Engineering Fair 2004
Hamilton, Ontario

"What are the noxious effects of Acid Rain"
Hamilton-Wentworth Science and Engineering Fair 2003
Hamilton, Ontario

Oral Presentation

"Strategies for Improving Delivery of Care to Those With Underlying Problematic Alcohol Use"
East Carolina GME Research Day 2017

"Is Your Teen Using? Identifying and Addressing Adolescent Substance Use in a New Era"
Eastern Carolina 5th Annual Mental Health Expo 2017

"Neuropsychiatric safety and efficacy of varenicline, bupropion, and nicotine patch in smokers with and without psychiatric disorders (EAGLES): doubleblind, randomized, placebo-controlled clinical trial"
East Carolina University Journal Club paper presentation 2017

"Opioids and chronic pain, challenges in management and review of complications"
East Carolina University Grand Rounds 2016

"Bright Light Therapy as Augmentation of Pharmacotherapy for Treatment of Depression – A MetaAnalysis"
East Carolina University GME Research Day 2015

"Evidence Based Practices on reducing re-hospitalizations"
Collaboration of Care Conference, Greenville NC 2015

"Utility of Integrated Pharmacogenomic testing to support treatment of major depressive disorder in a psychiatrically ill outpatient setting"
East Carolina University Journal Club paper presentation 2015

INTERNSHIPS AND PROJECTS

Improvement in Medical Practice (PIP) for Alcohol Use Disorders (AUD) 2017-current
- collaboration in putting together guidelines comprising of the latest evidence for handling AUD, for incorporation into an ABPN, MOC compliant, PIP

Survey of implementation of alcohol dependence pharmacotherapy among NC providers 2016-present
- state wide survey designed to determine causes of underutilizaion of FDA approved pharmacotherapies in the treatment of those with alcohol use disorders.

Digital Epidemiology of New Drugs of Abuse 2013-present
- online survey tracking use patters of cannabis synthetic canabinoids and bath salts in NC with feedback -- http://www.ecu.edu/areyouawarenc/

Bright Light Therapy 2013-present
- will consider RCT based on our meta-analysis supporting improvement and remission from major and bipolar depression using augmentive BLT

Gabapentin in augmenting Benzodiazepine taper 2013-2015
- case series of patients we tapered-off benzodiazepines faster relying on similar pharmacodynamics.

Electroconvulsive Therapy Survey 2013
- multi-institutional survey intended to track clinician's preference for various parameters (electrode placement, current) across country.

Neuroblastoma research (Dr Herman Yeger's laboratory) 2007-2008
The Hospital for Sick Children - Toronto, Ontario
- used drug induced genetic reprogramming to reverse aberrant epigenetic modifications that have set developmental programs off-track in NUB-7 neuroblastoma cell line

Autism research (Dr Stephen Scherer's laboratory) 2006-2007
The Hospital for Sick Children - Toronto, Ontario
- studied genomic imprinting and aberrant methylation patterns of susceptibility genes hypothetically involved in autistic phenotype

Leukemia research (Dr Nicoletta Sacchi's laboratory) 2005-2006
Roswell Park Cancer Institute – Buffalo, NY
- examined epigenetic modifications induced by AML1-MGT16 chimeric protein on AML1 target genes involved in proliferation, cell death

MEDIA INTERACTIONS

American Society of Addiction medicine, Member Focus – "Member Connect, Ruth Fox Winner":
http://email.asam.org/t/ViewEmail/t/DD7CCA632A55A1AC/F12E84C8B352594D46778398EADC2510

Psychiatric Advisor featured article, March 02, 2017 – "Bright Light Therapy For Nonseasonal Depression: An Emerging Intervention"
http://www.psychiatryadvisor.com/depressive-disorder/bright-light-therapy-underutilized-for-nonseasonal-depression/article/641554/

Interview, WNCT channel 9, Greenville, North Carolina, April 18, 2016
"New ECU website hopes to get better picture of drug problem in the East"
http://www.wnct.com/2016/04/18/new-ecu-website-hopes-to-get-better-picture-of-drug-problem

Podcast, American Journal of Psychiatry Residents' Journal
"Pain Killers that Cause Pain – Addressing a Rising, Poorly Recognized Complication"

The East Carolinian newspaper Jan 26, 2016
"Brody doctors using survey to track area drug use"
http://www.theeastcarolinian.com/news/article_3503ce24-c3ca-11e5-9fd0-13f4079e6da8.html

Interview, YouTube channel, October 22, 2015.
"Dangers of Vaping"
http://www.youtube.com/watch?v=3a9Lw-zKXXg

Interview, WNCT channel 9, Greenville, North Carolina, March 30 , 2015
"Website aims to give insight into drug abuse problem"
http://www.wnct.com/story/28653360/website-aims-to-give-insight-into-drug-abuse-problem

ASAM weekly Feb 10 2015 – top news "Mania After Misuse of Dextromethorphan: A Case Report and Brief Review of 'Robotripping'"
http://createsend.com/t/y-C993A42302D58417

Interview, WNCT channel 9, Greenville, North Carolina, September 10, 2014
"Potentially laced marijuana leading some to act psychotic"
http://www.wnct.com/story/26500745/dangerous-marijuana-side-affects-lead-to-increased-er-visits

SABA University Spotlight on Alumni
"Epidemic of Opioid Addiction Turns a Surgeon-in-the-making to Psychiatry""

LANGUAGE SKILLS

English - fluent
Romanian - fluent
French – conversational

HOSPITAL PRIVILEGES

Vidant Roanoke-Chowan Hospital (Ahoskie, NC)	2016-current
Vidant Roanoke-Chowan Behavioral Health Clinic (Ahoskie, NC)	2016-current

Michael J. Knight, MD
[redacted]

Curriculum Vitae

Demographic

[redacted]

Education

8/1974 – 12/1977
University of North Carolina
Chapel Hill, NC
BA Chemistry, 12/1977

6/1980-6/1984
University of North Carolina School of Medicine
Chapel Hill, NC
MD

6/1984 – 6/1985
Combined Medicine and Psychiatry Internship
Hartford Hospital and Institute of Living Hospital
Hartford, CT

6/1985 – 6/1988
Residency in Psychiatry
Institute of Living
President, Residents Association

(Moved from Hartford, CT to Portsmouth, NH 6/1988 to begin employment on 7/4/1988)

Board Certification

American Board of Neurology and Psychiatry
Adult Psychiatry
October, 1991

Employment

12/1977 – 6/1980
Software Engineer

Belk Stores Services
Retail and accounts payable computer programming and systems design

7/4/1988 – 10/1989
Psychiatrist
Seacoast Mental Health Center
Portsmouth, NH
Inpatient and outpatient, adult and adolescent. Pharmacy and quality care committees.

10/1989 – 4/2000
Psychiatrist
Portsmouth Regional Hospital and Pavilion
Inpatient, partial hospital, outpatient. Adult and adolescent.
Medical Records Committee, 1989-1990
Chief of Psychiatry1990-1991
Medical Executive Committee, 1990-1991
Medical Ethics Committee, 1992-2000

5/2000 – 7/2014
Psychiatrist
Medical Director
Hampstead Hospital
Inpatient and partial hospital, adult, adolescent, developmentally disabled, and chemical dependency services. Eating disorder service.

7/2014 – 3/31/17
Medical Director, Department of Psychiatry
Portsmouth Regional Hospital
Portsmouth, NH
Inpatient adult including behavioral health, substance abuse, consultation-liaison.
Medical Executive Committee
Chairman, Behavioral Event Response Committee (investigate and intervene in cases of breaches of hospital Code of Conduct)

3/2015 – 3/31/17
Medical Director, Center for Emotional Wellness
Parkland Hospital
Derry, NH
Inpatient adult including behavioral health, substance abuse, consultation-liaison

4/3/17 – present
Psychiatrist, New Hampshire Hospital
Instructor, Dartmouth School of Medicine
Chairman, Utilization Management Committee

2008-present
Consulting psychiatrist
Prest and Associates, Madison, WI
Peer review and educational outreach

7/1988– 10/ 2015
Private Practice
Outpatient adult and adolescent, including Suboxone therapy

7/1994 – 10/2008
Consulting Psychiatrist
Odyssey House Adolescent Therapeutic Community
Hampton, NH
Psychiatric evaluation and follow-up of adolescent residents

8/1999 – 7/2000
Consulting Psychiatrist
Liberty Mutual Insurance Company
Dover, NH
Managed Disability. Record reviews, liaison with utilization reviewers, case conferences, discussions with Medical Director regarding complex medical or surgical cases, telephone discussions with providers, and development of software for utilization review staff to provide clinical practice guidelines based on diagnosis.

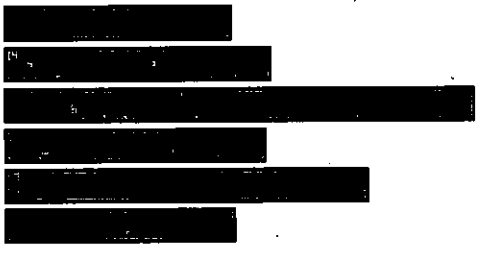
Other Experience
Peer Review
New Hampshire Foundation for Medical Care
1990 - 2000
Medicare and Medicaid record review for quality and utilization.

Honors and Memberships

National Merit Scholar
Morehead-Cain Scholar
Phi Beta Kappa
Alpha Omega Alpha Honor Medical Society
American Medical Association
American Psychiatric Association

Curriculum Vitae

Mark S. Cotterell, MD, FAPA



Education:

Creighton University, Omaha, Nebraska, Doctor of Medicine, May 1987.

- Committee on Curriculum and Educational Policy, 1984-87.
- Committee on Admissions, 1985-86.
- President, Creighton Chapter, American Medical Student Association, 1985-86.

Lewis & Clark College, Portland, Oregon, Bachelor of Arts (English), June 1981.

- College Committee on Curriculum, 1979-80.

Dartmouth College, Hanover, New Hampshire, 1977-78.

Medical Training:

Fellow in Forensic Psychiatry, 1995-96, Walter Reed Army Medical Center, Washington, District of Columbia.

- Training sites: Walter Reed Army Medical Center, National Naval Medical Center, Uniformed Services University of the Health Sciences, Georgetown University Law Center, Clifton T. Perkins Hospital Center (State of Maryland), United States Disciplinary Barracks (Fort Leavenworth, Kansas), National Center for the Analysis of Violent Crime (Federal Bureau of Investigation).

Resident in Psychiatry, 1990-93, Naval Medical Center, Portsmouth, Virginia.

Intern in Psychiatry, 1987-88, Naval Hospital, Portsmouth, Virginia.

Professional Affiliations:

Current Medical License in Connecticut (#038977)

Previous Medical Licenses in Virginia and Maryland

Diplomate, American Board of Psychiatry and Neurology

- General Psychiatry (#44278) 1997-2007, 2007-2017
- Additional Qualifications in Forensic Psychiatry (#916) 1999-2009, 2009-2019

American Psychiatric Association

- Elected as Fellow 2003

Connecticut Psychiatric Society

American Academy of Psychiatry and the Law

Professional Affiliations (continued):
American Medical Association
American Public Health Association
Connecticut Public Health Association

Military Service:
Commissioned Officer, Medical Corps, United States Naval Reserve, 1987-2000.
- Served on Active Duty for over thirteen years, achieved rank of Commander.

Commissioned Officer, United States Naval Reserve, 1983-87.

Occupational Experience:
Psychiatrist Manager and Principal Psychiatrist, August 2000 to present, Whiting Forensic Division, Connecticut Valley Hospital, Middletown, Connecticut.
- President of the Medical Staff, October 2012 to October 2013; Chairman of the Executive Committee of the Medical Staff, Member of the Hospital Governing Body.
- Forensic Monitor (2002-present): Reviewed records of persons found not guilty by reason of mental disease and prepared reports to Psychiatric Security Review Board (PSRB) utilizing risk management principles. Reviewed records and prepared reports with regard to assessment and restoration of competence to stand trial. Provided consultation to treatment teams on risk assessment and risk management. Provided testimony to PSRB and courts regarding status of patients and recommendations concerning disposition.
- Co-Chairman, Hospital Medical Records Committee, 2016 to present.
Chairman, Medical Staff Credentialing & Privileging Committee, 2003 to 2004.
- Member of Hospital Ethics Committee (2016-present), Hospital Pain Committee (2001-04), and Medical Staff Credentialing and Privileging Committee (2003-04).
- Clinical Team Manager (2000-02): Led multi-disciplinary team on acute care forensic units in providing care and evaluation services for persons committed by courts. Treatment related to restoration to competence to stand trial, post-conviction mental health evaluations, post-adjudication treatment planning, and civil commitment by probate court. Provided testimony and forensic psychiatry consultation to courts and administrative bodies.

Head, Mental Health Department, 1997-2000, Naval Ambulatory Care Center, Groton, Connecticut.
- Provided clinical and administrative supervision of multi-disciplinary team. Provided direct psychiatric care to military beneficiaries. Department received commendation from JCAHO/TJC inspectors. Served as consultant to military units and taught mental health assessment and care for fleet medical officers. Served as Chairman of the Case Review Committee for the Family Advocacy Program, and as a member of the Bioethics Review Committee and the Utilization Review Committee.

Occupational Experience (continued):

Staff Psychiatrist, 1996-97, National Naval Medical Center, Bethesda, Maryland, and Naval Medical Clinic, Quantico, Virginia.

• Provided direct psychiatric care to military beneficiaries. Worked as member of multi-disciplinary team. Acted as psychiatric consultant to Northeastern Regional Brig, Marine Corps Base, Quantico.

Head, Mental Health Department, 1994-95, and Head, Alcohol Rehabilitation Department, 1993-94, Naval Hospital, Orlando, Florida.

• Provided clinical and administrative supervision of multi-disciplinary team. Provided direct psychiatric care to military beneficiaries. Instituted program of clinical supervision and continuing education for alcohol counselors and Family Service Center social workers. Supervised closure of alcohol unit and mental health department as hospital decommissioned, facilitating transition of care to other facilities.

Medical Officer, 1988-90, USS Austin (LPD-4), Norfolk, Virginia.

• Sole medical provider to crew of 400. Monitored multiple aspects of crew's health, including environmental conditions, physical fitness, and weight control. Served on command assessment team, monitoring equal opportunity environment.

Teaching Experience:

Yale University, School of Medicine, Department of Psychiatry, Division of Law and Psychiatry, New Haven, Connecticut.

• Taught seminars for Fellows (Trainees) in Forensic Psychiatry on topics including: Competency to Stand Trial (Evaluation and Restoration), Informed Consent/Decisional Capacity, Voluntary/Involuntary Psychiatric Hospitalization, and Substituted Judgment to Medicate Incompetent Defendants.

American Academy of Psychiatry and the Law, Annual Meeting 2016, Portland, Oregon.

• Will present seminar for mental health professionals entitled "Can You Hear Me? Deaf Clients in Forensic Settings."

National Organization of Forensic Social Work, Annual Meeting 2008, Hartford.

• Taught seminar for mental health professionals entitled "Competency Restoration in the Hearing Impaired Defendant."

American Academy of Psychiatry and the Law, Annual Meeting 2005, Montreal.

•Taught seminar for mental health professionals entitled "Forced Medications to Restore Competence, a Hard 'Sell'."

National Organization of Forensic Social Work, Annual Meeting 2003, Phoenix.

• Taught seminar for mental health professionals entitled "When the Court is Your Client."

Valencia Community College, Orlando, Florida, 1995.

• Taught two courses for mental health professionals: "Introduction to DSM-IV" and "Differential Diagnosis of Psychopathology."

Clinical Experience:

Current Research Projects: "Connecticut's Experience with *Sell* Legislation," and "Study of Content Quality of NGRI Reports in Connecticut."

Consultant to Connecticut Department of Public Health, evaluating complaints against medical practitioners.

Expert Witness to Criminal Courts, Civil Courts, and Administrative Bodies in Connecticut, Florida, Maryland, and Virginia.

Expert Witness for Military Courts-Martial and Military Administrative Boards.

Family Advocacy Programs, Spouse Abuse and Child Abuse Case Review Committees.

Command/Hospital Ethics Committees.

Psychiatric Consultant to Military Brigs and Confinement Facilities.

Community Service:

Union Delegate, 2012 to present: SEIU Healthcare 1199NE;
Member, Contract Negotiating Committee, 2015 to present.

Pre-Publication Peer Reviewer, 2005 to 2008: Journal of the American Academy of Psychiatry and the Law.

Volunteer, 2000-05: Connecticut Trails Council, Girl Scouts of America, Middletown, Connecticut.

Volunteer, 1993-95, All Saints Episcopal Church, Winter Park, Florida.

Volunteer, 1979-83: Catholic Youth Organization, Portland, Oregon.

- Served as President of Board of Directors and volunteer in education and religious ministry.

Volunteer, 1976-83: Oregon Trail Chapter, American Red Cross, Portland, Oregon.

- Served on Chapter Board of Directors and service committees.

Awards and Achievements:

Navy and Marine Corps Commendation Medal, 2000.

> For meritorious service...[working as] psychiatric consultant and expert for the Northeast Region...[He] rendered expert support...in dealing with elaborate psychiatric issues...[and he was] always available and positively responsive to short notice consultation needs...[He demonstrated] steadfast dedication to patient care and clinical excellence...distinctive accomplishments, unrelenting perseverance, and steadfast devotion to duty.

Navy and Marine Corps Achievement Medal, 1995.

> For professional achievement in the superior performance of his duties...[He] consistently performed his demanding duties in an exemplary and highly professional manner...[with] exceptional professionalism, initiative, and loyal devotion to duty.

Samantha Gnanasegaram, M.D.

[redacted]

EDUCATION & TRAINING

East Carolina University Brody School of Medicine — Greenville, NC
Vidant Medical Center (formerly Pitt County Memorial Hospital) — July 2013– June 2017
Psychiatry Residency

St. George's University, School Of Medicine — Grenada, WI
Doctorate of Medicine — August 2009-May 2013

University of Toronto — Toronto, Ontario
Honors Bachelor of Science, Neuroscience and Psychology — August 2004-May 2008
Graduated with Distinction
Dean's Honor list

LICENSES/CERTIFICATIONS

North Carolina Medical License- *Resident Training License*
USMLE Steps 1-3, Passed
BLS

HONORS/AWARDS

International Peace Scholarship, St. George's University — 2009-2013
University of Toronto In-Course Scholarship for Academic Excellence — 2006-2008

PROFESSIONAL MEMBERSHIPS

Christian Medical and Dental Association — 2015 – current
American Psychiatric Association — 2013 – current
North Carolina Psychiatric Association — 2013 – current
American Medical Student's Association — 2009 - 2013

Samantha Gnanasegaram, M.D.

PRESENTATIONS

"Catatonia Induced by Sexual Trauma and Response to Electroconvulsive Therapy: A Case report", Poster Presentation at North Carolina Psychiatric Association Conference October 2015
"Efficacy and Safety of Brexpiprazole for the Treatment of Acute Schizophrenia" as published in American Journal of Psychiatry, Presentation at East Carolina University Journal Club May 2015

PUBLICATIONS

"Why are we not Addressing Alcohol Use in our Psychiatric Practice?" Current Psychiatry (Residents' Voices) – Accepted to be published September 2016
"Loperamide, The "Poor Man's Methadone" – Brief Review" – Submitted to Journal of Psychoactive Drugs
"Novel Approaches for Treating Agitation in Patients with Dementia" – In Process

TEACHING

Teaching and mentoring 3rd and 4th year medical students	2013-current
Psychiatry Shelf Exam Review for Medical Students	2015-2016

LANGUAGES

English Fluent
French – Bilingual Certificate Obtained June 2004
Tamil Conversational

CLINICAL EXPERIENCE

Outpatient Adult, Child, Geriatric, VA, and Dual Diagnosis Experience
Inpatient Adult, Geriatric and Dual Diagnosis
TMS
ECT
Outpatient and Inpatient Substance Abuse Treatment Experience
Training in various forms of psychotherapy

REFERENCES

Available upon request

David Dakin Williams, M.D. Ph.D.

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EMPLOYMENT

2015 - 2017: **Psychiatrist**, Merrimack Valley Counseling, Nashua, NH. In private outpatient practice, I served children, adolescents, and adults through private insurance, Medicaid, and self-pay.

2010 - 2014: **Child Psychiatrist**, Greater Nashua Mental Health Center, Nashua, NH. I treated child and adolescent patients at a community mental health center that served a catchment area of 100,000 persons in southern NH.

2010 - 2013: **Adult Psychiatrist**, Southern New Hampshire Medical Center, Nashua, NH. I provided psychiatric care to a 13-bed adult psychiatry unit on weekends. I also shared on-call duties on weeknights, and covered staff vacations for Foundation Medical Partners.

1992 - 1995: **Laboratory Research Associate**, Skin Biology Research Center of Johnson & Johnson Inc., Raritan, NJ. I researched the growth and cycling of hair follicles, using *in vitro* methods.

EDUCATION

2008 - 2010: **Child and Adolescent Psychiatry Fellowship**, University of Michigan, Ann Arbor, MI.

2005 - 2008: **Adult Psychiatry Residency**, University of Michigan, Ann Arbor, MI.

2004 - 2005: **Postdoctoral Research**, University of Alabama at Birmingham, AL.

2003 - 2004: **M. D.**, University of Alabama School of Medicine, Birmingham, AL.

1996 - 2003: **Ph. D. in Microbiology**, University of Alabama at Birmingham, AL. Dissertation: "Studies of *Bacillus anthracis* spore surface and discovery of peptide ligands for spore detection."

1987 - 1991: **B. S. in Biology**, Yale University, New Haven, CT.

PEER-REVIEWED RESEARCH

D. Williams and C. Turnbough, Jr. Surface layer protein EA1 is not a component of *Bacillus anthracis* spores but is a persistent contaminant of spore preparations. J. Bacteriol. **186**: 566 - 569. 2004.

J. Brigati, D. Williams, I. Sorokulova, V. Nanduri, I. Chen, C. Turnbough, Jr., and V. Petrenko. Diagnostic probes for *Bacillus anthracis* spores selected from a landscape phage library. Clin. Chem. **50**: 1899-1906. 2004.

D. Williams, O. Benedek, and C. Turnbough, Jr. Species-specific peptide ligands for the detection of *Bacillus anthracis* spores. Appl. Environ. Microbiol. **69**: 6288 – 6293. 2003.

D. Williams, P. Siock, and K. Stenn. 13-*cis*-Retinoic acid affects sheath-shaft interactions of equine hair follicles *in vitro*. J. Invest. Dermatol. **106**: 356 – 361. 1996.

D. Williams and K. Stenn. Transection level dictates the pattern of hair follicle sheath growth *in vitro*. Dev. Biol. **165**: 469 – 479. 1994.

D. Williams, K. Profeta, and K. Stenn. Isolation and culture of follicular papillae from murine vibrissae: an

introductory approach. Br. J. Dermatol. **130**: 290 – 297. 1994.

PROFESSIONAL

Board certified in Adult Psychiatry, January 2012.
Board certified in Child and Adolescent Psychiatry, November 2015.
New Hampshire state medical license #14951, June 2010.
DEA controlled substances license #FW1967821, June 2010.
National Physician Identification #1346374998.
American Psychiatric Association, member.
American Association of Child & Adolescent Psychiatry, member.
New England Council of Child & Adolescent Psychiatry, member.
New Hampshire Medical Society, member.
Medicaid #3091176.
Medicare # 2135901.

[redacted]

CURRICULUM VITAE
MERCY E. ISANG, MD, MPH, DABPN, FAPA

EDUCATION

08/1996-12/1998	**MPH** Emory University Rollins School of Public Health Atlanta, GA
10/1980-08/1986	**MBBS** University of Calabar College of Medical Sciences Calabar, Nigeria

TRAINING

09/2001-06/2002	**Training/Family Medicine**
07/2001-06/2002	**Chief Resident/Psychiatry**
07/1998-06/2002	**Residency/Psychiatry** Morehouse School of Medicine Atlanta, GA
07/1998-06/2002	**Training/Adult Outpatient, Child & Adolescent Psychiatry & Community Mental Health** Grady Memorial Hospital Atlanta. GA
07/1998-06/2002	**Training/General Adult & Forensic Psychiatry** Georgia Regional Hospital Atlanta, GA
07/1998-06/2002	**Training/Outpatient Adult Psychiatry** VA Hospital Tuskegee, AL
01/1990-03/1994	**Residency/Pathology** University of Calabar Teaching Hospital Nigeria
10/1986-10/1987	**Internship** Ikot Ekpene General Hospital Nigeria

RESEARCH

Available Upon Request

BOARD SPECIALTY

ABPN Certified

LICENSURE

GA #050528 & TN #36533

WORK HISTORY/AFFILIATIONS

03/2015-Present	**Medical Director**
12/2014-01/2015	**Locum Tenens** Greenleaf Center Valdosta, GA
10/2014-11/2014	**Locum Tenens** Shelby County Correctional Facility Memphis, TN
08/2014-09/2014	**Locum Tenens** Clayton County Jail Jonesboro, GA
08/2013-07/2014	**Vice Chief/Medical Staff**
10/2012-07/2014	**Medical Director/Geropsychiatric & General Outpatient**
05/2010-10/2012	**Medical Director/Geropsychiatric** Jamestown Regional Medical Center Jamestown, TN
09/2010-08/2012	**Psychiatrist** Highlands Rivers Health Dalton, GA
01/2008-08/2010	**Staff** MHM Correctional Services Inc. Vienna, VA
02/2007-01/2008	**Psychiatrist** St. Mary's Medical Center Knoxville, TN
2004- 2011	**Counselor/Medical** Hope of East Tennessee Inc. Oak Ridge, TN
01/2003-06/2010	**Staff** Private Practice/Mercy Behavioral Health Care Services, PC Oak Ridge, TN
01/2003-03/2002	**Staff/Partial Hospitalization Program & NIA Project** Integrated Life Center Decatur, GA
07/2002-11/2006	**Medical Director/Behavioral Medicine** Methodist Medical Center Oak Ridge, TN
07/2002-11/2006	**Staff/Medical** Parkwest Medical Center Knoxville, TN

07/2002-12/2005	**Staff/Medical** Fort Sanders Regional Medical Center Knoxville, TN
11/2001-06/2002	**Staff/Medical & Communicable Disease Prevention** Fulton County Health Department Atlanta, GA
08/2001-06/2002	**Staff/Medical** Georgia Regional Hospital Atlanta, GA
07/2000-12/2005	**Staff/Medical** Peninsula Behavioral Health Knoxville, TN
12/1987-12/1988	**Staff** National Youth Service Corps/Mercy Hospital Abak, Nigeria

ACADEMIC APPOINTMENT

04/1989-01/1990	**Lecturer/Chemical Pathology** University of Calabar Nigeria

PROFESSIONAL ASSOCIATIONS

American Psychiatric Association
Tennessee Physician Psychiatric Association

AWARDS AND RECOGNITION

05/2002 BEST RESIDENT OF THE YEAR, Pfizer Pharmaceutical Company
05/2002 RESIDENT OF THE YEAR, Black Psychiatrist Association of Atlanta
11/2001 ELI LILLY TRAVEL FELLOW
08/2001 Chester Pierce M.D., Sc.D. Resident of Distinction NATIONAL MEDICAL ASSOCIATION
2001 Physician's Recognition Award AMERICAN MEDICAL ASSOCIATION
05/2001 Participant at "Career Directions" Program ANNUAL APA MEETING New Orleans, Louisiana
12/2000 ACNP/ADVENTIS TRAVEL FELLOW
1993 NIGERIAN EDUCATION COMMISSION
1980-1986 CROSS RIVER STATE SCHOLARSHIP

PUBLICATIONS

Available Upon Request

SAMANTHA SWETTER, M.D.

[redacted]

TRAINING

Chief Resident, Department of Psychiatry
Expected Graduation: July 2018
The Mount Sinai Hospital; New York, NY

LICENSURE

New York State, Medical License and DEA

EDUCATION

Doctor of Medicine Program, May 2012-May 2014

Medical Scientist Training Program
Department of Biochemistry, July 2009-May 2012

Albert Einstein College of Medicine
Graduation Date: May 2014

B.S. Mechanical Engineering
Pre-medicine Professional Program
Minor: International Engineering
Honors Thesis: Resistance Characterization of a HiPIMS Plasma Discharge
University of Nebraska – Lincoln (UNL); Lincoln, NE
Aug 2003-May 2009

CLINICAL EXPERIENCE

Transcranial Magnetic Stimulation (TMS) Consultant
Nov 2017 – present
TMS Centers of America; New York, NY
Conduct initial TMS evaluations, brain mapping for TMS, and follow-up visits as an outpatient psychiatric consultant.

Insurance Appeals
July 2016 – present
The Mount Sinai Hospital; New York, NY
Evaluate insurance claim denials and make formal written appeals to the insurance providers.

Per Diem Staff Psychiatrist
September 2016 – September 2017
St. Joseph's Medical Center; Yonkers, NY
Per diem coverage of consult liaison, emergency room, and 29 inpatient beds on nights and weekends. Responsible for triaging new consults and staffing urgent consults/floor issues.

RESEARCH EXPERIENCE

Mental Health Perceptions in Rural Uganda,
March 2014-May 2014
Kisoro, Uganda
Develop, implement, and analyze surveys regarding mental health perceptions in the rural communities of Kisoro, Uganda.

P. falciparum infected erythrocytes as an aptamer target,
August 2009-March 2012
Albert Einstein College of Medicine, Bronx, NY
Artificially evolve ribonucleic small molecules to elucidate parasite biology and provide novel diagnostic/therapeutic strategies for *Plasmodium falciparum*-infected erythrocytes.

Clotting Factor Purification and Characterization,
May 2008 – May 2009
University of Nebraska – Lincoln
Purification of rFVIII from transgenic murine milk. Characterization of a portable fibrin sealant bandage for arterial hemorrhage

High Power Impulse Magnetron Sputtering Modeling,
August 2006-May 2008
University of Nebraska – Lincoln
Characterization and equation modeling of plasma field used in kinetic sputtering.

PUBLICATIONS

Hanna, J., **Swetter, S.** A Case of Delirium and Rhabdomyolsis in Severe Opiate Withdrawal. Manuscript in preparation.

Meyer, J.P., **Swetter, S.K.**, & Kellner, C.H. (2017). Electroconvulsive therapy (ECT) in geriatric psychiatry: A selective review. *Psychiatric Clinics of North America*. Manuscript accepted for publication.

Swetter, Samantha. (2017). Unexpected trauma. *The American Journal of Psychiatry – Residents' Journal. 12*(7),10.

Cumper, S., Ahle, G,, Liebman, L., & Kellner, C. (2014). Electroconvulsive therapy (ECT) in Parkinson's Disease: ECS and dopamine enhancement. *JECT. 30*(2), 122-124.

ADMINISTRATIVE PROJECTS

Value-Based Pilot for Health and Recovery Plan Members
The Mount Sinai Hospital; Sep 2016 – present
Consolidate referral data to Medicaid Home and Community-Based Services (HCBS) for high-risk populations and help analyze for quality improvement measures.

Suicide Risk Assessment Task Force
The Mount Sinai Hospital; Sep 2016 – Jun 2017
Worked on a team to standardize and incorporate evidenced-based methods into the hospital wide suicide risk assessment.

Quality Improvement for Clinical Scales Screening
The Mount Sinai Hospital; Oct 2016 – Jan 2017
Collaborated with clinic staff to increase screening of depression and anxiety via clinical scales.

TEACHING EXPERIENCE

Co-Leader for Psychiatry PGY1 Didactic Course, May 2016 – Jul 2017
Clinical Lectures to Psychiatry PGY1s, Aug 2016 – Mar 2017:
Lectures given include: First break psychosis, Delirium, contraindications to common PRNs, Alcohol use disorder
Clinical Case Lecture to Psychiatry PGY2s, Oct 2015
Ethics Case Lecture to Psychiatry PGY1s, Mar 2015
Psychiatry Shelf Review for Medical Students, Mar 2015
Physiology Lab Teaching Assistant, May 2008 – Dec 2008

PRESENTATIONS

Grand Rounds – The Borderline Façade
Mount Sinai Hospital. Oct 2017

Summer Roundabouts – Widening Your Differential Diagnosis
Mount Sinai Hospital. Aug 2017
Case-based presentation to residents of all years regarding how to formulate patients and acquire sufficient information for a diagnosis.

"Me Too"
Albert Einstein College of Medicine. Mar 2017
Invited discussant for presentation on mental illness in physicians and medical students.

Poster Presentation – Recombinant Clotting Proteins for use in Arterial Bandages
University of Nebraska – Lincoln. May 2008

Poster Presentation – High Power Impulse Magnetron Sputtering Modeling
University of Nebraska – Lincoln. May 2008

INTERNATIONAL EXPERIENCE

Telesupervisor for nurse practitioner in Liberia, Aug 2017 – present
Global Health Fellow – Uganda, Mar 2014 – May 2014
Global Mental Health Rotation – St. Vincent, Jan 2014 – Feb 2014
Business and Globalization in India, Mar 2007
Mechanical Engineering Student Semester Exchange - Brazil, Jan 2006 - Jul 2006
Engineering, Culture, and Portuguese Language in Brazil,

May 2005 - Jun 2005
Engineering and Culture in Italy, Jul 2004

PROFESSIONAL EXPERIENCE

Oilfield Services Engineering Intern, May 2007 – Aug 2007
Schlumberger; Shreveport, Louisiana
Open and cased hole field work. Began process to establish an electronic inventory system.

Manufacturing and Industrial Engineering Intern,
Jan 2007 – May 2007
Hamilton Sundstrand; York, Nebraska
Support the development of manufacturing assemblies and corresponding production processes in a precision machining facility.

International Engineering Education Student Coordinator,
Oct 2004 - Jan 2007
University of Nebraska – Lincoln
Program evaluation and the program coordinator for the Fund for the Improvement of Postsecondary Education (FIPSE).

CONTINUING EDUCATION

Suboxone Training;
The American Osteopathic Academy of Addiction Medicine
Apr 26, 2017

Transforming Clinical Practice Initiative;
APA learning collaborative on collaborative care for New York residents led by University of Washington
Sep 2016 – Dec 2016

PROFESSIONAL AFFILIATIONS

American Psychiatric Association Feb 2017 – present
Community Service Committee Mar 2017 – present
Anxiety and Depression Association of America Oct 2017 – present

ACTIVITIES (leadership bolded)

Active member and presenter in Reproductive Psychiatric Journal Club, May 2015 – present
Post-secondary education counseling at Frederick Douglas Academy III, May 2012 – present
Student-run ECHO free clinic, Apr 2013 – May 2014
Session Coordinator
Homeless Outreach Program at Einstein, May 2012 – May 2013
Einstein Journal of Biological Medicine, May 2011 – May 2012
Assistant Editor
Engineers Without Borders – University of Nebraska (EWB-UN),
Co- President, Aug 2008 – May 2009,
Community Health Assessment Committee Chair,
Nov 2008 – May 2009
Volunteered at Bryan LGH Medical Center, Emergency Room,

Nov 2007 – May 2009
Notetaker for Students with Disabilities, Jan 2004 – May 2004, Jan 2009 – Feb 2009
International Association for the Exchange of Students for Technical Experience, **President**, Sep 2004 – Mar 2007
Peer Mentor for University Honors Program, Sep 2004 – Dec 2004

HONORS AND AWARDS

Nominated for AADPRT/George Ginsberg Fellowship Award, Sep 2017
Global Health Fellow to Uganda, Jan 2013
Grant recipient for undergraduate research (UCARE), May 2006, May 2008
NASA Nebraska Space Grant Scholarship Recipient, Nov 2007
Milton E. Mohr Mechanical Engineering Scholarship Recipient, July 2007
InfoUSA sponsee in "This is India!" study abroad program, Mar 2007
Department of Education grant recipient for foreign exchange to Brazil (FIPSE), Dec 2006
Society of American Military Engineers Scholarship, Nov 2006
Tau Beta Pi Inductee, Aug 2005
Pi Tau Sigma Inductee, Jan 2005
University Honor's Program, May 2003
Regent's Four Year Tuition Scholarship, May 2003
Engineering & Technology Four Year Scholarship, May 2003

Thatcher R. Newkirk, M.D.
[redacted]

Education

Residency:	St. Elizabeth's Medical Center General Psychiatry, Brighton, MA	2014-Current
Medical School:	M.D., Tufts University School of Medicine, Boston, MA	2010-2014
Undergraduate:	Harvard Extension School Health Careers Program, Cambridge, MA	2007-2009
	B.A., Oberlin College, Oberlin, OH	2003-2007

Current Position

Chief Resident of Psychiatry — 2016-present
St. Elizabeth's Medical Center
Brighton, MA

As chief resident I am responsible for organizing the call schedule, structuring and leading monthly meetings where resident concerns are fielded, facilitating third-year medical student presentations, and giving biweekly lectures to the PGY-1 class about a variety of introductory topics.

Awards

Tufts University School of Medicine Excellence in Teaching Award for 2015-2016

Standardized Tests

2016 PRITE scores
- Neurosciences: 660
- Clinical Neurology: 711
- Clinical Psychiatry: 709

Previous Employment

Substitute Teacher — 2009-2010
Waterville Senior High School
Waterville, ME

I substituted an average of four days a week for grades 9-12. Since this was my high school alma mater and teachers knew me well, they gave me lots of independence in teaching classes ranging from 9th grade remedial English to AP Chemistry.

Assistant Track and Field Coach — 2009-2010
Waterville Senior High School
Waterville, ME

I was the assistant coach responsible for the distance runners in both indoor and outdoor track and field. The girls' outdoor team won a state title. Three of the runners I coached went on to be individual state champions in the 3200 meter run.

Other Teaching Experiences

Group Leader for Tufts University School of Medicine Interviewing Course 2014-2016
St. Elizabeth's Medical Center
Brighton, MA

I was responsible for teaching four first-year medical students at Tufts as part of their interviewing course. This involved leading discussions about the principles of medical interviewing, monitoring student interviews, reading weekly student reflections, and providing written feedback on those reflections.

Experimental College 2006
Oberlin College
Oberlin, OH

The Experimental College is a program that allows undergraduates to create courses that other undergraduates can take for college credit. I designed and taught a semester long course about censorship. It met once a week for two hours for the duration of the semester.

Margaret D. Abbott

[redacted]

EDUCATION:

Post Masters Certificate in Mental Health, Rivier College, Nashua, NH, June, 2012
Master of Science in Gerontological Nursing, University of Massachusetts Lowell
Lowell, Massachusetts, 2003
Bachelor of Science, University of Lowell, Lowell, Massachusetts, 1987

PROFESSIONAL STATUS:

Advanced Registered Nurse Practitioner:
Board Certified Gerontological Nurse Practitioner, American Nurses Credentialing Center, 2004
Board Certified Adult Nurse Practitioner, American Academy of Nurse Practitioners, 2003
Board Certified Psychiatric Adult Mental Health, American Nurses Credentialing Center, 2013

PROFESSIONAL EXPERIENCE:

October 2016-Present-Dartmouth Hitchcock, NH Hospital, Concord, NH
APRN-provide psychiatric care to patients on H-Unit, a long-term inpatient unit for patients with persistent and severe mental illness. Responsibilities include coordination of care with a team focus, to include stabilization of patients and their mental illness, whether with psychopharmacologic agents and/or behavioral interventions. Assist team in coordination of safe discharge plans. Develop and maintain Treatment Plans for care. Participation in various committees, including Ethics Committee and other general hospital wide committees. Participate in court related issues, including HE-M 306, Probate Hearings, Guardianship Hearings. Participate in transfer of patients to Secure Psychiatric Unit.

February 2015 to October 2016-Generations Geriatric Mental Health, Manchester, NH
APRN-provide psychiatric services for residents in Long Term Care settings. Assess and formulate treatment plans for older adult residents with dementia and other psychiatric illnesses, including chronic mental illness. Provide medication management and establish non-pharmacological interventions to decrease behaviors associated with dementia or other psychiatric issues. Conduct cognitive assessments, educate staff and family members on treatment options to assist in decreasing behaviors and improving quality of life. Provide psychiatric coverage at **Elliot Hospital Geriatric Psychiatric Unit**. This is a 25 bed unit for seniors whom have psychiatric issues, predominantly dementia with behaviors, but also those battling depression or other chronic mental illnesses. Responsibilities include behavioral and medication management, education of staff and families. Provide psychiatric support to emergency department and inpatient units at The Elliot Hospital, for guidance on treatment options for older patients with behavioral issues.

November 2013-February 2015-Harbor Homes Health and Wellness Center, Inc., Nashua, NH
APRN-outpatient provider community mental health center, primarily provided psychopharmacological treatment for adults. Provided inpatient psychiatric consults for St. Joseph Hospital, Nashua, on their medical units and for their Emergency Department to provide mental health evaluations and recommendations for treatments for patients needing psychiatric intervention. Frequently treating patients with dual diagnosis. This role included assisting in ETOH detox management in ICU/ED settings, determining need for IEA transfer. Provided coverage for Partial Hospitalization Program at

Southern NH Hospital, Nashua, providing psychiatric evaluations and medication management for adult patients with mental health issues.

March 2012-December 2014-Moving Forward Healthcare for Older Adults, LLC

APRN- owner of business that performed dementia evaluations in private homes and Assisted Living Facilities. Provided care to diagnose, treat and/or educate families and staff on ways to care for the person with dementia. Performed cognitive evaluations and developed treatment plans. Devoted significant time to work and communicate the best practice for care.

November 2012- September 2013-St. Joseph Hospital, Nashua, NH

APRN-Provided physical assessments and medication management for **Acute Inpatient Rehabilitation Unit**. Variety of illnesses treated including patients recovering from strokes, surgery, fractures and those dealing with Parkinson's disease. Responsibilities included monitoring for progress with rehabilitation treatment and medical management of their medical diagnoses. Coordinated acute care needs with Hospitalists as needed. Facilitated communication amongst nursing staff, families and consultants for medical needs.

Continued to perform inpatient Adult psychiatric consults on medical floors and ED with responsibilities including mental health assessments, managing acute and/or chronic psychiatric issues with psychopharmacological intervention, assessing for need for IEA transfers and managing the patient's psychopharmacological treatment until transfer was arranged. Managed adult patients needing detox in ICU and ED settings, coordinating care with Hospitalists. Provided treatment and educated providers and staff frequently on treatment of acute delirium.

November 2009-December 2012

APRN- Senior Adult Mental Health Unit. Acute Psychiatric Unit for older adults, focus was on gerontological population with mental health issues, primarily Alzheimer's Disease, but other types of chronic mental illness as well. Perform mental health assessments, diagnose and treat the problems identified. Provide daily assessments and coordinate treatment. Frequent interaction with families, educating on the course of treatment. Worked closely with Psychiatrists and other team members of the unit. Traveled to local nursing homes and Assisted Living Facilities performing cognitive assessments on older adults living in these homes, assessing and treating accordingly. Outpatient practice- provided psychiatric treatment for older patients in the community, whom were referred by their Primary Care Providers for assessments. This care could include dementia, depression or other chronic mental health issues. Treatment included medication, referral for psychotherapy and/or ongoing monitoring and support. Frequent component of this job included education for patients, families and staff. Style of communication was adapted, based on the needs of the individual being treated. Ability to be patient and flexible was a key component for effectiveness of treatment. This position also required psychiatric assessments of adults of all ages on the hospital medical units, ICU and Emergency Department, for assessments of acute psychiatric illnesses, including the need to determine whether medication management was needed and/or transfer to an acute psychiatric hospital was appropriate. Assessed and managed patients in ICU/ED for acute detox, collaborating with Hospitalists.

September 2007-December 2008-Harmony Health Care Institute, Inc., Merrimack, NH

Nursing Faculty-Clinical Nursing Instructor for LPN students. English as second language for majority of students. Developed and presented lecture material and exams for Issues and Trends, Anatomy & Physiology, Pharmacology, Human Lifespan and Leadership. Clinical Sites in Long term care setting.

July 2006-October 2012-PESI

Speaker-Developed and presented at least annually for full day presentations. Topic was "Challenging Geriatric Behaviors". Attendees are from various disciplines within the healthcare system. Audience consists of 25-75 participants. Personally developed the Power point presentation. Travel throughout the US.

March 2006-May 2010 -Monadnock Community Hospital, Peterborough, NH

ARNP-Perform comprehensive medical evaluations, as well as episodic visits for long term care residents. Review weight loss, falls and wounds and treat accordingly. Monitor behaviors and responses to medication treatment, provide education for alternatives to medications for behaviors. Communicate with physicians, staff members and families, to provide necessary education, guidance on caring for elderly residents.

September 2005-May 2007-New Hampshire Community Technical College, Keene, NH

Clinical Nursing Instructor-guide clinical experiences for 8 students enrolled as seniors in an Associate Degree Registered Nurse Program, on Oncology Unit. Evaluate care plans, evaluations, as well as providing ongoing feedback on clinical performance.

October 2004-August 2005-Holden Health Career Training Center, Nashua, NH

LPN Instructor-Responsible for lecturing 40 LPN students with 14 week courses; Pharmacology I, Mental Health Nursing and Gerontological Nursing. Developed own lecture material and exams. Majority of student population has English as second language.

August 2004-March 2006-Genesis Physician Services, Keene, NH

ARNP-Perform comprehensive medical evaluations, as well as episodic visits for long term care residents. Review weight loss, falls and wounds and treat accordingly. Monitor behaviors and medication responses, provide alternatives to medications for behaviors. Communicate with physicians, staff members and families, to provide necessary education, guidance on caring for elderly residents.

December 2003-August 2004-New England Geriatrics, Springfield, MA.

Nurse Practitioner-perform consults for geriatric residents of long-term care facilities with psychiatric or behavioral issues, review medication regimen and make treatment recommendations. Perform quarterly psychiatric assessments, psychopharmacology and behavioral evaluations and titration of medications as per OBRA guidelines.

October 2003-April 2004-St. Joseph School of Practical Nursing, Nashua, NH.

Clinical Nursing Instructor-guide clinical experiences for LPN students enrolled in intense 11-month program in Monadnock Region, on 30-bed medical surgical unit, as well as long-term care rotations for gerontology and pediatrics with a separate rotation to provide active participation in order to prepare for leadership roles. Evaluate care plans, review evaluation assessments on clinical roles, provide ongoing feedback on clinical performance.

July 2003-November 2003-Monadnock Community Hospital Health Services, Peterborough, NH

Staff Office Nurse-fast paced 3 physician Internal Medicine Office, varied responsibilities to include patient review of systems, injections, blood draws, coordination of tests for patients, patient education on healthcare issues.

September 2001- July 2003- Monadnock Community Hospital, Peterborough, NH

Senior Mental Health Unit –RN responsibilities included coordinating care for patients, assessing physical/mental health responses to new treatment plans for psychiatric illness. Presented in-service, "Assessment of Pain in Demented Elders."

Utilization Review Coordinator and Quality Improvement Coordinator. Review patients for appropriateness of care, notifying insurance companies of patient status and plan of care, working with interdisciplinary team members to assure effectiveness of treatment plans. Review of patient charts for measurable QI components, as well as peer review.

May 1999 - September 2001- Monadnock Community Hospital, Peterborough, NH

Unit Manager, Adult Pediatric Unit-assumed total responsibility for the daily operational function of 30-bed unit. Developed effective self-governance model, for patient care, for staff members. Promoted customer service process. Similar responsibilities to Clinical Leader, described below.

Stacy Ann Sorrell PMHCNS, APRN

Education

1998

University of Massachusetts Lowell, Lowell, MA • Master of Science, Psychiatric – Mental Health Nursing

1994

University of Massachusetts Lowell, Lowell, MA • Bachelor of Science, Nursing

Certification

ANCC Certified Clinical Nurse Specialist in Psychiatric Mental Health Nursing Since 1999

Professional Experience

October 2016 – Present

Inpatient Psychiatric Provider

Dartmouth Hitchcock Department of Psychiatry at New Hampshire Hospital
Concord, New Hampshire

- Provides comprehensive evaluation of patients on Psychiatric Admitting Unit
- Serves as a Team Leader as Attending Provider for 12 patient Team
- Provides ongoing evaluation and works with others collaboratively to provide and facilitate care that supports improvement and ongoing stabilization
- Serves as a Team Leader as Attending Provider for 12 patient Team
- Is an active clinical participant in legal process as Attending Provider in admission and commitment to treatment through Involuntary and Voluntary admissions, Revocation of Conditional Discharge and Emergency Treatment processes
- Prescribes and evaluates effectiveness of psychiatric medications
- Facilitates and initiates development of individualized treatment plans and
- Provides direction and clinical guidance for follow through to safe and effective transitions of care
- Assists in coordination of care to out-patient facilities/providers
- Facilitates family meetings and correspondence with Guardians and alternate decision makers as needed

September 2015 – October 2016

Inpatient Psychiatric Provider

Franklin Regional Hospital
Franklin, NH

- Provides comprehensive evaluation of patients on the ten bed locked Psychiatric Unit
- Serves as a resource for compliance with legal steps for admissions through Involuntary, Voluntary and Revocation of Conditional Discharge processes
- Prescribes and evaluates effectiveness of psychiatric medications
- Facilitates development of individualized treatment plans and
- Provides direction and oversight for follow through to safe and effective transitions of care
- Assists in coordination of care to out-patient facilities
- Provides brief problem-focused counseling and directs theme of group programs to improve effective coping of patients on unit
- Facilitates family meetings and correspondence with Guardians and alternate decision makers
- Provides fiscally responsible direction of care
- Resource for psychiatric policy development and establishment of compliance standards

August 2012 – September 2015

Clinical Director – Psychiatric Service

LRGHealthcare
Franklin NH and Laconia NH

- Assisted in quality assurance and improvement plan and processes
- Instrumental in developing policies, procedures, safety measures and programmatic schedule for new Involuntary Psychiatric Unit that opened October 2013 at Franklin Regional Hospital
- Facilitated orientation of staff for opening of that unit
- Facilitated and developed policies and procedures for the two Psychiatric Units and care of patients with psychiatric issues throughout hospital
- Facilitated development of new service lines, laying framework for availability of expanded out-patient and electro-convulsive therapy treatments
- Served as a consultant in issues related to psychiatric patients on the non-psychiatric unit
- Provided ongoing educational offerings related to understanding issues related to the care of patients with psychiatric conditions
- Worked with multi-departmental leaders and personnel to support fiscal responsibility and improve customer satisfaction
- Served as a liaison between the hospital system and state and community agencies
- Represented the hospital and the patients served, as an advocate for improved resources and access to services in the state
- Actively involved in comprehensive assessment, treatment plan development and care of patients on the Psychiatric Unit
- Served as a consultant in assessment and treatment of psychiatric patients being cared for in other patient care departments
- Engaged in collaborative processes to improve mental health system in local area and state of New Hampshire through active roles in Behavioral Health Leaders Group and Psychiatric Emergency Service Group facilitated by the Bureau of Behavioral Health

October 2007 – August 2012

Program Director – Senior Psychiatric Services

LRGHealthcare
Laconia NH

- Actively involved in comprehensive assessment, treatment plan development and care of patients on Senior Psychiatric Unit
- Served as a hospital resource for mental health issues and with Risk Management of medico-legal issues

Program Director – Senior Psychiatric Services (Continued)

- Actively involved in therapeutic individual and group sessions for patients
- Actively involved in family support and education
- Actively involved in marketing of services
- Assisted in facilitation of complicated discharge plans
- Assisted Psychiatrists in implementation of treatment plans
- Developed continuous quality improvement plans and facilitated changes to enhance services
- Served as a consultative resource to other units/departments regarding psychiatric patients and psycho-social system issues
- Provided clinical direction of staff and education offerings to improve skill level and understanding of complex issues impacting patient population
- Facilitated or presented community and provider education related to psycho-social issues and psychiatric illness

March 2000 – October 2007

Coordinator – Pain Management Center

LRGHealthcare
Laconia, NH

- Actively involved in comprehensive assessment and individualized care of patients
- Actively involved in marketing and education
- Initiated and organized educational programs for the local providers and community members
- Worked collaboratively with physician group and administration to provide continuous quality improvement of the Center and care of patients
- Assisted with development and monitoring of the Pain Center budget
- Maintained supervisory role of staff
- Served as a resource for psycho-social issues related to illness and injury
- Developed and facilitated group programs for patients and families impacted by chronic pain
- Worked collaboratively with administration on development and significant expansion of Pain Management Center from a program servicing twenty patients at inception of new role to a center servicing hundreds of new patients each year
- Strategically led development and implementation of offerings to best meet needs of patients, medically community reducing utilization of costly and fragmented episodic care in emergency and urgent appointment settings

September 1998 – March 2000
Care Manager – Pain Management Center
LRGHealthcare (formerly known as Lakes Region General Hospital)
Laconia, NH
· Worked with multidisciplinary team to assess and treat pain management patients

· Provided clinical care/case management of pain program patients

· Assisted with program development and marketing

· Worked with multidisciplinary team members to provide educational programs for patients and community members

August 1994 – September 1998
Staff Nurse – Behavioral Health Services Inpatient Unit
Lakes Region General Hospital
· Provided care to inpatients admitted with primary psychiatric and co-occurring substance abuse issues

· Facilitated individual and group therapeutic sessions

· Served as a member of hospital-wide crisis intervention and psychiatric support team

· Developed educational tools for patients explaining medications, diagnoses and coping skills

June 1993 – August 1994
Nurse Extern – Behavioral Health Services Inpatient Unit
· Under direction of Nursing staff, provided care to inpatients admitted with primary psychiatric and co-occurring substance abuse issues

References Available Upon Request

MARYANNE FOURNIER, JD, MSN, PMHNP-BC

Experience:

2/16 – present

Center for Life Management **Derry, NH**
Adult and Geriatric Psychiatric Nurse Practitioner

Assessment and treatment of an outpatient population of clients with varying degrees of mental illness and dual diagnosis. Coordination with team members providing services in the home and in the community for patients. Prescribing medications, treatment, and services as appropriate for those with serious comorbid illness. Patients include ACT clients, Clozaril and injectable medication patient management as well as adult outpatient and CSP clients.

12/14 -4/16

Parkland Medical Center **Derry, NH**
Nurse Manager of Behavioral Health Unit

Prepare and open new 14 bed inpatient adult psychiatric (newly opened on March 3, 2015.) Responsible to put systems and processes into place, prepare policies, obtain supplies, staff, train, and orient new employees, interface with other departments, scheduling, payroll, full time function as floor staff as well.

1/13-10/15

Whittier Pavilion Hospital **Haverhill, MA**
Director of Nursing, Director of Admission, Outpatient Nurse Practitioner

65 bed inpatient psychiatric hospital consisting of Two adult dual diagnosis units and one geropsych unit. Responsible for the day to day operations, policies, and staffing of the facility Also, responsible for the twenty-four-hour management of the Admissions Department. Carried a small caseload of 50-80 patients in the Outpatient Department.

5/13-6/15
Closed

The Psychological Center **Lawrence, MA**
Psychiatric Nurse Practitioner

Responsible for the evaluation and monitoring of psychiatric and dual diagnosis of patients in the community. Prescription of medication and treatment as appropriate with productivity of 4/hr.

* Assisted facility in closing, assuring patients had follow up and medication.

6/10 – present

Northeast Behavioral Health (now Lahey Behavioral) **Lawrence, MA, Lowell MA**
Nurse Practitioner, former Program Director of Crisis Stabilization Unit

Responsible to oversee the operation and staffing of a six bed crisis unit for adult psychiatric patients. Patients receive therapeutic treatment, medication, groups and case management Staff includes social worker, nurses, nurse practitioners, peer counselors, and mental health counselors.

* **Presently** providing initial clinical assessment of patients, medication evaluation and psychiatric stabilization as weekend and holiday coverage.

2012
Program closed

Whittier Pavilion – Outreach **Haverhill, MA**
Psychiatric Nurse Practitioner in Long Term Care Facilities

Psychiatric evaluations and consultation liaison work in long term care and rehabilitation facilities. Includes preparation of Rogers and Guardianship documents for the courts.

6/01 - 7/05

Melrose Wakefield Hospital **Melrose, MA**
Registered Nurse/Charge Nurse – Emergency Department

Staff nurse/Charge nurse in a community hospital serving 45,000+ patients per year. Volume consists of adult and pediatric medical, surgical, trauma, and psychiatric patients. Cardiac patients medically prepared for cardiac catheterizations, coordination of aftercare.

6/94 – 2/00

Hale Hospital **Haverhill, MA**
Registered Nurse/Charge Nurse and Nursing Supervisor

Staff and charge nurse in a community setting to a full scope of medical, cardiac, surgical, trauma, psychiatric, and pediatric patients. Specialized care given to victims of domestic violence and sexual assault. Geriatric psychiatric care.

Nursing Supervisor for the hospital during the evening and night shift to make administrative and staffing decisions.

Education:

May 1983	**Northeastern University** *Paramedic Certification*
May 1992	**Northern Essex Community College** *Registered Nurse- Associates Degree*
May 1997	**Regis College** *Baccalaureate in Nursing*
June 2000	**Massachusetts School of Law** *Juris Doctor*
May 2011	**Regis College** MSN – Adult Psychiatric Mental Health Nurse Practitioner
June 25, 2017	**Chamberlin College of Nursing** *Doctor of Nursing Practice*

Certifications / Licensure

Attorney - Admitted to the Bar in Massachusetts
RN – MA and NH,
PMHNP-BC, MA and NH,
CPR for healthcare providers

Teaching Experience:

current	Regis College- Adjunct faculty for nurse practitioner students Rivier University – Adjunct faculty for graduate nursing students Regis College, Weston MA – clinical preceptor for NP students
past	Emergency Medical Services Education – didactic and clinical Clinical Instructor of EMS- Massachusetts Bay Community College Clinical Adjunct Faculty- New Hampshire Technical College Dana Faber Cancer Institute- "Woman to Woman" Community breast cancer education and research project – didactic

Sheena D. McAroy, MS, APRN, FNP-C, PMHNP-BC

Education

- **Post-Masters Certificate, Psychiatric/Mental Health Nurse Practitioner**, May 2015
  RIVIER UNIVERSITY, Nashua, NH
- **MS, Family Nurse Practitioner**, May 2013
  RIVIER UNIVERSITY, Nashua, NH
- **AS, Nursing**, May 2010
  RIVIER COLLEGE, Nashua, NH
- **BS, Forensic Science**, May 1996
  UNIVERSITY OF CENTRAL OKLAHOMA, Edmond, OK

Licensures and Certifications

- American Nurses Credentialing Center Certification PMHNP-BC, Psychiatric Mental Health Nurse Practitioner Certification #2015003345
- American Academy of Nurse Practitioners NP-C, Family Nurse Practitioner Certification # F06131153
- New Hampshire APRN License #062795-23
- New Hampshire RN License # 062795-21
- Vermont APRN Licenses for FNP and PMHNP
- Certified Volunteer Court Appointed Special Advocate, CASA of NH, April 2004

Professional Associations

- American Association of Nurse Practitioners
- New Hampshire Nurse Practitioner Association

Work Experience

Rivier University, Nashua, NH
Adjunct Faculty, Department of Nursing Graduate Studies, September 2017- Present

- Co-teach graduate family medicine and family psychiatric/mental health nurse practitioner students
- Teach core curriculum course work for graduate nursing courses

MHM Services/Department of Corrections, State of NH, Berlin, NH
Outpatient Psychiatric Nurse Practitioner, May 2017- March 2019

- Served as sole psychiatric prescriber for inmate/patients at Northern New Hampshire Correctional Facility
- Assessed patients in acute crisis for danger of harm to self or others
- Performed intake psychiatric assessments
- Provided urgent care medical services
- Collaborated with team lead medical APRN and nursing to provide holistic treatment for patients with comorbid medical and psychiatric conditions
-

MHM Services/Department of Corrections, State of NH, Concord, NH
Assistant Program Manager/CQI Coordinator/Medical and Psychiatric APRN, April 2014-May 2017

- Performed medical and psychiatric intake assessments to establish a treatment plan for new male and female patients
- Provided call coverage approximately one week per month for psychiatric services
- Managed care for patients with chronic illnesses and co-occurring mental health diagnoses
- Diagnosed and treated patients presenting for acute and chronic medical concerns

- Supervised greater than 30 staff members including psychiatrists, physicians, nurse practitioners, dentists, and psychologists to provide administrative guidance as MHM Assistant Program Manager for the Medical, Psychiatric, and Forensic contracts
- Evaluated current medical and mental health procedures and practices for continuous quality improvement
- Collaborated with medical and mental health providers and security staff to streamline communications and patient care
- Recruited and interviewed medical, forensic, dental, and mental health providers

Monadnock Community Hospital, Peterborough, NH
Occupational Health APRN, November 2013-October 2014

- Performed pre-employment physical examinations for local companies to ensure employee health was consistent with demands of unique work environments
- Certified to perform Medical Examinations for Department of Transportation physicals
- Evaluated and treated patients with acute and chronic injuries from worker's compensation claims
- Performed clinical breast exams, PAP exams and patient education for the State of New Hampshire's Let No Woman be Overlooked program for uninsured women

St. Joseph Home and Hospice Care, Milford, NH
Nurse Case Manager Home Care and Hospice Nurse, October 2010-June 2013

- Delivered care to extensive patient population including those with acute and chronic illnesses
- Educated patients on medications, pathophysiology, disease management, and symptom management
- Assessed acute patients and coordinated care with providers
- Monitored patients for progress towards goals in homecare setting as part of a collaborative team of physical therapists, occupational therapists and medical social workers

Lowell Road Veterinary Center, Hudson, NH
Chief Financial Officer/Co-owner, March 2001-March 2013

- Developed hospital operating budget and performed all book-keeping functions
- Supervised 9-12 employees including doctors, technicians and office staff
- Evaluated new products and pharmaceuticals for patient and cost efficacy
- Consulted on ordering to maintain stock levels and reduce costs

Office of the Chief Medical Examiner, Oklahoma City, OK
Forensic Chemist January 1994-May 1999

- Tested bodily fluids and tissue for qualitative identification and quantitative measurement of pharmacological and illicit substances
- Maintained legal chain of custody for biological specimens
- Assisted in research on toxic drug levels and drug interactions
- Worked as part of an inter-disciplinary team of doctors, histologists, chemists, police and toxicologists to determine cause of death

Special Assignment for the Alfred P. Murrah Federal Building Bombing, Oklahoma City, OK
Liaison for Coordinating Recovery and Identification of the Deceased, April-May 1995

- Provided logistical support of personnel and supplies to rapidly meet demands in a mass casualty situation
- Supervised military GRAVES unit and military reservists to assist in removing decedents from crime scene
- Briefed FBI, CIA, police, Department of the Treasury and fire department on recovery efforts
- Performed on site field examinations on 140 homicide victims for initial field identification

SUZY J. KOSTRZEWSKI [redacted]

EDUCATION AND LICENSURE

Post-Masters Certificate, Family Psychiatric Mental Health Nurse Practitioner (PMHNP), Rivier University, Nashua, NH, May 2018
MSN, Clinical Nurse Leader (CNL)-certified, University of New Hampshire, Durham, NH, 2013
Paramedic Certificate, New England EMS Institute, Elliot Hospital, Manchester, NH 2003
MS, Geography, Statistics focus, Oklahoma State University, Stillwater, Oklahoma, 1993
BA, Geography, Keene State College, Keene, New Hampshire, 1990
FEMA Emergency Management Institute, Incident Command System 100, 200, 210, 300, 700, 800, and 100 for Healthcare/Hospitals

Family PMHNP-BC, American Nurses Credentialing Center, July 2018, #2018019166, Exp. July 2023
APRN, NH Board of Nursing, License #068472-23, Exp. July 2021
RN, NH Board of Nursing, August 2013, #068472-21, Exp. July 2021
CNL, Commission on Nurse Certification, July 2013, #10660133, Exp. December 2019

PROFESSIONAL AND CLINICAL EXPERIENCE

New Hampshire State Prison – Men's October 2018-present
Psychiatric Nurse Practitioner

- Provide psychiatric assessment, diagnosis and treatment for incarcerated offenders.
- Collaborate with behavioral health team to provide mental health services to offenders with psychiatric disorders and mental health problems in a correctional outpatient setting.
- Deliver psychoeducation to offenders on intended and potential adverse effects of treatment options.
- Prescribe psychotropic and related medications based on patient clinical indicators, including diagnostic and lab test results, to treat symptoms of psychiatric disorders and improve functional health status.
- Provide leadership and guidance to multidisciplinary team members in the development, implementation and evaluation of individual treatment and behavioral plans.
- Work with behavioral health, medical, nursing and security departments to ensure delivery of psychiatric, medical and behavioral health care to offenders in compliance with facility policy and treatment guidelines.
- Accept monthly on-call duty for psychiatric services to NH Secure Psychiatric Unit, NH State Prison-Men's, Women's and Northern Correctional Facility.

New Hampshire Hospital January-April 2018
Riverbend Community Mental Health September-December 2017
New Hampshire State Prison – Men's January-April 2017

- Conducted psychiatric assessments and medication management of chronically mentally ill patients in collaboration with supervising preceptor.
- Developed clinical interviewing skills to facilitate a therapeutic relationship with adult clients, including those in crisis and young adults transitioning from adolescent psychiatric care.
- Managed client mental health care consistent with current practice guidelines, standards of care, and facility policy.
- Integrated the knowledge and skills essential to psychiatric practice while critically evaluating research findings to provide mental health care under the supervision of a PMHNP.
- Utilized site tools to access, document and disseminate data to promote optimum patient outcomes.

Same Day Surgery, VAMC, Manchester, NH January-July 2013

- Six-month MSN Immersion and Capstone student RN stipend position in VA Ambulatory Care Unit.
- Provided direct patient care to veteran patients in Pre-Op and PACU under supervision of preceptor.
- Designed, proposed thesis project; coordinated research and data collection; analyzed data to prepare QI project that sought to improve patient management and pain assessment during gastrointestinal procedures under moderate sedation.
- Policy on pain assessment during moderate sedation modified as a direct result of project findings.
- Presented research at 3rd Evidence-Based Practice Symposium, VAMC, Manchester, NH, January 2014.

Ms. Carmel Rehabilitation & Nursing Center Manchester, NH
Registered Nurse November 2014-September 2018

- Staff RN, preceptor, Resource RN, alternate shift supervisor at NH Catholic Charities 220-bed rehabilitation and nursing center.
- Provide nursing assessment, planning, implementation, and monitoring of patients and residents on three units: short-term rehabilitation, dementia/Alzheimer's care, and long-term care.
- Coordinate patient/resident care with nursing staff, APRNs, Medical Director and Administration.

University of New Hampshire Durham, NH
Teaching Assistant 2011

- Instructor for 4 anatomy laboratory sections (100 students) of BMS 507: Anatomy & Physiology I.
- Researched, prepared and presented PowerPoint lectures and module quizzes; coordinated with anatomy teaching assistants to design, construct and administer laboratory practicals.

Frisbie Memorial Hospital Rochester, NH
Registered Paramedic 2003-2007

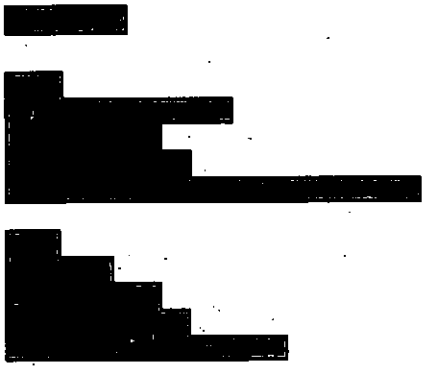
- Full-time, night, Senior Paramedic with Level III hospital-based EMS service providing 911 EMS response to city of 30,000 and 2-county mutual aid catchment area.
- Integral member of Emergency Department (ED) team with physicians, APRNs, PAs and nurses.
- Excelled in high-stress environment while maintaining customer focus and patient confidentiality utilizing strong interpersonal and time management skills.
- Effectively transitioned between Senior Paramedic on-call 911 duties and ED assignments.
- Possessed National Registry and NH Paramedic license, CPR, Advanced Cardiac Life Support, Pediatric Advanced Life Support, and Basic Trauma Life Support certificates.
- Maintained annual, biennial currencies in: rapid sequence intubation, needle crichothyrotomy, conscious sedation, malignant hyperthermia, HIPPA, Non-Violent Crisis Intervention, and fire/hazmat.

MEMBERSHIP/RECOGNITION

- Sigma Theta Tau International Honor Society of Nursing, Eta Iota Chapter.
- Gamma Theta Upsilon International Geographic Honor Society.
- USCG Special Operations Service ribbon, USCGAux Commendation Medal w/ Operational Distinguishing Device (OpDD), USCGAux Commandant's Letter of Commendation w/ OpDD, USCGAux Meritorious Unit Award (3), USCGAux Meritorious Team Award (7), USCGAux 20 year Sustained Service Award.

CURRICULUM VITAE

Aliaksandr Shakhau



Employment history

September 2001 – March 2005	Assistant professor, Department of Histology, Cytology and Embryology, Vitebsk State Medical University, Vitebsk, Belarus
June 2008 – June 2009	Research assistant/volunteer, Department of Neurology and Psychiatry, Saint Louis University, St. Louis, MO, 63104
July 2015 – Current	Instructor in Psychiatry, Department of Psychiatry Geisel School of Medicine at Dartmouth. Attending Psychiatrist, Inpatient Geriatric Unit New Hampshire Hospital 36 Clinton Street Concord, NH 03301 Attending psychiatrist, Healthy aging and brain care clinic at Dartmouth Hitchcock Medical center One medical center Dr, Lebanon, NH 03756

Education and training

September 1993 – June 1999	Medical School Vitebsk State Medical University M.D. program, Vitebsk, Belarus
September 1999 – September 2001	Postgraduate research, Department of Histology, Cytology and Embryology, Central Scientific Laboratory of Vitebsk State Medical University Vitebsk, Belarus
July 2011 – June 30, 2013 PGY-1 PGY-2	Psychiatry Residency program Department of Neurology and Psychiatry, Saint Louis University, St. Louis, MO, 63104

July 1, 2013 – June 30, 2015
PGY-3 PGY-4

Psychiatry Residency program
Department of Psychiatry
1 Medical Center Drive, Lebanon, NH 03756
Dartmouth Hitchcock Medical Center
The Geisel School of Medicine at Dartmouth

Awards:

1. 2014 GMHF Honors Scholar by the Geriatric Mental Health Foundation (GMHF).
2. 2012 Caring physician award nominee at St. Louis University hospital.

PROFESSIONAL DEVELOPMENT ACTIVITIES.

1. ABPN (adult psychiatry) certified 9/24/2015.
2. Chairperson of NHH Pharmacy and Therapeutics committee.
3. Medical Student Clerkship and Residency Training Coordinator at New Hampshire Hospital.

Teaching activities:

1. Supervising and coordinating training models for Fellows, residents and students at Geriatric inpatient unit at NHH.
2. Supervising fellows and residents at outpatient geriatric clinic "Healthy aging and brain care clinic " at Dartmouth Hitchcock Medical Center.

Memeberships:

NH Medical society, AAGP.

Publications and presentations

- Post stress blood pressure hypotension as a result of influence of autonomic nervous system activation of cardiovascular system in young people. I.V Solodkova, A.P.Solodkov, V.I.Brazulevich, A.V. Shakhau // Reabilitation of patients with cardiovascular desease in Belarus Republic; Vitebsk 1997, p. 132-133
- Features of stress reaction in rats with various emotional activity. A.V. Shakhau, I.U. Shcherbinin // Theoretical and practical questions of medicine and pharmacology. Materials of conference of students and young scientists; Vitebsk 2000, p. 43-45
- Model of a hypobiotic condition of the organism caused by combined action of hunger and a deep prolonged hypothermia. O.A.Bobr, A.V.Shakhau, O.V.Morozova // Materials of the anniversary scientifically-practical conference devoted 40 years of Central scientific laboratory and 55 years of student scientific society VSMU; Vitebsk 2003, p.241-243
- Influence of an autonomic nervous system on degree of arterial pressure change in the conditions of a psychoemotional stress. Questions of fundamental and applied medicine. // A.P. Solodkov, I.V. Solodkova, A.V.Shakhau / Theses of conferences of student scientific society and young scientists. – Vitebsk,-1995. p.35

SHAREE N. LIGHT, PH.D.

ASSISTANT PROFESSOR OF PSYCHOLOGY & NEUROSCIENCE, *GEORGIA STATE UNIVERSITY*
07/2015-CURRENT

ADJUNCT ASSISTANT PROFESSOR OF REHABILITATION MEDICINE,
EMORY UNIVERISTY SCHOOL OF MEDICINE
12/2016-CURRENT

BRIEF INTRODUCTION

I am currently the Director of the *Positive Affective Neuroscience Laboratory* (P.A.N.E.L.) within the Department of Psychology at Georgia State University, and I lead the Affective Neuropsychology Clinic within the Neuropsychology Division of the Department of Rehabilitation Medicine at Emory School of Medicine. I am well trained in affective neuroscience (i.e., the study of the neural basis of emotional experience) and clinical neuropsychology (i.e., the study of brain-behavior relationships primarily in clinical populations), having been mentored by leaders in the fields of affective neuroscience (i.e., Dr. Richard J. Davidson) during graduate school at Wisconsin, and clinical neuropsychology at the post-doctoral level at Michigan (i.e., Dr. Linas Bieliauskas). I am one of few clinical neuropsychologists in the field that has integrated traditional clinical neuropsychology and affective neuroscience research. I am both interested in "cold" clinical neuropsychological constructs such as executive function, and "hot" affective neuroscience constructs such as empathy and positive emotion/anhedonia.

CURRENT LICENSURE

Psychologist (License #PSY003977) | Georgia
SPECIALTY: CLINICAL NEUROPSYCHOLOGY
PRIMARY POPULATION SERVED: ADULTS

EDUCATION

Post-Doctoral Fellow | University of Michigan Medical School, Neuropsychology Section, Department of Psychiatry
09/2013 – 06/2015
FACULTY/RESEARCH ADVISORS: LINAS A. BIELIAUSKAS, PH.D., ABPP-CN; STEPHAN TAYLOR, M.D.; JON-KAR ZUBIETA, M.D., PH.D.

PH.D. | University of Wisconsin-Madison
01/2004 – 08/2013
FACULTY/RESEARCH ADVISOR: RICHARD J. DAVIDSON, PH.D.
MAJOR: **CLINICAL PSYCHOLOGY**
MINOR: **NEUROSCIENCE**

Pre-doctoral Clinical Internship | William S. Middleton Memorial Veterans Hospital
08/2012 – 08/2013
DUTIES INCLUDED: (1) ADMINISTERING EVIDENCE BASED INDIVIDUAL PSYCHOTHERAPY (E.G. CBT), (2) LEADING A **BEHAVIORAL ACTIVATION (BA) GROUP**, A **DIALECTICAL BEHAVIOR THERAPY (DBT) GROUP**, AND A **"POSITIVE PSYCHOLOGY" GROUP**, AND (3) CONDUCTING **NEUROPSYCHOLOGICAL ASSESSMENTS** (INCLUDING THE GENERATION OF WRITTEN REPORTS SUMMARIZING NEUROPSYCHOLOGICAL TEST RESULTS).
SPECIAL INTERESTS: TRAUMATIC BRAIN INJURY, EMPATHY AND POSITIVE AFFECT DEFICITS IN NEUROPSYCHOLOGICAL PATIENT POPULATIONS.

B.S. in Education and Social Policy | Northwestern University
09/2000 – 12/2003
MAJOR: **HUMAN DEVELOPMENT & PSYCHOLOGICAL SERVICES**
MINOR: **COGNITIVE SCIENCE**

TEACHING

Psyc 9950M: Advanced Practicum (graduate level course) | Instructor
SUMMER 2018, FALL 2018

Completely new course prep (Summer 2018):

This practicum is a joint venture between GSU and the Neuropsychology Clinic housed within Rehabilitation Medicine-Emory University School of Medicine. This practicum offers specialized training for students interested in gaining experience in neuropsychological testing with individuals with prominent psychiatric symptoms. Students deliver a neuropsychological test battery to individuals with psychiatric diagnoses where there is a question about whether the patient may also meet criteria for a neurological disorder. Students generally conduct one half-day assessment per week, for a total of 4 assessments per month.

Psyc 1101: Honors Introduction to General Psychology (undergraduate level course) | Instructor
FALL 2017, 2018

Completely new course prep (Fall 2017):
Creation of test items, quizzes, assignments, etc.
Development of class project
Lecture development

Psyc 8610: Behavioral Neuroscience (graduate level course) | Instructor
SPRING 2016, SPRING 2017, SPRING 2018

Completely new course prep (Spring 2016):
Creation of test items, quizzes, assignments, etc.
Development of class project
Lecture development

Psyc 8620: Introduction to Clinical Neuropsychology (graduate level course) | Instructor
FALL 2016

New course prep:
Creation of test items, quizzes, assignments, etc.
Development of class project
Lecture development

Psyc 9950A, B & C: Assessment Supervision (graduate level course) | Instructor
FALL 2016, SPRING 2017, FALL 2017, FALL 2018

New course prep (Fall 2016):
Supervision of graduate students doing neuropsychological assessments in the GSU in-house Psychology Clinic and/or Emory Affective Neuropsychology Clinic. Duties include:
- Interview coaching
- Report editing
- Didactic development
- Review of video
- Live review of student clinicians while in-session

Psyc 8615: Functional Human Neuroanatomy (graduate level course) | Instructor
FALL 2015

Test/quiz item development
Lecture development
Development of class project

CURRENT/RECENT FUNDING SOURCES (GRANTS)

Center for Advanced Brain Imaging (CABI) Seed Grant Recipient | Georgia State University/Georgia Tech | $8,500
2018-2019
"FRONTO-STRIATAL AND CLINICAL NEUROPSYCHOLOGICAL CORRELATES OF EMPATHY SUBTYPES IN INDIVIDUALS WITH DEPRESSIVE DISORDERS."

Neuroscience Institute "Brains & Behavior" Seed Grant Recipient | Georgia State University | $30,000
2017-2018
"FRONTO-STRIATAL CORRELATES OF EMPATHY SUBTYPES IN CLINICALLY ANHEDONIC INDIVIDUALS WITH DEPRESSION."

Center for Advanced Brain Imaging (CABI) Seed Grant Recipient | Georgia State University/Georgia Tech | $8,500
2015-2016
"FRONTO-STRIATAL CORRELATES OF EMPATHY SUBTYPES."

SUBMITTED/TO BE SUBMITTED EXTERNAL GRANTS

R01 | National Institute of Mental Health (NIMH)
SUBMITTED JANUARY 2019
"FUNCTIONAL NEUROIMAGING CORRELATES OF EMPATHY SUBTYPES AS TARGETS FOR ANHEDONIA TREATMENT."

The proposed study focuses on determining the neural basis of empathy subtypes, and the feasibility of utilizing an "empathic happiness" (i.e. vicarious happiness) paradigm as a treatment for anhedonia (i.e. a reduced ability to experience pleasure) in mood disorders.

R01 | National Institute of Neurological Disorders and Stroke (NINDS)
TO BE SUBMITTED JUNE 2019
"FUNCTIONAL NEUROIMAGING CORRELATES OF THE EFFECT OF PAINKILLERS ON EMPATHY SUBTYPES."

The proposed study focuses on determining whether administration of over-the-counter pain medication, such as Tylenol™ enhances "empathic happiness" (i.e. vicarious happiness) and reduces anhedonia (i.e. a reduced ability to experience pleasure) in healthy controls, whereas it has been found to dampen empathic concern (i.e. vicarious sadness) likely via alteration of the opioid analgesic system.

PRIMARY RESEARCH AREAS

- Human fMRI data collected from healthy older adults and healthy younger adults during visuospatial processing, with emphasis on relating brain activity to neurocognitive functioning. Mentored by Dr. Linas Bieliauskas.
- Human functional magnetic resonance imaging data (fMRI) collected from clinically depressed participants; with analysis of fMRI data in conjunction with participant's responsivity to emotionally positive visual stimuli (i.e. happy human faces) before, and following, repeat transcranial magnetic stimulation (rTMS). Co-investigation led by Dr. Stephan Taylor at the University of Michigan.
- Human positron emission tomography (PET) data collected from clinically depressed adult participants, with analysis of opioid and dopamine neurotransmitter systems in relation to anhedonia and executive functioning pre- to post-treatment with an SSRI medication. Mentored by Dr. Jon-Kar Zubieta.

- Comparison of the functional brain activity evoked during the presentation of emotionally positive images between healthy controls versus depressed adults (before and during the course of pharmacotherapy), with an emphasis on elucidating the prefrontal correlates of the symptom of anhedonia.
- Investigation of frontal cortex (via EEG) activity evoked during the evocation of positive affect in children aged 6-10 years as it relates to (1) different forms of positive affect (e.g. contentment versus joy) and (2) empathy.
- Development and validation of a self-report measure of "positive empathy" (i.e. the ability to experience vicarious emotion in response to the positive affect of others + an other-oriented feeling of goodwill).
- Development of a psychophysiological/behavioral paradigm utilizing video clips for use with adults to parse two components of empathy: (1) vicarious emotion and (2) feelings of goodwill (i.e. a feeling/desire to do good to others); with the aim to relate these two components to positive affect.
- Behavioral analysis of video recordings of children and adolescents responding to emotionally evocative questions as part of the New York High Risk Project initiated in 1971. Our aim was to detect and quantify various emotions displayed during these interviews conducted with the child/adolescent. The theoretical aim of this project was to determine whether emotional behavior during the interview predicted participants' subsequent diagnosis of schizophrenia or mood disorder, versus no diagnosis.

PUBLICATIONS

- Mirabito, G., Taiwo, Z, Bezdek, M. & **Light, S.N.** (2019). Fronto-striatal activity predicts anhedonia and positive empathy subtypes. *Brain Imaging and Behavior*, in press.
- Gooding, D.C., Zahn-Waxler, C., **Light, S.N.**, Kestenbaum, C., & Erlenmeyer-Kimling, L. (2018). Affective indicators of risk for adulthood psychopathology during childhood: Findings from the New York High-Risk Project. *Journal of Psychiatry and Brain Science*. DOI: https://doi.org/10.20900/jpbs.20180004
- **Light, S.N.**, Bieliauskas, L.A., & Zubieta, J-K. (2017). "Top-down" mu-opioid system in humans: Mu-opioid receptors in ventrolateral prefrontal cortex mediate the relationship between hedonic tone and executive function in Major Depressive Disorder (MDD). *Journal of Neuropsychiatry and Clinical Neurosciences*, DOI: 10.1176/appi.neuropsych.16090171.
- Drag, L.L., **Light, S.N.**, Langenecker, S.A., Hazlett, K.E., Wilde, E.A., Welsh, R., Steinberg, B.A. & Bieliauskas, L.A. (2016). Patterns of frontoparietal activation as a marker for unsuccessful visuospatial processing in healthy aging. *Brain Imaging and Behavior*, DOI 10.1007/s11682-015-9428-y.
- **Light, S.N.**, Moran, Z.D., Swander, L., Le, V., Cage, B., Burghy, C., Westbrooke, C., Greishar, L. & Davidson, R.J. (2015). Electromyographically assessed empathic concern and empathic happiness predict increased prosocial behavior in adults. *Biological Psychology, 104*, 116-129.
- **Light, S.N.** & Bieliauskas, L.A. (2014). Frontal activation as a marker for unsuccessful visuospatial processing in healthy aging [Abstract]. *The Clinical Neuropsychologist, 28*, 409.
- Heller, A.S., Johnstone, T., **Light, S.N.**, Peterson, M., Kolden, G., Kalin, N., & Davidson, R.J. (2012). Relationships Between Changes in Sustained Fronto-Striatal Connectivity and Positive Affect in Major Depression Resulting From Antidepressant Treatment. *American Journal of Psychiatry*, doi: 10.1176/appi.ajp.2012.12010014
- **Light, S.N.** & Zahn-Waxler, C. (2011). Nature and forms of empathy in the first years of life. In J. Decety (Ed.), *Empathy: from bench to bedside.* Cambridge, MA: MIT Press.

- **Light, S.N.**, Heller, A.S., Johnstone, T., Kolden, G.G., Peterson, M.J., Kalin, N. & Davidson, R.J. (2011). Reduced ventrolateral prefrontal cortex activity while inhibiting positive affect is associated with improvement in hedonic capacity after 8 weeks of antidepressant treatment in Major Depressive Disorder. *Biological Psychiatry, 70,* 962-968.

- **Light, S.N.**, Coan, J.A., Zahn-Waxler, C., Frye, C., Goldsmith, H.H. & Davidson, R.J. (2009). Empathy is associated with dynamic change in prefrontal brain electrical activity during positive emotion in children. *Child Development,* 80, 1210-1231.

- **Light, S.N.**, Coan, J.A., Frye, C., Goldsmith, H.H. & Davidson, R.J. (2009). Dynamic variation in pleasure in children predicts non-linear change in lateral frontal brain electrical activity. *Developmental Psychology, 45,* 525-533.

- Heller A. S., Johnstone, T., Shackman, A. S., **Light, S.N.**, Peterson, M., Kolden, G., Kalin, N., & Davidson, R. J. (2009). Reduced capacity to sustain positive emotion in major depression reflects diminished maintenance of fronto-striatal brain activation. *Proceedings of the National Academy of Sciences,* 106, 22445–22450.

- **Light, S.N.**, Johnstone, T., Kalin, N.H., Urry, H.L., van Reekum, C.M. & Davidson, R.J. (2006). Reduced activity in ventromedial prefrontal cortex during the regulation of positive affect is a neural marker of anhedonia [Abstract]. *Psychophysiology, 43*(Suppl 1), S59.

PUBLICATIONS UNDER REVIEW/IN PREPARATION

*Denotes P.A.N.E.L. mentee

- Taiwo, Z.,* Bezdek, M.,* Mirabito, G.* & **Light, S.N.** (2019). Prefrontal Cortex and Empathic Responding: The Role of Executive Function. *NeuroImage,* manuscript under review.

- **Light, S.N.** (2019). The heterogeneity of empathy: Possible treatment for anhedonia? *Frontiers Psychiatry*, manuscript under review.

- **Light, S.N.**, Moran, Z.D., Zahn-Waxler, C. & Davidson, R.J. (2019). The measurement of positive forms of empathy and their relation to hedonic capacity & other depressive symptomatology. *Frontiers Psychology*, manuscript under review.

- **Light, S.N.**, Bieliauskas, L.A., & Taylor, S. (2018). Measuring change in anhedonia using the "Happy Faces Task" pre- to post- rTMS treatment in Major Depressive Disorder (MDD). *Translational Psychiatry*, manuscript under review.

RECENT ORAL PRESENTATIONS

*Denotes P.A.N.E.L. mentee

- **Light, S.N.** (2017). *Individual differences in positive empathy subtypes are associated with trait anhedonia.* Presented as an "individual podium presentation" at the 5th World Congress of the International Positive Psychology Association in Quebec, Canada.

- **Light, S.N.**, Zubieta, J-K & Bieliaskas, L. (2017). *Mu-opioid receptors in ventrolateral prefrontal cortex mediate the relationship between hedonic tone and executive function in MDD.* Presented as a "paper presentation" at the INS Mid-Year Congress in Cape Town, South Africa on Thursday July 6, 2017.

- Taiwo, Z.* (2017). *Whole brain analyses reveal overlapping and unique neural correlates of empathic processing: The role of verbal fluency.* Presented as a "paper presentation" at the INS Mid-Year Congress in Cape Town, South Africa on Thursday July 6, 2017.

RECENT PRESENTATIONS

*Denotes P.A.N.E.L. mentee

- Mirabito, G., Taiwo, Z., Bezdek, M. & **Light, S.N.** (2017). Globus pallidus activity predicts positive empathy subtypes in healthy adults. Psychology Undergraduate Research Conference (PURC), Georgia State University. **Awarded 3rd place.**

- **Light, S.N.,** Taiwo, Z.,* Bezdek, M.* (2017). Unique prefrontal correlates of empathy subtypes and the role of anhedonia revealed by fMRI. Poster presented at the Mid-Year Congress of the International Neuropsychological Society in Cape Town, South Africa on July 8, 2017.

- **Light, S.N.,** Taiwo, Z.,* Mirabito, G.,* Bezdek, M.* (2017). Fronto-striatal correlates of empathy subtypes in healthy adults. Poster presented at the 45th annual meeting of the International Neuropsychological Society in New Orleans, LA.

- Taiwo, Z.,* Bezdek, M.,* Mirabito, G.* & **Light, S.N.** (2017). The role of executive function in empathic processing of positive versus negative emotions. Poster presented at the 45th annual meeting of the International Neuropsychological Society in New Orleans, LA.

- Bezdek, M.,* Taiwo, Z.,* Mirabito, G.* & **Light, S.N.** (2017). Does emotion recognition ability predict neural responses of empathic happiness? Poster presented at the 45th annual meeting of the International Neuropsychological Society in New Orleans, LA.

Invited/Ad Hoc Journal Consulting

- Motivation and Emotion
- Aging, Neuropsychology and Cognition
- Measurement
- Psychiatry and Clinical Neurosciences
- Archives of General Psychiatry (JAMA Psychiatry)
- Psychophysiology
- Developmental Science
- Scientific Reports

Invited Journal Editorial Board Membership

- *Clinical Applications of Positive Psychology: An International Perspective*

Professional Memberships

- International Neuropsychological Society (INS)
- National Academy of Neuropsychology (NAN)
- Edward Bouchet Graduate Honor Society
- Society for Clinical Neuropsychology (SCN, Division 40) of the American Psychological Association (APA)

Awards

- Early-Career Investigator Best Individual Presentation Award for the Research Entitled *"INDIVIDUAL DIFFERENCES IN POSITIVE EMPATHY SUBTYPES ARE ASSOCIATED WITH TRAIT ANHEDONIA"* presented at the Fifth World Congress on Positive Psychology held in Montreal, Quebec **(2017)**
- NIH National Research Mentoring Network (NRMN) mentee **(2016)**
- American Academy of Clinical Neuropsychology (AACN) Diversity Scholarship **(2014)**
- Edward Bouchet Graduate Honor Society Inductee **(2013)**
- National Graduate Student Research Conference, National Institutes of Health, Bethesda, MD October 8-10 **(2012)**
- Named a *"Schwartz Fellow"* (Marian Schwartz established the Marian S. Schwartz Fund in the Psychology Department at the University of Wisconsin-Madison to support exceptional graduate student research in cognitive and experimental psychology) **(2012)**
- James L. Davis Fellowship for Affective Neuroscience **(2011)**
- Workshop on Biology of Social Cognition Scholarship, Cold Spring Harbor Laboratory **(2010)**
- Ford Foundation Dissertation Fellowship Honorable Mention **(2010)**
- Tursky Award for Excellence in Pre-doctoral Research in Psychophysiology (Society for Psychophysiological Research) for poster presentation entitled: *"REDUCED ACTIVITY IN VENTROMEDIAL PREFRONTAL CORTEX DURING THE REGULATION OF POSITIVE AFFECT IS A NEURAL MARKER OF ANHEDONIA."* **(2006)**
- Alliance for Graduate Education and the Professoriate Consortium Grant for Diversity Summer Research Award, National Science Foundation (NSF) **(Summer of 2007, 2008, 2009, 2010)**
- *Emotion Research Training Grant Fellowship*, National Institute of Mental Health (NIMH) **(2004-2007)**
- *Millennium Fellow,* Society for Research in Child Development (SRCD) **(2003)**
- *Gates Millennium Scholar,* Bill Gates Foundation **(2000-2003)**

Service

- Dean's Equity and Engagement Committee Member **(Summer 2018 -)**
- Voted onto GSU Psychology Chair Triennial Evaluation Committee **(2017)**
- GSU Neuroscience Institute "Brains and Behavior" Associate Faculty Member **(2017 -)**
- GSU Psychology "Brains and Behavior" Committee Member **(2016 -)**

Debra A. Fournier, MHCDS, MSN, RN, APRN, ANP-BC, PMHNP-BC

License and Certifications:

2004 to present	APRN: Advanced Practice Registered Nurse (Adult Primary Care & Psychiatry / Mental Health): State of New Hampshire. License No: 050234-23, expiration date: 11/07/19
2004 to 2024	Adult Nurse Practitioner (ANP) Board Certification, American Nurses Credentialing Center (ANCC). Certification No: 0383367-21
2003 to 2023	Adult Psychiatric and Mental Health Nurse Practitioner (PMHNP) Board Certification, ANCC. Certification No: 0385475-34
2002 to present	RN: Registered Nurse: State of New Hampshire. License No: 050234-21, expiration date: 11/07/19
2008 to present	Approved Ed RN BS Instructor. License No: 00127
1995 to present	Certification: CPR / AED / BLS for Healthcare Providers. AHA
2011 to 2016	Certified Brain Injury Specialist, Academy of Certified Brain Injury Specialists, Brain Injury Association of America. Cert. number: 10309
2002 to 2003	Registered Nurse: State of Connecticut.
1995 to 2005	Certification: Crisis Prevention (CPI) and restraint safety. Valley Regional Hospital, Claremont, NH

Formal Education and Degrees Earned:

2016	MHCDS (Masters in Health Care Delivery Science). Dartmouth College and Tuck School of Business. Hanover, NH
2003	MSN (Master of Science in Nursing) with specialty in Psychiatry-Mental Health and Adult Primary Care. Yale University School of Nursing, Sigma Theta Tau. Post RN clinical experience: Yale-New Haven VA, The Post Traumatic Stress Center in New Haven, CT, Resident Care Clinic at Kendal of Hanover, Dartmouth-Hitchcock Medical Center Consult & Liaison Service in Lebanon, NH.
2002	Certificate in Nursing, Yale University School of Nursing.
1999 to 2000	Organic Chemistry I, II and lab, University of Connecticut, Storrs / Hartford
1999	General Chemistry II, Notre Dame College, Manchester, NH
1998 to 1999	Physics I & II, Dartmouth College, Hanover, NH
1998	General Chemistry, New Hampshire Technical College, Claremont, NH
1992	BA in Psychology, with a minor in Women's Studies. Colby Sawyer College, New London, New Hampshire, summa cum laude.

Professional Experience:

2016 to present	Director, Psychiatric APRN Services at New Hampshire Hospital, Department of Psychiatry, Dartmouth-Hitchcock Health System, Concord, NH
2018 to present	Director of Quality Improvement at New Hampshire Hospital, Concord, NH
2016 to present	Nurse Practitioner, Department of Psychiatry, Dartmouth-Hitchcock Medical Center, Lebanon, NH
2016 to present	Instructor, Advanced Clinical Pharmacology (MSN), School of Nursing and Health Sciences Colby-Sawyer College, New London, NH

2015 to 2016	Clinical Research Lead, ACS Level I Trauma Program. Dartmouth-Hitchcock Medical Center, Lebanon, NH.
2013 to 2016	Nurse Practitioner, Division of Trauma and Acute Surgical Care, Section of General Surgery, Department Surgery, Dartmouth-Hitchcock Medical Center, Lebanon, NH
2006 to 2013	Nurse Practitioner, Section of Physical Medicine and Rehabilitation, Department of Orthopedic Surgery, Dartmouth-Hitchcock Medical Center, Lebanon, NH.
2005 to 2006	Nurse Practitioner, Division of Nursing Home Practices, Section of General Internal Medicine, Department of Community and Family Medicine, Dartmouth-Hitchcock Medical Center, Lebanon, NH.
2005 to 2007	Instructor; Mental Health Nursing, Colby-Sawyer College, New London, NH.
2002 to 2004	Nurse Manager / Nurse Practitioner, Behavioral Health Department, Valley Regional Hospital, Claremont, NH.
2002	Psychiatric Nurse, Valley Regional Hospital, Claremont, NH.
1999 to 2002	Study Coordinator, "The Women and Stress / Life Stress Study", University of Connecticut Health Center, Farmington / Hartford, CT.
2001	Abstracter, "Childhood Obesity Meta-Analysis." Yale-Griffin Prevention Research Center, Derby CT.
2001	Child Care Provider, Private home.
1997 to 2000	Research Assistant, "The Treatment of PTSD in Female Survivors of Childhood Sexual Abuse," Dartmouth College and The National Center for Posttraumatic Stress Disorder, White River Jct., VT.
1995 to 1999	Behavioral Health Worker, Valley Regional Hospital, Claremont, NH.
1995 to 1997	Emergency Services Clinician, West Central Services, Inc., Claremont, NH.
1994 to 1997	Clinical Case Manager, West Central Community Support Services, Claremont, NH.
1992 to 1994	Family Educator, The Family Place Parent-Child Center, White River Jct., VT.

Academic Appointments:

2016 to present	Instructor, Colby-Sawyer College School of Nursing, New London, NH
2005 to present	Instructor, Geisel School of Medicine at Dartmouth. Hanover, NH
2015 to 2016	Academic Community Partner (mentor to senior Capstone group), Colby-Sawyer College School of Nursing, New London, NH
2005 to 2007	Instructor, Colby-Sawyer College School of Nursing, New London, NH

Publications:

Donnelly, K., Goldberg, S., Fournier, D.: A qualitative study of a group-based yoga intervention designed to facilitate community reintegration for people with traumatic brain injury and their caregivers. *Disability and Rehabilitation.* 2019

Hanson, G., Lyons, K. W., Fournier, D. A., Lollis, S. S., Martin, E. D., Rhynhart, K. K. Handle, W. & Pearson, A. M. Reducing radiation and lowering costs with a standardized care pathway for nonoperative thoracolumbar fractures. *Global Spine Journal.* 2019

Chen, J.J., Blanchard, M.A., Finn, C.T., Plunkett, M.L., Home, K., Fournier, D.A., Suresh, G.K., Nugent, W.C.: Creation of a clinical pathway for guardianship at Dartmouth-Hitchcock Medical Center: A Quality Improvement Collaborative. *Joint Commission Journal on Quality and Patient Safety.* 40(9):389-97. 2014.

Fournier, D.: Mood Disorders (Ch 245) in Buttaro, T. M., Trybulski, J, Bailey, P. P. & Sandberg-Cook, J. (Eds). *Primary Care; A Collaborative Practice 4th Edition.* Mosby, 2012

Fournier, D.: Anxiety Disorders (Ch 246) in Buttaro, T. M., Trybulski, J, Bailey, P. P. & Sandberg-Cook, J. (Eds). *Primary Care: A Collaborative Practice 4th Edition.* Mosby, 2012.

Fournier, D.: Depressive Disorders (Ch 261) in Buttaro, T. M., Trybulski, J, Bailey, P. P. & Sandberg-Cook, J. (Eds). *Primary Care; A Collaborative Practice 3rd Edition.* Mosby, 2008.

Fournier, D.: Posttraumatic Stress Disorder (Ch 264) in Buttaro, T. M., Trybulski, J, Bailey, P. P. & Sandberg-Cook, J. (Eds). *Primary Care: A Collaborative Practice 3rd Edition.* Mosby, 2008.

Hamrin, V., Weycer, A., Pachler, M. & Fournier, D.: Evaluation of peer-led support groups for graduate nursing students. *Journal of Nursing Education* 45(1): 39-43, 2006.

McDonagh, A., Friedman, M.J., McHugo, G., Ford, J., Sengupta, A., Mueser, K., Demment, C. C., Fournier, D., Schnurr, P.P. & Descamps, M.: Randomized trial of cognitive-behavioral therapy for chronic posttraumatic stress disorder in adult female survivors of childhood sexual abuse. *Journal of Counseling and Clinical Psychology* 73(3): 515-524, 2005.

Fournier, D., Ford, J & Talley, S.: Responses of Adults with Severe Mental Illness Participating in a Trauma-focused Assessment Study. Unpublished thesis 2003.

Posters and Scientific Conference Presentations:

Goldberg, S., Donnelly, K. & Fournier, D. A Community-based Gentle Yoga Program for People Impacted by Traumatic Brain Injury: A Qualitative Study. Poster at American Public Health Association's 146th Annual Meeting, San Diego, CA, November 2018.

Fournier, D., Goldberg, S., Figucia, C., Kennedy, P., Krauss, K., Smith, C. & Springmann, J.: An Interdisciplinary TBI Clinic; Understanding the Patient Experience. Poster at North American Brain Injury Society Annual Conference, Tampa, FL. April 2016.

Fournier, D., Martin, E. & Singer, R.: Do Patients with mild Traumatic Brain Injury Need to be Transferred to a level one Trauma Center? Poster at North American Brain Injury Society Annual Conference, Tampa, FL. April 2016.

Fournier, D., Handel, W., Hawkins, H., Lollis, SS., Pearson, A., Martin, E., Rhynhart, Fulton, Gwen, Carter, D., Batulis, N., Hanson, G.: Multidisciplinary Development of Bracing Protocol for Stable Thoracolumbar Fractures. Poster at American Congress of Rehabilitation Medicine Annual Conference, Dallas, Texas. October 2015.

Fournier, D., Rhynhart, K., Martin, E., Lollis, S.S., Pearson, A., Tobin, D., Hawkins, H., Fulton, G., Plant, C., Sweetland, D.: Management of Non-Operative Spine Fractures. Poster created for DHMC DoS Care Path project. September 2014.

Fournier, D., Pellico, L. & Hamrin, V.: Introduction of a Vicarious Traumatization Prevention Strategy for Nursing Students. Poster presented at the 20th Annual International Society for Traumatic Stress Studies Conference, New Orleans, LA. November, 2004.

Fournier, D. Hamrin, V & Weycer, A.: The Role of Peer-led Small Groups in Supporting First-year Nursing Students. Poster presented at the International Society of Psychiatric Nurses annual conference. April 2003.

Fournier, D., Thompson, L., & Ford, J.: Somatization, Health Perception and Avoidance Symptoms in Adults with Severe Mental Illness. Poster presented at the 18th Annual International Society for Traumatic Stress Studies Conference, Baltimore, MD. November, 2002

McDonagh-Coyle, A., Friedman, M.J., McHugo, G., Ford, J., Mueser, K., Descamps, M., Demment, C. & Fournier, D.: Psychometric Outcomes of a Randomized Clinical Trial of Psychotherapies for PTSD-CSA. In Symposium, PTSD-CSA Treatment: Psychological, Physiological and Hormonal Responses, Matthew J. Friedman, M.D., Ph.D. (Chair). At the 17th Annual International Society for Traumatic Stress Studies Conference, New Orleans, Louisiana. December, 2001.

Fournier, D., Ford, J.D. & Moffitt, K.H.: Reactions By SMI Adults to Participating in a Trauma Assessment Study. Poster presented at the 17th Annual International Society for Traumatic Stress Studies Conference, New Orleans, Louisiana. December, 2001.

Ford, J., McDonagh-Coyle, A., Fournier, D., Moffitt, K., & Smith, S.: PTSD and Disorders of Extreme Stress (DESNOS): Two Samples of Women in Psychotherapy. Symposium presentation at the 17th Annual International Society for Traumatic Stress Studies Conference, New Orleans, Louisiana. December, 2001.

Fournier, D., Ford, J.D. & Moffitt, K.H.: Patterns of Health Service Utilization – Adults with Trauma Histories. Poster presented the 17th Annual International Society for Traumatic Stress Studies Conference, New Orleans, Louisiana. December, 2001.

McDonagh-Coyle, A., Friedman, M. J., McHugo, G., Ford, J., Mueser, K., Schnurr, P. P., Descamps, M., Demment, C. C. & Fournier, D.: Cognitive Restructuring and Exposure Treatment for CSA Survivors with PTSD. In Symposium, Recent Advances in the Treatment of Chronic PTSD Related to Childhood Abuse and Multiple Traumatization, Marylene Cloitre, Ph.D. (Chair). At the 21st Annual Meeting of the Anxiety Disorders Association of America, Atlanta, GA. March 2001.

Ford, J.D., Fournier, D. & Moffitt, K.H., Disorders of Extreme Stress and PTSD in Women with Severe Mental Illness.: Symposium presentation at the 16th Annual International Society for Traumatic Stress Studies Conference, San Antonio, Texas. November 2000.

McDonagh-Coyle, A., Friedman, M.J., McHugo, G., Ford, J., Mueser, K., Demment, C., Descamps, M. & Fournier, D.: Cognitive Restructuring and Exposure Therapy for PTSD related to Childhood Sexual Abuse. Symposium presentation at 16th Annual Meeting of the International Society for Traumatic Stress Studies, San Antonio, Texas. November 2000.

McDonagh-Coyle, A., Friedman, M.J., McHugo, G., Ford, J., Mueser, K., Demment, C., Descamps, M. & Fournier, D.: Cognitive-Behavioral Treatment for Childhood Sexual Abuse Survivors with PTSD. Symposium presentation at 15th Annual ISTSS meeting, Miami, Florida. November 1999.

Local (Regional) Presentations:

Fournier, D. : Our Privilege and Our Burden. Nursing Grand Rounds, New Hampshire Hospital, Concord, NH, June 2019.

Fournier, D.: Lessons Learner: Challenges for Advanced Practice Leaders in Integrated Care Settings. Northern New England Nurse Practitioner Conference. Nashua, NH.

Fournier, D.: Communication After a Crisis. Nursing Grand Rounds, New Hampshire Hospital, Concord, NH, Feb 2019.

Fournier, D.: Safety Culture and Quality Improvement. Nursing Grand Rounds, New Hampshire Hospital, Concord, NH, October 2018

Rice, V., Farver, R., & Fournier, D.: Everything You Need to Know About Borderline Personality Disorder in 75 Minutes or Less. Nursing Grand Rounds, New Hampshire Hospital, Concord, NH, May 2018

Fournier, D.: Fundamental Attribution Errors and Strangely Simple Solutions. Nursing Grand Rounds, New Hampshire Hospital, Concord, NH, April 2018.

Fournier, D.: Translating Ideas into Action. Nursing Grand Rounds, New Hampshire Hospital, Concord, NH, October 2017.

Fournier, D.: Traumatic Brain Injury and Falls. NH State Falls Conference. Bedford, NH. October 2017.

Allen, D. & Fournier, D.: After the Storm. Building Resiliency Following Violence. Nursing Grand Rounds, New Hampshire Hospital, Concord, NH, August 2017

Goldberg, S. & Fournier, D.: LoveYourBrain Yoga; Past, Present and Future. NH Brain Injury Association 34th Annual Conference, Concord, NH, May 2017

Handle, W. & Fournier, D.: Optimizing Neuroplasticity and Resilience in Clinical Practice. NH Brain Injury Association Annual Conference, Concord, NH, May 2017.

Donnelly Pearce, K. & Fournier, D.: Yoga and Meditation for TBI: Evidence, Innovations, and Ways Forward. VCU Brain Injury Rehabilitation Conference, Williamsburg, VA, May 2017

Fournier, D.: Optimizing Neuroplasticity and Resilience in Clinical Practice. American Associate of Neuroscience Nurses. Green and White Mountain Chapter Quarterly Meeting, Hanover, NH, January 2017.

Fournier, D., Figucia, C., Kennedy, P., Krauss, K., Smith, C. & Springmann, J.: From Classroom to Clinic: Researching the Patient Experience to Build a New Model of Care for Patients with Traumatic Brain Injury. Nursing Grand Rounds, DHMC Lebanon, NH, April, 2016.

Fournier, D., Hawkins, H., Handel, W., Sweetland, D.: Closing the Quality and Cost Gaps: Improving the Care of Patients with Non-Operative Traumatic Spine Fractures. Value Grand Rounds, DHMC, Lebanon, NH, September 2015. Nursing Grand Rounds, DHMC February 2016.

Fournier, D.: Update from the World Congress on Brain Injury; Rehab Implications. DHMC, Lebanon, NH, April 2014

Fournier, D.: Resiliency. Palliative Care In-service. Lebanon, NH. April 2014

Fournier, D.: TBI series: TBI, transitions of care, and effects on the family. DHMC, Lebanon, NH Nov 2013, Jan 2014.

Fournier, D.: Assessment and Management of Traumatic Brain Injury in Primary Care. Lecture delivered to General Internal Medicine Associate Providers at Dartmouth-Hitchcock Medical Center, Lebanon, NH. June 2013.

Fournier, D.: Polypharmacy in Geriatrics. Lecture for Geriatric RN / APRN Boot Camp at Dartmouth-Hitchcock Medical Center. Feb 2013, April 2013, June 2013, April 2014.

Fournier, D. & Morneau, G.: Traumatic Brain Injury and Return to Work. Lecture for New England Association of Case Management, Dartmouth-Hitchcock Medical Center. May 2013.

Fournier, D.: Traumatic Brain Injury in the Clinic Setting; What is Resiliency? Workshop at the DHMC Annual Rehab Medicine Conference. Lebanon, NH, Sept 2012.

Fournier, D., Kimball, J.: Recovery After Brain Injury. Lecture delivered at the NH Brain Injury Association Annual Conference, Concord, NH. May 2012.

Fournier, D.: Cervical Collars; Understanding appropriate immobilization following cervical spine injury. Lecture delivered at Residents' Trauma Conference, Dartmouth-Hitchcock Medical Center, June 2011.

Fournier, D: Physical Medicine and Rehabilitation at DHMC. Lecture delivered Dartmouth Medical School, Hanover, NH. April 2011.

Fournier, D., Gallagher, M., Gates, C., Muller, D., Smith, J.: Multidisciplinary Care: Selected Cases from Rehabilitation; Special Nursing Grand Rounds. Delivered October 2010

Silveira, R., Fournier, D.: Brain Injury; The Beauty and the Beast. Lecture series for the Sunapee Visiting Nurses Association, New London, NH. October, 2010

Fournier, D., Atkinson, D., Stinson, M., Pauw, S., Walsh, M.: Rehabilitation Efforts in Haiti. Multiple presentations delivered, including DHMC Medical Grand Rounds April 2010

Fournier, D.: Treating Patients with Traumatic Brain Injury. Lecture series for training staff nurses at DHMC, August and October 2010.

Fournier, D.: Care of Older Adults Following a Trauma: Rehabilitation Issues. Lecture delivered at Residents' Trauma Conference, DHMC, October 2009

Fournier, D.,: Physical Medicine and Rehabilitation at DHMC: Evolution and Future Goals. Lecture delivered at Residents' Trauma Conference, July 2009.

Fournier, D: The Anatomy and Physiology of Mild Traumatic Brain Injury; and why we need to know. NH Brain Injury Association Annual Conference, Manchester NH, May 2009.

Fournier, D: Clinical Evaluation of Depression and Anxiety in Cancer. Keynote Address at Oncology NP Retreat, Stowe, Vermont, October 2008.

Fournier, D.: Nursing and Vicarious Traumatization. Lecture delivered at the Yale School of Nursing. September 2003.

Fournier, D.: Strategies for Passing Standardized Exams. Lecture delivered at Connecticut Mental Health Center, April 2003.

Fournier, D.: Life After Trauma: How 9/11 and other stressors effect our lives. Community lecture delivered at the Blackstone Library, Connecticut. May 2002.

Fournier, D.: PTSD and Nursing Practice. Lecture delivered at the Yale School of Nursing. February, 2002

Fournier, D., Robinson, K., Thompson, L. & Weycer, A.: Issues Facing the Student Nurse in a Psychiatric Setting. Panel discussion at the Yale School of Nursing. January, 2002.

Fournier, D. & Pellico, L.: Vicarious Traumatization and Other Consequences of Caring. Lecture delivered at the Yale School of Nursing. September, 2001.

Fournier, D., Moffitt, K.H. & Ford, J.D., Disorders of Extreme Stress and PTSD in Women with Severe Mental Illness: An Introduction. Presentation at the University of Connecticut's Conference on Women and Gender. March 2001.

Fournier, D.: The Sequelae of Potentially Traumatic Events. Lecture delivered at the Yale School of Nursing. February, 2001

Recent Conferences Attended:

2019	Value Institute Annual Conference at Dartmouth. Lebanon, NH
2018	Patient Experience, Empathy and Innovation Summit. Cleveland, OH
2017	Joint Commission, Behavioral Healthcare Conference. Chicago, IL
2017	NH Brain Injury Association Annual Conference. Concord, NH
2017	Williamsburg Brain Injury Rehab Conference, TBI Model System, Virginia Commonwealth University, Williamsburg, VA
2016	Advanced Practice Provider Executives Leadership Summit, Boston, MA
2016	North American Brain Injury Society (NABIS) Annual Conference on Brain Injury. Tampa, FL.
2015	American Congress of Rehab Medicine Annual Conference; Progress in Rehabilitation Research. Dallas, TX. Member of Brain Injury SIG
2015	Arkansas Trauma Rehabilitation Conference, Arkansas Trauma Rehabilitation Program, Little Rock, Arkansas.
2015	The Dartmouth Institute and the Masters in Health Care Delivery Science Symposium. Hanover, NH
2014	Summit on Health Care Delivery, United Health Care. Minnetonka, MN
2014	International Brain Injury Association, 10th World Congress on Brain Injury. San Francisco, CA
2013	11th Annual North American Brain Injury Conference, New Orleans, LA
2012	NH Brain Injury Association Annual Conference. Concord, NH
2012	Williamsburg Brain Injury Rehab Conference, TBI Model System, Virginia Commonwealth University, Williamsburg, VA
2011	Trauma Rehabilitation, Spaulding Rehab, Boston, MA
2010	American Congress of Rehab Medicine Annual Conference; Progress in Rehabilitation Research. Member of Brain Injury Special Interest Group
2010	Brain Injury Family Intervention Training, TBI Model System, Virginia Commonwealth University, Williamsburg, VA
2009	DHMC 19th Annual Conference on Trauma, Lebanon, NH
2009	New Hampshire Brain Injury Association Annual Conference, Manchester, NH
2008	American Academy of Physical Medicine and Rehabilitation, Sixty-ninth Annual Assembly, San Diego, CA
2008	Vermont's Twentieth Annual Brain Injury Conference, Burlington, VT

2008	New Hampshire's Twenty-fifth Annual Brain Injury Conference, Manchester, NH
2007	American Academy of Physical Medicine and Rehabilitation, Sixty-eighth Annual Assembly, Boston, MA

Other Professional Activities and Awards:

2017 to present	Chair of the New Hampshire Hospital Quality Council (appointed position)
2016 to 2018	Board of Governors Member representing more than 500 associate providers. Elected position (3 year term)
2017	Active Committee Participation within New Hampshire Hospital: Quality Council (Chair: Deb Fournier) Personal Safety Emergency Reviews (co-Chair: Deb Fournier) Executive Safety Committee (Chair: Allen Coen) Adverse Medication Event Committee (Chair: Kelly Cummings)
2014 to 2016	Committee Participation within Dartmouth-Hitchcock Medical Center: Development of Interdisciplinary TBI Assessment Clinic (Lead: Deb Fournier) Development of Multidisciplinary Poly-Trauma Clinic (Lead: Deb Fournier) Trauma and Acute Care Surgery Research Development (Lead: Deb Fournier) Nursing Research Development (Lead: Gay Landstrom / Jean Coffey) Promoting Professionalism Committee (Lead: Rick Barth) Professional Nurse Advancement Model (Lead: Johanna Beliveau) Graduate School Development (Lead: Gay Landstrom) Strategic Planning for Professional Nursing (Lead Gay Landstrom)
2014	DHMC Department of Surgery Care Path Award for *Management of Non-Operative Spine Fractures* (value $12,500)
2014	Awarded tuition scholarship to the Masters in Health Care Delivery Science program at Dartmouth. (Approximate value $100,000)
2004 to present	Member of the New Hampshire chapter of the American Nurses Association
2003 to 2007	Member of the Women's Supportive Services Board of Directors, Claremont, NH
2002 to present	Inducted member of the International Honor Society for Nurses: Sigma Theta Tau – Delta Mu chapter, currently; Colby-Sawyer/DH chapter.
2001 to 2002	Member of Special Interest Ethics group of the Center for Nursing Policy and Ethics at the Yale School of Nursing
1999 to 2000	Volunteer for local HeadStart Program (provided support to classroom teachers of 3-5 year-old children with multiple psychosocial stressors)
1998 to 2005	Member of International Society of Traumatic Stress Studies
1992 to 1993	Volunteer for Women's Informational Services, Lebanon, NH
1992	Summa Cum Laude, Colby-Sawyer College, New London, NH
1991 to 1992	Volunteer for Women's Supportive Services, Claremont, NH

Research and Selected Quality Improvement Projects:

2016 to present	Participating in the LoveYourBrain Yoga Program: The Experiences of the Traumatic Brain Injury Community. CPHS 2016 study #00029657 ($3000 grant from NH Brain Injury Association) Principle Investigator: Kyla Donnelly Pearce, MPH Co-Investigators: Deb Fournier, APRN, Shari Goldberg, PhD
2015 to 2016	Evaluation of an Interdisciplinary Traumatic Brain Injury Clinic at Dartmouth-Hitchcock; Patient Experience. CPHS 2015 study #00029167 (unfunded). Principle Investigator: Deb Fournier, APRN Co-Investigator: Shari Goldberg, PhD

2015 to 2016	Clinical management and transfer status of patients with mild traumatic brain injury. CPHS 2015 Study #00028907 (unfunded). Principle Investigator: Deb Fournier, APRN Co-Investigators: Eric Martin, MD, Kirk Dufty, MD, Bob Singer, MD
2010 to 2016	Management of non-operative traumatic thoracolumbar fractures: TLSO standardization. CHPS 2014 Study # 00028200 (unfunded). Principle Investigator: Deb Fournier, APRN. Physician representatives: Kurt Rhynhart, Adam Pearson, S. Scott Lollis
1995 to 2000 (funding period)	"The Treatment of PTSD in Female Survivors of Childhood Sexual Abuse" The Principal Investigator on this grant was Matthew J. Friedman, M.D., Ph.D. Research Assistant: Deb Fournier

[redacted]

Elizabeth Ann Sanders, MD

[redacted]

Profile	Board Certified in Family Medicine 1997, recertified in 2004 and 2011.
Employment	
8/11-current	Dartmouth Hitchcock Concord, Concord, NH. Large, multispecialty group; general family medicine.
2/01-8/11	Sanders Family Medicine, PLLC, Concord, NH, owner. General family medicine.
6/97-1/01	Family Physicians of Hopkinton, Hopkinton, NH. General family medicine.
3/94-5/95	Antrim Girls Shelter, Antrim, NH. Adolescent gynecology and medicine.
1/94-5/95	Concord Feminist Health Center, Concord, NH. Office gynecology, colposcopy and LEEP. Special interest in cervical dysplasia.
4/94-5/95	Planned Parenthood of Northern New England, Bedford, NH. Gyn consultant, colposcopy clinics.
1/92-8/93	Dubai London Clinic, Dubai, UAE. Small multispecialty group; general OB/Gyn, general adult medicine, some pediatrics.
7/90-10/91	Fargo Clinic, Fargo, ND. Large multispecialty group; general OB/Gyn, special interest in cervical dysplasia, colposcopy and lower genital tract laser.
7/89-5/90	Clinical Associates, Baltimore, MD. Large multispecialty group, general OB/Gyn.
Education	
5/95-6/97	Dartmouth Family Practice Residency, Concord, NH
9/85-6/89	State University of New York at Buffalo OB/Gyn Residency, Buffalo, NY. Russell B. Van Coevering award for excellence in patient care.
9/81-6/85	University of Minnesota, Minneapolis, MN, Doctor of Medicine. Volunteer work in Uganda with Minnesota International Health Volunteers; volunteer work with Riverside People's Center (free clinic).
9/80-6/81	University of Minnesota, Minneapolis, MN, graduate work in genetics.
8/76-6/80	Stanford University, Palo Alto, CA, BA English. Women's soccer; semester in Vienna, Austria; volunteer work with homeless in Hemel Hempstead, England.
9/63-6/76	Breck School, Minneapolis, MN. National Merit Scholar.

Member, American Academy of Family Physicians since 1997

Member, International Society for Clinical Densitometrists, since 2012

Certified Clinical Densitometrist

Member, National Osteoporosis Foundation, since 2012

Medical Director, Equality Health Center (previously known as the Concord Feminist Health Center) since 2013

References available on request

Andrea Muschett, Ed.D.

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Licensure
Licensed Psychologist, State of Texas TSBEP-37491

Education

Argosy University – Denver, Colorado **2008-2012**
Doctor of Education, Counseling Psychology-Clinical and Forensic Concentration

University of Houston – Houston, Texas **2004-2006**
Master of Social Work

New Mexico State University-Las Cruces, New Mexico **1997-2000**
Bachelor of Arts, Criminal Justice

Clinical/Work Experience

Texas Department of Health and Human Services **(8/2011-Current)**

Kerrville State Psychiatric Hospital
Forensic inpatient psychiatric setting with Not Guilty by Reason of Insanity (NGRI) and Incompetent to Stand Trial patients; conducts psychological evaluations and assessments; administers and interprets psychological instruments; interviews patients, recommends treatment and prepares reports; conducts dangerous risk assessments; forensic consultations. Competency evaluations; counsels patients and families on a variety of problems; conducts individual and group psychotherapy; participates in research projects and program evaluation; plans and conducts training programs; and performs related work as assigned.

North Texas State Psychiatric Maximum Security Hospital-Vernon Campus
Adolescent Forensic Program conduct Incompetent to Stand Trial evaluations, comprehensive psychological and achievement assessments, programs for patients with co-occurring psychiatric and substance use disorders, and treatment including a full range of rehabilitation therapies, education, individual and group psychotherapy, and family intervention. Administered and conducted clinical interviews, Mental Status Exams, Elopement Risk Assessments, Dangerous Risk Assessments, and Individual Functional Behavioral Analysis. Suicide prevention and crisis intervention services; created individual treatment plans for patients with mental health and/or substance abuse diagnoses.

Adult Forensic Program on Spruce Unit/Maximum Security- conducted competency and malingering evaluations. Perform evaluation of defendants to determine competency to stand trial. Provide reports to the committing courts and attorneys regarding adjudicative competency.

San Antonio State Hospital
Three rotations in the Adolescent, Adult Acute and Forensic Management Units with comprehensive psychological and neuropsychological assessments, programs for patients with co-occurring psychiatric and substance use disorders, and treatment including a full range of rehabilitation therapies, education, individual and group psychotherapy, and family intervention. Administered COPS-D and Suicide Risk Assessments intakes and discharges, restraint debriefings, suicide prevention and crisis intervention

services; created individual treatment plans for patients with mental health and/or substance abuse diagnoses.

Jefferson County Human Services, Department of Children, Youth and Families **7/2006- 8/2011**
Lead Social/License Worker for Collaborative Foster Care Program, Golden, CO-
Ongoing evaluation and assessment of the safety and risk-level and needs of children, youth and families within the foster care system; managing and evaluation of foster and group centers; crisis management; establishing and/or monitoring safety; and conducted Structured Analysis Family Evaluation (SAFE) psychosocial home studies.

Tomball Regional Hospital RehabCare Center- **8/2005 to 5/2006**
Social Work Intern, Tomball, TX - A 250 bed acute care; the unit serves those over age 18 with medical diagnosis including but not limited to stroke; knee, hip, and other orthopedic surgery; amputation; spinal cord injury and any condition resulting in limitation in mobility, independent living skills or activities of daily living. Conducted initial assessments, assists patient and family in finding resources to best fit patients needs; attend weekly interdisciplinary team conferences, community meetings; co-facilitate stroke patient support group; individual care coordinator and supportive counseling; and record individual long-term goals and interventions on patient evaluations, and short-term goals on weekly notes.

Texas Department of Protective and Regulatory Services **2003 to 2005** ***Child Protective Service- Investigator, Houston, TX*** - Intensive investigation unit. Investigated physical abuse and neglect cases ages 0-6 years to assess current or future risk to children by interviewing parents, family members and others; interviewing and examine children; assessing home environment; and gathering pertinent information from other sources. Determined action to be taken to remove or lessen an immediate threat to the safety of a child.

State of Wisconsin Department of Corrections- **2002 to 2003**
Probation/Parole Agent, Milwaukee, WI - Maintained offender contacts and conduct home visits in accordance with level of supervision; collected urine specimens to monitor offender consumption of alcohol and drugs; prepared assessments and developed of case plans for offenders; and assessed the risk that the offender presents to the public and the nature and causes of the offender's problems to determine level of supervision in accordance with the case classification.

Court House Inc. -Senior Counselor **2000 to 2002**
Marilee Residential Treatment Center, Denver, CO - for at-risk male youth, which provided outreach and crisis intervention. Prepared daily shift reports and counseling unit planning. Provided counseling and social interaction opportunities for adolescents and other family members; prepared cases, assisted in police intervention, aided victims and families, and participated in prosecution of abusers; provided resources to students; served as a mediator and negotiator providing dispute resolution.

Teaching Experience:

2011-	Adjunct Professor-Bachelors Level, *Study* Skills for Success and Business Psychology
2009-10	Teaching Assistant-Masters Level, *Criminal Profiling*, *Social Research* and *Ethics*

Co-Facilitator of 8-week Trauma Support Group for Foster Parents- I participated in pilot project through the Kempe Center and The National Child Traumatic Stress Network with Dr. Frank Bennett. This trauma group is to help assist foster and adoptive families in understanding and applying cognitive and behavior modification through techniques to the children in their care that have been physically, sexually, emotionally abused and maltreated.

Teaching Assistant for Kristy Eldredge- Argosy University-Denver, CO-
Psychology and Criminal Justice Module, Spring 2010-how psychologists influence the process of police interrogation, lie detection, and hypnosis.

References:

Billy James, Ph.D.
Director of Psychology at Kerrville State Hospital
721 Thompson Dr.
Kerrville, TX 78028
830-258-5234 (work)
Billy.James@dshs.texas.gov

John Tobis, MD
Unit Psychiatrist Kerrville State Hospital
721 Thompson Dr.
Kerrville, TX 78028
830-258-6629(work)
John.Tobis@dshs.texas.gov

Cristal Stevens, LCSW
Social Worker III, Kerrville State Hospital
721 Thompson Dr.
Kerrville, TX 78028
830-258-5227(work)
Cristal.Stevens@dshs.texas.gov

Sergio Orozco, Ph.D.
Texas Center for Infectious Control
2303 SE Military Dr.
San Antonio, TX 78223
210-531-4960 (work)
210-219-0730 (cell)
sergio.orozco@dshs.state.tx.us

Jason Miller, DO-Psychiatrist
518 Stonewood
San Antonio, TX 78216
210-332-2727
Jasonmillerpsych@gmail.com

Patricia Hernandez, Ph.D.
Director of Psychology
North Texas State Hospital-Maximum Security
Adolescent Forensic Program
4730 College Dr.
Vernon, TX 76384

Barbara E. Dieckman RN, MS, MBA

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Summary of Qualification

Ms. Dieckman is an analytically driven leader of change in clinical process and performance improvement. She has worked in healthcare with providers for over 20 years initially as a nurse progressing to a senior leadership role in healthcare consulting. Among her accomplishments are:

- Lead process and performance improvement projects including metric development, and data visualization for several clients in a consulting role.
- Lead the analytics team for large Houston based cancer center and delivered on time the analytics and reporting needs for the institution during their Epic implementation
- Lead several development teams in implementing a cohort discovery tool used in translational research for academic medical institutions
- Provided industry expertise to developers for large data warehouse implementations focused on providing metrics for payers on quality and cost of care

Ms. Dieckman has deep industry experience in both clinical workflows and technical systems used in healthcare. Her strengths include the ability to view and quickly derive insights from large clinical data sets, excellent communication skills, team building capabilities and she develops deep lasting client relationships.

Education

- M.S. Clinical Evaluative Sciences, Dartmouth Medical School Dartmouth
- MBA Whittemore School of Business University of New Hampshire
- BS University of Minnesota Minneapolis, Minnesota
- ADN Inver Hills College Inver Grove Heights, Minnesota

Work History and Experience

October 2011 to present Sr. Manager, Accenture

- Patient throughput process improvement lead for large not for profit health system in Georgia
- Analytics and Reporting project manager for large cancer center in Houston, Texas for Epic implementation
- Capacity Management project clinical lead for large health system in Georgia
- Clinician Change Management Project Manager at a large Healthcare system in Boston
- Clinical Lead for a Supply Chain cost savings initiative at a Children's Hospital

August 2010 to October 2011 Healthcare Quality Consultant Recombinant Data Corp

- Project Manager for several academic medical centers in New England implementing data warehouse functionality for quality and translational research

- Provided subject matter expertise in development of an analytic database for quality measures

December 2009 to July 2010 Consultant Encore Health Resources

- Provided consulting services to a large for profit healthcare system during a large scale EMR implementation

February 2006 to August 2009 Associate Perot Systems Corporation

- Clinical Transformation lead at a large academic medical center in Boston
- Change Management lead for a province wide initiative for the Public Health Department of Nova Scotia to reduce surgical wait times

July 2003 to February 2006 Industry Expert, Computer Sciences Corporation

- Subject matter advisor for a process improvement effort in Supply Chain related to OR for a major Baltimore-area health care system.
- Subject matter advisor for a team designing a clinical data warehouse, creating/validating nearly 100 provider-level measures of quality and efficiency.
- Participated in creation of a clinical data warehouse to measure health care delivery processes and outcomes.

December 1998 to February 2002 Dartmouth Hitchcock Medical Center (NH)

- Clinical Data Analyst, Clinical Quality Resources Department. Prepared data displays to answer providers' clinical quality questions
- Staff Nurse, ICU

April 1997 to October 1998 Concord Hospital (NH)

- Staff Nurse, Emergency Department.
- Chaired the Emergency Department Quality Assurance Council

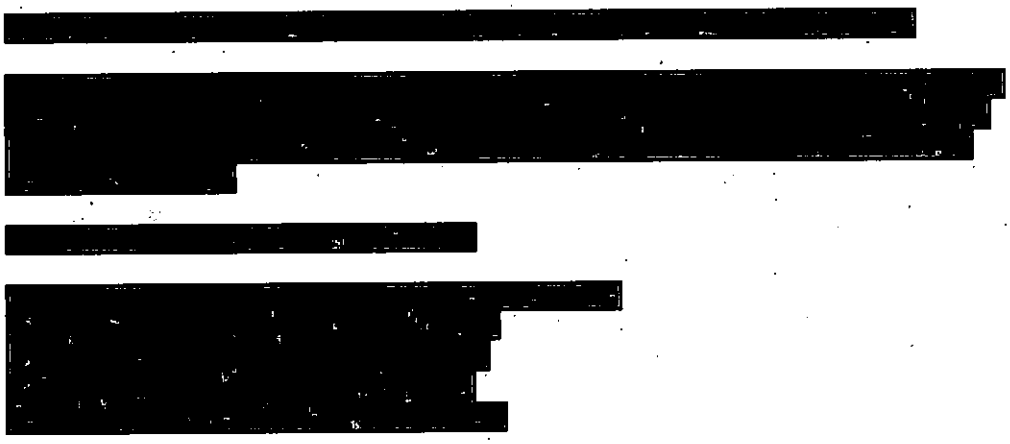
September 1990 to January 1997 Abbott Northwestern Hospital (MN)

- Staff Nurse, Emergency Department
- Appointed to Interim Director, managing a staff of 75 nurses and paraprofessionals
- Managed ED and Urgent Care Center/Clinic
- Held various leadership roles within the hospital and the Allina System, including Chair of the Professional Patient Care Council
- Served on the Allina Foundation Task Force working with community resources to develop a computer link between emergency department staff, other health care agencies and social services organizations to improve outcomes for victims of domestic violence

January 1984 to September 1990 University of Minnesota Hospitals and Clinics

- Staff nurse in Medical –Surgical Intensive Care and specialized in adult and pediatric bone marrow transplant care

Matthew J. Friedman, M.D., Ph.D.
Curriculum Vitae



Education:

University of Kentucky College of Medicine, Lexington, KY, 1969, M.D.
Albert Einstein College of Medicine, Bronx, NY, 1967, Ph.D., in Pharmacology
Dartmouth College, Hanover, NH, 1961, A.B. in Mathematics and Psychology

Postdoctoral Training:

Harvard School of Public Health, Boston, MA, Program for Chiefs of Clinical Services, October 3-14, 1983
Psychiatric Residency, Dartmouth-Hitchcock Medical Center, Hanover, NH 1972-73
Psychiatric Residency, Massachusetts General Hospital, Boston, MA, 1970-72
Rotating Internship, University of Kentucky Medical Center, Lexington, KY, 1969-70

Licensure and Certification:

Vermont, New Hampshire,
American Board of Psychiatry and Neurology, April 12, 1976

Academic Appointments:

1988-	Professor of Psychiatry and Pharmacology & Toxicology, Dartmouth/Geisel School, of Medicine Hanover, NH
1982-88	Associate Professor of Psychiatry and Pharmacology & Toxicology, Dartmouth/Geisel School of Medicine Hanover, NH
1978-82	Associate Professor of Clinical Psychiatry and Pharmacology & Toxicology, Medical School, Hanover, NH
1976-78	Assistant Professor of Psychiatry and Pharmacology, Dartmouth Medical School, Hanover, NH
1973-76	Assistant Professor of Psychiatry, Dartmouth Medical School, Hanover, NH
1967-69	Part-time instructor in Pharmacology, University of Kentucky College of Medicine, Lexington, KY

Other Professional Positions:

2017-	Vice Chair for Research, Department of Psychiatry
2014-	Senior Advisor, National Center for PTSD, Department of Veterans Affairs
2014-	Director, National PTSD Brain Bank, Department of Veterans Affairs
2014-	Director, Office of Research Mentoring, Geisel School of Medicine at Dartmouth
1989-2013	Executive Director, National Center for PTSD, Department of Veteran's Affairs,
1980-	Attending Staff, Dartmouth-Hitchcock Medical Center, Lebanon, NH
1973-2013	Attending Staff, VA Medical center, White River Junction, VT
1990-	Editorial Director, *PTSD Research Quarterly*, published by the National Center for PTSD every 3 months since Spring 1990
1984-89	Attending Staff, Alice Peck Day Memorial Hospital, Lebanon, NH
1978-89	Chief, Psychiatry Service, Veterans Administration Medical and Regional Office Center, White River Junction, VT
1977-78	Acting Chief, Psychiatry Service, Veterans Administration Medical and Regional Office Center, White River Junction, VT
1973-77	Staff Psychiatrist, Veterans Administration Medical and Regional Office Center, White River Junction, VT
1972-74	Psychiatric Consultant, Sullivan County Mental Health Clinic, Claremont, NH
1971-73	Research Consultant, Erich Lindemann Mental Health Center, Boston. MA
1961-63	Research Assistant in Perceptual and Social Psychology at the Association for the Aid of Crippled Children, New York, NY

Awards and Honors:

1960	Phi Beta Kappa
1961	Graduated Summa Cum Laude with High Distinction in Major Subjects (Mathematics and Psychology)
1964-66	Belding Student Award from Association for Aid of Crippled Children, New York.
1969	Neurosciences Award from the University of Kentucky College of Medicine
1975	National Commander's Award, Disabled American Veterans (for work with Vietnam Veterans)
1983	National Commander's Award, Disabled American Veterans (for work with Vietnam Veterans)
1988	Certificate of Significant Achievement, Hospital and Community Psychiatry Achievement Awards Board
1988	Outstanding Federal Employee of Vermont
1988--2003	American Psychiatric Association: Fellow
1990	Steven's Who's Who in Health & Medical
1991	William C. Porter Award, AMSUS (Association of Military Surgeons of the United States)
1991-	Marquis Who's Who in the East
1992-	Who's Who in Psychology
1993-	Dictionary of International Biography
1993-	Men of Achievement
1993-	Who's Who in American Education
1993	Vietnam Veterans of America, Special Recognition Award
1994-	The Best Doctors in America
1994-	International Who's Who in Medicine
1994-	American Men and Women of Science
1996	Patrick J. Leahy VA Research Award
1999	Lifetime Achievement Award, International Society for Traumatic Stress Studies
2003	American Psychiatric Association: Distinguished Fellow
2006	American Psychiatric Association: Distinguished Lifetime Fellow
2009	ISTSS Public Advocacy Award
2011	Pfizer-Supported Visiting Professorship: Medical College of South Carolina
2011	Samuel J. Heyman Service to America Medals – Finalist for Career Achievement

2017 Bruce A. Gibbard, M.D., Award for Clinical Excellence, VT Psychiatric Association

Major Committee Assignments and Consultations:

International:

2005-2017 WHO International Health Regulations Roster of Experts
1997-2003 International Advisory Board - European University Center for Mental Health and Human Rights (World Health Organization), Copenhagen
1996-97 Program Advisor: The 12th Tokyo Institute of Psychiatry International Symposium: Research & Treatment of PTSD, Tokyo
1999-2000 International Scientific Advisory Committee: Third World Conference for the International Society for Traumatic Stress Studies, Melbourne
2003 Co-Director (with Anica Kos MD) NATO Advanced Research Workshop: The Importance of Psychosocial Well Being of Children in the Post War Period for Social Reconstruction and Stability of Terrorist and War Affected Regions, Ljubljana, Slovenia, June 7-9, 2003
2006- International Advisory Board, Master of Advanced Studies in Psychotraumatology Curriculum, University of Zurich, Switzerland
2007 Department of Veterans Affairs Scientific Delegation to Israeli Ministry of Defense, January 2007
2007-11 APA DSM V Anxiety Disorders Work Group
2007 White House Pandemic Flu Psychological Support Work Group

National:

2016-present DoD: Pharmacotherapies for Alcohol & Substance Abuse (PASA) Consortium Data Safety Monitoring Board
2013-present VA/DoD PTSD Clinical Practice Guideline (Co-Chair)
2013-present PTSD Guidelines development Panel, American Psychological Association
2011-present US-UK Mental Health Work Group, Department of Veterans Affairs
2011- present DoD/VA Psychological Health (PH) - Traumatic Brain Injury (TBI) Work Group
2009 VA Consensus Conference on Treatment of Co-Morbid PTSD, mTBI, and Pain
2009-12 DoD Blue Ribbon Symposium on Acute Interventions for War Zone Stress and TBI
2008-10 Advisory Committee, VA Rural Health Resource Center – Eastern Region
2008-12 VA/DoD PTSD Clinical Practice Guidelines (Co-Chair)
2008 VA Secretary Peake's International Symposium on Traumatic Brain Injury
2007-12 APA DSM-V Anxiety Disorders Work Group: Chair, Trauma/PTSD/Dissociative Disorders Sub Workgroup
2007 White House Pandemic Flu Psychological Support Work Group
2006-present Scientific Advisory Board, Walter Reed Army Institute of Research
2006-present Advisory Board, USUHS Center for the Study of Traumatic Stress
2006-09 SAMHSA Disaster Mental Health Round Table
2006-present VA, HSR&D VETR Twin Study Steering Committee
2006-present VA, HSR&D PTSD Disability Assessment (E3) Study
2006-10 NIMH Rapid Assessment Post Impact of Disaster (RAPID) Research Review Committee
2005 -07 APA DSM-V/ICD-11 Stress-Related Fear Circuitry Disorders Workgroup
2005-11 Joint VA/DoD Deployment Mental Health Workgroup
2004-05 VA Mental Health Strategic Planning Workgroup
2002-04 APA PTSD Practice Guidelines Work Group
2002-04 VA/DoD PTSD Clinical Practice Guidelines Task Force

2002	18th Annual Rosalyn Carter Symposium on Mental Health Policy: Status Report: Meeting the Mental Health Needs of the Country in the Wake of September 11, 2001, Atlanta, GA (November 6-7, 2002)
2002	ADAA Conference on Acute Post-Traumatic Reactions [Planned & Chaired entire conference] Chantilly, VA, June 2-4, 2002
2002	SAMHSA Experts Roundtable: Disaster, Terror and Trauma in the Workplace: What We Knew Before 9/11 and What We Have Learned Since, Washington, DC, April 25, 2002
2001	DoD/VA/DoJ/HHS Consensus Workshop on Mass Violence and Early Intervention, Warrenton, VA, Oct 29-Nov 1, 2001.
2000-05	VA Mental Health Field Advisory Board
2000-05	VA New Knowledge Mental Health Advisory Committee
2000	NIMH Constituency Outreach and Partners Program
1997	NIMH Spokesperson on PTSD: National Anxiety Disorders Program
1997-99	DoD/VA/HHS Recruit Database Task Force
1997	Ad Hoc Reviewer-American Institute of Biological Sciences/U.S. Army Medical Research & Material Command
1997-2003	NIMH Violence and Traumatic Stress, BBBP-5 and other ad hoc research review committees
1997-99	Presidential Review Committee (PRD-5) Research Working Group
1996	VA HSR&D IIR Scientific Review and Evaluation Board
1995	NIMH/National Center for PTSD Consensus Conference on PTSD
1993-2000	Persian Gulf Expert Scientific Committee (VA, DoD, HHS)
1993	Ad Hoc Reviewer - NIMH Violence and Traumatic Stress Section
1993-95	Interdepartmental Task Group on Disaster Crisis Counseling (ITGDCC)
1992	Ad Hoc Reviewer - VA Merit Review Board
1991	NIMH Rapid Assessment Post Impact of Disaster (RAPID) Research Review Committee
1989-94	Member, Chief Medical Director's Special Committee on Post-Traumatic Stress Disorder
1985-88	National VA Task Force to Develop Standards for Hospital and Ambulatory Treatment of Post-Traumatic Stress Disorder
1984-89	Chair, Chief Medical Director's Special Committee on Post-Traumatic Stress Disorder (this Committee has been constituted by legislation to submit a report to Congress each year since 1985)

Regional:

1996-97	VA Feasibility Work Group on Mental Health and Substance Abuse, VA New England Health Care System
1986-88	VA Northeast Region #1 Mental Health Task Force on Alternatives to Hospital-Based Treatment
1983-86	Chair, Veterans Administration New England District #1, Chiefs of Psychiatry

Institutions:

Dartmouth/Geisel Medical School Committees

2014-	(Chair) SYNERGY Office of Research Mentoring Steering Committee
2014-	Department of Psychiatry, Promotions Committee
2012-	Department of Psychiatry Executive Committee
2012-	Geisel School of Medicine, Research Mentor for Department of Psychiatry
1996-97	Search Committee for Dean, Dartmouth Medical School
1995-96	Department of Pharmacology Search Committee for Chair

1993-94	Chair, VA Chief of Staff (DMS Associate Dean for VA Affairs) Search Committee
1987-88	Department of Medicine Search Committee for Chair
1986-91	Clinical Pharmacologist Search Committee
1985-87	Psychopharmacologist Search Committee
1982-87	Department of Psychiatry Project CORK-Executive Board
1981-87; 1992-2000	Department of Psychiatry Research Committee
1977-89	Department of Psychiatry Executive Committee
1977-89	VA Deans Committee
1975-78; 1989-1995	Department of Psychiatry Graduate Education Committee
1975-1990	Department of Psychiatry Continuing Education Committee

Local VA Committees:

1982-89	Space Committee
1982-89	MEDIPP (Long Range Planning) Committee
1982-89	Psychiatry Clinical Care Committee
1979-89	Library Committee
1977-89	Clinical Executive Board
1977-89	Professional Standards Board
1976-89	Pharmacy and Therapeutic Agents Committee
1975-84	Research and Development Committee (1979-Chair)
1993-99	R&D Resources Subcommittee (Chair)
1999-2010	Board of Directors, Medical Research & Educational Corporation

Editorial Boards:

1998-2005	Journal of Aggression, Maltreatment, & Trauma
1998	Psychiatric Annals (Guest Editor)
1999	Seminars in Clinical Neuropsychiatry (Guest Editor)
2003	Biological Psychiatry (Guest Editor)
2005	CNS Spectrums (Guest Editor)
2006-07	Journal of Traumatic Stress (Guest Editor)
2017-18	Current Psychiatric Reports (Guest Editor)

Journal Referee Activities:

Reviewer of articles submitted to Science, New England Journal of Medicine, Journal of the American Medical Association, American Journal of Psychiatry, Psychosomatics, Hospital and Community Psychiatry, Journal of Nervous and Mental Disease, Journal of Clinical Psychiatry, Journal of Clinical and Counseling Psychology, Biological Psychiatry, General Hospital Psychiatry, Behavior Therapy, Psychological Medicine

Memberships, Office and Committee Assignments in Professional Societies:

2000-10	Anxiety Disorders Association of America Scientific Advisory Board (Vice Chair 2004-2006; Chair 2006-2008)
1991-92, 1993-97	International Society for Traumatic Stress Studies Executive Committee (President 1995-96)
1991-97	International Society for Traumatic Stress Studies Board of Directors
1989-95	DSM-IV Task Force on PTSD
1988-90	Co-Chair, Psychiatric Curriculum Committee
1986-	International Society for Traumatic Stress
1984-89	National Association VA Chiefs of Psychiatry

1984-86	Delegate-at-Large
1984-86	Chair, Committee on Academic Affairs
1981-89	National Association VA Physicians
1981-90	Physicians for Social Responsibility
1977-88	American Psychiatric Association: General Member
1977-	Vermont Psychiatric Association
1975-90	Society of Biological Psychiatry

Teaching Experience:

1. Dartmouth Medical Students

a. Psychiatry

2000-13	PTSD lecture: Scientific Basis of Medicine
1975-89	Weekly clinical supervision (DMS III)
1979-85	Geriatric Psychiatry-4 lectures (DMS II)
1975-84	Lectures on Psychopharmacology (DMS II)
1975-77	Clinical Interviewing-6 seminars (DMS II)

b. Pharmacology

1985-88	Lecture on Antidepressants (CPT Course DMS IV)
1976-86	Lecture on Drug Abuse (DMS II)
1977-81	Pharmacology labs & Discussion Groups
1979-80	Lecture on Clinical Pharmacology (DMS II)

2. Psychiatric Residents (& Psychology Interns)

2011-present	Psychiatry Resident Supervision (Psychopharmacology Clinic & Inpatient)
2010-present	Psychology Internship annual seminars
1993-95	Psychology Intern Monica Descamps, Ph.D.
1991-1993	PTSD Research fellowship (PG 5 & 6) Robert Peck, M.D
1993-1995	Annmarie McDonagh-Coyle, M.D.
1989-1996	Towards a Biology of Personality Disorders (PG 4)
1988-	Advanced PTSD seminar (weekly)
1988-	Academic Psychiatry (PG 4)
1985-	Six month research elective (PG 4)
1983-	PTSD (PG 1 & 2)
1980-92	VA Journal Club (weekly)
1989-	PTSD Journal Club (weekly)
1977-90-	Co-directed Neurobiology and Psychopharmacology Seminar (12-14 sessions (PG 1-4))
1991-	Continued participation in this Seminar
1974-2000	Weekly Psychotherapy supervision (1-3 hours per week)
1976-81-	Introduction to Psychotropic Drugs (PG 1)

3. Continuing Education

Approximately 280 invited lectures including participation in symposia at professional or scientific meetings, national and regional training CME conferences, Grand Rounds presentations, etc., on the following topics: PTSD, Clinical Psychopharmacology, Biological Psychiatry, Anxiety Disorders,

Affective Disorders, Psychotic Disorders, Alcoholism, Substance Abuse and Utilization of Clinical Services.
A complete list with dates is attached

Research Interests:

Post-Traumatic Stress Disorder
Clinical Psychopharmacology
Biological Psychiatry
Clinical Utilization and Outcome Research
Relationship between Psychiatric and Medical Illnesses
Public mental health

Research Funding:

1. Research Starter Grant, Pharmaceutical Manufacturers Association, ($10,000), 1/1/73-12/31/75, Friedman, M.J.

2. Three experiments on the interrelationship between depression and hypertension, Veterans Administration Merit Review, ($38,500), 6/1/75-5/31/77, Friedman, M.J.

3. Studies on physiological and biochemical aspects of sympathetic nervous system function in depressive illness, Veterans Administration Merit Review, ($56,000), 7/1/77-6/30/80, Friedman, M.J., & Stolk, J.M.

4. Decentralization through Integration of Psychiatric Outpatient Services Research and Development, Veterans Administration HSR&D, ($364,000), 10/1/78-3/31/82, Friedman, M.J.

5. Plasma Drug and HVA Levels During Neuroleptic Treatment, Veterans Administration Merit Review, ($160,000), 1/1/82-6/30/84, Friedman, M.J., Harris, P.Q., & Bacopoulos, N.G.

6. The Effects of Terminating Psychiatric Community Care, Veterans Administration HSR&D, ($217,000), 1/1/83-12/31/85, Friedman, M.J.

7. Alprazolom vs Propranolol in Panic Disorder: Comparison of Effectiveness During Waking Hours and During Sleep, The Upjohn Company, ($50,000), 1/1/83-12/31/87, Hauri, P., Friedman, M.J., & Ravaris, C.L.

8. Human Tryptophan Metabolism During Chronic Alcoholism and the Abstinent State, Veterans Administration Merit Review, ($88,000), 7/1/83-6/30/86, Friedman, M.J., Krstulovic, A.N., & Severinghaus, J.M.

9. Decentralized/Integrated VA Community Care: A Model for Mental Health Treatment in Rural Areas, Veterans Administration Region #1 Mental Health Initiative, ($945,000), 10/1/86-9/30/89, Friedman, M.J.

10. Precursors to the Later Development of PTSD: The Dartmouth Class of 1968, Veterans Administration Merit Review, ($164,000), 7/1/86-6/30/90, Friedman, M.J., Rosenberg, S.D., & Schnurr, P.P.

11. Factors Affecting Utilization and Outcome in VA Outpatient Psychiatric Treatment, Veterans Administration Health Services Research and Development, ($218,000), 7/1/87-6/30/90, Friedman, M.J., & West, A.N.

12. Epidemiological and Service Utilization Studies of PTSD Among Ethnocultural Minority Vietnam-Era Veterans. A Congressionally mandated study (Public Law 101-507) and Service-Directed VA HSR&D Project, ($4,000,000.00), 10/1/91 - 9/30/96, Friedman, M.J., Marsella, A.J., Keane, T.M., Manson, S.A., & Ashcraft, M.

13. Double-Blind Comparison of Sertraline vs. Placebo in Outpatients with Post-Traumatic Stress Disorder ($50,000), 7/1/94-6/30/96, Pfizer Pharmaceuticals. Friedman, M.J., Weeks, W.B., & Wallace, A.

14. A study of PTSD in World War II Mustard Gas Test Participants ($230,000) 10/1/93-9/30/96 VA Office of Public Health and Environmental Hazards. Friedman, M.J., Schnurr, P.P., Green, BL.

15. PTSD and Chronic Pain: Response to Trauma Imagery ($40,690). 1/1/95-12/31/95, NIMH RO3-MHS-4486-01. Zayfert, C, & Friedman, M.J.

16. Evaluation of Cognitive Functioning in Persian Gulf War Veterans. VA Medical Research Service Environmental Hazards Centers. ($260,300) 10/1/94-9/30/99. Wolfe, J., White, R.F., & Friedman, M.J., principal investigators.

17. Group Treatment of PTSD ($3,600,000). 1996-00, VA Cooperative Studies Program #420. Friedman, M.J., & Schnurr, P.P., co-principal investigators.

18. Treatment of PTSD in Female Sexual Abuse Survivors. ($743,374). 1996-1999. NIMH RO1 (MH52787-02). Friedman, M.J., McDonagh-Coyle, A., & McHugo, G.J., co-principal investigators.

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Newsletters

1. Friedman, M.J. (Editorial Director). *PTSD Research Quarterly*, White River Jct., VT: National Center for PTSD, (published every three months since Spring 1990).
I personally wrote the following issues:
Vol. 1 No. 1 The National Center for PTSD, Spring 1990.
Vol. 1 No. 2 Biological Aspects of PTSD: Laboratory and Clinical Research, Summer 1990.
Vol. 3 No. 2 A Selective Review of the Literature on Ethnocultural Aspects of PTSD, Spring 1992.
Vol. 6 No. 4 Neurobiological Research on PTSD, Fall 1995.
Vol 10 No 4 The national Center for PTSD: The last 10 years (with Paula Schnurr), Fall 1999
Vol 11 No. 1 A guide to the literature on pharmacotherapy for PTSD. Winter, 2000
Vol. 19 No. 3 Treatments for PTSD: Understanding the Evidence: Pharmacotherapy, Summer 2008.
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Journal Articles

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3. Friedman, M.J., Culver, C.M., & Ferrell, R.B. (1978). On the safety of long-term treatment with lithium. *Toxicology Abstracts*, 1, 22.

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5. Friedman, M.J. (1986). Book Review: The Language of the Heart, by James J. Lynch. *Quarterly Review of Biology*, 61, 438.

6. Zetin, M., & Friedman, M.J. (1986). Clonazepam in bipolar affective disorder. [Letter]. *American Journal of Psychiatry*, 143, 1055.

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9. Friedman, M.J. (1988). Pharmacotherapy for PTSD. [Reply]. *American Journal of Psychiatry*, 145, 1484-1486.

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3. Friedman, M.J. (Chair), Kolb, L., Arnold, A., Baker, R., Falcon, S., Furey, J., Gelsomino, J., Gusman, F., Keane, T., Petty, S., Podkul, T., & Smith, J. *Third Annual Report of the (VA) Chief Medical Director's Special Committee on Post-Traumatic Stress Disorder.* Submitted to US Congress February 1, 1987.

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5. Friedman, M.J. (Chair), Batres, A., Boudewyns, P., Falcon, S., Furey, J., Gelsomino, J., Gusman, F., Harrington, J., Petty, S., Podkul, T., & Wittlin, B. *Fifth Annual Report of the (VA) Chief Medical Director's Special Committee on Post-Traumatic Stress Disorder.* Submitted to Congress December 28, 1988.

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Scientific Presentations

1. Richardson, S.A., & Friedman, M.J. "Some characteristics of children who express normative and atypical values toward physical disability." Presentation at the Society for Research in Child Development. Minneapolis, MN., March 24-27, 1965.

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3. Schwartz, G.E., Fair, P.L., Greenberg, P.S., Friedman, M.J., & Klerman, G.L. "Facial electromyography in the assessment of emotion." Presentation at the Society for Psychophysiological Research. Galveston, TX, October 25-28, 1973.

4. Fair, P.L., Schwartz, G.E., Friedman, M.J., Greenberg, P.S., & Klerman, G.L. "Facial expression and emotion: An electroymographic study." Presentation at the Eastern Psychological Association. Philadelphia, PA, April 18-20, 1974.

5. Friedman, M.J. "Tricyclic antidepressants: Relevance of the catecholamine hypothesis to mechanism of action." Presentation at the Winter Conference on Brain Research, Steamboat Springs, CO, January 18-25, 1975.

6. Friedman, M.J. "The place of drugs in psychotherapy." Presentation at the Psychiatric Outpatient Centers of America. Boston, MA, May 13-14, 1975.

7. Friedman, M.J. "Serum dopamine-beta-hydroxylase in depression and hypertension." Presentation at the Department of Psychiatry Seminar, University of Michigan Medical School. Ann Arbor, MI, October 14, 1975.

8. Friedman, M.J., & Stolk, J.M. "Dopamine-beta-hydroxylase in depression and hypertension." Presentation (tape/slide) at the Winter Conference on Brain Research. Keystone, CO, January 17-24, 1976.

9. Nies, A., Friedman, M.J., & Green, R. "Antidepressant drug response and aging." Presentation at the American Society for Clinical Pharmacology and Therapeutic Meeting. Seattle, WA, March 17-19, 1976.

10. Friedman, M.J. "Treatment of depression in the elderly." Presentation at the Vermont Psychiatric Association Spring Meeting, April 21, 1978.

11. Friedman, M.J. "Receptor sensitivity in depressive illness: Depression and hypertension." Guest Speaker at the Fourth Annual Maine Biomedical Science Symposium, University of Maine. Orono, ME, June 9, 1978.

12. Stolk, J.M., Hurst, J.H., Friedman, M.J., Harris, P.Q., Van Riper, D.A., & Nisula, B.C. "Serum dopamine-beta-hydroxylase: Indicator of what?" Presentation at the Conference on Enzymes, Neurotransmitters and Mental Disease. Haifa, Israel, August 27-30, 1979.

13. Friedman, M.J., & Clark, A.G. "A Delphi weighting of nine mental health outcome scales." Presentation at the Program Evaluation Conference, Region I, ADAMHA. Durham, NH, July 18, 1980.

14. Harris, P.Q., Friedman, M.J., Cohen, B.M., & Cooper, T.B. "Radioreceptor assay for fluphenazine: A longitudinal clinical study." Presentation at the Society of Biological Psychiatry, 35th Annual Meeting, Boston, MA, September 5-7, 1980.

15. Griffin, S.J., & Friedman, M.J. "Propranolol and depression: Are they related?" Presentation at the Annual Meeting, Group Without A Name, Hanover, NH, September 5-6, 1980.

16. Krstulovic, A.M., Colin, H., Guiochon, G., & Friedman, M.J. "Investigation of human tryptophan metabolism in chronic alcoholism and the abstinent state." Presentation at the 3rd International Symposium on HPLC of Proteins, Peptides and Poly-nucleotides. Monaco, November 14-16, 1983.

17. Hauri, P., Friedman, M.J., Ravaris, C.L., & Fisher, J. "Sleep in agoraphobia with panic attacks." Presentation at the 25th Annual Meeting, Sleep Research Society. Seattle, WA, July 9-12, 1985.

18. Ravaris, C.L., Friedman, M.J., & Hauri, P. "A double-blind trial of alprazolam vs. propranolol in agoraphobics with panic disorder." Presentation at the 139th Annual Meeting of the American Psychiatric Association. Washington, DC, May 10-16, 1986.

19. Ravaris, C.L., Friedman, M.J., & Hauri, P. "Alprazolam and propranolol in panic and phobic patients." Presentation at the World Psychiatric Association, October 13-16, 1988.

20. Schnurr, P.P., Friedman, M.J., & Rosenberg, S.D. "The Dartmouth Study: Identifying the predictors of PTSD." Part of a symposium entitled "Recent Advances in the Study of Combat-Related PTSD." Presentation at the 98th Annual Meeting of the American Psychological Association, Boston, MA, August 13, 1990.

21. Schnurr, P.P., Friedman, M.J., & Rosenberg, S.D. "Premilitary MMPI scores as predictors of combat-related PTSD symptomatology." Poster presentation at the 99th Annual Meeting of the American Psychological Association. San Francisco, CA, August 18, 1991.

22. Woodward, S.H., Bliwise, D.L., Friedman, M.J., & Gusman, D.F. "Sleep architecture in chronic severe combat-related PTSD." Presentation at the Eighth Annual Meeting of the International Society for Traumatic Stress Studies. Los Angeles, CA, October 24, 1992.

23. Litz, B.T., Friedman, M.J., Moscowitz, A.K., Batres, A., Gelsomino, J., & Blank, A.S. "PTSD prevalence in a national sample of service-seeking ODS veterans." Poster presentation at the Eighth Annual Meeting of the International Society for Traumatic Stress Studies. Los Angeles, CA, October 23, 1992.

24. Friedman, M.J., Peck R., McDonagh-Coyle, A.M. "A double-blind trial of cyproheptadine for PTSD patients with traumatic nightmares." Presentation at the Lake George Conference on PTSD. Lake George, NY, January 14, 1993.

25. Garfein, A.J., Friedman, M.J., Bates E.W., Ronis, D.L., Galcon S.P., & Furey, J. "On the relationship of post-traumatic stress disorder (PTSD) to cardiovascular, cerebrovascular, and gastrointestinal problems: Use of VA inpatient services." Presentation at the Annual Meeting of American Public Health Association, San Francisco, CA, October 24-28, 1993.

26. Friedman, M.J. "Post-traumatic stress disorder and kindling/-sensitization models." Presentation at the Conference on Low Level Exposure to Chemicals and Neurobiologic Sensitivity, DHHS Agency for Toxic Substances and Disease Registry. Baltimore, MD, April 6-7, 1994.

27. Friedman, M.J. "Psychiatric problems among Persian Gulf returnees." Presentation at The Persian Gulf Experience and Health Conference, NIH Technology Assessment Workshop, NIH, Bethesda, MD, April 27-29, 1994.

28. Friedman, M.J., Ashcraft, M.L., Manson, S.M., Marsella, A.J., Takeuchi, D., Beals, J.L., & Keane, T.M. "The Vietnam Veterans Project: Epidemiological, clinical, and psychosocial studies of PTSD among American Indians (Navajo and Sioux), Japanese Americans, and Native Hawaiians." Part of symposium entitled "The Future of Mental Health Research," Presentation at the National Foundation for Brain Research, Washington, DC, November 8-9, 1993.

29. Proctor, S.P., Wolfe, J., Friedman, M. "Evaluation of health symptoms reported by Gulf War veterans." Presentation at the Joint Conference of the International Society for Environmental Epidemiology and the International Society for Exposure Analysis (ISEE/ISEA), Research Triangle Park, NC, September 18-21, 1994.

30. Orsillo, S.M., Litz, B.T., Bergman, E.D., Friedman, M.J., Ehlich, P. "Changes over time in the peacekeeping mission in Somalia." Poster presentation at the Annual Meeting of the International Society for Traumatic Stress Studies, Chicago, IL, November 5-9, 1994.

31. Herman, D.S., Litz, B.T., Moskowitz, A., Friedman, M.J. "Physical complaints of Persian Gulf veterans 18 months post-deployment." Poster presentation at the Annual Meeting of the International Society for Traumatic Stress Studies, Chicago, IL, November 5-9, 1994.

32. Friedman, M.J. "Biological difference between PTSD and major depression." Discussant at symposium at the Annual Meeting of the International Society for Traumatic Stress Studies, Chicago, IL, November 5-9, 1994.

33. Herman, D.S., Litz, B.T., Moskowitz, A., Friedman, M.J. "The longitudinal course of PTSD: Persian Gulf veterans six, 12, and 18 months post-deployment." Poster presentation at the Annual Meeting of the International Society for Traumatic Stress Studies, Chicago, IL, November 5-9, 1994.

34. Murburg, M.M. (Chair), S.H. Woodward, R. Yehuda, & M.J. Friedman, "Biological differences between PTSD and depression." Presented at the Annual Meeting of the International Society for Traumatic Stress Studies, Chicago, IL, November 1994.

35. Orsillo, S.M., Litz, B.T., Goebel, A.E., Friedman, M.J., Ehlich, P., & Bergman, E.D. "An investigation of the psychological sequelae associated with peacemaking in Somalia." Paper presented at the Annual Meeting of the Association for Advancement of Behavior Therapy, San Diego, CA, November 1994.

36. Orsillo, S.M., Litz, B.T., Goebel, A.E., Friedman, M.J., Ehlich, P., & Bergman, E.D. "Changes over time in the peacemaking mission in Somalia." Paper presented at the Annual Meeting of the International Society for Traumatic Stress Studies. Chicago, IL, 1994.

37. Herman, D.S., Litz, B.T., Moscowitz, A., & Friedman, M.J. "The longitudinal course of PTSD: Persian Gulf veterans six, 12, and 18 months post-deployment." Poster presentation at the Annual Meeting of the International Society for Traumatic Stress Studies. Chicago, IL, November 1994.

38. Friedman, M.J., Orsillo, S.M., Litz, B.T., Goebel, A.E., Ehlich, P., & Bergman, E.D. "Psychological sequelae associated with U.N. peacekeeping operations in Somalia." Presented at fourth European Conference on Traumatic Stress, Paris, France, May 7-11, 1995.

39. Litz, B.T., Friedman, M.J., King, L.A., Orsillo, S.M., & King, D.W. "Unique stressors and psychological sequelae associated with peacekeeping in Somalia." Paper presented at the Annual Meeting of the International Society of Traumatic Stress Studies, Boston, MA, November 4-6, 1995.

40. Schnurr, P.P., Friedman, M.J., & Green, B.L. "PTSD among WWII mustard gas test participants." Poster presented at the Annual Meeting of the International Society of Traumatic Stress Studies, Boston, MA, November 4-6, 1995.

41. Friedman, M.J., Litz, B.T., & Orsillo, S.M. "Psychological consequences of UN peacekeeping in Somalia." Paper presented at the Annual Meeting of American Psychiatric Association, New York, NY, May 5-9, 1996.

42. Schnurr, P.P., Friedman, M.J., & Rosenberg, S.A. "Psychological risk factors for the development of PTSD." Paper presented at the Annual Meeting of American Psychiatric Association, New York, NY, May 5-9, 1996.

43. Friedman, M.J. "Drug treatment for PTSD: Answers and questions." Paper presented at New York Academy of Sciences Conference: Psychobiology of Posttraumatic Stress Disorder, New York, NY, September 7-10, 1996.

44. Schnurr, P.P., Ford, J.D., Friedman, M.J., Green, B.L., & Dain, B.J. "PTSD in WWII mustard gas test participants: Prevalence and risk factors." Paper presented at New York Academy of Sciences Conference: Psychobiology of Posttraumatic Stress Disorder, New York, NY, September 7-10, 1996.

45. Litz, B.T., Roemer, L., Orsillo, S., Ehlich, P., & Friedman, M.J. "An examination of chronic PTSD associated with peacekeeping in Somalia." Paper presented at the Annual Meeting of the International Society for Traumatic Stress Studies, San Francisco, CA, November 1996.

46. McDonagh-Coyle, A., McHugo, G.J., Friedman, M.J., Descamps, M., Zayfert, C., & Schnurr, P.P. "Psychophysiological reactivity in female sexual abuse survivors." Paper presented at the Annual Meeting of the International Society for Traumatic Stress Studies, San Francisco, CA, November 1996.

47. Orsillo, S.M., Roemer, L., Litz, B.T., Ehlich, P.J., & Friedman, M.J. The impact of peacekeeping on personal beliefs." Paper presented at the Annual Meeting of the International Society for Traumatic Stress Studies, San Francisco, CA, November 1996.

48. Roemer, L., Orsillo, S.M., Ehlich, P.J., Friedman, M.J., & Litz, B.T. "The lasting psychological sequelae of peacekeeping in Somalia for US military personnel." Paper presented at the Annual Meeting of the International Society for Traumatic Stress Studies, San Francisco, CA, November 1996.

49. Roemer, L., Litz, B.T., Orsillo, S.M., Ehlich, P.J., & Friedman, M.J. "PTSD predicts elevated reports of combat exposure among veterans of the Somalia peacekeeping mission." Paper presented at the Annual Meeting of the International Society for Traumatic Stress Studies, San Francisco, CA, November 1996.

50. McDonagh-Coyle, A., McHugo, G.J., Friedman, M.J., Descamps, M., Zayfert, C., & Schnurr, P.P. "Psychophysiological reactivity in female sexual abuse survivors." Paper presented at the Annual Neuroscience Day, Dartmouth College, Hanover, NH, January 1997.

51. Friedman, M.J., Litz, B.T., & Orsillo, S.M. "Predictors of PTSD among US troops deployed to Somalia." Paper presented at the Annual Meeting of the ESTSS, Maastricht, The Netherlands, June-July 1997.

52. Friedman, M.J., Proctor, S., & Wolfe, J. "Medical complaints and psychological distress among US Persian Gulf War veterans." Paper presented at the Annual Meeting of the ESTSS, Maastricht, The Netherlands, June-July 1997.

53. Friedman, M.J., Schnurr, P.P., Marmar, C., Foy, D., & Gersons, B. "Development of a 10-site Co-Operative Study on group psychotherapy for PTSD." Paper presented at the Annual Meeting of the ESTSS, Maastricht, The Netherlands, June-July 1997.

54. Schnurr, P.S., & Friedman, M.J. Design issues in planning a clinical trial of group psychotherapy for PTSD." Annual Meeting of the Association for Clinical Psychosocial Research, Boston, October 1997.

55. Friedman, M.J. Stress and health: Relevance to Persian Gulf veterans? Paper presented at the Annual Meeting of the International Society for Traumatic Stress Studies, Washington, DC, November 1998.

56. Friedman, M.J., Advances in pharmacotherapy for PTSD. Paper presented at the Consensus Conference on PTSD, European College of Neuropsychopharmacology, Nice, France, March 1999.

57. Friedman, M.J., Marmar, C., Clary, C.M., & Farfel, G.M. "Effects of sertraline and placebo in men with posttraumatic stress disorder (PTSD)." Annual Meeting of the American Psychiatric Association, Chicago, IL, May 13-18, 2000.

58. Friedman, M.J. Discussant for Symposium "New findings on the treatment of chronic PTSD in veterans. Annual Meeting of the International Society for Traumatic Stress Studies, San Antonio, TX, November 2000.

59. Friedman, MJ, Schnurr, PP, Ruzek, J, Watson, PW, Raphael, B & Wessley S. "Current best practice for early intervention following mass violence." Consensus Workshop on Mass Violence & Early Intervention, Warrenton, VA, October 2001.

60. Friedman, M.J. "Monitoring biological outcomes in psychosocial treatment research." Annual Meeting Association for Clinical Psychosocial Research, Portland, ME, October 2001.

61. Friedman, M.J. Keynote Address: "Post-traumatic distress: From normal fear to PTSD." Annual New York State Office of Mental Health Research Conference" Albany, NY, December 2001.

62. Friedman, M.J. Discussant: "Community based treatment of complex PTSD: Reports from the victims of violence program." Annual Meeting of the International Society for Traumatic Stress Studies, New Orleans, LA, December 2001.

63. Friedman, MJ. "Neurohormonal findings during treatment of women with PTSD due to CSA." Annual Meeting of the International Society for Traumatic Stress Studies, New Orleans, LA, December 2001.

64. Friedman, MJ. "Predictors of outcome in trauma focused vs. present centered group therapy." Annual Meeting of the International Society for Traumatic Stress Studies, New Orleans, LA, December 2001.

65. Friedman, M.J. "PTSD and medical illness: Theory and practice." Medical manifestations of PTSD, VAMC, New York and VISN #3, NY, February 2002.

66. Friedman, M.J. Disaster, terror, and trauma in the workplace: What we knew before 9/11 and what we have learned since." CMHS/APA Experts Roundtable Meeting, Washington, DC, April 2002.

67. Friedman, M.J. "New directions in mental health response to disaster and large-scale crises, childhood trauma: Intervention and aftermath.". Access to Quality Care: What Works? Annual Meeting of the American Psychiatric Association, Philadelphia, PA, May 2002.

68. Friedman, M.J. "Government response to terrorism." Access to Quality Care: What Works? Annual Meeting of the American Psychiatric Association, Philadelphia, PA, May 2002.

69. Friedman, M.J. Organized and moderated this entire conference, Consensus Conference on Acute Posttraumatic Reactions - Anxiety Disorders Association of America, Chantilly, VA, June 2002.

70. Friedman, M.J., Beebe, K.L., Duff, D., Truman, M. "Paroxetine for sleep disturbance in posttraumatic stress disorder." European College of Neuropsychopharmacology, Montreal, Canada, June 2002.

71. Friedman, M.J. "Treating PTSD: Translating science into practice." VISN 3 PTSD Conference, New York City, NY, June 2002.

72. Friedman, M.J. "National Center for PTSD." International Rehabilitation Center for Torture Victims, Copenhagen, Denmark, June 2002.

73. Friedman, M.J. "Early intervention following traumatic events." Hard Embrach Psychiatric Institute, Hard Embrach, Switzerland, June 2002.

74. Friedman, M.J. "Towards psychological model for resilience and vulnerability in PTSD." Burghselzhi Psychiatric Institute, Zurich, Switzerland, June 2002.

75. Friedman, M.J. "Acute interventions for traumatized survivors of the September 11 attacks." NY Office of Mental Health and Project Liberty Retreat, New York City, NY, July 2002.

76. Friedman, M.J. "PTSD practice guidelines work group roundtable discussion." American Psychiatric Association, Washington, DC, September 2002.

77. Friedman, M.J. "PTSD and physical health." Vietnam Veterans of America Ecological Conference on Consequences of Vietnam War, Yale University, New Haven, CT, September 2002.

78. Friedman, M.J. "Paroxetine effectively treats post-traumatic stress disorder (PTSD) in males." 15th European College of Neuropsychopharmacology, Barcelona, Spain, October 5-9, 2002.

79. Friedman, M.J. "Schizophrenia, trauma and PTSD." Annual Meeting of the International Society for Traumatic Stress Studies, Baltimore, MD, November 2002.

80. Friedman, M.J. "Psychotherapy for PTSD: A tale of two trials." Presentation at Walter Reed Army Hospital, Washington, DC, December 2002.

81. Friedman, M.J. "Pharmacotherapy: Prevention and treatment of PTSD." Annual Meeting and Science Innovation Exposition of the American Association for Advancement of Science, Denver, CO, February 2003.

82. Friedman, M.J. "Acute post-traumatic reactions" Anxiety Disorders Association of America, 23rd National Conference, Toronto, Canada, March 2003.

83. Flashman, L.A., Saykin, A.J., Roth, R.M., Ricketts, S.M., Vidaver, R.M., McAllister, T.W., Wishart, H.A., McDonald, B.C., Friedman, M.J., Mueser, K.T., Mamourian, A.C. "Brain activation patterns associated with listening to trauma-related words in patients with schizophrenia and healthy controls: A preliminary fMRI study." International Congress on Schizophrenia Research, Colorado Springs, CO, April 2003.

84. Friedman, M.J. "Bridging sciences to services." Creating a Road Map for Disaster Preparedness: Strengthening State Capacity for Disaster Mental Health and Substance Abuse Response, Washington, DC, June 2003.

85. Friedman, M.J. "Post-war communities overcoming trauma and loss." NATO Conference on the Importance of Psychosocial Wellbeing of Children in the Post-War Period for Social Reconstruction and Stability of Terrorist and War-Related Regions, Ljubljana, Slovenia, June 2003.

86. Morland, L.A., Goebert, D., Fraterelli, L., Cayetano, R., & Friedman, M.J. "Trauma, stress & pregnancy." Global Pacific Health Conference, Honolulu, HI, June 2003.

87. Friedman, M.J., McDonagh-Coyle., A., Jalowiec, J., McHugo, G., & Wang, S. "Reductions in 24-hour cortisol levels following CBT for PTSD." Annual Meeting of the International Society for Traumatic Stress Studies, Chicago, IL, October 31, 2003.

88. Friedman, M.J. (Chair). "In the aftermath of trauma: Individual to societal perspectives." Satellite research symposium. " Annual Meeting of the Anxiety Disorders Association of America, Miami, FL, March 11, 2004.

89. Friedman, M.J. "Urinary cortisol levels in PTSD-CSA before and after treatment." International Society for Traumatic Stress Studies, New Orleans, LA, November 2004.

90. Friedman, M.J. "Deployment research issues: Stress and physical disorders." American Psychiatric Association, Atlanta, GA, May 2005.

91. Friedman, M.J. "Managing distress and psychiatric disorder after terrorism: Collaborative session with NIMH." American Psychiatric Association, Atlanta, GA, May 2005.

92. Friedman, M.J. "Posttraumatic stress disorder." Preliminary Stress and Fear Circuitry Disorders Conference, American Psychiatric Association and World Health Organization, Arlington, VA, June 2005.

93. Friedman, M.J. "Neurobiology of PTSD." Artiss Memorial Conference, Walter Reed Army Medical Center, Bethesda, MD, June 2005.

94. Johnson, C., Krahn, D., Ahearn, E., Friedman, M., & Coe, C. "Short-term prednisone as adjunctive treatment for PTSD exacerbations." International Society for Traumatic Stress Studies, Toronto, ON, November 2005.

95. Monson, C., Schnurr, P., Resick, P. A., Friedman, M., Stevens, S., Price, J., & Ranslow, E. "Cognitive processing therapy for military-related PTSD." International Society for Traumatic Stress Studies, Toronto, ON, November 2005.

96. Onoye, J., Morland, L., Goebert, D., Frattarelli, L., & Friedman, M. "The role of PTSD in postpartum health for an ethnically diverse sample." International Society for Traumatic Stress Studies, Toronto, ON, November 2005.

97. Friedman, M. J. "Research on trauma and terror: Returning veterans." NIMH Alliance for Research Progress, NIMH Winter Science Meeting, Bethesda, MD, January 2006.

98. Friedman, M. J. "Diagnosis and assessment of PTSD." Institute of Medicine, Washington, DC, February 2006.

99. Friedman, M. J. "Evidence relevant to compensation awards for PTSD." Institute of Medicine, Washington, DC, May 2006.

100. Friedman, M. J. "Early intervention following disasters: NIMH panel." The Spirit of Recovery: All Hazards Behavioral Health Preparedness and Response-Building on the Lessons of Hurricanes Katrina, Rita and Wilma. SAMHSA, New Orleans, LA, May 2006.

101. Friedman, M. J. "Role of psychopharmacology in early intervention." Sidney Frank Conference on Early Psychological Intervention, Valhalla, NY, June 2006.

102. Engel, C., Friedman, M.J., Foa, E., Shea, T.M., Schnurr, P.P., & Resick, P.A. "CSP #494: Randomized clinical trial of prolonged exposure for PTSD in veteran and active duty women." International Society for Traumatic Stress Studies, Hollywood, CA, November 2006.

103. Friedman, M.J., & Schnurr, P.P. "PTSD research: Treatment and dissemination." VA Mental Health Summit, Washington, DC, July 2007.

104. Monson, C.M., Friedman, M.J., Pineles, S.L., Putnam, K.M., & Jalowiec, J.E. "Cortisol functioning and cognitive processing therapy outcomes." International Society for Traumatic Stress Studies, Hollywood, CA, November 2006.

105. Monson, C.M., Friedman, M.J., Pineles, S.L., Putnam, K.M., & Jalowiec, J.E. "Neurohormonal functioning and cognitive processing therapy outcomes." International Society for Traumatic Stress Studies, Hollywood, CA, November 2006.

106. Monson, C.M., Macdonald, A., Price, J.L., Schnurr, P.P., Resick, P.A., & Friedman, M.J. "Cognitive processing therapy for military-related PTSD: Secondary outcomes from a randomized controlled trial." Association of Behavioral and Cognitive Therapies (ABCT), Chicago, IL, November 2006.

107. Ruzek, J. I., Eftekhari, A., Foa, E., Hembree, E., Schnurr, P. P., & Friedman, M. J. "Dissemination of Prolonged Exposure treatment in the Veterans Healthcare Administration: Prospects and challenges." International Society for Traumatic Stress Studies, Baltimore, MD, November 2007.

108. Friedman, M. J. "Looking towards DSM-5." Medical University of South Carolina, Charleston, SC, April 2011.

109. Miller, M.W., Wolf, E. J., Marx, B., Holowka, D., Resnick, H., Kilpatrick, D., Gates, M., Rosen, R., Guey, L., Keane, T., & Friedman, M. J. Pilot study of a DSM-V internet survey instrument in a US Department of Veterans Affairs PTSD sample. International Society for Traumatic Stress Studies Annual Meeting, Baltimore, MD, November 2011.

110. Friedman, M.J. "Update on proposed DSM-V criteria for PTSD." International Society for Traumatic Stress Studies, Baltimore, MD, November 5, 2011.

111. Friedman, M.J. "Pharmacotherapy update: New research on PTSD treatment." International Society for Traumatic Stress Studies, Los Angeles, CA, November 2012.

112. Friedman, M.J. (Discussant), Jain, S. (Chair). "Do veterans with posttraumatic stress disorder receive evidence-based pharmacotherapy? A presentation of recent finding." International Society for Traumatic Stress Studies, Los Angeles, CA, November 2012.

113. Bernardy, N.C., Lund, B., Alexander, B., & Friedman, M.J. "Declining benzodiazepine use in veterans with posttraumatic stress disorder." International Society for Traumatic Stress Studies, Los Angeles, CA, November 2012.

114. Abrams, T., Lund, B., & Friedman, M.J. (Poster). "Aligning clinical practice in posttraumatic stress disorder: Variations in presenting frequencies according to provider type." International Society for Traumatic Stress Studies, Los Angeles, CA, November 2012.

115. Friedman, M.J. (Discussant). Monson, C. (Chair). Symposium on Innovations in PTSD treatment: "Expanding the treatment repertoire for traumatic stress." International Society for Traumatic Stress Studies, Los Angeles, CA, November 2012.

116. Friedman, M.J. (Discussant). Bernardy, N.C. (Chair). Symposium on Innovations to expand services in PTSD residential treatment programs: "Meeting the needs of new veterans." International Society for Traumatic Stress Studies, Los Angeles, CA, November 2012.

117. Schnurr, P.P., Friedman, M.J., Oxman, T.E., Dietrich, A.J., Smith, M.W., Shiner, B., Forshay, E., Gui, J., & Thurston, V. "RESPECT-PTSD: Re-Engineering Systems for the Primary Care Treatment of PTSD." International Society for Traumatic Stress Studies, Los Angeles, CA, November 2012.

118. Friedman, M.J. (Discussant). Maerker, A. (Chair). Symposium on World Health Organization Preparation of ICD-11: "Clinical utility of diagnostic criteria for trauma-related disorders, Part 1." International Society for Traumatic Stress Studies, Los Angeles, CA, November 2012.

119. Friedman, M.J. "Towards a neurobiology of PTSD." 1st Annual Henry Series: Physiology of Anxiety and Stress, Dartmouth Medical School, May 29, 2013 Schroeder Lecture.

120. Osei-Bonsu PE, Bass D, Friedman MJ, Felker B, Nugent S, Hagel Campbell E, Spoont M. Supporting adherence to clinical practice guidelines through provider training and a decision support tool. Poster presented at the 32nd annual meeting of the International Society for Traumatic Stress Studies. November 2016; Dallas, TX.

Invited Lectures

1. "The practical use of psychoactive agents." Eastern Maine Psychiatric Institute, Bangor, ME, March 21, 1974.

2. "The place of drugs in psychotherapy." Annual Meeting, Psychiatric Outpatient Centers of America, Boston, MA, May 13, 1975.

3. "Informed consent and ECT." Dartmouth Symposium on Law and Psychiatry, Hanover, NH, August 27, 1976.

4. "Depression: Recognition and treatment." University of Massachusetts School for Continuing Education, Amherst, MA, June 1, 1977.

5. "Psychotropic drugs: Response and compliance." Medication Therapy II: A Seminary for Nurses and Pharmacists, Dartmouth-Hitchcock Medical Center, White River Junction, VT, October 19, 1977.

6. "Antidepressant colloquium on psychopharmacology." New Hampshire Department of Health and Welfare, Manchester, NH, January 20, 1978.

7. "Treatment of depression in the elderly." Spring Meeting, Vermont Psychiatric Association, Mendon, VT, April 21, 1978.

8. "Psychotherapeutic medication for schizophrenia." Current issues in Psychopharmacology: Implications for Clinical Practice, Albany Medical School, Albany, NY, December 1, 1978.

9. "Current concepts in psychopharmacology." Berkshire Medical Center, Pittsfield, MA, February 23, 1979.

10. "Prescribing for the elderly." Diagnosis and Management of the Confused Elderly Person. Brattleboro Retreat, Brattleboro, VT, June 22, 1979.

11. "Diagnosing depression in the elderly: Senility or What?" Brattleboro Retreat, Brattleboro, VT, November 30, 1979.

12. "Psychiatric treatment of the elderly." Current Concepts in the Management of Cardiac and Mental Health Problems of the Older Adult. New Hampshire Foundation for Medical Care, Merrimack, NH, October 1, 1980.

13. "Post-Traumatic Stress Disorder." Post Vietnam Syndrome, Dartmouth Medical School, West Lebanon, NH, November 21, 1980.

14. "Psychopharmacology update." New Hampshire Hospital, April 2, 1981.

15. "Psychopharmacology: State of the art." Spring Meeting, Vermont Psychiatric Association, Fairlee, VT, April 24, 1981.

16. "Current concepts in psychopharmacology." Spring Meeting, New Hampshire Psychiatric Association, June 27, 1981.

17. "Post-traumatic stress disorder: Diagnosis and treatment." Symposium: PTSD, University of Connecticut Medical School, Hartford, CT, September 11, 1981.

18. "Use of amytal interviews in forensic psychiatry." McLean Hospital, Belmont, MA, February 17, 1982.

19. "Diagnosis of depression." Current Concepts on Depression, Brattleboro Retreat, March 19, 1982, Brattleboro, VT.

20. "Post-traumatic stress disorder." Blackstone Valley Mental Health Association, Framingham, MA, May 13, 1982.

21. "Psychopharmacology of anxiolytics." Psychopharmacology Course, 34th Institute on Hospital and Community Psychiatry, Louisville, KY, October 13, 1982.

22. "Depression." Wentworth-Douglas Hospital, Dover, NH, December 6, 1982.

23. "Post-traumatic stress disorder: Neurological implications." Neurology Grand Rounds, Boston VA Medical Center, Boston, MA, February 10, 1983.

24. "New antidepressants." Manchester VA Medical Center, Manchester, NH, February 24, 1983.

25. "Psychiatric aspects of stroke." Veterans Administration Northeast RMEC, White River Junction, VT, March 31, 1983.

26. "Latest information on the treatment of depression." Symposium: Second Annual Psychopharmacology Teaching Day, Albany Medical School, Albany, NY, April 14, 1983.

27. "Overview of treatment of PTSD." New England Regional Conference on Post-Traumatic Stress Disorder, Northampton, MA, June 23, 1983.

28. "Diagnosis and treatment of PTSD." Post-Traumatic Stress Disorders, Veterans Administration Southwest RMEC, Phoenix, AZ, June 27-28, 1983.

29. "Diagnosis and treatment of PTSD." Post-Traumatic Stress Disorders, Veterans Administration Southwest RMEC, Long Beach, CA, June 30-July 1, 1983.

30. "Panic disorders." Lakes Region Hospital, Laconia, NH, April 10, 1984.

31. "Concept of demoralization and the Vietnam veteran an advance case seminar: Understanding and using traumatic dream and flash-back phenomena in treatment." Phase V Regional Training: Advanced Clinical Conference for Team Leaders, Veterans Administration Northeast RMEC, Providence, RI, May 23, 1984.

32. "Post-traumatic stress disorder." Anxiety, Panic and Post-Traumatic Disorders, Brattleboro Retreat, Brattleboro, VT, October 19, 1984.

33. "Use of medication for PTSD." Specialized Inpatient PTSD Units: Sharing Perspectives, Veterans Administration Mid-Atlantic RMEC, Cleveland, OH, May 3, 1985.

34. "Preview of the First Annual Report of the (VA) Chief Medical Director's Special Committee on PTSD." American Psychiatric Association, Dallas, TX, May 28, 1985.

35. "PTSD in the Veterans Administration: New directions." Southeast Region Readjustment Counseling Service Clinical Training Conference, Orlando, FL, January 30, 1986.

36. "Diagnosis and pharmacologic treatment of typical anxiety disorders seen in an office practice." Anxiety 1986, A Practical Guide to Understanding and Treatment, Dartmouth-Hitchcock Medical Center, Hanover, NH, February 8, 1986.

37. "Psychopharmacology and PTSD." Diagnosis and Management of Post-Traumatic Stress Disorders in the VA, Mid-Atlantic RMEC, (lecture and workshop), Hyannis, MA, May 22, 1986.

38. "Treatment of PTSD on a psychiatric unit in a general medical and surgical hospital." Diagnosis and Management of Post-Traumatic Stress Disorders in the VA, Mid-Atlantic RMEC, New Orleans, LA, July 31, 1986.

39. "Psychopharmacology and PTSD." Diagnosis and Management of Post-Traumatic Stress Disorders in the VA, Mid-Atlantic RMEC, New Orleans, LA, August 1, 1986.

40. "Rational psychopharmacology for PTSD." Mid-Atlantic RMEC, Orlando, FL, February 25, 1987.

41. "The impact of trauma." Conference Organizer and Moderator. Dartmouth-Hitchcock Medical Center, West Lebanon, NH, May 20, 1987.

42. "Biological alterations associated with PTSD." Northeast RMEC, Northport, NY, September 22, 1987.

43. "Anxiety disorders." Primary Care Psychiatry, Dartmouth-Hitchcock Medical Center. West Lebanon, NH, November 18, 1987.

44. "Psychiatric aspects of aging." The Dynamics of Aging, Dartmouth-Hitchcock Medical Center. West Lebanon, NH, January 20, 1988.

45. "Diagnosis and treatment of PTSD: An Overview." Post-Traumatic Stress Disorder, Interwest RMEC, Menlo Park, CA, February 25-26, 1988.

46. Testimony before the U.S. Senate Committee on Veterans Affairs, Washington, DC, July 14, 1988.

47. "Overview of Veterans Administration clinical, educational and research Program on Post-Traumatic Stress Disorder." Ninety-sixth Annual Convention, American Psychological Association, Atlanta, GA, August 13, 1988.

48. "Recent clinical and research progress concerning biological substrates of PTSD." Fourth Annual Meeting, Society for Traumatic Stress Studies, Dallas, TX, October 23, 1988.

49. "Accessible psychiatric outpatient treatment for veterans." Fortieth Institute on Hospital and Community Psychiatry, New Orleans, LA, October 24, 1988.

50. "The treatment of Post-Traumatic Stress Disorder (Course)." One Hundred and Forty-second Annual Meeting, American Psychiatric Association, San Francisco, CA, May 7, 1989.

51. "PTSD in Vietnam veterans: From stigma to treatment." Symposium: One Hundred and Forty-second Annual Meeting, American Psychiatric Association, San Francisco, CA, May 8, 1989.

52. "Psychiatry curriculum: Presidential task force on curriculum, education and training." Fifth Annual Meeting of the Society for Traumatic Stress Studies, San Francisco, CA, October, 1989.

53. "A symposium on Post-Traumatic Stress Disorder." Brattleboro Retreat, Brattleboro VT, November 17, 1989.

54. "PTSD in survivors of the California earthquake." Dartmouth Medical School, March 12, 1990.

55. "PTSD." Dartmouth Medical School Symposium on Anxiety Disorders, March 30, 1990.

56. "PTSD following natural disasters and non-combat trauma." Grand Rounds, New Hampshire Hospital, Concord, NH, April 19, 1990.

57. "Biological aspects of PTSD: Basic research and psychopharmacology." Grand Rounds, Brown Medical School and VAMC, Providence, RI, April 30, 1990.

58. "Status report: Clinical psychopharmacology of PTSD." Symposium: National Center for PTSD: Biological Research, American Psychiatric Association, New York, NY, May 15, 1990.

59. "New developments in PTSD: Biological research and clinical psychopharmacology." Grand Rounds, VAMC, Northampton, MA, June 13, 1990.

60. "National Center for Post-Traumatic Stress Disorder: Conceptual foundation and rationale." Symposium: American Psychological Association, Boston, MA, August 14, 1990.

61. "Assessing readiness and preparation for treatment: Co-Morbidity psychopharmacology." Salt Lake City RMEC training program, Advanced Clinical Skills in PTSD, San Antonio, TX, August 21-22, 1990.

62. "Principal trends in scientific studies on PTSD in the USA." International Symposium on Medico-Psychological Problems of Natural Disasters and Catastrophes, Moscow, USSR, September 18-19, 1990.

63. "The Loma Prieta earthquake of 1989." Chaired symposium at the Sixth Annual Meeting of the Society of Traumatic Stress Studies, New Orleans, LA, October, 1990.

64. "PTSD - an overview." Annual Meeting, National Association of Social Workers, Boston, MA, November, 1990.

65. "Pharmacological treatment of acute combat stress." Northport RMEC and Office of Emergency Preparedness Conference, Interventions in Traumatic Stress: VA/DoD Contingency Plan, Indianapolis, IN, December, 1990.

66. "The National Center for PTSD" and "A curriculum on PTSD for psychiatric residents." Annual Meeting, Association of Directors of Psychiatric Residency Training Programs, Tucson, AZ, January, 1991.

67. "Biological aspects of the diagnosis and treatment of PTSD." Coatesville VAMC Conference, "PTSD: Ten Years of Progress," Coatesville, PA, March, 1991.

68. "Operation Desert Storm." Annual Teaching Day, VAMC Brooklyn, Brooklyn, NY, April, 1991.

69. "PTSD - an overview." Canadian Department of Veterans Affairs, Montreal, Canada, April, 1991.

70. "Transcultural and transnational aspects of PTSD." Chaired symposium at the 144th Annual Meeting of the American Psychiatric Association, New Orleans, LA, May, 1991.

71. "Diagnosis and treatment of PTSD." Veterans Administration Medical Center, Togus, ME, June, 1991.

72. "War in the Persian Gulf: Psychological trauma in times of war and peace." Harvard Medical School, Boston, MA, June, 1991.

73. "The psychiatric perspective on war trauma." Public Forums on The Vietnam Conflict, Rutland, VT, September, 1991.

74. "The National Center for PTSD." Clinical Grand Rounds, Department of Psychiatry, Dartmouth Medical School, Hanover, NH, September, 1991.

75. "PTSD and disability." Veterans Employment and Training Conference, Fairlee, VT, September, 1991.

76. "The National Center for PTSD." Eighth Users' Stress Workshop, NATO Research Study Group and U.S. Army Health Care Studies, San Antonio, TX, September, 1991.

77. Keynote Speech. 1991 Upper Valley Disability Awareness Conference, West Lebanon, NH, October 15, 1991.

78. "Trauma and public policy." Chaired symposium at the Seventh Annual Meeting of the International Society for Traumatic Stress Studies, Washington, DC, October 27, 1991.

79. "PTSD among women veterans." Showcase for Women Veterans, U.S. Department of Labor (Woman's Bureau, Boston), Vermont Statehouse, Montpelier, VT, November 15, 1991.

80. William C. Porter Award Lecture. Annual Meeting of the Association of Military Surgeons of the United States (AMSUS), San Antonio, TX, November, 18, 1991.

81. "Biological aspects of diagnosis and treatment of PTSD." Annual Meeting, AMSUS, San Antonio, TX, November 19, 1991.

82. "Biological aspects of PTSD and implications for treatment." Grand Rounds, Department of Psychiatry, Dartmouth Medical School, Hanover, NH, December 17, 1991.

83. "PTSD and OCD: Obsessive Compulsive Disorder (OCD) and related problems." Dartmouth Medical School, Lebanon, NH, December 18, 1991.

84. "Psychopharmacological treatment of PTSD." Grand Rounds, Department of Psychiatry, University of Minnesota, Hennipen County Medical Center, Minneapolis, MN, January 14, 1992.

85. "Biological aspects in diagnosis and treatment." Chaired symposium at World Conference of the International Society for Traumatic Stress Studies, Amsterdam, The Netherlands, June 22, 1992.

86. "The Gulf War: Military and civilian experiences and consequences." Co-chaired symposium at World Conference of International Society for Traumatic Stress Studies, Amsterdam, The Netherlands, June 24, 1992.

87. Testimony before the Senate Veterans Affairs Committee on the Women Veterans' Health Care Equity Act of 1992, Washington, DC, July 2, 1992.

88. "Veterans psychiatric benefits: Enter courts and attorneys." Twenty-third Annual Meeting of American Academy of Psychiatry and the Law, Boston, MA, October 15, 1992.

89. "Perspectives on biological research strategies in PTSD." Eighth Annual Meeting of the International Society for Traumatic Stress Studies, Los Angeles, CA, October 23, 1992.

90. "Assessment and neurobiological investigation of dissociative states." Eighth Annual Meeting of the International Society for Traumatic Stress Studies, Los Angeles, CA, October 24, 1992.

91. Marsella, A.J., Friedman, M.J., & Spain, H. "Ethnocultural aspects of PTSD". Presented at the 146th Annual Meeting of the American Psychiatric Association. San Francisco, CA, May 22-27, 1993.

92. "PTSD treatment innovations." Workshop, Veterans Affairs Mental Health Services: Model for the 21st Century, L.F. Sparr (Chair), presented at the 146th Annual Meeting of the American Psychiatric Association. San Francisco, CA, May 22-27, 1993.

93. "PTSD and VA benefits." Workshop, Veterans Affairs Psychiatric Benefits: Enter Courts and Attorneys, L.F. Sparr (Chair), presented at the 146th Annual Meeting of the American Psychiatric Association. San Francisco, CA, May 22-27, 1993.

94. "PTSD: Treatment and research agenda." Full-day course, M.J. Friedman (Chair) offered at the 146th Annual Meeting of the American Psychiatric Association. San Francisco, CA, May 22-27, 1993.

95. "Psychological trauma and the seriously mentally ill." Conference, Post-Traumatic Stress Disorder in Serious Mental Illness, presented at the Department of Mental Health, Commonwealth of Massachusetts, October, 14-15, 1993.

96. "Psychobiological techniques in the assessment of PTSD." A pre-institute meeting on Instrumentation in the Field of Traumatic Stress. Ninth Annual Meeting of the International Society for Traumatic Stress Studies. October 1993.

97. "Workshop on Post-Traumatic Stress Disorder." symposium, The Future of Mental Health Research, M.J. Friedman (Chair), presented at the National Foundation for Brain Research. Washington, DC, November 8-9, 1993.

98. "African-American veterans and Post-Traumatic Stress Disorder." VA Readjustment Counseling Service and National Center for PTSD. St. Louis, MO, June 22-24, 1994.

99. "Compassion fatigue: The stress of caring too much." Teleconference, C. Figley, moderator. Public Broadcasting System Adult Learning Satellite Service. Alexandria, VA, June 23, 1994.

100. "The Persian Gulf experience and health," Teleconference, Department of Veterans Affairs. Washington, DC, July 21, 1994.

101. "Cross-cultural considerations in the assessment and treatment of PTSD." Presented at Anxiety Disorders among American Indians: Cultural Issues in Treatment and Clinical Research. University of Colorado Health Science Center, Denver, CO, October 25, 1994.

102. "Traumatic memories: A psychobiological perspective." The Susan J. Wise Memorial Lecture, The Boston Psychoanalytic Society, Cambridge, MA, April 29, 1995.

103. a] "Psychological risks to emergency personnel." b] "Caring for the caregiver: Critical incident trauma debriefing," (with Julian Ford, Ph.D.) Trauma, Injury, and Human Suffering Conference. Dartmouth-Hitchcock Medical Center, Lebanon, NH, June 12, 1995.

104. "The psychological impact of U.N. interventions in the Persian Gulf and Somalia." Walter Reed Army Hospital, Washington, D.C., June 14, 1995.

105. "Impact of violence on health." Panel Discussant at the Third Annual Forum on Minority Health Outcomes in a Changing Health Care Environment, Urban Health Institute at Harlem Hospital Center, Tarrytown, N.Y., September 15-16, 1995.

106. Presentations at the Eleventh Annual Meeting, International Society for Traumatic Stress Studies, Boston, MA, November 2-6,1995.

a. Pre-Meeting Institute: "Psychobiological strategies for assessing PTSD: The current state of the art: Applications of psychobiological research to the treatment of traumatic stress". Chair and Discussant.

b. "Promoting and recognizing journalistic excellence in reporting on victims of violence." Chair and Discussant.

c. "New medical issues in the treatment of veterans with PTSD." Discussant.

d, "Developing the network of Department of Veterans Affairs PTSD." Chair and Discussant.

e. "A cognitive-behaviorally based program for training professionals in PTSD treatment." Discussant.

107. "Reporting on victims." Panel Discussant at the 41st Annual Convention, The New England Society of Newspaper Editors, Kennebunkport, ME, November 16-18, 1995.

108. "Pharmacotherapy for PTSD." Presented at the Eighth Annual New York State Office of Mental Research Conference, Albany, NY, December 4-6, 1995.

109. Testimony on "Stress, PTSD, and Adverse Health Outcomes," Presidential Advisory Committee on Gulf War Veterans, Washington, DC, April 22, 1996.

110. Discussant: "Repairing the Shattered Self from Trauma." Industry Symposium presented at Annual Meeting of American Psychiatric Association, New York, NY, May 4-6, 1996.

111. "Pharmacotherapy for PTSD: A promise as yet unfulfilled." Paper presented at Second World Conference of the International Society for Traumatic Stress Studies, Jerusalem, Israel, June 9-13, 1996.

112. "PTSD: Psychobiology and Clinical Pharmacology." Rocky Mountain Emotional Trauma Symposium, Whitefish, MT, June 27-29, 1996.

113. "Psychological consequences of trauma: Recognition and intervention." Annual Dartmouth-Hitchcock Medical Center Conference on Trauma, Hanover, NH, October 1996.

114. "Cry, the beloved country: Truth and consequences in dealing with the aftermath of apartheid." Twelfth Annual Meeting of the International Society for Traumatic Stress Studies, San Francisco, CA, November 1996.

115. "Impact of VA reorganization on mental health and PTSD care." Twelfth Annual Meeting of the International Society for Traumatic Stress Studies, San Francisco, CA, November 1996.

116. "Trauma and the media: Educating the public about trauma without traumatizing trauma victims." Twelfth Annual Meeting of the International Society for Traumatic Stress Studies, San Francisco, CA, November 1996.

117. "Presentation of the Matsunaga Report." VACO: Top manager's meeting, Washington, DC, November 1996.

118. "Disaster mental health." Dartmouth Medical School Department of Psychiatry Grand Rounds, Hanover, NH, April 1997.

119. "Coping with loss during adulthood." Rocky Mountain Emotional Trauma Symposium: Victims of traumatic loss, Whitefish, MT, June 1997.

120. "Physiologic effects of traumatic and non-traumatic stress." (Health consequences of Persian Gulf Service) Regional Medical Education Conference, Long Beach, CA, June 1997.

121. "PTSD: Treatment issues, current controversies, and future research." Annual Meeting of the National Medical Association, Honolulu, HI, August 1997.

122. "Keynote speech: Current advances in PTSD treatment." Regional Medical Education Conference, Brockton, MA, September 1997.

123. "Neurobiology and pharmacotherapy of PTSD." The 12th Tokyo Institute of Psychiatry International Symposium." Tokyo, Japan, October 1997.

124 "Neurobiological advances in PTSD research." Psychiatric Grand Rounds, University of Michigan, Ann Arbor, MI, October 1997.

125. Keynote Speech: "Homecoming experience of a war veteran." The First International Conference on Psychosocial Consequences of War. World Veterans Federation. Dubrovnik, Croatia, April 1998.

126. "National Center for PTSD." PTSD Conference, Royal Canadian Legion, Veterans Affairs Canada & Canadian Department of National Defense, Charlottetown, Prince Edward Island, October 1998.

127. "Post-traumatic stress disorder." PTSD Conference, Royal Canadian Legion, Veterans Affairs Canada & Canadian Department of National Defense, Charlottetown, Prince Edward Island, October 1998.

128. "A forum on the future of the National Center for PTSD." American Legion Headquarters, Washington, DC, November 1998.

129. "History of the National Center for PTSD: Thirty years after Tet: The enduring legacy of the Vietnam War." Annual Meeting of the International Society for Traumatic Stress Studies, Washington, DC, November 1998.

130. "Human memory processes: Traumatic memory and delayed recall of events." Annual Meeting of the International Society for Traumatic Stress Studies, Washington, DC, November 1998.

131. "PTSD: A brain disorder and chronic mental illness." Annual Meeting of the National Alliance for the Mentally Ill (NAMI), Chicago, IL, July 1999.

132. "PTSD in the primary care setting: Cost-effectiveness of early detection and rapid intervention." VA Summit on PTSD and Primary Care, San Francisco, CA, September 1999.

133. "Detection and treatment of acute combat stress reactions. Annual Meeting of NATO Psychiatrists, Ottawa, Canada, October 6, 1999.

134. Discussant for "Health problems and medical morbidity risk factors in chronic PTSD." Annual Meeting of the International Society for Traumatic Stress Studies, Miami, FL, November 1999.

135. Foa, E.B., Keane, T.M., & Friedman, M.J. (Co-Chairs). "Treatment guidelines I & II." Annual Meeting of the International Society for Traumatic Stress Studies, Miami, FL, November 1999.

136. "Pharmacotherapy for PTSD." Annual Meeting of the International Society for Traumatic Stress Studies, Miami, FL, November 1999.

137. Discussant for Symposium "Expert consensus treatment guidelines for PTSD. Annual Meeting of the International Society for Traumatic Stress Studies, Miami, FL, November 1999.

138. "Advances in psychobiological approaches to the diagnosis and treatment of PTSD." Grand Rounds, University of Vermont, Burlington, VT, January 28, 2000.

139. Keynote Address. "Post-traumatic syndromes in the 21st century: Does PTSD have a future?" Third World Conference for the International Society for Traumatic Stress Studies, Melbourne, Australia, March 16-19, 2000.

140. Friedman, M.J., & Schnurr, P.P. "Trauma-focus group therapy for chronic PTSD." Third World Conference for the International Society for Traumatic Stress Studies, Melbourne, Australia, March 16-19, 2000.

141. "Recent research on PTSD treatment." National Centre for PTSD, West Heidleberg, Australia, March 20, 2000.

142. "Treating PTSD: Are there any safe ports in the storm?" Westmead Hospital, Sydney, Australia, March 21, 2000.

143. "Early detection and treatment of PTSD." Australian Defense Forces and Department of Veterans Affairs, Canberra, Australia, March 22, 2000.

144. Friedman, M.J., Foy, D., Litz, B. "Assessment and treatment of post-traumatic stress disorder." A two day workshop for the Canadian Department of National Defense, Halifax, Nova Scotia, April 19-20, 2000.

145. "Mental health problems of refugees and internally displaced people." International conference, stressful changes: Psychological aspects of postcommunist transformations, Babes-Bolyai University, Cluj-Napoca, Romania, June 24-25, 2000.

146. "Mission-related stress among UN peacekeepers and civilian field personnel, ECOSOC meeting, United Nations, New York, NY, July 19, 2000.

147. "Evidence-based intervention research—state-of-the-art interventions." OVC/CMHS working group meeting on mental health response to incidents of mass criminal victimization, Washington, DC, July 27-28, 2000.

148. "Treating adults with PTSD." 5th African American Conference on PTSD, Howard University, Washington, DC, September 11-12, 2000.

149. "The National Center for PTSD." Conference on PTSD, VA Canada, Charlottetown, Prince Edward Island, September 17-18, 2000.

150. Discussant. "Treatment of mental disorders in VA medical settings." VA Primary Care/Mental Healthcare Town Hall Meeting, Washington, DC, September 26, 2000.

151. Friedman, M.J. "Mission-related stress among UN Peacekeepers and Civilian Field Personnel." Annual Meeting of the International Society for Traumatic Stress Studies, San Antonio, TX, November 2000.

152. Friedman, M.J. "Psychobiological strategies to foster resilience." Annual Meeting of the International Society for Traumatic Stress Studies, San Antonio, TX, November 2000.

153. Friedman, M.J. "Social deprivation." Annual Meeting of the International Society for Traumatic Stress Studies, San Antonio, TX, November 2000.

154. Friedman, M.J. "The diagnosis and treatment of PTSD." University of Pristina, Kosovo, November 2000.

155. Friedman, M.J. "VA satellite broadcast on compensation & pension exams for PTSD, February 2001.

156. Friedman, M.J. " Clinical consultation forum: PTSD." Annual Meeting of the Anxiety Disorders Association of America, Augusta, GA, March 2001.

157. Friedman, M.J. " Evaluating treatment guidelines for PTSD: What the clinician should know before trying the recommendations at home." Annual Meeting of the Anxiety Disorders Association of America, Augusta, GA, March 2001.

158. Friedman, M.J. "The VA's National Center for PTSD." Department of Justice Substance Abuse and Victimization Forum, Washington, DC, March 2001.

159. Friedman, M.J. "Pharmacotherapy for PTSD." Annual Meeting of the American Psychiatric Association, New Orleans, LA, May 2001.

160. Friedman, M.J., "Rationale for studying trauma focus group therapy." Annual Meeting of the European Society for Traumatic Stress Studies, Edinburgh, Scotland, May 2001.

160. Schnurr, P.P., Glynn, S., Friedman, M.J., & Foy, D. "Trauma focus group treatment of PTSD." Annual Meeting of the European Society for Traumatic Stress Studies, Edinburgh, Scotland, May 2001.

161. Friedman, M.J., "The physical and mental impact of stress." VA EES Conference on the Impact of Mental Health on Medical Illness in the Primary Care Setting and the Aging Veteran, New York City, NY, June 2001.

162. Friedman, M.J. "Keynote Address: Current Status of Treatment for PTSD." PTSD Symposium, VA Medical Center, White River Junction, VT, June 2001.

163. Friedman, M.J. "PTSD Allostatic Load and Medical Illness." Satellite Conference, Palo Alto, CA, August 2001.

164. Friedman, M.J. "Pharmacological treatment of PTSD." Symposium on the Psychoneurobiological Frameworks of PTSD. Croatian Medical Association, Zagreb, Croatia, September 2001.

165 Friedman, M.J. "New developments in the pharmacological treatment of PTSD." Primary Care - PTSD Conference, Washington, DC, October 2002.

166. Friedman, M.J. "Annual Meeting of the International Society for Traumatic Stress Studies, Baltimore, MD, November 2002.

a. Discussant: Schizophrenia, Trauma & PTSD

b. Expert Clinical Consultation

c. Discussant: Developing Networks in the Field of Traumatic Stress

167. Friedman, M.J. "New management strategies for PTSD." Walter Reed Army Hospital, Washington, DC, December 2002.

168. Friedman, M.J., & Schnurr, P.P. "Psychotherapy for PTSD: A tale of two trials." Walter Reed Army Medical Center, Washington, DC, December 2002.

169. Friedman, M.J. "Future pharmacotherapy for PTSD - prevention and treatment." EES/MIRECC 16, New Orleans, LA, January 2003.

170. Friedman, M.J. "Pharmacotherapy for chronic PTSD." EES/MIRECC 16, New Orleans, LA January 2003.

171. Friedman, M.J. "VA/DoD practice guidelines." EES/MIRECC 16, New Orleans, LA, January 2003.

172. Friedman, M.J. "Follow-up status report: Meeting the mental health needs of the country in the wake of September 11, 2001." Annual Rosalynn Carter Symposium on Mental Health Policy, Washington, DC, April 2003.

173. Friedman, M.J. "Workshop on early intervention following mass casualties, lessons from 9/11." Annual Meeting of the American Psychiatric Association, San Francisco, CA, May 2003.

174. Friedman, M.J. "Biological abnormalities and pharmacological treatments." University of Zagreb Summer Institute on Traumatology, Dubrovnik, Croatia, June 2003.

175. Friedman, M.J. Pharmacotherapy for treatment resistant post-traumatic stress disorder. Presented at "Difficult to Treat Mood and Anxiety Disorders," Washington, DC, October 17-18, 2003.

176. Friedman, M.J. "The Joint VA/DoD Clinical Practice Guideline for Traumatic Stress." H. Kudler (Chair) Annual Meeting of the International Society for Traumatic Stress Studies, Chicago, IL, October 29, 2003.

177. Friedman, M.J. "Memory and Identity in PTSD: A new perspective on trauma and treatment" (Chair and Discussant). Annual Meeting of the International Society for Traumatic Stress Studies, Chicago, IL, October 30, 2003.

178. Friedman, M.J. "An integration of the pathophysiology and the pharmacotherapy for PTSD." Annual Meeting of the International Society for Traumatic Stress Studies, Chicago, IL, October 31, 2003.

179. Friedman, M.J. "Integrating treatments in the wake of trauma: When, who, and how? Annual Meeting of the International Society for Traumatic Stress Studies, Chicago, IL, November 1, 2003.

180. Friedman, M.J. New developments in pharmacotherapy for PTSD. New York State Office of Mental Health, December 19, 2003.

181. Friedman, M.J. & Schnurr, P.P. "A tale of two studies: VA Cooperative Studies on treatment of PTSD." Psychiatric Grand Rounds, Dartmouth Medical School, March 2, 2004.

182. Friedman, M.J. "Biological approaches to treatment of PTSD and acute stress reactions." Psychiatric Grand Rounds, Brown Medical School, March 3, 2004.

183. Friedman, M.J. "All day workshop on PTSD diagnosis and treatment." Brattleboro Retreat, Brattleboro, VT, April 4, 2004.

184. Friedman, M.J. "Update on psychopharmacology of PTSD." Psychopharmacology Update, Baylor College of Medicine, Houston, TX, October 2004.

185. Danieli, Y., Galea, S., Greiger, T., Cohen Silver, R., & Friedman, M.J. "Terrorism, the US experience: Questions answered, questions raised." International Society for Traumatic Stress Studies, New Orleans, LA, November 2004.

186. Friedman, M.J., Holloway, H.C., Litz, B.T., & Solomon, Z. "Military psychiatry, then and now." International Society for Traumatic Stress Studies, New Orleans, LA, November 2004.

187. Friedman, M.J. "Overview: Advances in our understanding and treatment of PTSD." Tripler Army Medical Center, Honolulu, HI, February 2005.

188. Friedman, M.J. "PTSD and health: Evidence and theory." Schofield Barracks, Honolulu, HI, February 2005.

189. Friedman, M.J. "Forensic issues regarding PTSD." Georgetown Law School, Georgetown University, Washington, DC, February 2005.

190. Friedman, M.J. "Overview of the National Center for PTSD." Joint DoD/VA Conference on Post Deployment Mental Health, Alexandria, VA, March 2005.

191. Friedman, M.J., & Schnurr, P.P. "Town hall meeting on the war in Iraq." Department of Psychiatry, Dartmouth Medical School, Lebanon, NH, March 2005.

192. Friedman, M.J. "Advances in treatment of PTSD." 10th Annual Zurcher - Psychotraumatologie Tagung, Psychiatrischa Poliklinik, UniversitatsSpital, Zurich, Switzerland, April 2005.

193. Friedman, M.J. "The future of PTSD science and practice." 10th Annual Zurcher - Psychotraumatologie Tagung, Psychiatrischa Poliklinik, UniversitatsSpital, Zurich, Switzerland, April 2005.

194. Friedman, M.J. "Conceptual and empirical advances concerning pharmacotherapy for PTSD." University of Wisconsin, Madison, WI, May 2005.

195. Friedman, M.J., "Improving primary care for trauma-related psychiatric disorders in general medical settings." American Psychiatric Association, Atlanta, GA, May 2005.

196. Friedman, M.J. "Normal distress to PTSD." Trauma and Dissociation Conference, Ottawa, Canada, June 2005.

197. Friedman, M.J. "PTSD and risk factor for medical illness." Trauma and Dissociation Conference, Ottawa, Canada, June 2005.

198. Friedman, M.J. "Pharmacotherapy." Trauma and Dissociation Conference, Ottawa, Canada, June 2005.

199. Friedman, M.J. "Psychosocial treatment." Trauma and Dissociation Conference, Ottawa, Canada, June 2005.

200. Friedman, M.J. "The future of PTSD." Trauma and Dissociation Conference, Ottawa, Canada, June 2005.

201. Friedman, M.J. "OEF/OIF experience: Before, during and after deployment." 804th Medical Brigade Symposium, Burlington, MA, September 2005.

202. Friedman, M. J. "Combat & trauma: What we know now." Nieman Foundation Conference, Harvard School of Journalism, Boston, MA, October 2005.

203. Friedman, M. J. "OEF/OIF experience: Before, during and after deployment." Turner Lecture, Dartmouth Medical School, Lebanon, NH, October 2005.

204. Benedek, D., Zatzick, D., Friedman, M., Ursano, R., & Pynoos, R. "Use of practice guidelines to disseminate recommendations: Pros and cons." International Society for Traumatic Stress Studies, Toronto, ON, November 2005.

205. Friedman, M. J. "Practice guidelines for PTSD treatment: What they can and can't tell us." International Society for Traumatic Stress Studies, Toronto, ON, November 2005.

206. Friedman, M. J. "Pharmacotherapy: What we do and do not know about medication treatment for PTSD, treating acute stress disorders, and posttraumatic stress disorder." PTSD Alliance, Washington, DC, December 2005.

207. Friedman, M. J. "Psychiatric aspects of disaster recovery." Hong Kong Academy of Medicine, 3rd Intercollegiate Scientific Meeting, Hong Kong, China, February 2006.

208. Friedman, M. J. "Acute post-traumatic reactions and PTSD." Hong Kong College of Psychiatry, Hong Kong, China, February 2006.

209. Friedman, M. J. "Veterans of the war in Iraq and their families." Vermont Trauma Institute, Burlington, VT, April 2006.

210. Friedman, M. J. "PTSD and depression: A psychopharmacology update." Conference on Trauma Survivors in our Community: Integrating Mental Health into Primary Care. Georgetown University, Washington, DC, April 2006.

211. Friedman, M. J. "PTSD and disaster." Arkansas Psychological Association, Little Rock, AR, May 2006.

212. Friedman, M. J. "A call to service: Minimizing the effects of trauma." Arkansas Psychological Association, Little Rock, AR, May 2006.

213. Friedman, M. J. "War zone reactions in veterans." From the War Zone to the Home Front. Military, Family and Community Network of Vermont & Norwich University, Northfield, VT, June 2006.

214. Friedman, M. J. "PTSD research - past, present and future." Quality and Innovations Forum: Transforming VHA Mental Health Services. VHA National Leadership Board, Arlington, VA, June 2006.

215. Friedman, M. J. "Current trends in PTSD research and treatment." Australian Centre for Posttraumatic Mental Health, Melbourne, Australia, September 2006.

216. Friedman, M. J. "Current best practice in the assessment and treatment of PTSD." ASTSS/ACPMH Joint Annual Conference, Adelaide, Australia, September 2006.

217. Friedman, M. J. "Traumatic stress research: Past, present and future." ASTSS/ACPMH Joint Annual Conference, Adelaide, Australia, September 2006.

218. Friedman, M. J. "PTSD: Signs, symptoms, and treatment." PTSD - Extreme Challenge to the Human Spirit, National Association for Mental Illness, St. Cloud, MN, October 20, 2006.

219. Friedman, M.J. "Early intervention following mass casualties and disasters." Psychiatric Grand Rounds, New York University, New York, NY, November 16, 2006.

220. Friedman, M.J. "Recognition and management of post-traumatic stress among emergency room patients." PTSD Symposium, Cleveland Clinic, Cleveland, OH, November 29, 2006.

221. Friedman, M.J. "Normal and pathological readjustment among returning troops." Grand Rounds, Lerner School of Medicine, Cleveland, OH, November 30, 2006.

222. Friedman, M.J. "Treating PTSD: Master clinician meet the expert." Annual Meeting of the Anxiety Disorders Association of America, St. Louis, MO, March 31, 2007.

223. Friedman, M.J. "Pharmacotherapy for PTSD, Evidence-based treatments for PTSD evolving paradigms." Department of Veterans Affairs, Las Vegas, NV, April 22, 2007.

224. Friedman, M.J. "Acute posttraumatic reaction and PTSD." 12th Annual Psychiatric Update, University of Texas Medical Branch, Galveston, TX, April 27, 2007.

225. Friedman, M.J. "Keynote Address: PTSD-progress and challenges." 2nd Annual Operational Stress Injuries Symposium, VA Canada, Montreal, QE, May 8, 2007.

226. Friedman, M.J. "Keynote Address: Looking back and looking ahead: PTSD since 1980." VA VISN 16 & 17 PTSD Workshop, Houston, TX, May 14, 2007.

227. Friedman, M.J. "PTSD among military returnees from Afghanistan and Iraq." Annual Meeting of the Massachusetts Medical Society, Waltham, MA, May 23, 2007.

228. Friedman, M.J. "Phenomenology of PTSD and diagnostic criteria, clinical assessment. Differential diagnosis and pharmacotherapy." Laureate Psychiatric Clinic and Hospital, Tulsa, OK, May 29, 2007.

229. Friedman, M.J. Conference planner and facilitator. "From injury to home: Continuity, coordination and collaboration in care." RAND Corporation, Arlington, VA, May 31, 2007.

230. Friedman, M.J. "Psychopharmacology of PTSD." APNA Psychopharmacology Institute Annual Meeting, American Psychiatric Nurses Association, Cambridge, MA, June 22, 2007.

231. Friedman, M.J., & Schnurr, P.P. "PTSD treatment: Research and dissemination. Transforming mental health care: Promoting recovery and integrated care." VA Office of Mental Health Services, Alexandria, VA; July 16, 2007.

232. Friedman, M.J. "Pharmacotherapy in early intervention." Force Health Protection Conference, US Army Center for Health Promotion and Preventive Medicine, Louisville, KY, August 8, 2007.

233. Friedman, M.J. "PTSD and TBI." 4th Annual Behavioral Health Conference, Samaritan Hospital, Watertown, NY, October 9, 2007.

234. Friedman, M.J. "PTSD: Progress and challenges." Psychiatric Grand Rounds, Mount Sinai Medical School, New York, NY, October 23, 2007.

235. Friedman, M.J., Keane, T.M., Schnurr, P.P., & Watson, P.J. "Research into practice: PTSD, strategies for integrating care, and disseminating effective treatment." AMSUS, Salt Lake City, UT, November 2007.

236. Slone, L.B., & Friedman, M.J. "Mental health following deployment: A community solution." National Council for Community Behavioral Healthcare Conference, Boston, MA, May 2008.

237. Friedman, M.J. "PTSD-science and practice." International Conference on Behavioral Health and Traumatic Brain Injury. Congressional Brain Injury Task Force, Patterson, NJ, October 2008.

238. Friedman, M.J. "The future of PTSD: Towards DSM-V/ICD-11." American Psychiatric Institute for Research and Education, American Psychiatric Association, New York, NY, November 2008.

239. Friedman, M.J. "An update on the DSM-V development process." International Society for Traumatic Stress Studies, Chicago, IL, November 2008.

240. Slone, L.B., Friedman, M.J., Southwick, S.M., Stecker, T., & Washam, T. "How to overcome military member's mental health stigma and barriers to care." International Society for Traumatic Stress Studies, Chicago, IL, November 2008.

241. Friedman, M.J. "PTSD: Looking back and looking ahead: Progress and challenges." Psychiatric Grand Rounds, Vanderbilt University School of Medicine, Nashville, TN, May 2009.

242. Friedman, M.J. & Hurley, R.A. Convened "Consensus Conference on Treatment of co-morbid PTSD, mTBI, and Pain." VA Central Office, Washington, DC, June 2009.

243. Friedman, M.J. & Hurley, R.A. "Practice recommendations for the treatment of Veterans with comorbid PTSD, mild TBI, and pain: Results from the June 2009 Consensus Conference." VA Meeting the Diverse Mental Health needs of Veterans: Implementing the Uniform Services Handbook, VA OMHS, Baltimore, MD, July 2009.

244. Friedman, M.J. & Hurley, R.A. "Practice recommendations for the treatment of Veterans with comorbid PTSD, mild TBI, and pain: Results from the June 2009 Consensus Conference." Evolving Paradigms II Conference, Department of Veterans Affairs, Las Vegas, NV, September 2009.

245. Friedman, M.J. "Practice guidelines for pharmacotherapy for PTSD." American Psychiatric Institute of Research and Education, New York, NY, October 2009.

246. Friedman, M.J. "Trauma-focused strategies for prevention." VA/DoD Mental Health Summit, Washington, DC, October 2009.

247. Bernardy, N.C., Hamblen, J.L., Ruzek, J.I., Friedman, M.J., McFall, M. "The model of the VA Mentoring Program." International Society for Traumatic Stress Studies, Atlanta, GA, November 2009.

248. Friedman, M.J. "Considering PTSD for DSM-V." International Society for Traumatic Stress Studies, Atlanta, GA, November 2009.

249. Green, B.L., Danieli, Y., Pynoos, R., Friedman, M.J., Briere, J., & Newman, E. (2009). Presidential panel: ISTSS over time. International Society for Traumatic Stress Studies, Atlanta, GA, November 2009.

250. Friedman, M.J. "Treatments for PTSD." When Veterans come home, Columbia School of Journalism and Carter Center, Atlanta, GA, January 2010.

251. Friedman, M.J. "Stigma and barriers to care." Stigma Conference Uniformed Services University of Health Sciences, Bethesda, MD, March 2010.

252. Friedman, M.J. "Moderator and Discussant." Amygdala Conference, USUHS, Bethesda, MD, April 2010.

253. Friedman, M.J. "PTSD in military populations." Annual Meeting of the American Psychiatric Association, New Orleans, LA, May 2010.

254. Friedman, M.J. "PTSD, ASD & AD: Looking towards DSM-5, DSM-V Update Series: Part III." Annual Meeting of the American Psychiatric Association, New Orleans, LA, May 2010.

255. Friedman, M.J., & Hurley, R.A. "Implementing clinical practice guidelines in the PSCT in the treatment of Veterans with co-occurring conditions, a team approach to Veterans with co-morbid conditions." VA EES, Orlando, FL, June 2010.

256. Friedman, M.J., Koffman, R., & Ruzek, J.I. "VA/DoD clinical practice guidelines for management of posttraumatic stress update-2010." VA OMHS Annual Meeting, Baltimore, MD, July 2010.

257. Friedman, M.J., Koffman, R., & Lowry, P. "Evidence-based management of posttraumatic stress: 2010 VA/DoD posttraumatic stress clinical practice guideline update." DoD Force Health Protection Annual Meeting, Phoenix, AZ, August 2010.

258. Friedman, M.J. "VA National Center for PTSD." Institute of Medicine, Washington, DC, February 28, 2011.

259. Friedman, M.J. "Pfizer Visiting Professor." Medical University of South Carolina, Charleston, SC, April 11-15, 2011.

260. Friedman, M.J. "Resilience - Congressional Briefing." American Psychiatric Association, US Capitol, Washington, DC, May 3, 2011.

261. Friedman, M.J. "Discussant: Scope, current evidence and innovative approaches in managing PTSD in the military." American Psychiatric Institute for Research and Education (APIRE), American Psychiatric Association, Honolulu, HI, May 14, 2011.

262. Friedman, M.J. "Discussant: Evidence-based and innovative approaches for managing PTSD in the military." American Psychiatric Association Annual Meeting, Honolulu, HI, May 25, 2011.

263. Friedman, M.J. "Testimony: PTSD treatment in the VA." House Veterans Affairs Committee, Washington, DC, June 13, 2011.

264. Friedman, M.J. "Chair and Discussant: New developments in pharmacotherapy." VA OMHS Annual Meeting, Baltimore, MD, August 24, 2011.

265. Friedman, M.J. "Home from the war: Challenges for veterans & families." Turner Lecture, Dartmouth Medical School, Hanover, NH, October 27, 2011

266. Bloom, S., Courtois, C., Figley, C., & Friedman, M.J. "Keynote address: We couldn't have done it without them: Four pioneers discus the social bonds that shaped the field of traumatic stress." International Society for Traumatic Stress Studies, Baltimore, MD, November 2, 2011.

267. Friedman, M.J., Bernardy, N.C., Jeffreys, M., & Gibson, C. "Doing the benzodiazepine dance: Challenges for PTSD prescribers." International Society for Traumatic Stress Studies, Baltimore, MD, November 3, 2011.

268. La Bash, H., De John, J., Silove, D., & Friedman, M.J. "Looking through the lens of local culture: Implications for the assessment and treatment of post-conflict populations." International Society for Traumatic Stress Studies, Baltimore, MD, November 4, 2011.

269. Friedman, M.J. "Department of Veterans Affairs Treatment of PTSD; at Unleashing the Power of Health Information Technology for Wounded Warriors. One mind for research & Center for International Rehabilitation." Library of Congress, Washington, DC, November 14, 2011.

270. Friedman, M.J. "PTSD: Individual and cultural contexts." Historical trauma and healing in Native Americans, Dartmouth College, May 25, 2012.

271. Friedman, M.J. "Deconstructing PTSD." American Psychopathological Association, New York, NY, March 7, 2013.

272. Friedman, M.J. (Webinar). "New DSM-5 criteria for PTSD." Home Base (MGH) Academy & NCPTSD), May 2013.

273. Friedman, M.J. "Proposed adjustment disorder subtype: Acute stress disorder/posttraumatic stress disorder." American Psychiatric Association, San Francisco, CA, May 2013.

274. Friedman, M.J. "Trauma and stressor-related disorders." American Psychiatric Association, San Francisco, CA, May 2013.

275. Friedman, M.J. "DSM-5 diagnostic criteria for PTSD, Boston VA Medical Center, Boston, MA, July 2013.

276. Friedman, M.J. (Webinar). "DSM-5 criteria for PTSD and related disorders, International Society for Traumatic Stress Studies, August 2013.

277. Friedman, M.J. (Webinar). "Trauma and stressor-related disorders." American Psychiatric Association, August 2013.

278. Friedman, M.J. "Trauma and stress-related disorders." Grand Rounds, Geisel School of Medicine at Dartmouth, September 2013.

279. Friedman, M.J. "Trauma & stressor-related disorders." Department of Veterans Affairs, Webinar, August 2013; Telecast, September 2013.

280. Friedman, M.J. (chair), Brewin, C., Kilpatrick, D., Lanius, R., & Scheering, M. (2013), Featured panel. "DSM-5: New data, new subtypes and comparisons with ICD-11. International Society for Traumatic Stress Studies, Philadelphia, PA.

281. Schnurr, P.P. (chair). Friedman, M.J., Weathers, F. & Marx, B. (2013) Pre-Meeting Institute. Assessing PTSD according to DSM-5. International Society for Traumatic Stress Studies, Philadelphia, PA.

282. Friedman, M.J. "Clinical practice guidelines for PTSD: New developments and new questions" Grand Rounds, McLean Hospital, Belmont, MA, October 26, 2016.

283. Friedman, M.J. "VA's National PTSD Brain Bank", Brain Trust Meeting, Harvard Medical School, Boston, MA, May 17, 2017.

Mary Hitchcock Memorial Hospital

Key Personnel

Name	Job Title	Salary	% Paid from this contract	Amount Paid from this Contract
Jeff Fetter	Chief Medical Officer	330,000	100%	330,000
Gary Moak	Associate Medical Director	307,661	100%	307,661
Lisa Mistler	General Psychiatrist	270,375	100%	270,375
Erika Ebert	General Psychiatrist	270,375	100%	270,375
John Hink	General Psychiatrist	270,375	100%	270,375
Patrick Hattan	General Psychiatrist	253,483	100%	253,483
Corneliu Stanciu	General Psychiatrist	272,950	100%	272,950
Michael Knight	General Psychiatrist	270,375	100%	270,375
Mark Cotterell	General Psychiatrist	271,920	100%	271,920
Samantha Gnanasegaram	General Psychiatrist	265,225	100%	265,225
David Williams	General Psychiatrist	259,921	100%	259,921
Mercy Isang	General Psychiatrist	272,651	100%	272,651
Samantha Swetter	General Psychiatrist	252,000	100%	252,000
Thatcher Newkirk	General Psychiatrist	250,000	100%	250,000
TBH	General Psychiatrist	260,000	100%	260,000
TBH	General Psychiatrist	260,000	100%	260,000
Margaret Abbott	Psychiatric APRN	131,306	100%	131,306
Stacy Sorrell	Psychiatric APRN	131,306	100%	131,306
Maryanne Fournier	Psychiatric APRN	128,451	100%	128,451
Shena McAroy	Psychiatric APRN	127,504	100%	127,504
Susan Kostrzewski	Psychiatric APRN	123,011	100%	123,011
TBH	Psychiatric APRN	131,306	100%	131,306
TBH	Psychiatric APRN	131,306	100%	131,306
TBH	Psychiatric APRN	131,306	100%	131,306
Alaiksander Shakau	Geropsychiatrist	275,625	100%	275,625
Sharee Light	Director of Neuropsychology Laboratory	72,500	100%	72,500
Deb Fournier	Director of Quality Systems and APRN Services	148,720	100%	148,720
Rotating	Neuropsychologist Trainees	49,000	100%	49,000
Rotating	Neuropsychologist Trainees	49,000	100%	49,000
Rotating	Neuropsychologist Trainees	49,000	100%	49,000
Elizabeth Sanders	General Medical Director	263,718	100%	263,718
TBH	General Medical Physician	257,500	100%	257,500
Andrea Muschett	Forensic Psychologist	116,298	100%	116,298
Rotating	PGY IV Residents	0	100%	0
Rotating	PGY II Residents	58,288	100%	58,288
Rotating	PGY II Residents	29,144	100%	29,144
Rotating	Geropsychiatry Fellow	33,117	100%	33,117
Barbara Dieckman	Director of Health System Data and Information Services	142,314	100%	142,314
TBH	Research Manager	70,806	100%	70,806
Matt Friedman	Research Mentor/Investigator (Psychiatrist or Psychologist)	40,899	100%	40,899
TBH	Research Director	190,000	100%	190,000

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STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF THE COMMISSIONER

Jeffrey A. Meyers
Commissioner

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June 4, 2019

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services to exercise a renewal option and amend an existing agreement with Mary Hitchcock Memorial Hospital (a component of Dartmouth-Hitchcock - Vendor #177160) of One Medical Center Drive, Lebanon, New Hampshire, 03756, for the provision of Physician Clinical and Administrative Services to meet the specialized health and related clinical and administrative needs of the residents of the State of New Hampshire, by increasing the price limitation by $43,350,069 from $36,554,042 to an amount not to exceed $79,904,111, and by extending the completion date from June 30, 2019 to June 30, 2022, effective upon Governor and Executive Council approval. 28% Federal Funds, 32% General Funds, and 40% Other Funds.

This agreement was originally approved by the Governor and Executive Council on September 7, 2016, (Item #6A), and subsequently amended on January 9, 2019 (Item # 5A).

Funds are anticipated to be available in the following accounts for State Fiscal Years 2020, 2021, and 2022, with authority to adjust amounts within the price limitation, and adjust encumbrances between State Fiscal Years through the Budget Office, if needed and justified.

SEE ATTACHED FISCAL DETAILS

EXPLANATION

The purpose of this request is to continue to provide physician clinical and administrative services to specific populations served by the Department in the seven (7) distinct service areas listed below:

Service Area #1 – New Hampshire Hospital
Service Area #2 – Glencliff Home
Service Area #3 – Medicaid
Service Area #4 – Children, Youth and Families
Service Area #5 – Behavioral Health
Service Area #6 – Elderly and Adult Services
Service Area #7 – Developmental Services

Service Area #1 – New Hampshire Hospital

The Contractor provides clinical and administrative services to New Hampshire Hospital and provides staffing for all inpatient care units with medical staff including Advanced Practice Registered Nurses, research and general hospital clinical support. New Hampshire Hospital achieved Joint Commission Accreditation in September 2018 as an Acute Psychiatric Hospital. The hospital is executing strategic initiatives that focus on safety culture, efficiency and effectiveness of work flow, and becoming a data driven organization. The Contractor provides a Director of Quality Systems and APRN Services who oversees a comprehensive Quality

Assurance program that ensures New Hampshire Hospital is meeting regulatory performance metrics that focus on excellence of patient care and prioritize a culture of safety. Additionally, this position provides oversight and supervision to the Advanced Practice Registered Nurses, ensuring standardized practice in line with established practice guidelines in psychiatric medicine. The Contractor also provides a Director of Health Systems Data and Information Services who serves as the conduit for data collection within New Hampshire Hospital, including overseeing Health Information Services, Information Technology, and the Electronic Health Record.

Service Area #2 – Glencliff Home

The Department operates the Glencliff Home to provide a continuum of services for New Hampshire's developmentally disabled, and/or mentally ill population in a home-like setting, with an emphasis on independence, dignity, and acceptance. The Contractor provides to the Department, through the expertise a Medical Director, direct psychiatric services, treatment, and associated services for all residents of the Glencliff Home. The Medical Director serves other functions, including, but not limited to, oversight of physicians, as well as other administrative duties, including review of medication use for compliance with federal law. The Director serves as the liaison with other healthcare organizations.

Service Area #3 – Medicaid

The Department is responsible for the administration of the Medicaid medical assistance program and is dedicated to the identification of New Hampshire's health care needs through the assessment and implementation of health care and social services delivery systems. To assist the Department in the furtherance of these responsibilities, the Contractor provides the services of a full-time Chief Medical Officer. The Chief Medical Officer's responsibilities include developing strategic clinical relationships with physicians, as well as growing partnerships with academic institutions and federal agencies, with a focus on quality improvement and the implementation of federal health care reforms. Additionally, the Chief Medical Officer provides medical oversight of the state's publicly funded health insurance programs, assists in making policy decisions, and shapes administrative planning strategies to enhance the operating efficiency of Medicaid and related healthcare initiatives across the state.

Service Area #4 – Children, Youth, and Families

The Department is responsible for providing supervision and rehabilitative services to youth adjudicated under state law as delinquent or as children in need of services (CHINS). The Department provides supervision, case management, and an array of rehabilitative services to youth through its staff of Juvenile Probation and Parole Officers (JPPOs) and a network of community-based providers. The Contractor provides the services of a full-time psychiatrist to provide psychiatric services to youth served by the Department. The psychiatrist provides treatment planning oversight, clinical consultations, and assessments to treatment coordinators and JPPOs as well as providing psychiatric evaluations and direct care to youth served by the Department. Additionally, the psychiatrist provides program development at the Sununu Youth Services Center (SYSC) and fosters improved interagency collaboration between Juvenile Justice Services, area mental health agencies, and New Hampshire Hospital to enhance mental health services for adjudicated youth. This request, if approved, will add a full-time psychologist who will assume many of the duties that are currently performed by the full-time psychiatrist, and will reduce the psychiatrist services for DCYF to a part-time position.

Service Area #5 – Behavioral Health

Through its integrated behavioral health services, the Department promotes respect, recovery, and full community inclusion for adults who experience a mental illness, and for children with emotional disturbances. The Department, through its behavioral health program, seeks to sustain the development and implementation of evidence-based practices through the provision

of technical assistance and training made possible through this contract, as well as through state and federal grant opportunities. The Contractor provides the personnel needed to help the Department achieve positive outcomes for individuals served by the behavioral health program. Personnel include a Medical Director who provides direction and expertise on key policy initiatives as well as evidence-based practices, and training consultants, who provide support in sustaining and fostering continuous quality improvement of the evidence-based practices that are implemented across the New Hampshire Community Mental Health Centers system.

Service Area #6 – Elderly and Adult Services

A critical component of the Department's statewide delivery system is its community-based provider network. The Department coordinates long-term care support services through contracts at the local level, thus reflecting the commitment of the Department to strengthen the autonomy of local communities and to direct resources to where they are needed most. In order to assist the Department in the provision of social and long-term supports to adults aged 60 and older and to adults between the ages of 18 and 60 who have a chronic illness or disability, the Contractor provides the services of a Medical Director. The Medical Director assists in the planning and direction of the Department's policies and programs for the purpose of sustaining and improving the quality of services for those elderly and adults served by the Department.

Service Area #7 – Developmental Services

The developmental services system offers individuals with developmental disabilities and acquired brain disorders a wide range of supports and services through partnerships with community based service networks developed through the leadership and oversight of the Department. The Contractor provides the services of a Medical Director for psychiatric consultation services as well as expert guidance and training to the Department's developmental services staff. The Contractor also provides the services of two Developmental Services Interdisciplinary Clinic Teams with the clinical expertise needed to conduct evaluations of both adults and children with developmental disabilities and acquired brain injuries. These evaluations are conducted based on referrals from Area Agencies.

More than 4,286 people have received services under this contract during the past three years. This request, if approved, will provide critical support for the delivery of services by the Department to more than 4,187 individuals statewide for the next three years.

The original agreement included language in Exhibit C-1, that allows the Department to renew the contract for up to two (2) additional three (3) year periods, contingent upon satisfactory delivery of services, available funding, agreement of the parties, and approval of the Governor and Council. This request, if approved, will exercise the first three (3) year period of this renewal option.

The Department will monitor the effectiveness of the Contractor and the delivery of services required under this contract using the following performance measures:

- Staffing levels - target 100%
- Psychiatric progress notes
- Patient length of stay trending
- Treatment plan audits
- Annual evaluations of staff performance
- Adherence to certification guidelines
- Individual metrics based on outcome targets
- Documented monitoring of work hours and attendance

Should the Governor and Executive Council not authorize this request, the Department may not be able to provide essential services in the service areas identified above, thereby putting at risk many of the State's most vulnerable residents.

Area Served: Statewide

Source of Funds: 28% Federal Funds from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medical Assistance Program, Code of Federal Domestic Assistance Number (CFDA) 93.778; 32% General Funds, and 40% Other Funds (Medicare, Medicaid & third party insurance).

In the event that the Federal Funds become no longer available, additional General Funds will not be requested to support this contract.

Respectfully submitted,

Jeffrey A. Meyers
Commissioner

FISCAL DETAILS

05-95-48-481010-33170000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: ELDERLY AND ADULT SERVICES, GRANTS TO LOCALS, ADMIN ON AGING SVCS GRANT-SMPP

SFY	Class/ Account	Class/Title	Activity Code	Current Budget	Increase/ (Decrease)	Modified Budget
2017	102-500731	Contracts for Program Services	48130284	$21,000	$0	$21,000
2018	102-500731	Contracts for Program Services	48130284	$28,153	$0	$28,153
2019	102-500731	Contracts for Program Services	48130284	$29,199	$0	$29,199
			Sub-Total	**$78,352**	**$0**	**$78,352**

05-95-48-481010-78720000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: ELDERLY AND ADULT SERVICES, GRANTS TO LOCALS, ADM ON AGING GRANTS

SFY	Class/ Account	Class/Title	Activity Code	Current Budget	Increase/ (Decrease)	Modified Budget
2020	540-500382	Social Service Contracts	TBD	$0	$39,197	$39,197
2021	540-500382	Social Service Contracts	TBD	$0	$41,809	$41,809
2022	540-500382	Social Service Contracts	TBD	$0	$44,110	$44,110
			Sub-Total	**$0**	**$125,116**	**$125,116**

05-95-92-922010-41170000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: BEHAVIORAL HEALTH DIV, BUREAU OF MENTAL HEALTH SERVICES, CMH PROGRAM SUPPORT

SFY	Class/ Account	Class/Title	Activity Code	Current Budget	Increase/ (Decrease)	Modified Budget
2017	102-500731	Contracts for Program Services	92204117	$0	$0	$0

FISCAL DETAILS

2018	102-500731	Contracts for Program Services	92204117	$0	$0	$0
2019	102-500731	Contracts for Program Services	92204117	$0	$0	$0
2020	102-500731	Contracts for Program Services	92204117	$0	$517,056	$517,056
2021	102-500731	Contracts for Program Services	92204117	$0	$544,803	$544,803
2022	102-500731	Contracts for Program Services	92204117	$0	$572,319	$572,319
			Sub-Total	**$0**	**$1,634,178**	**$1,634,178**

05-95-42-421510-79150000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: SUNUNU YOUTH SERVICE CENTER, HEALTH SERVICES

SFY	Class/ Account	Class/Title	Activity Code	Current Budget	Increase/ (Decrease)	Modified Budget
2017	102-500730	Medical Payments to Providers	42151501	$325,491	$0	$325,491
2018	102-500730	Medical Payments to Providers	42151501	$392,391	$0	$392,391
2019	102-500730	Medical Payments to Providers	42151501	$407,002	$0	$407,002
2020	102-500730	Medical Payments to Providers	42151501	$0	$396,688	$396,688
2021	102-500730	Medical Payments	42151501	$0	$392,444	$392,444

FISCAL DETAILS

		to Providers				
2022	102-500730	Medical Payments to Providers	42151501	$0	$413,867	$413,867
			Sub-Total	**$1,124,884**	**$1,202,999**	**$2,327,883**

05-95-47-470010-79370000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS:OFC OF MEDICAID & BUS. PLCY, OFF. OF MEDICAID & BUS. POLICY, MEDICAID

SFY	Class/ Account	Class/Title	Activity Code	Current Budget	Increase/ (Decrease)	Modified Budget
2017	102-500731	Contracts for Program Services	47000021	$278,300	$0	$278,300
2018	102-500731	Contracts for Program Services	47000021	$374,358	$0	$374,358
2019	102-500731	Contracts for Program Services	47000021	$388,407	$0	$388,407
			Sub-Total	**$1,041,065**	**$0**	**$1,041,065**

05-95-47-470010-50000000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: COMMISSIONER'S OFFICE, OFF. OF MEDICAID & BUS. POLICY, MEDICAID

SFY	Class/ Account	Class/ Title	Activity Code	Current Budget	Increase/ (Decrease)	Modified Budget
2020	102-500731	Contracts for Program Services	TBD	$0	$408,628	$408,628
2021	102-500731	Contracts for Program Services	TBD	$0	$432,119	$432,119

FISCAL DETAILS

2022	102-500731	Contracts for Program Services	TBD	$0	$455,193	$455,193
			Sub-Total	**$0**	**$1,295,940**	**$1,295,940**

05-95-94-940010-87500000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: NEW HAMPSHIRE HOSPITAL, NEW HAMPSHIRE HOSPITAL, ACUTE PSYCHIATRIC

SFY	Class/ Account	Class/ Title	Activity Code	Current Budget	Increase/ (Decrease)	Modified Budget
2017	102-500731	Contracts for Program Services	494058000	$8,407,616	$0	$8,407,616
2018	102-500731	Contracts for Program Services	494058000	$11,471,661	$0	$11,471,661
2019	102-500731	Contracts for Program Services	494058000	$11,862,758	$0	$11,862,758
2020	102-500731	Contracts for Program Services	494058000	$0	$11,640,759	**$11,640,759**
2021	102-500731	Contracts for Program Services	494058000	$0	$12,717,827	**$12,717,827**
2022	102-500731	Contracts for Program Services	494058000	$0	$13,366,111	**$13,366,111**
			Sub-Total	**$31,742,035**	**$37,724,697**	**$69,466,732**

05-95-94-940010-87500000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: NEW HAMPSHIRE HOSPITAL, NEW HAMPSHIRE HOSPITAL, BEHAVIORAL HEALTH

FISCAL DETAILS

SFY	Class/ Account	Class/ Title	Activity Code	Current Budget	Increase/ (Decrease)	Modified Budget
2017	102-500731	Contracts for Program Services	92204117	$351,661	$0	$351,661
2018	102-500731	Contracts for Program Services	92204117	$477,825	$0	$477,825
2019	102-500731	Contracts for Program Services	92204117	$494,500	$0	$494,500
			Sub-Total	**$1,323,986**	**$0**	**$1,323,986**

05-95-91-910010-57100000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: NEW HAMPSHIRE HOSPITAL, NEW HAMPSHIRE HOSPITAL, GLENCLIFF

SFY	Class/ Account	Class/Title	Activity Code	Current Budget	Increase/ (Decrease)	Modified Budget
2017	101-500729	Contracts for Program Services	91000000	$114,511	$0	$114,511
2018	101-500729	Contracts for Program Services	91000000	$152,935	$0	$152,935
2019	101-500729	Contracts for Program Services	91000000	$158,555	$0	$158,555
2020	101-500729	Contracts for Program Services	91000000	$0	$139,309	$139,309
2021	101-500729	Contracts for Program Services	91000000	$0	$148,447	$148,447
2022	101-500729	Contracts for	91000000	$0	$156,475	$156,475

FISCAL DETAILS

		Program Services				
			Sub-Total	**$426,001**	**$444,231**	**$870,232**

05-95-93-930010-51910000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: DEVELOPMENTAL SERV DIV OF, DIV OF DEVELOPMENTAL SVCS, SPECIAL MEDICAL SERVICES

SFY	Class/ Account	Class/Title	Activity Code	Current Budget	Increase/ (Decrease)	Modified Budget
2017	561-500911	Specialty Services	93001000	$20,000	$0	$20,000
2018	561-500911	Specialty Services	93001000	$30,000	$0	$30,000
2019	561-500911	Specialty Services	93001000	$30,000	$0	$30,000
2020	561-500911	Specialty Services	93001000	$0	$30,000	$30,000
2021	561-500911	Specialty Services	93001000	$0	$30,000	$30,000
2022	561-500911	Specialty Services	93001000	$0	$30,000	$30,000
			Sub-Total	**$80,000**	**$90,000**	**$170,000**

05-95-93-930010-59470000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: DEVELOPMENTAL SERV DIV OF, DIV OF DEVELOPMENTAL SVCS, PROGRAM SUPPORT

SFY	Class/Account	Class/Title	Activity Code	Current Budget	Increase/ (Decrease)	Modified Budget
2017	102-500731	Contracts for Program Services	93005947	$93,096	$0	$93,096
2018	102-500731	Contracts for Program Services	93005947	$119,981	$0	$119,981
2019	102-500731	Contracts for Program Services	93005947	$125,376	$0	$125,376

FISCAL DETAILS

2020	102-500731	Contracts for Program Services	93005947	$0	$254,893	$254,893
2021	102-500731	Contracts for Program Services	93005947	$0	$280,264	$280,264
2022	102-500731	Contracts for Program Services	93005947	$0	$297,751	$297,751
			Sub-Total	**$338,453**	**$832,908**	**$1,171,361**

05-95-93-930010-59470000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: DEVELOPMENTAL SERV DIV OF, DIV OF DEVELOPMENTAL SVCS, PROGRAM SUPPORT

SFY	Class/Account	Class/Title	Activity Code	Current Budget	Increase/ (Decrease)	Modified Budget
2017	103-502664	Contracts for Operational Svcs	93015947	$106,480	$0	$106,480
2018	103-502664	Contracts for Operational Svcs	93015947	$143,673	$0	$143,673
2019	103-502664	Contracts for Operational Svcs	93015947	$149,113	$0	$149,113
			Sub-Total	**$399,266**	**$0**	**$399,266**
			Grand Total	**$36,554,042**	**$43,350,069**	**$79,904,111**

State of New Hampshire
Department of Health and Human Services
Amendment #2 to the Physician Clinical and Administrative Services Contract

This 2nd Amendment to the Physician Clinical and Administrative Services contract (hereinafter referred to as "Amendment #2"), is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Mary Hitchcock Memorial Hospital, (hereinafter referred to as "the Contractor"), a nonprofit corporation with a place of business at One Medical Center Drive, Lebanon, New Hampshire 03756.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on August 24, 2016, (Item #6A) as amended on January 9, 2019 (Item # 5A), the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract and in consideration of certain sums specified; and

WHEREAS, the State and the Contractor have agreed to make changes to the scope of work, payment schedules and terms and conditions of the contract; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 18, and Exhibit C-1, Revisions to General Provisions, Paragraph 3, the State may modify the scope of work and the payment schedule of the contract upon written agreement of the parties and approval from the Governor and Executive Council; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, and modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Form P-37, General Provisions, Block 1.7, Completion Date, to read:

   June 30, 2022.

2. Form P-37, General Provisions, Block 1.8, Price Limitation, to read:

   $79,904,111.

3. Form P-37, General Provisions, Section 14.2, delete: "and issued by insurers licensed in the State of New Hampshire" at the end of said section.

4. Form P-37, General Provisions, Section 15.2, modify the first sentence only to read (italicized font added to reflect newly added language): To the extent Contractor is subject to the requirements of N.H. RSA Chapter 281-A, Contractor shall maintain, and require any subcontractor or assignee to secure and maintain, payment of Workers' Compensation in connection with the activities which the person proposes to undertake pursuant to this Agreement *as required in N.H. RSA Chapter 281-A.*

5. Form P-37, General Provisions, Section 18, by adding the following language to the end of said section: "In the event the State wishes to change the location(s) in which the services are performed by the Contractor hereunder, in whole or in part, the State shall provide Contractor with reasonable advance written notice of the same. Thereafter, the parties shall meet in good faith in order to mutually agree upon possible adjustments to the terms and conditions, if required, which shall be documented in the form of an amendment to this Agreement in accordance with this Section 18.

6. Delete Exhibit A Amendment #1, Scope of Services in its entirety, and replace with Exhibit A Amendment #2, Scope of Services.

7. Delete Exhibit B, Methods and Conditions Precedent to Payment, in its entirety and replace with

Exhibit B Amendment #2, Method and Conditions Precedent to Payment.

8. Exhibit C, Section 10, to read (italicized font added to reflect newly added language): **Confidentiality of Records**: All information, reports, and records maintained hereunder or collected in connection with the performance of the services and the Contract shall be confidential and shall not be disclosed by the Contractor, *except as necessary in connection with the performance of the services and permitted by law*, provided however, that pursuant to state laws and the regulations of the Department regarding the use and disclosure of such information, disclosure may be made to public officials requiring such information in connection with their official duties and for purposes directly connected to the administration of the services and the Contract; and provided further, *that with respect to any records which constitute patient records, such records may be used and disclosed as permitted or required by applicable federal and state privacy laws, including but not limited to HIPAA; and provided further* that the use or disclosure by any party of any information concerning a recipient for any purpose not directly connected with the administration of the Department or the Contractor's responsibilities with respect to purchased services hereunder *or not permitted or required by law* is prohibited, except on written consent of the recipient, his attorney or guardian.

   Notwithstanding anything to the contrary contained herein the covenants and conditions contained in the Paragraph shall survive the termination of the Contract for any reason whatsoever.

This amendment shall be effective upon the date of Governor and Executive Council approval, or July 1, 2019, whichever is later.
IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

6/4/19
Date

Name:
Title:

Mary Hitchcock Memorial Hospital

6/5/2019
Date

Name: Edward J. Merrens
Title: Chief Clinical Officer

Acknowledgement of Contractor's signature:

State of New Hampshire County of Grafton on June 5, 2019, before the undersigned officer, personally appeared the person identified directly above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.

Signature of Notary Public or Justice of the Peace

Laura Rondeau, Notary Public
Name and Title of Notary or Justice of the Peace

My Commission Expires: April 19, 2022

LAURA K. RONDEAU
STATE OF
- MY -
COMMISSION
EXPIRES
APRIL 19,
2022
NEW HAMPSHIRE
NOTARY PUBLIC

The preceding Amendment, having been reviewed by this office, is approved as to form, substance, and execution.

OFFICE OF THE ATTORNEY GENERAL

6/7/2019
Date

Name: Lisa M. Eykel
Title: Special Attorney

I hereby certify that the foregoing Amendment was approved by the Governor and Executive Council of the State of New Hampshire at the Meeting on: _____ (date of meeting)

OFFICE OF THE SECRETARY OF STATE

_____
Date

Name:
Title:

Exhibit A Amendment #2

Scope of Services

1. Provisions Applicable to All Services

1.1. The Contractor will submit a detailed description of the language assistance services they will provide to persons with limited English proficiency to ensure meaningful access to their programs and/or services within ten (10) days of the contract effective date.

1.2. The Contractor agrees that, to the extent future legislative action by the New Hampshire General Court or federal or state court orders may have an impact on the Services described herein, the State has the right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance therewith.

2. Scope of Services

2.1. Covered Populations and Services

The Contractor shall provide physician clinical and administrative services to various populations served by DHHS, in all seven (7) Service Areas identified below and as described herein:

2.1.1. Service Area #1 – New Hampshire Hospital (NHH)

2.1.2. Service Area #2 – Glencliff Home

2.1.3. Service Area #3 – Medicaid

2.1.4. Service Area #4 – Children, Youth and Families

2.1.5. Service Area #5 – Behavioral Health

2.1.6. Service Area #6 – Elderly and Adult Services

2.1.7. Service Area #7 – Developmental Services

2.2. General Requirements Applicable to All Service Areas

2.2.1. The Contractor shall provide psychiatric and other professional services to all service areas through the employment of appropriate Contractor staff described in the following sections, and requiring such staff to perform required services.

2.2.2. The Contractor shall work with DHHS to continue to develop and refine an integrated mental health care system applying principles of managed care for clinical treatment, educational and training programs, and related research.

2.2.3. The Contractor shall work with DHHS to jointly maintain and develop an applied research and evaluation capacity, the general purpose of which shall be to identify and address medical research issues relative to the DHHS mission under RSA 135-C. The activities shall be directed at enhancing applied research resources, capacities and activities within the State mental health services system and implementing a program of

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applied research relative to that system.

2.2.4. All personnel provided by the Contractor under this contract shall be employees or consultants of the Contractor. No personnel provided by the Contractor under this contract shall be considered an employee of the State of New Hampshire.

2.3. Specific Service Requirements for Service Area #1 – New Hampshire Hospital

2.3.1. Chief Medical Officer's Administrative/Clinical Responsibilities

2.3.1.1. Subject to (1) the statutory authority of the DHHS Commissioner or designee, and (2) the authority of the NHH CEO (NHH CEO) with respect to administrative/clinical matters, the Chief Medical Officer shall be responsible for the following:

a. To coordinate with the NHH CEO all clinical activities in order to accomplish the day-to-day clinical operation of NHH in a manner consistent with RSA Chapter 135-C and the rules adopted pursuant thereto, all NHH policies, and all standards of TJC and CMS;

b. To participate in the formulation, implementation, and supervision of all clinical programs for the diagnosis, assessment, treatment, care, and management of patients of NHH, and all clinical personnel engaged in said programs to participate in the formulation, implementation, and supervision of all clinical educational, clinical research, and clinical training programs within NHH;

c. To supervise all documentation requirements of all staff psychiatrists and other clinical personnel employed by the Contractor and providing services under this contract at NHH;

d. To ensure adequate coverage on weekends and holidays to maintain compliance with documentation requirements to justify medical necessity of stay. This may include the need for daily progress notes on children and adults covered by Medicaid, Medicare or commercial insurance. Notwithstanding the foregoing, the parties acknowledge and agree that clinical care responsibilities may from time to time impede the providers' ability to complete daily progress notes on weekends and holidays. In such an event, the next progress note shall be written as soon thereafter as reasonably possible.

e. To perform annual performance evaluations and discipline as necessary for all staff psychiatrists and other clinical personnel employed by the Contractor and providing services under this contract at NHH. In preparing these evaluations, the Chief Medical Officer shall consult with and seek input from the NHH CEO as to the Department's satisfaction with the services

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provided by any such individual under review;

f. To perform an annual administrative review of all clinical personnel employed by the Contractor and providing services under this contract at NHH to assure compliance with NHH policy, including but not limited to: training, record keeping, matters of medical records, CPR and CMP training/retraining, TJC requirements, customer service responsibilities, and HIPAA compliance and attendance at mandated in-service training. The Chief Medical Officer shall take whatever action necessary to assure compliance with these requirements and take whatever disciplinary action necessary in instances of non-compliance of NHH policy or NHH Medical Staff Organization bylaws;

g. To comply with all applicable performance standards set forth in this contract pertaining to staff psychiatrists;

h. To provide consultation to DHHS relative to the development of the State mental health service system;

i. To support NHH's customer service culture by adhering to and assuring that psychiatrists under his/her direction, adhere to the established Customer Service Guidelines for Physicians;

j. To report to the NHH CEO issues known to him/her regarding all admissions, patient care or any other situation that may pose a significant risk to patients or the community or that may result in adverse publicity or in any way undermine public confidence in the clinical care provided by NHH;

k. To participate as a member of the NHH's Administrative Executive Committee;

l. To participate as an ex officio non-voting member of the Executive Committee of the Medical Staff Organization of NHH who represents the NHH CEO;

m. To participate with the NHH CEO in the development of the clinical budget of NHH;

n. To participate in the recruitment of other clinical DHHS personnel, upon the request of the NHH CEO;

o. To establish, subject to the NHH CEO approval, an employment schedule for all clinical personnel employed by the Contractor to provide services at NHH;

p. To assist the NHH Chief Executive Office with the clinical

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supervision and education of all other clinical staff at NHH; and

q. To provide clinical coverage of Contractor staff as necessary.

2.3.2. Associate Medical Director Responsibilities

2.3.2.1. Subject to (1) the statutory authority of the DHHS Commissioner or designee, and (2) the authority of the NHH CEO with respect to administrative/clinical matters, the Associate Medical Director shall be responsible for the following:

a. To coordinate with the NHH Chief Medical Officer and NHH CEO all clinical activities in order to accomplish the day-to-day clinical operation of NHH in a manner consistent with RSA Chapter 135-C and the rules adopted pursuant thereto, all NHH policies, and all standards of TJC and CMS;

b. Serves in the capacity of the chief medical officer during his/her absence;

c. To participate with the Chief Medical Officer in the formulation, implementation, and supervision of all clinical programs for the diagnosis, assessment, treatment, care, and management of patients of NHH, and all clinical personnel engaged in said programs to participate in the formulation, implementation, and supervision of all clinical educational, clinical research, and clinical training programs within NHH;

d. To supervise all documentation requirements of all staff psychiatrists and other clinical personnel employed by the Contractor and providing services under this contract at NHH;

e. To participate with the Chief Medical Officer in performing annual performance evaluations and discipline as necessary for all staff psychiatrists and other clinical personnel employed by the Contractor and providing services under this contract at NHH. In preparing these evaluations, the Associate Medical Director shall assist the Chief Medical Officer who shall consult with and seek input from the NHH CEO as to the Department's satisfaction with the services provided by any such individual under review;

f. To work with the CMO to perform an annual administrative review of all clinical personnel employed by the Contractor and providing services under this contract at NHH to assure compliance with NHH policy, including but not limited to: training, record keeping, matters of medical records, CPR and CMP training/retraining, TJC requirements, customer service responsibilities, and HIPAA compliance and attendance at mandated in-service training. The Associate Medical Director shall assist the Chief Medical Officer who shall take whatever action necessary to assure compliance with these requirements

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and take whatever disciplinary action necessary in instances of non-compliance of NHH policy or Medical Staff Organization bylaws;

g. To comply with all applicable performance standards set forth in this contract pertaining to staff psychiatrists;

h. To provide consultation to DHHS relative to the development of the state mental health service system;

i. To support NHH's customer service culture by adhering to and assuring that psychiatrists under his/her direction, adhere to the established Customer Service Guidelines for Physicians;

j. To report to the NHH Chief Medical Officer and to the CEO issues known to him/her regarding all admissions, patient care or any other situation that may pose a significant risk to patients or the community or that may result in adverse publicity or in any way undermine public confidence in the clinical care provided by NHH;

k. To participate as a member of the NHH's Administrative Executive Committee;

l. In the absence of the Chief Medical Officer, participates as an ex officio non-voting member of the Executive Committee of the Medical Staff Organization of NHH representing the NHH CEO;

m. To participate with the NHH Chief Medical Officer and the NHH CEO in the development of the clinical budget of NHH;

n. To participate in the recruitment of other clinical DHHS personnel, upon the request of the NHH CEO;

o. To assist in establishing, subject to the NHH Chief Medical Officer and NHH CEO approval, an employment schedule for all clinical personnel employed by the Contractor to provide services at NHH; and

p. To assist the NHH Chief Medical Officer and the NHH CEO with the clinical supervision and education of all other clinical staff at NHH; and

q. To provide clinical coverage as necessary and to the extent possible when there are vacancies with the staff psychiatrists or advanced psychiatric nurse practitioners.

2.3.3. General Psychiatrist Responsibilities

2.3.3.1. The following responsibilities are applicable to all psychiatrists the Contractor provides to NHH under this contract. Staff psychiatrists shall be responsible for the following:

a. The formulation and implementation of individual treatment plans and clinical services, in cooperation with treatment

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teams, for the diagnosis, assessment, treatment, care and management of patients of NHH;

b. Maintaining and directing a clinically appropriate treatment plan for assigned cases in concert with the multidisciplinary staff consistent with NHH norms;

c. Determination, consistent with RSA 135-C, of the appropriateness of admissions, transfers and discharges;

d. Participation with other staff physicians, the NHH Chief Medical Officer, and the Associate Medical Director to provide on-call afterhours coverage and serve as on-site, after-hours coverage, on a 24-hour a day, 7-day a week, year round basis when necessary as determined by the NHH CEO, the NHH Chief Medical Officer, and/or the Associate Medical Director;

e. Participation in research and education activities consistent with the mission of NHH and subject to the approval of the NHH CEO;

f. Participation in the Medical Staff Organization and other administrative committees of NHH, assigned committees and task forces;

g. Performance of medical/psychiatric consultation on patients from facilities other than NHH, consistent with current NHH policy;

h. Timely completion of all necessary documentation as required by TJC and CMS standards;

i. Responsibility for completing NHH's Incident Reports in compliance with NHH policy;

j. Completion of all medical record documentation in the timeframes required by the NHH's Policy and Procedure "Medical Record Documentation" and other relevant policies and procedures, including ongoing and timely documentation of clinical care regarding medical necessity, including daily progress notes to document and support medical necessity

k. Adherence to all NHH policies, including, but not limited to policies on Medical Records Documentation and Progress Notes;

l. Ensuring that documentation is consistent with normative data collected by the NHH compliance officer and NHH utilization review manager;

m. Provision of other services as required, which are consistent with the mission of NHH and the intent of this contract;

n. Appearing and testifying in all court and administrative hearings

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as required by the Department;

o. Developing and maintaining positive relationships with NHH staff, patients, families, advocates, community providers and other interest groups vital to the functioning of NHH and the DHHS system of care, including for the purpose of transition planning. In accomplishing this requirement, psychiatrists shall adhere to the standards set forth in NHH's Customer Service Guidelines for Physicians;

p. Meaningfully participating in utilization review processes, including appeals and other processes, as required by the NHH Chief Medical Officer, the Associate Medical Director, and the NHH CEO; and

q. Demonstrating value added achievements with academic and scholarly activities including, but not limited to: teaching (clinical and didactic); attendance and participation in case conferences; engagement with the profession with presentation and/or publication; hospital in-services; and service to the hospital and community through committee work, task force work, community service with advocacy groups; and involvement with the work of DHHS, as well as other public and private agencies that serve the mentally ill, e.g. law enforcement, corrections, the court, the legislature, colleges and universities and other related entities.

r. For a period of twenty-four (24) months commencing on the Amendment #2 Effective Date, one research psychiatrist will contribute 0.15 full-time equivalent (FTE) to serve as a research mentor to the NHH staff and Research Manager and will act as a liaison to trainees pursuing research opportunities at NHH. In addition, this psychiatrist will help to prepare for the work of a research investigator (Ph.D., Psy.D., M.D., or D.O.) who will begin on the thirteenth (13th) month after the Amendment #2 Effective Date. Thus, beginning on the first day of the thirteenth (13th) month after the Amendment #2 Effective Date and continuing for the remainder of the Term specified in Block 1.7 of Amendment #2, a research investigator will be added full-time, or 1.0 full-time equivalent (FTE) to serve as a research mentor to the NHH staff and Research Manager, to act as a liaison to trainees pursuing research opportunities at NHH, and to facilitate research projects at NHH

2.3.3.2. All psychiatrists shall provide services on a full-time basis, and limit their practice to treating NHH patients only.

2.3.3.3. Notwithstanding the above, psychiatrists serving under this contract may perform occasional outside practice duties, with the advance written approval of the Chief Medical Officer and the NHH CEO, but

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only if said duties do not, in the sole judgment of the NHH CEO, interfere with the psychiatrists' duties at the NHH.

2.3.3.4. For subsection 2.3.3.2., the term "full-time" shall mean that each psychiatrist shall be required to account, through appropriate record keeping as specified by NHH, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities, subject to the Contractor's normal and customary employee leave policies.

a. Said minimum hours must be satisfied through hours devoted to clinical activities onsite at NHH.

b. Psychiatrists may be permitted, subject to prior notice and the approval of both the Chief Medical Officer and the NHH CEO, to work up to a maximum of 4 hours per week devoted to educational or research activities so long as those activities further the mission and goals of NHH. Psychiatrists approved for such activities shall provide documentation to the Chief Medical Officer and the NHH CEO that time spent devoted to educational or research activities furthers the mission and goals of NHH.

2.3.3.5. Notwithstanding the foregoing allowance for educational or research activities specified in subsection 2.3.3.4.a., psychiatrists shall be physically present onsite at NHH not less than 36 hours per week, unless otherwise accommodated for through the Contractor's normal and customary employee leave policies.

2.3.4. Residents/Post Graduate Fellows Responsibilities

2.3.4.1. The responsibilities of all residents and postgraduate fellows (PGY) shall be outlined, monitored, and reviewed by the Chief Medical Officer or the Associate Medical Director, and the appropriate attending psychiatrist.

2.3.4.2. Responsibilities for Residents/Post Graduate Fellows shall involve the advancement of the clinical initiatives underway at NHH under the supervision of the Chief Medical Officer.

a. General Psychiatry Residents (PGY II and PGY IV) – The Contractor shall ensure that Residents are an integral part of the Contractor's ACGME approved psychiatric residency program. Additionally, the Contractor shall provide faculty oversight, clinical supervision, didactic education and appropriate research opportunities in the field of public psychiatry.

b. Child/Adolescent Fellows – The Contractor shall ensure that Fellows are an integral part of the Contractor's ACGME approved child/adolescent training program. The Contractor shall incorporate a full spectrum of child/adolescent coursework and clinical experience to facilitate the NHH rotation,

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emphasizing areas of child welfare, family intervention, wraparound services and the juvenile justice system. Fellows shall provide coverage for the entire calendar year.

c. Geropsychiatry Fellow – The Contractor shall ensure that the Fellow is an integral part of an ACGME approved fellowship program in geriatric psychiatry. Additionally, the Contractor shall provide faculty oversight, clinical supervision, didactic education and appropriate research opportunities in the care of the elderly.

2.3.5. Psychiatric Advanced Practice Registered Nurses (APRN) Responsibilities

2.3.5.1. Psychiatric Advanced Practice Registered Nurses shall provide clinical services in extended care and admissions areas with patients with severe mental illness and medical co-morbidity morbidity in accordance with the scope of practice described in RSA 326-B:11.

2.3.5.2. The responsibilities for Psychiatric APRNs shall include but not be limited to performing advanced assessments; diagnosing; prescribing; administering and developing treatment regimens; and providing consultation as appropriate.

2.3.5.3. APRNs shall independently prescribe, dispense, and distribute psychopharmacologic drugs within the formulary and act as treatment team leaders in accordance with State law and medical staff by-laws.

2.3.5.4. APRNs shall provide the same level of documentation as required of psychiatrists as outlined in subsection 2.3.3.1.

2.3.6. NHH Research Manager Responsibilities

2.3.6.1. The Research Manager working with the research psychiatrist (in years one (1) and two (2) and with the research investigator in years two (2) and three (3) shall be responsible for assisting in the development and management of all research at NHH. The Research Manager shall play a pivotal role in initiating and cultivating research that is efficient and responsive to the needs of the NHH CEO, psychiatrists, nursing staff, clinical investigators, administration, and patient community, and works with the Chief Medical Officer to market the research opportunities at NHH while tracking and reporting the growth and development of research activities.

2.3.6.2. The Research Manager shall develop policies and procedures to ensure that research endeavors function effectively and manages and trains support staff in studies as the research program continues to grow and develop.

2.3.6.3. The Research Manager shall serve as the primary contact for all incoming and proposed studies, assesses feasibility and potential use of resources and guides potential projects through the process from initial proposal to planning for staffing, finding resources, reviewing

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budgets, and providing guidance with hospital, state and federal regulations through to completion of the project.

2.3.7. After Hours Coverage

2.3.7.1. The Contractor shall provide on-call after-hours coverage, 24 hours per day, 7 days per week, year round. Coverage shall be provided by no less than one (1) full-time psychiatrist. Additional personnel who are provided for coverage may be either a psychiatrist or a Psychiatric Advanced Practice Registered Nurse. The coverage will be assigned in one-week increments in rotation among the full-time New Hampshire Hospital psychiatric staff. The after-hours coverage will include back-up to the psychiatry residents who provide in-house after-hours coverage and will cover in-house in the event that the assigned in-house physician is not able to provide the service.

2.3.7.2. The Contractor shall provide on-site after-hours coverage, 16 hours per day, Monday through Friday, and 24 hours per day on weekends and holidays, year round.

a. The on-site after-hours coverage on weekdays, weekends and holidays shall be provided by a physician or psychiatric advanced practice registered nurse who is certified or eligible for certification by the American Board of Psychiatry and Neurology, or, is in training in an accredited psychiatry residency program with at least three years of training experience, or is credentialed as a psychiatric APRN through the American Nurse Credentialing Center or equivalent credentialing body.

b. The Contractor shall maintain a pool of psychiatric physicians or resident physicians or psychiatric APRNs, or a combination thereof, who are credentialed with New Hampshire Hospital for the after-hours work, and the after-hours physicians will be assigned to in-house after-hours coverage by the Chief Medical Officer or Associate Medical Officer with a six (6) month rolling calendar. The pool shall be of sufficient size and appropriate qualifications to ensure the Contractor's ability to meet 100% staffing level requirements and performance standards specified herein at section 4. Performance Standards and Outcomes.

2.3.8. Applied Clinical Research

2.3.8.1. The Contractor, working jointly with DHHS, shall identify and perform applied clinical research for the purpose of advancing the goals of the public mental health services system. All clinical research projects shall be approved by DHHS in advance. This shall include assessing the system's capacity, developing and/or refining clinical strategies, and training clinical staff in emerging treatment technology. The Contractor shall work jointly with DHHS to seek and obtain

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appropriate financial support (federal, State and foundation) to continue to build on the existing research projects. The Contractor shall, subject to DHHS approval, ensure that publication of the findings of this research shall receive the widest possible dissemination in the services delivery system in New Hampshire and through conferences and special reports nationally and internationally.

2.3.9. Additional Requirements

2.3.9.1. The Contractor shall provide clinical personnel to perform the services required for clinical, educational, research, and training programs at NHH. The Contractor shall provide psychiatrists and other clinical personnel with sufficient professional skills and qualifications to provide the educational and research services needed by NHH.

2.3.9.2. At the direction of the NHH CEO, Contractor staff may be assigned to conduct telepsychiatry or offsite consultation not arising from the clinical operation and administration of New Hampshire Hospital or any other public health or clinical service offered by the Department. Contractor staff assigned to telepsychiatry shall have professional malpractice insurance in effect in an amount satisfactory to the Department. The Contractor shall be responsible for ensuring that staff members have malpractice insurance in effect and in amounts satisfactory to DHHS.

2.4. Specific Service Requirements for Service Area #2 – Glencliff Home

2.4.1. General Requirements

2.4.1.1. The Contractor shall provide routine or emergency telephone consultation by the Medical Director (described below) or an equally qualified physician at no additional cost, twenty-four (24) hours per day, seven (7) days per week, fifty-two (52) weeks per year, to clinical and administrative staff at the Glencliff Home.

2.4.2. Medical Director Responsibilities

2.4.2.1. The Contractor shall provide a geropsychiatrist to serve as the Medical Director. The Medical Director shall be responsible for the following:

a. Coordination of all medical care and direct psychiatric services, treatment and associated follow up to all residents of Glencliff Home;

b. Provide administrative functions, including but not limited to policy review and establishment that reflect current standards of practice; oversight of physicians; attendance at mandatory committee meetings, including but not limited to continuous quality improvement, infection control, and admissions; regularly review the use of psychotropic medications for

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compliance with the Omnibus Budget Reconciliation Act (OBRA) regulations; and the provision of other assistance in meeting standards for annual State inspections and Federal regulations;

c. Deliver expert testimony in probate court as needed (e.g. guardianship cases, electroconvulsive therapy, do not resuscitate orders). Preparation may include consultation with legal counsel, records review, and travel;

d. Provide written patient evaluations on each patient as frequently as required by the Department but in no case less than once per calendar year;

e. Serve as liaison with other organizations, such as NHH or Dartmouth-Hitchcock Medical Center, when a Glencliff Home resident is receiving services at another healthcare institution; and

f. Provide the applicable services as described herein at subsection 2.3.3.1. and its subparagraphs.

2.5. Specific Service Requirements – Service Area #3 – Medicaid

2.5.1. Department of Health and Human Services Chief Medical Officer Responsibilities

2.5.1.1. The Contractor shall provide for the term of the contract, the full-time services of a designated physician, to serve as the Department's Chief Medical Officer.

2.5.1.2. For the Chief Medical Officer, the term "full-time" shall mean that the Chief Medical Officer shall be required to account, through appropriate record keeping as determined by DHHS, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities, subject to the Contractor's normal and customary employee leave policies.

2.5.1.3. The Chief Medical Officer shall maintain regular office hours consistent with DHHS' regular business hours for senior executive team members. The Contractor shall ensure that the Chief Medical Officer is provided a flexible work schedule that is consistent with the expectations of a senior executive manager at DHHS, subject to the approval of the DHHS Designee.

2.5.1.4. The Chief Medical Officer shall maintain his or her professional calendar electronically, in a format subject to DHHS approval, and make same available to the DHHS Designee as necessary. The Contractor shall ensure the calendar is kept up to date and includes approved leave time, conferences, trainings, etc.

2.5.1.5. The Contractor shall ensure that any out of state travel for

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conferences and/or trainings for the Chief Medical Officer shall be subject to the prior approval of the DHHS Designee.

2.5.1.6. The Chief Medical Officer's primary workspace shall be located in Concord, New Hampshire, in a DHHS designated facility. DHHS shall provide office space, furniture, a computer with access to DHHS shared network drives as necessary, the usual and customary office supplies, a cell phone for business use and administrative and clerical support. The Contractor shall ensure the Chief Medical Officer utilizes DHHS-provided information and technology resources consistent with applicable State policies.

2.5.1.7. The Chief Medical Officer shall plan and direct all aspects of DHHS' medical policies and programs to ensure the provision of integrated primary care services to individuals eligible for the Medicaid program, in collaboration with the DHHS Designee.

2.5.1.8. The responsibilities of the Chief Medical Officer shall include but not be limited to the following:

a. Developing strategic clinical relationships with physicians and in growing public/private partnerships with academic institutions and federal agencies with a focus on quality improvement and the implementation of federal health care reforms, such as but not limited to the Patient Protection Affordable Care Act (ACA), and any amendments thereto;

b. Overseeing the development of the clinical content in marketing and educational materials and ensures all clinical programs are in compliance with state and federal regulations;

c. Participating in the writing of research publications to support clinical service offerings;

d. Providing medical oversight of the state's publicly funded health insurance programs, making key policy decisions, and shaping administrative planning strategies to enhance the operating efficiency of Medicaid and CHIP and related healthcare initiatives across the state;

e. In collaboration with the DHHS Designee, directs the day-to-day operations of the DHHS program area responsible for clinical programs, benefit management, and quality improvement activities. Also serves as chief clinical liaison to other state program units, insurance providers, and professional organizations;

f. Serving as the clinical authority in reviewing and determining requests for covered and uncovered medical services and pharmacy services;

g. Participating in the development of procedural reimbursement

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policy;

h. Promoting and assures effective and efficient utilization of facilities and services using quality improvement methodologies. Oversees the development of a formal quality assurance and quality improvement function within the NH Medicaid program;

i. Identifying new developments and emerging trends in clinical practices and research that would have an impact on medical policy and/or costs, and recommends options and courses of action;

j. Within the context of implementation of federal health care reforms, such as but not limited to the Affordable Care Act and any amendments thereto, provides leadership in the planning, Medicaid program response, development of health care delivery systems, clinical quality initiatives, and related policy issues;

k. Representing the DHHS Designee at meetings and other events and serving as DHHS designee for any committees, boards, and commissions as requested;

l. Analyzing proposed and new federal legislation related to benefits management and recommends options and courses of action;

m. Maintaining and enforces policies, procedures, administrative rules, and State plan provisions that govern Medicaid medical benefits; and

n. Overseeing the implementation of contracted services, maintaining working relationships with contractors, managing contractor deliverables and services, and measuring contractor performance; and

o. Regularly attending Medicaid Management Team meetings.

2.5.1.9. Additionally, the Chief Medical Officer shall assist the DHHS Designee with managing the operations of the clinical and benefits management functions within the Medicaid program. This may include providing to the DHHS Designee input and making recommendations on staffing needs, performance standards, and other matters applicable to DHHS staff.

2.5.1.10. The Chief Medical Officer shall also provide executive team office coverage as needed and requested by the DHHS Designee.

2.6. Specific Service Requirements – Service Area #4 –

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Exhibit A Amendment #2

Children, Youth and Families

2.6.1. DCYF Staff Psychologist Responsibilities

2.6.1.1. The Contractor shall provide, for the term of the contract, the full-time services of a designated psychologist, who is a faculty member and/or employee of the Contractor, to provide psychological services to the programs within the Children, Youth and Families service area. For purposes of this paragraph, the term "full-time" shall mean that the staff Psychologist shall be required to account, through appropriate record-keeping as determined by the DHHS designee, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities, subject to the Contractor's normal and customary employee leave policies.

2.6.1.2. The staff psychologist is expected to work additional hours, including attending non-business hour meetings as required in order to meet the business needs of DHHS without additional cost to DHHS.

2.6.1.3. The staff psychologist shall maintain regular office hours consistent with those of DHHS senior executive team members.

2.6.1.4. The staff psychologist shall maintain his or her professional calendar electronically, in a form subject to DHHS approval, and make it available to the DHHS designee as necessary, and will keep it up to date to include leave time, conferences and trainings.

2.6.1.5. The Contractor shall ensure that the staff psychologist provided under this contract is subject to the Contractor's normal and customary employee benefits and policies, including leave provisions for a senior executive level position. However, the Contractor and DHHS agree that the continuous provision of services is essential, and in addition to any required approvals by the Contractor for its employees, the staff psychologist shall provide timely, prior notification to the designated DHHS representative of any leave time taken. Absences due to vacation and continuing education shall be planned in advanced, in consideration of the business needs of the DHHS designated program areas.

2.6.1.6. The Contractor shall ensure that any out of state travel for conferences and/or trainings for the staff psychologist shall be subject to the prior approval of the DHHS designee.

2.6.1.7. The Contractor shall ensure that any vacation or continuing education leave time by the staff psychologist shall be planned in advance and consider the business needs of DHHS, including ensuring appropriate coverage for any clinical and/or operational responsibilities or tasks that need oversight.

2.6.1.8. The staff psychologist's primary workspace shall be located in Manchester, New Hampshire, in a DHHS designated facility. DHHS shall provide office space, furniture, a computer with access to DHHS

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shared network drives as necessary, the usual and customary office supplies, a cell phone for business use and administrative and clerical support. The Contractor shall ensure the staff psychologist utilizes DHHS-provided information and technology resources consistent with applicable State policies

2.6.1.9. The Contractor shall work directly with the DHHS designee for the Sununu Youth Services Center (SYSC), and shall ensure the following services are provided by the staff psychologist under the contract:

a. Provide treatment planning oversight, clinical consultations, and assessments to treatment coordinators and Juvenile Probation and Parole Officers. Documents the number of treatment team meetings and clinical consultations attended annually with multi-disciplinary team members at SYSC;

b. Provides program development at SYSC, using a resiliency-building framework, and implementation of evidence-based practices to include interpersonal problem-solving skills, trauma-focused cognitive behavioral therapy, and dialectical behavioral therapy. Documents specific types and numbers of evidence-based treatment interventions implemented annually at SYSC;

c. Oversees implementation of research initiatives on the effectiveness and outcomes of services and programs within and for JJS;

d. Fosters improved interagency collaboration between JJS services, the area mental health agencies, and NHH to enhance mental health services for adjudicated youths, and to improve transitional processes between residential and community-based programs for court-involved youths. Documents the number of youths consulted on annually by Juvenile Probation and Parole Officers and interagency collaborative teams.

2.6.2. DCYF Staff Psychiatrist Responsibilities

2.6.2.1. The Contractor shall provide the services of a designated psychiatrist, for no less than .25 FTE, who is a faculty member and/or employee of the Contractor, to provide psychiatric services to the programs within the Children, Youth and Families service area. For purposes of this paragraph, the term ".25 FTE" shall mean that the staff psychiatrist shall be required to account, through appropriate record-keeping as determined by the DHHS designee, for a minimum of 10 hours of work per week devoted to his or her psychiatric service duties and responsibilities pursuant to this section, subject to the Contractor's

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normal and customary employee leave policies.

2.6.2.2. Psychiatric services shall include, but are not limited to:

a. Medical and psychiatric services at SYSC.

b. Documenting the number of comprehensive psychiatric evaluations and units of psychiatric services provided annually in direct care to youths in SYSC and the Juvenile Justice System.

c. Clinical supervision and teaching of child psychiatry residents and fellows at SYSC.

d. Teaching and supervision contacts with interns, residents, and fellows at SYSC

2.6.3. Psychiatric Consultant

2.6.3.1. The Contractor shall, provide the services of a designated psychiatrist, who is a faculty member and/or employee of the Contractor, to provide psychiatric consultation services to the programs within the Children, Youth and Families service area. This position shall be a .25 Full-Time Equivalent.

2.6.3.2. The Contractor shall ensure that the psychiatric consultant provides consultation to the Department on psychotropic medication prescriptions for youth who are in out-of-home care at a location other than SYSC. This consultation will typically include a review of the psychotropic medication prescriptions for identified youth and peer-to-peer consultation with prescribers to help ensure the appropriate utilization of psychotropic medications.

2.6.3.3. Notwithstanding the foregoing, the State acknowledges and agrees that the consultation services provided pursuant to this Section 2.6.3 may be limited in scope and nature due to the staffing of this position as a 0.25 Full-Time Equivalent (FTE).

2.7. Specific Service Requirements – Service Area #5 – Behavioral Health

2.7.1. Medical Director Responsibilities

2.7.1.1. The Contractor shall provide a part-time Medical Director and the necessary personnel to fulfill four major service components, in addition to a time study requirement in the area of behavioral health

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services. The four components are:

a. Medical Director for the Behavioral Health program;

b. Evidence-Based Practices Training and Consultation;

c. Behavioral Health Policy Institute (BHPI); and

d. Committee for the Protection of Human Subjects (CPHS).

2.7.1.2. The Medical Director shall be available on-site, at a DHHS designated location, for twenty (20) hours per week to provide services to the Behavioral Health service area. The Medical Director shall be available via telephone, email, and in person by appointment during that time.

2.7.1.3. The Medical Director shall, in collaboration with the DHHS designee be responsible for the following:

a. Meet weekly with the DHHS designee;

b. Address Behavioral Health clinical issues;

c. Review and inform Behavioral Health policy issues;

d. Enhance housing support capacity planning;

e. Review and inform Medicaid and state rule issues;

f. Assist in developing Telemedicine capacity;

g. Utilizes electronic medical records;

h. Coordinate between NHH and CMHC care;

i. Oversite and consultation of Evidence Based Practices (EBP) implementation;

j. Develop funding and reimbursement strategies;

k. Review and inform the sustainability of behavior change programs.

l. Assess the needs of patients in NHH and Transitional Housing Services who might be served in the community; and

m. Attend meetings between the Behavioral Health program and various community stakeholder groups, such as the Community Behavioral Health Association and the Disabilities Rights Center, to communicate about and also garner support for and input regarding Behavioral Health initiatives.

n. Serve as the Lead Manager for the ProHealth integration grant, working in collaboration with DHHS and identified programs to implement grant deliverables.

2.7.1.4. The Medical Director shall fulfill the additional following responsibilities:

a. Participate on key departmental and legislative committees, as

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required by DHHS, including the Mental Health Commission, the Mental Health Council, the Drug Utilization and Review Board, and the DHHS Institutional Review Board;

b. Serve as secretary for the Mental Health Council, to ensure that the work of the council supports the goals of DHHS;

c. Serve as a member of the Drug Utilization and Review Board to ensure that the Medicaid Preferred Drug List and work of the Board addresses the needs of consumers with mental illness disabilities;

d. Attend regular case conferences and sentinel event reviews. Analyze challenging clinical cases or events and recommend improvements in policy or services to address problem areas;

e. Attend monthly Institutional Review Board meetings, review research protocols as needed each month to ensure safety of DHHS research participants;

f. Participate on several Behavioral Health System Transformation Workgroups, including the EBP Steering Committee, Programmatic Workgroup, and Quality Assurance Group;

g. Coordinate and meet with DHHS leadership as required by DHHS;

h. Conduct monthly or more frequent Behavioral Health Medical Director's meeting to coordinate efforts, between Behavioral Health and CMHCs, regarding medical/treatment issues related to both hospital and outpatient care of people with serious mental illness and to consult on other relevant issues or concerns, including: preferred drug list issues, coordination with NHH admissions and treatment, Medicaid interruption during institutionalization, enhancement of community housing supports, use of information technology, medical director administrative issues, use of best practices, implementation of EBP's, documentation burden, integration of mental and physical health care, smoking cessation, coordinating local, state and national agendas regarding public mental health care, electronic health records, health information exchange, education and training for CMHC prescribers regarding evidence-based use of antipsychotic medications and monitoring for cardio metabolic side effects;

i. Monitor the effectiveness of the preferred drug list in enhancing cost effective and safe psychotropic medication prescribing in NH including engaging in ongoing discussions with CMHC leaders regarding the Preferred Drug List and direct education and training for CMHC prescribers regarding evidence-based

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use of antipsychotic medications and monitoring for cardio metabolic side effects;

j. Communicate regularly with, and provide clinical consultation (including potential site visits, conference calls, and written reports) to all Behavioral Health management staff regarding current, challenging clinical issues, including conditional discharges, Medicaid consumer cases, and suicide monitoring;

k. Collaborate with the other DHHS Medical Directors, on a regular basis to monitor medical care and related patient care issues throughout New Hampshire, including drug choice for the Preferred Drug List, performance and impact of the Preferred Drug List on clinical care, Medicaid interruption during hospitalization and incarceration, integration of medical, mental health, and substance abuse services, and enhancement of addiction treatment capacity; and

l. Provide oversight and continuing implementation of Evidence Based Practices, including practices as part of the Medicaid Program for Community Mental Health Services as well as those practices specifically required in the Community Mental Health Agreement.

2.7.2. Evidence-Based Practices Training and Consultation

2.7.2.1. The Contractor shall provide Evidence-Based Practices Training and Consultation services as described in Appendix I, of RFP-2017-OCOM-01-PHYSI, for the purpose of sustaining and continuously improving the quality of three (3) Evidence-Based Practices (EBP) that are implemented across the New Hampshire Community Mental Health Centers (CMHC) system. The EBPs are Illness Management and Recovery (IMR), Evidence-Based Supported Employment (EBSE), and Assertive Community Treatment Teams (ACT). Additional EBPs may take the place of these based on the availability of federal funding to support the implementation of additional EBPs in New Hampshire.

2.7.2.2. The Contractor shall provide education, training, technical assistance and consultation to the DHHS Behavioral Health service area and the CMH Program and Providers. The deliverables described below shall be provided directly to DHHS-designated Behavioral Health program staff and CMH staff designated by DHHS.

2.7.2.3. DHHS shall designate a specific DHHS Behavioral Health staff member to oversee the deliverables specified herein. The Contractor shall designate a specific representative of the Contractor to work directly with the DHHS designee in the fulfillment of these deliverables.

2.7.2.4. **Training the CMH Workforce**: To sustain and improve the quality of

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IMR, EBSE, and ACT services, the Contractor shall provide education and training to DHHS designated CMH staff. The contractor shall provide a total of 18 days of training, but schedules and requirements for each EBP as outlined below may be adjusted upon mutual agreement between the DHHS and Contractor in order to meet the needs of the CHM staff.

a. The Contractor shall ensure that the training and education is provided in central locations and in a manner that best facilitates the learning of key skills and strategies that are necessary to provide IMR, EBSE, and ACT in ways that support the most effective outcomes for consumers at each of the CMHCs. The training shall be designed to fulfill the specifications described in He-M 426 for CMHC programs of EBPs in NH.

b. Each training event shall include, at a minimum:

Invitations provided to CMHC staff before the training event;

A description of who should attend the training;

Outcomes for participants attending the training;

Sufficient time to provide instruction and practice for skills;

Content designed to improve the fidelity of the practice at CMHC's;

Documentation of all participants attending the training; and

Certificates of attendance for all participants completing the training.

c. Each training event shall be staffed by Contractor staff or other qualified professionals; such individuals shall be subject to approval of the DHHS designee.

2.7.2.5. **Illness Management and Recovery (IMR):** The Contractor shall develop, in collaboration with the DHHS designee, specific topic areas for CMH staff providing IMR services. The topic areas shall be subject to the DHHS designee's approval.

a. The Contractor shall provide the IMR trainings in the following formats:

No less than fifteen (15) hours of training, to be presented in one (1) or two (2) training sessions, for new IMR practitioners to fulfill the specifications described in He-M 426 to provide IMR services. The capacity for each of these training events shall be twenty participants and up to thirty participants depending on the availability of the training space;

No less than fifteen (15) hours of training, to be presented

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in two (2) to six (6) training sessions, for experienced IMR practitioners, of which the combination of attending any two of these events shall fulfill the specifications described in He-M 426 for ongoing providers of IMR services. The capacity for each of these training events shall be at least twenty participants and up to thirty participants depending on the availability of the training space.

No less than eight (8) hours of training, to be presented in one (1) or two (2) training sessions, for IMR supervisors that shall fulfill the specifications in He-M 426 for ongoing providers of IMR services. The content shall include information on supporting the learning of IMR skills for colleagues and improving the quality and outcomes of IMR services through practice-specific supervision. The capacity for this training event shall be twenty participants.

2.7.2.6. **Evidence Based Supported Employment (EBSE):** The Contractor shall develop, in collaboration with the DHHS designee, specific topic areas for CMH staff providing EBSE services. The topic areas shall be subject to the DHHS designee's approval.

a. The Contractor shall provide the EBSE trainings in the following formats:

No less than thirty (30) hours of training, to be presented in full-day training sessions, for new EBSE practitioners, to fulfill the specifications described in He-M 426 to provide EBSE services. The capacity for each of these training events shall be twenty participants.

No less than eight (8) hours of training, to be presented in one (1) or two (2) training sessions for experienced EBSE practitioners, the combination of attending these two events shall fulfill the specifications described in He-M 426 for ongoing providers of EBSE services. The capacity for each of these training events shall be twenty participants.

No less than eight (8) hours of training, to be presented in one (1) or two (2) training sessions for experienced EBSE practitioners and EBSE supervisors. The combination of attending these two events shall fulfill the specifications described in He-M 426 for ongoing providers of EBSE services. The content shall include information on developing and improving collaboration with the New Hampshire Department of Vocational Rehabilitation and other important community partners in providing effective EBSE services. The capacity for each of these training

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events will be twenty participants.

2.7.2.7. **Assertive Community Treatment Teams (ACT):** The Contractor shall develop, in collaboration with the DHHS designee, specific topic areas for CMH Program staff providing ACT services. The topic areas shall be subject to the DHHS designee's approval.

a. The Contractor shall provide the ACT trainings in the following formats:

No less than thirty (30) hours of training, to be presented in full-day training sessions for new ACT practitioners, to fulfill the specifications described in He-M 426 to provide EBSE services. The capacity for each of these training events shall be twenty participants.

No less than eight (8) hours of training, to be presented in one (1) or two (2) training sessions for experienced ACT practitioners, the combination of attending these two events shall fulfill the specifications described in He-M 426 for ongoing providers of ACT services. The capacity for each of these training events shall be twenty participants.

No less than eight (8) hours of training, to be presented in one (1) or two (2) training sessions for experienced ACT practitioners and ACT supervisors. The combination of attending these two events shall fulfill the specifications described in He-M 426 for ongoing providers of ACT services. The capacity for each of these training events will be twenty participants.

2.7.2.8. **Assessing Fidelity to Evidence Based Practices (EBPs):** The Contractor shall assess the fidelity (organizational faithfulness to the principles of the practice) of ACT and EBSE for all CMH Programs, as designated by the DHHS designee.

a. Fidelity assessments shall be conducted for the purpose of monitoring the implementation of ACT and EBSE and for providing information about the capacity, strengths and areas in need of improvement in providing the practice at the designated CMH programs.

b. The Contractor shall develop, in collaboration with the DHHS designee, a specific schedule designating specific time periods for each CMH program, ACT and EBSE fidelity or QIP review. The schedule shall be subject to the advanced approval of the DHHS designee.

c. The Contractor shall ensure that each fidelity assessment includes, at a minimum:

Written instructions to the CMH program regarding

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necessary observations, interviews, data access and other activities for the assessment.

A description of CMH program staff, other community providers, consumers and family members who will need to be interviewed for the assessment.

A specific written assessment schedule jointly developed by the Contractor and the CMH program.

Sufficient time to assess and evaluate the CMH program's delivery of ACT or EBSE.

A debriefing at the end of the assessment to review themes from the review with CMH program leadership.

Documentation of the assessment process, findings and scoring of fidelity items for CMH program leadership and the Department no later than four weeks following the assessment.

2.7.2.9. **Consultation to CMH Program Leadership and Workforce Development**: The Contractor shall provide agency-based consultations to all CMH programs as designated by the DHHS designee to assist agencies in sustaining and providing continuous quality improvement for IMR, ACT and EBSE services. The Contractor shall ensure that CMH program leadership has access to consultations at their agencies after they have received the written documentation of the findings of each fidelity assessment described herein at subsection 2.7.2.8. Consultations shall include the development of ideas, strategies and interventions that each individual CMH program may utilize to most effectively sustain and improve IMR, ACT and EBSE services.

a. In cases where CMH programs would benefit from specific agency-based workforce development interventions from the Contractor's staff, the Contractor shall ensure that such further interventions are provided only when collaboratively agreed upon by the DHHS designee, the Contractor and CMH program leadership. These interventions shall be time-limited (customarily one half-day, single events) and specifically tailored to improving designated fidelity areas that are identified as a result of agency-based post fidelity consultations.

2.7.2.10. **NH Behavioral Health Service Area Consultations and Collaboration**: In order to most effectively fulfill the deliverables described in this document for the purposes of sustaining and improving the quality of IMR, ACT and EBSE services in the NH Community Mental Health system, the Contractor shall work in a highly integrated fashion with the DHHS designee and additional DHHS Behavioral Health resources identified by the DHHS designee. This integrated alliance shall also be extended to other state and

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community agencies as collaboratively agreed upon by the DHHS designee and the Contractor.

a. In addition to attending designated meeting or events, the Contractor shall prepare research information, specific ideas, interventions, feedback, data and strategies, as collaboratively agreed upon by the DHHS designee and the Contractor. Specific activities for consultation and collaboration shall include:

The Contractor's attendance at the State EBP advisory committee bi-monthly meetings by the Contractor and/or designees;

The Contractor's attendance at weekly meetings with the DHHS designee;

Attendance of Contractor staff at monthly meetings with the DHHS designee and any additional DHHS Behavioral Health resources identified by the DHHS designee;

The Contractor's attendance at quarterly meetings with the DHHS designee, and any additional DHHS Behavioral Health resources identified by the DHHS designee, to review progress of these deliverables and make any necessary resource allocations within the scope based; as collaboratively agreed upon by the DHHS designee and the Contractor;

The Contractor's attendance at DHHS designated meetings with NH Bureau of Vocational Rehabilitation (NHBVR) personnel to improve collaboration between EBSE services and NHBVR at both state-wide and regional levels to better assist CMHC consumers in achieving their vocational goals;

The Contractor's attendance at DHHS designated meetings with Granite State Employment Project (Medicaid Infrastructure Grant) personnel to improve collaboration between EBSE services and the Granite State Employment Project at both state-wide and regional levels to better assist CMHC consumers in achieving their vocational goals;

The Contractor's attendance at DHHS designated meetings with DHHS Behavioral Health personnel regarding Behavioral Health strategies and interventions, including proposed rule or policy and procedure changes, to better facilitate the sustaining and improvement of IMR, ACT and EBSE services in the NH Community Mental Health

system;

The Contractor's attendance at designated meetings with key CMHC personnel, including monthly meetings of CMHC Community Support Program directors, regarding the Contractor's activities and to better facilitate the sustaining and improvement of IMR, ACT and EBSE services; and

The Contractor's attendance at other events, as collaboratively agreed upon by the DHHS designee and the Contractor, for the purposes of sustaining and improving the quality of IMR, ACT and EBSE services.

2.7.3. Behavioral Health Policy Institute (BHPI)

2.7.3.1. Under the direction of the DHHS designee and the Behavioral Health Medical Director providing services to the Behavioral Health program, the Contractor shall conduct periodic analyses, the frequency of which shall be determined by DHHS, of Medicaid claims to address policy issues and questions under consideration from the Behavioral Health program. The Contractor shall participate in regular meetings with the DHHS designee and the Behavioral Health Medical Director to review these analyses, and associated policy implications.

2.7.4. Committee for the Protection of Human Services (CPHS)

2.7.4.1. The Contractor shall achieve the following CPHS related deliverables for the purpose of sustaining and supporting a committee to oversee research funded by federal agencies and other non-state sources, and conducted in New Hampshire DHHS-funded programs that serve people with mental illness, developmental disabilities, and substance abuse or dependence disorders, in fulfillment of NH RSA 171-A:19-a. Because of federal regulations governing the composition and operation of such committees, a certain number of scientific experts must be present on the committee. The Contractor shall provide research, scientific and human subject's expertise to the CPHS under the contract.

2.7.4.2. The Contractor shall provide staff to support the CPHS who shall:

a. Attend and fully participate in CPHS full committee meetings (once per month);

b. Conduct expedited reviews as requested by the CPHS Administrator (averaging about three per month);

c. Provide consultation, support, and guidance to the CPHS Administrator, Chairperson, and Committee members regarding the interpretation of federal regulations and human subject's protections (e.g., pre-reviewing materials, reviewing requirements for exempt and expedited determinations,

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reviewing significant adverse event reports);

d. Serve on the Consent Form Template and Forms sub-committees, or others as requested by the CPHS Chairperson; and

e. Serve as the Co-Vice Chair to the CPHS.

2.7.4.3. Revision of the aforementioned deliverables may be done by mutual agreement of the Contractor and the DHHS designee. The availability of additional federal funds to support the implementation of additional Evidence Based Practices may also necessitate a renegotiation of priorities outlined in this deliverables plan, and a reallocation of the Contractor's time in order to assist with the construction of federal grant applications. Changes agreed upon may be subject to Governor and Executive Council approval.

2.7.5. Time Studies

2.7.5.1. The Contractor shall be responsible for performing regular time studies in accordance with CMS and DHHS Medicaid Cost Allocation procedures in order to document activities, relating directly to the administration of the Medicaid program, to draw down federal matching revenues, which will be utilized to support costs associated with the Behavioral Health Medical Director's salary, benefits, and indirect expenses. These studies shall be provided in and documented in a format approved by DHHS.

2.8. Specific Service Requirements – Service Area #6 – Elderly and Adult Services

2.8.1. Medical Director Responsibilities

2.8.1.1. The Contractor shall provide a part-time Medical Director (.125 FTE) to the Elderly and Adult Services service area. The Medical Director, subject to the FTE allotment, shall provide services for the purposes of consultation and improving the quality of services for older adults and adults with disabilities in NH.

2.8.1.2. The Medical Director shall:

a. Provide consultation and direction of the organization's clinical components to policies and procedures and administrative rules;

b. Serve as a technical advisor for wellness and prevention initiatives to improve the lives of individuals served by Elderly and Adult Services service area;

c. Perform medical consultation, clinical oversight and authority and guide education instruction, within the Elderly and Adult Services service area;

d. Provide guidance and consultation regarding new

developments and emerging trends in clinical practice, research and best practices that would have an impact on service development, service delivery and clinical policy and practice;

e. When requested, participate in the quality initiative, Sentinel Event Reviews and other case consultation and case review convening's as requested;

f. Meet bi-monthly with DHHS designee to review initiatives and check in on consultation services.

2.9. Specific Service Requirements – Service Area #7 – Developmental Services

2.9.1. Medical Director Responsibilities

2.9.1.1. The Contractor shall provide a part-time Medical Director to the Developmental Services service area. The Medical Director shall provide services that includes two days of psychiatric consultation services per week, and is allocated at 0.4 Full-Time Equivalent.

2.9.1.2. The Medical Director must dedicate two (2) days each week to the activities described below:

a. Referrals from the ten (10) Area Agencies, and referrals from Special Medical Services (SMS). These referrals must be prioritized over all other duties, and may include performing evaluations, consultations, and medication reviews by the Medical Director.

b. Based on He-M 1201, the Medical Director will facilitate Developmental Services' Medication Committee meetings as chairperson, and provide will provide expert opinion and leadership to ensure that the committee functions effectively.

c. Assistance for the DHHS Developmental Services staff in addressing medical issues related to quality assurance activities or Sentinel Event Reviews.

d. Educational training to DHHS Developmental Services staff, Area Agencies, and subcontract agencies and other stakeholders, as identified and directed by Developmental Services.

e. Providing expertise and assistance in efforts to improve New Hampshire's developmental services system.

2.9.2. Developmental Services Interdisciplinary Clinic Team

2.9.2.1. The Contractor shall provide an interdisciplinary clinic team for children and adults. The Contractor shall provide the following staffing and fulfill the following responsibilities for the Interdisciplinary Clinic.

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Team for Adults:

a. **Psychiatrist (Child Psychiatrist if applicable)** – the psychiatrist shall serve as the clinic director, coordinating the team / providers involved in this clinic. The psychiatrist shall conduct a comprehensive psychiatric examination; including reviewing the client's entire past psychiatric treatment and medical history. The psychiatrist shall make recommendations as part of the comprehensive report regarding evidence based treatment for optimal care for each client;

b. **Neuropsychologist** – the neuropsychologist shall review all past psychiatric, medical records, neuropsychological testing and behavioral incidents. The neuropsychologist shall document their recommendations as part of the comprehensive report. The neuropsychologist shall supervise the neuropsychology fellow and shall oversee the documentation of historical information regarding the client;

c. **Neuropsychology fellow** – the neuropsychology fellow shall review all past medical, past psychiatric records, neuropsychological testing, behavioral incidents and document pertinent historical information regarding each person as part of the comprehensive report;

d. **Neurologist** – the neurologist shall review past medical records, conduct a physical examination, and document their findings and recommendations as part of the comprehensive report;

e. **Primary Care Physician** – the primary care physician shall review past medical records, conduct a physical examination, and document their findings and recommendations as part of the comprehensive report;

f. **Occupational Therapist** – the occupational therapist shall review past medical records, conduct an occupational therapy evaluation, document their findings and recommendations as part of the comprehensive report; and

g. **Administrative Support** – the administrative support will schedule the appointment, review received documents and checklist of requested documents, copy records for providers and fax completed reports.

2.9.2.2. The interdisciplinary clinic team for shall provide the following services:

a. The Contractor shall ensure the team accepts children and adults being referred from the Area Agencies. Should the number of referrals exceed the number of clients able to be seen, then the Contractor shall prioritize clients based on the

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most immediate need and critical situation;

b. The Contractor shall support the goal of the interdisciplinary clinic team by providing high quality interdisciplinary evaluations to children and adults with developmental disabilities and acquired brain injuries. The Contractor shall provide a comprehensive understanding of the client with a focus on a biological, psychological, social/environmental approach and the interaction of these factors as they relate to the clients' strengths, skills, and interests. The Contractor shall generate one comprehensive report with recommendations that can be utilized by the Systemic – Therapeutic – Assessment – Resources – and Treatment (START) Coordinators, Area Agencies, service providers and medical providers to provide the best quality of care for each person. The Contractor shall serve as one point of access to a team of expert providers which will reduce each client's number of medical appointments and reduce each client's need to travel to multiple appointments.

c. The Contractor shall convene the interdisciplinary clinic team one time per month and shall conduct a face-to-face appointment with two clients per month, for a total of twenty-four (24) clients per year. The interdisciplinary clinic team meetings and face-to-face client appointments shall take place at a location designated by DHHS. The Contractor shall review all previous records of each client prior to each face-to-face appointment. The Contractor's interdisciplinary clinic team of providers shall meet with the client and the client's team of caregivers as part of the evaluation to obtain history / concerns and examine the client. After meeting and examining the client, the Interdisciplinary Clinic Team shall meet to discuss recommendations. The interdisciplinary clinic team shall generate a comprehensive report regarding the visit and recommendations. The report shall be made available within 15 business days from the date of the last meeting of the interdisciplinary clinic team.

d. The Contractor shall have the client or the client's authorized representative sign a release form identifying the parties to whom the Contractor may distribute the comprehensive reports.

e. The Contractor shall submit encounter documentation as directed by the Department.

3. Staffing

3.1. General Requirements Applicable to All Service Areas:

3.1.1. The following requirements apply to all personnel provided under the

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contract:

3.1.1.1. The Contractor shall recruit and retain qualified individuals for the staffing needs specified herein at subsections 3.3 through 3.9, and as otherwise necessary to fulfill the requirements described herein at: Section 2, Scope of Services; Section 4, Performance Standards and Outcomes; and Section 5, Reporting.

3.1.1.2. All such individuals shall be subject to DHHS approval prior to the Contractor notifying candidates of assignment/hire to fulfill a specified staffing role. DHHS shall inform the Contractor of its applicable designee for this purpose per position or service area. The designee, at his or her discretion, shall be entitled to interview any such candidate; the Contractor shall facilitate coordinating such interviews upon the DHHS designee's request.

3.1.1.3. DHHS, at its sole discretion, may rescind, either permanently or temporarily, its approval of any Contractor personnel providing any services under this contract for any of the following reasons:

a. Suspension, revocation or other loss of a required license, certification or other contractual requirement to perform such services under the contract;

b. Providing unsatisfactory service based on malfeasance, misfeasance, insubordination or failure to satisfactorily provide required services;

c. Arrest or conviction of any felony, misdemeanor, or drug or alcohol related offense;

d. Abolition of the role due to a change in organizational structure, lack of sufficient funds or like reasons; or

e. Any other reason that includes, but is not limited to: misconduct, violation of DHHS policy, or violation of state or federal laws and regulations pertaining to the applicable DHHS service area, or a determination that the individual presents a risk to the health and safety of any staff member or any individual served by the Department.

In the event of such rescission, the Contractor's applicable staff member shall be prohibited from providing services under the contract for the period of time that DHHS exercises this right. In the event DHHS chooses to exercise this right, DHHS shall provide reasonable advance notice to the Contractor.

3.1.1.4. DHHS shall provide the Contractor with prior notice of exercising its right under subsection 3.1.1.3. and the reason for which DHHS has exercised its right. If DHHS removes Contractor personnel for any reason, no additional payments shall be paid by the State for any staff

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removed from duty by the Department

3.1.1.5. In the event that DHHS exercises its right under subsection 3.1.1.3.

a. The Contractor shall provide replacement personnel who shall meet all of the applicable requirements under the contract, including but not limited to being subject to the DHHS approval specified in 3.1.1.2.;

b. The Contractor shall be responsible for providing transition services to the applicable DHHS service area to avoid the interruption of services and administrative responsibilities at no additional cost to DHHS;

c. DHHS shall inform the Contractor of the anticipated duration for which approval will remain rescinded. If the position is assigned to NHH, and if the duration of a temporarily rescinded approval is greater than seven (7) calendar days, the Contractor shall furnish within ten (10) business days replacement Contractor staff who shall meet all of the requirements for the applicable position under the contract. The Contractor shall be responsible for providing, at no additional cost to the Department, transition services to NHH to avoid service interruption;

d. It shall be at the Contractor's sole discretion whether to initiate any internal personnel actions against its own employees. However, nothing herein shall prohibit the Contractor from seeking information from DHHS regarding DHHS' decision, unless such information is otherwise restricted from disclosure by DHHS based on internal DHHS policies or rules, State of New Hampshire personnel policies, rules, collective bargaining agreements, or other state or federal laws.

3.1.1.6. The Contractor shall ensure that, prior to providing the applicable services for the applicable DHHS service area or facility, all required licenses, certifications, privileges, or other specified minimum qualifications are met for all staff, and where applicable, are maintained throughout the provision of services for the full term of the contract. The Contractor shall provide the applicable DHHS designee with a copy of all such documents. The Contractor acknowledges and agrees that DHHS shall not be held financially liable for any fees or costs for any licenses, certifications or renewal of same, nor for any fees or costs incurred for providing copies of said licenses or certifications.

3.1.1.7. The Contractor shall ensure that all staff provided under this contract are subject to the Contractor's normal and customary employee benefits and policies, including leave provisions. However, whereas the Contractor and DHHS agree that the continuity of operations and continuous provision of the staffing described in this contract is of

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paramount importance to the State, in addition to any required approvals by the Contractor for its employees, Contractor staff providing services shall provide timely, prior notification to the applicable DHHS designee for any anticipated leave time, unless otherwise stated herein for a specific position or service area. All positions allocated in this contract are to be 100% filled or in active recruitment. In the event that a position remains vacant (due to the need to fill the position or recruit for the position) for more than 30 days, the contractor shall reduce the monthly invoice by amount budgeted for that position until the position is filled. The Contractor shall provide DHHS with monthly updates on the recruitment process for all unfilled positions.

3.1.1.8. All personnel provided by the Contractor shall be subject to the identified criminal background, registry, screening and medical examinations, as specified in the table below, for the applicable Service Area to which the individual is assigned contractual service responsibilities. The Contractor shall ensure the successful completion of these requirements for each individual assigned by the Contractor to perform contractual services prior to commencing work and shall ensure that such requirements are kept up to date as required; the Department shall receive copies of all documentation prior to the commencement of services and shall not be responsible for any costs incurred in obtaining the documentation described below:

Service Area		Required Background, Registry, Screening, and Medical Examinations
1	New Hampshire Hospital	Criminal Background, BEAS State Registry, DCYF Central Registry, Health Assessment (including TB testing and physical capacity examination).
2	Glencliff Home	Criminal Background (including RSO and OIG), BEAS State Registry, DCYF Central Registry, TB Testing
3	Medicaid Program	Criminal Background, BEAS State Registry, DCYF Central Registry
4	Children, Youth & Families	Criminal Background, DCYF Central Registry, TB Testing
5	Behavioral Health	Criminal Background, BEAS State Registry, DCYF Central Registry
6	Elderly and Adult Services	Criminal Background, BEAS State Registry
7	Developmental Services	Criminal Background, BEAS State Registry, DCYF Central Registry

3.2. General Staffing Requirements Applicable to Service Area

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#1 – New Hampshire Hospital

3.2.1. The following additional requirements shall apply specifically to personnel provided to fulfill the contractual requirements applicable to Service Area #1 – NHH, for the duration of the contract:

3.2.1.1. The Contractor shall ensure that the Chief Medical Officer actively participates in the recruitment of all other staffing needs required under the contract for the provision of services at NHH.

3.2.1.2. The Contractor shall ensure that, prior to commencing practice at NHH, all psychiatrists are licensed to practice medicine in the State of New Hampshire, as well as boarded in their particular specialty or are board eligible, and shall commence the privileging process of the Medical Staff Organization of NHH as authorized by its by-laws. Such licenses and clinical privileges must be maintained throughout the term of the contract.

3.2.1.3. The Contractor shall ensure that all clinical personnel maintain appropriate licensure/certification relevant to the practice of their clinical disciplines.

3.2.1.4. DHHS reserves the right to jointly, with the Contractor, or separately, interview, research or otherwise screen and consider candidates the Contractor designates for the Chief Medical Officer role.

3.2.1.5. In addition to the provisions stated herein at subsection 3.1.1.7., staff providing services to NHH shall provide timely, prior notification to the Chief Medical Officer and the NHH CEO for any anticipated leave time. The Contractor shall be solely responsible for providing, at no additional cost to DHHS, qualified, sufficient staff coverage to fill any gap in coverage during any anticipated leave time, including sick leave, lasting more than three (3) consecutive days unless otherwise agreed upon by the NHH CEO on a case-by-case basis, and for providing appropriate transition between staff members covering for those on leave. Qualified sufficient staff coverage shall mean personnel who meet or exceed the qualifications of the vacating staff member.

3.2.1.6. The Contractor acknowledges and understands that DHHS' expectation is that staffing will be at a level that ensures no impact on the number of NHH beds available, and that NHH units will not stop admissions due to the lack of coverage for Contractor staff. All positions allocated in this contract are to be 100% filled or in active recruitment. In the event that a position remains vacant (due to the need to fill the position or recruit for the position) for more than 30 days, the contractor shall reduce the monthly invoice by amount budgeted for that position until the position is filled. The Contractor shall provide DHHS with monthly updates on the recruitment process

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for all unfilled positions.

3.2.2. DHHS reserves the right, through its NHH CEO, or other designee in the absence of the NHH CEO or a vacancy in that position, at its sole discretion to rescind, either temporarily or permanently, its approval of any Contractor staff member providing services at NHH for any of the following reasons:

3.2.2.1. Loss of medical staff privileges at NHH pursuant to medical staff by-laws;

3.2.2.2. Revocation or suspension of the Chief Medical Officer's New Hampshire medical license;

3.2.2.3. Arrest or conviction of a felony, misdemeanor or drug or alcohol related offense; or

3.2.2.4. Any other reason, which includes, but is not limited to: misconduct, violation of NHH or DHHS policy or state or federal laws or regulations, malfeasance, unsatisfactory work performance, or a determination that the individual presents a risk to the health and safety of any staff member or any individual served by the Department.

3.2.3. Should DHHS exercise this right, the applicable staff member shall be prohibited from providing services under the contract for any period of time DHHS chooses.

3.2.4. If the NHH CEO removes Contractor staff assigned to this service area, including the Chief Medical Officer, for any reason, the Contractor shall not be entitled to payment for the staff member during the period of removal.

3.2.5. If approval of the Chief Medical Officer is temporarily rescinded, pursuant to subsection 3.1.1.3., the Contractor shall furnish within ten (10) business days a psychiatrist to serve full-time as interim NHH Chief Medical Officer, until such time as the existing Chief Medical Officer either resumes duty full-time or is replaced by a new Chief Medical Officer. The interim Chief Medical Officer shall meet all of the requirements for the Chief Medical Officer as set forth under the contract. The Contractor shall be responsible for providing transition services to NHH, at no additional cost, to avoid the interruption of services and administrative responsibilities.

3.2.6. DHHS shall provide Contractor staff at NHH with adequate facilities and DHHS-employed administrative support staff. Facilities shall include, but not be limited to, office space, equipment, and furnishings. Sufficient space to accomplish educational, training, and research missions shall also be made available. Administrative support staff shall include, but not be limited to, secretarial assistance, including one full-time executive secretary to support the Chief Medical Officer.

3.2.7. The Contractor, the Chief Medical Officer and all other clinical staff

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provided by the Contractor shall execute their responsibilities pursuant to this contract consistent with RSA Chapter 135-C, any applicable administrative rules, the by-laws of the NHH's Medical Staff Organization, The Joint Commission (TJC), Centers for Medicare and Medicaid Services (CMS), and in accordance with generally accepted medical standards and practices.

3.3. Specific Staffing Requirements – Service Area #1 – New Hampshire Hospital

3.3.1. Chief Medical Officer

3.3.1.1. The Contractor shall provide for the term of the contract, the full-time services of a qualified physician to serve as the Chief Medical Officer for NHH. The Chief Medical Officer shall possess the following qualifications and meet the following requirements:

a. The Chief Medical Officer shall be a Board Certified Psychiatrist licensed to practice in the State of New Hampshire. The Chief Medical Officer shall, at all times, maintain both a license to practice medicine in the State of New Hampshire and clinical privileges at NHH.

b. The Chief Medical Officer shall be a senior administrative psychiatrist having a minimum of five (5) years of experience in a position of clinical leadership for a major public sector program, psychiatric hospital, governmental authority, state or national medical/psychiatric society organization involved in the delivery of public sector psychiatric services. The Chief Medical Officer shall have completed an ACGME approved residency program with board certification in Psychiatry by the American Board of Psychiatry and Neurology. Additional subspecialty certification in forensic, geriatric or child/adolescent psychiatry may be substituted for 2 years of administrative leadership. Completion of a graduate curriculum in medical administration preferred.

c. For purposes of this paragraph, the term "full-time" shall mean that the Chief Medical Officer shall be required to account, through appropriate record-keeping as determined by NHH, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities pursuant to the contract, subject to the Contractor's normal and customary employee leave policies. Said minimum hours must be satisfied through hours devoted to clinical activities onsite at NHH.

3.3.1.2. The Chief Medical Officer may be permitted with prior notice and approval of the NHH CEO to work up to a maximum of 4 hours per week devoted to educational or research activities so long as those activities further the mission and goals of NHH. The Chief Medical Officer shall be responsible for providing documentation to the NHH

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CEO that time spent devoted to educational or research activities furthers the mission and goals of NHH.

3.3.1.3. Notwithstanding the foregoing allowance for educational or research activities, the Chief Medical Officer shall be physically present onsite at NHH not less than 36 hours per week. The Chief Medical Officer shall also participate with staff psychiatrists in on call, after-hours coverage above the 40-hour week to ensure a 24-hour a day, 7 day per week provision of Psychiatrist-On-Call services without additional compensation to the Contractor or the Chief Medical Officer.

3.3.1.4. In the event the Chief Medical Officer resigns, or is otherwise removed from providing services to NHH under this contract, the Contractor shall furnish within ten (10) business days, not including holidays, a psychiatrist to serve full-time as interim NHH Chief Medical Officer, until such time as the existing Chief Medical Officer either resumes duty full-time or is replaced by a new Chief Medical Officer. The interim Chief Medical Officer shall meet all of the requirements for the Chief Medical Officer as set forth under the contract. The Contractor shall be responsible for providing transition services to NHH, at no additional cost, to avoid the interruption of services and administrative responsibilities.

3.3.1.5. The Chief Medical Officer shall demonstrate:

a. Clear success in the fields of clinical psychiatry and psychiatric education at the graduate or undergraduate level;

b. Development of innovative clinical programs specific to the needs of the severely and persistently mentally ill, (SPMI) population;

c. Successful collaboration with state government leadership in the areas of program planning, budget, personnel policies, staffing levels, and the legislative process;

d. Cooperation with consumer organizations; and

e. Competence in program evaluation and evidence based outcomes related clinical practice. Research experience; particularly in public sector relevant research as a principal investigator or co-principal investigator is preferred.

3.3.1.6. On an annual basis, the Chief Medical Officer and the NHH CEO shall establish staffing needs for NHH, which shall include psychiatric, research and related clinical personnel. A schedule of personnel shall be developed and written notice shall be provided to the Contractor prior to commencement of the applicable contract year.

3.3.2. Associate Medical Director

3.3.2.1. The Contractor shall provide for the term of the contract, the full-time services of a qualified physician to serve as the Associate Medical

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Director for NHH. The Associate Medical Director shall possess the following qualifications and meet the following requirements:

a. The Associate Medical Director shall be a Board Certified Psychiatrist licensed to practice in the State of New Hampshire. The Associate Medical Director shall, at all times, maintain both a license to practice medicine in the State of New Hampshire and clinical privileges at NHH.

b. The Associate Medical Director shall be a senior administrative psychiatrist having a minimum of five (5) years of experience in a position of clinical leadership for a major public sector program, psychiatric hospital, governmental authority, state or national medical/psychiatric society organization involved in the delivery of public sector psychiatric services. The Associate Medical Director shall have completed an ACGME approved residency program with board certification in Psychiatry by the American Board of Psychiatry and Neurology. Additional subspecialty certification in forensic, addiction, geriatric or child/adolescent psychiatry may be substituted for 2 years of administrative leadership. Completion of a graduate curriculum in medical administration preferred.

c. For purposes of this paragraph, the term "full-time" shall mean that the Associate Medical Director shall be required to account, through appropriate record-keeping as determined by NHH, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities pursuant to the contract, subject to the Contractor's normal and customary employee leave policies. Said minimum hours must be satisfied through hours devoted to clinical activities onsite at NHH.

3.3.2.2. The Associate Medical Director may be permitted with prior notice and approval of the NHH CEO to work up to a maximum of 4 hours per week devoted to educational or research activities so long as those activities further the mission and goals of NHH. The Associate Medical Director shall be responsible for providing documentation to the NHH CEO that time spent devoted to educational or research activities furthers the mission and goals of NHH.

3.3.2.3. Notwithstanding the foregoing allowance for educational or research activities, the Associate Medical Director shall be physically present onsite at NHH not less than 36 hours per week. The Associate Medical Director shall also participate with staff psychiatrists in on call, after-hours coverage above the 40-hour week to ensure a 24-hour a day, 7 day per week provision of Psychiatrist-On-Call services without additional compensation to the Contractor or the Chief Medical Officer.

3.3.2.4. In the event the Associate Medical Director resigns, or is otherwise removed from providing services to NHH under this contract, the

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Contractor shall furnish, within 10 business days, not including holidays, a psychiatrist to serve full-time as interim NHH Associate Medical Director, until such time as the existing Associate Medical Director either resumes duty full-time or is replaced by a new Associate Medical Director. The interim Associate Medical Director shall meet all of the requirements for the Chief Medical Officer as set forth under the contract. The Contractor shall be responsible for providing transition services to NHH, at no additional cost, to avoid the interruption of services and administrative responsibilities.

3.3.2.5. The Associate Medical Director shall demonstrate:

a. Clear success in the fields of clinical psychiatry and psychiatric education at the graduate or undergraduate level;

b. Development of innovative clinical programs specific to the needs of the severely and persistently mentally ill, (SPMI) population;

c. Successful collaboration with state government leadership in the areas of program planning, budget, personnel policies, staffing levels, and the legislative process;

d. Cooperation with consumer organizations; and

e. Competence in program evaluation and evidence based outcomes related clinical practice. Research experience; particularly in public sector relevant research as a principal investigator or co-principal investigator is preferred.

3.3.2.6. On an annual basis, the Associate Medical Director, together with the Chief Medical Officer and the NHH CEO, shall establish staffing needs for NHH, which shall include psychiatric, research and related clinical personnel. A schedule of personnel shall be developed and written notice shall be provided to the Contractor prior to commencement of the applicable contract year.

3.3.3. Psychiatrists

3.3.3.1. The Contractor shall provide eleven (11) General Psychiatrists for the adult units at NHH:

a. All psychiatrists shall have appropriate experience in the specialty they are boarded or board eligible in;

b. All psychiatrists shall have completed an ACGME approved residency program in psychiatry;

c. At least one psychiatrist shall be dedicated full-time to provide services to the Inpatient Stabilization Unit (ISU); and

d. At least one psychiatrist shall be certified in addiction treatment this psychiatrist shall be a physician who is certified in general psychiatry and has significant clinical experience in addiction medicine. A fellowship training and/or board certification in

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Addiction Medicine or Addiction Psychiatry is highly desirable.

3.3.4. Child/Adolescent Psychiatrists

3.3.4.1. The Contractor shall provide four (4) Child/Adolescent Psychiatrists who have successfully completed their fellowship.

a. All psychiatrists shall have completed both an ACGME approved residency program in psychiatry and a 2-year ACGME approved fellowship in child/adolescent psychiatry.

3.3.5. Geropsychiatrist

3.3.5.1. The Contractor shall provide one (1) geropsychiatrist who has:

a. Completed an ACGME approved residency program in psychiatry, and be board certified by the American Board of Psychiatry and Neurology in Psychiatry; and

b. Completed a 1-year geropsychiatry fellowship and is specialty certified by the American Board of Psychiatry and Neurology in geriatric psychiatry. Two years of additional clinical experience in geriatric psychiatry may be substituted for fellowship training.

3.3.6. Director of Neuropsychology Laboratory

3.3.6.1. The Contractor shall provide a senior neuropsychologist who has:

a. Past experience shall include leadership responsibilities in MRI operations and the ability to integrate cognitive test results with data from structural and functional brain imaging;

b. A Ph.D. or Psy.D. in clinical psychology or neuropsychology and shall have completed a neuropsychology postdoctoral fellowship (Houston guidelines); and

c. Evidence of scientific productivity in relation to the SPMI population and the ability to generate proposals for federal and foundation support is preferred.

3.3.7. Neuropsychologist Trainees

3.3.7.1. The Contractor shall provide three neuropsychologist trainees who:

a. Shall be clinical psychology graduate students who are obtaining specialty training in neuropsychology; and

b. Shall have three to four years of graduate instruction and training, including training experience in general psychology.

3.3.8. General Medical Director

3.3.8.1. The Contractor shall provide one full-time physician to fulfill the role of General Medical Director who shall be a primary care or internal medicine physician who has completed residency with at least three years of experience in supervising primary care clinicians. A board

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certification in a primary care field is preferred.

3.3.9. General Medical Physician

3.3.9.1. The Contractor shall provide one full-time physician who is a primary care or internal medicine physician who has completed residency with at least three years of experience. A board certification in a primary care field is preferred.

3.3.10. Forensic Psychologist

3.3.10.1. Beginning in SFY 2018, the Contractor shall provide a full-time forensic psychologist. The forensic psychologist shall be a clinical psychologist (PhD or Psy.D.) with significant clinical experience in forensic psychology. A certification in forensic psychology is preferred.

3.3.11. Residents/Post Graduate Fellows

3.3.11.1. For all residents or postgraduate fellows the Contractor provides to NHH under this contract, the responsibilities shall be outlined, monitored and reviewed by the Chief Medical Officer and the appropriate, attending psychiatrist.

a. General Psychiatry Residents (PGY II and PGY IV) – The Contractor shall rotate PGY II residents and a PGY IV (chief resident) through NHH.

b. Child/Adolescent Fellows – The Contractor shall rotate three (3) child/adolescent fellows (combined 1 FTE) apportioned through the PGY IV and PGY V years or PGY V and VI years (1st and 2nd year fellows) through NHH.

c. Geropsychiatry Fellow – The Contractor shall rotate a geropsychiatry fellow (PGY V) through the NHH.

3.3.12. Psychiatric Advanced Practice Registered Nurses (APRN)

3.3.12.1. The Contractor shall provide six full-time Psychiatric Advanced Practice Registered Nurses.

a. Psychiatric APRNs shall possess an APRN degree and have board certification as Psychiatric–Mental Health Nurse Practitioner-Board.

b. At least one Psychiatric APRN with specialty in addiction or the requisite number of hours of experience in addiction treatment shall be provided.

c. At least one Psychiatric APRN shall be dedicated full-time to provide services to the ISU.

3.3.13. NHH Research Manager

3.3.13.1. The Contractor shall provide a full-time NHH Research Manager, as described below:

a. The Research Manager requires a thorough knowledge and

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understanding of clinical research, research protocols, and clinical operations, knowledge of GCPs and federal regulations related to human subject research, knowledge of patient privacy and confidentiality, ability to manage teams of professionals, maintain meticulous study records, laboratory data and other information related to research protocols, and manage complex schedules and competing priorities.

b. The Research Manager shall meet the following minimum experience and education requirements:

Master's degree in management or health or research related area;

Five or more years of relevant experience in clinical trials research support;

Experience with industry sponsored, federally sponsored and investigator initiated clinical research;

Experience with clinical trial budgets and billing;

Through knowledge of clinical research, research protocols and clinical operations; and

Knowledge of Good Clinical Practices (GCP's) and federal regulations related to research.

3.3.14. Director of Quality Systems and APRN Services

3.3.14.1. The Contractor shall provide a full time Director of Quality and APRN Services, as described below:

a. Licensed as an Advance Practice Registered Nurse

b. Two of more years of relevant experience in a psychiatric setting.

c. Experience with quality systems, development and enhancement of organizational systems and processes.

d. Serves as Chair of the Quality Council.

e. Provides clinical standards and provides leadership for all Psychiatric APRNs.

f. Builds community relationships with professional organizations to enhance both the quality programs and APRN programs.

g. Five or more years of experience in leadership of teams.

h. May supervise clinical and non-clinical NHH staff as directed by the Chief Medical Officer and/or the Chief Executive Officer.

3.3.15. Director of Health Systems Data and Information Services

3.3.15.1. The Contractor shall provide a full time Director of Health Systems

Data and Information Services, as described below:

a. Five or more years of experience with collecting, analyzing, documenting and reporting hospital and/or health systems data.

b. Five or more years of experience with Electronic Health Records and development of Health Services Data Program.

c. Five or more years of experience in leadership of teams.

d. May supervise clinical and non-clinical NHH staff as directed by the Chief Medical Officer and/or the Chief Executive Officer.

3.3.16. Schedule and Allocation of Positions – Service Area #1 – NHH

3.3.16.1. The following schedule shall reflect the full staffing complement for which the Contractor shall provide the required staff, consistent with the requirements described in the Contract for the full term of the contract. All positions allocated in this contract are to be 100% filled or in active recruitment. In the event that a position remains vacant (due to the need to fill the position or recruit for the position) for more than 30 days, the contractor shall reduce the monthly invoice by amount budgeted for that position until the position is filled. The Contractor shall provide DHHS with monthly updates on the recruitment process

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for all unfilled positions.

Position Title	Full-Time Equivalent
a. Chief Medical Officer	1.0
b. Associate Medical Director	1.0
c. General Psychiatrists	11.0
d. Psychiatric APRNs	6.0
e. Child/Adolescent Psychiatrists	4.0
f. Geropsychiatrist	1.0
g. Director of Neuropsychology Laboratory	0.5
h. .Director of Quality Systems and APRN Services.	1.0
i. Neuropsychologist Trainees	3.0
j. General Medical Director	1.0
k. General Medical Physician	1.0
l. Forensic Psychologist	1.0
m. PGY IV Residents	1.0
n. PGY II Residents	1.5
o. Child/Adolescent Fellow	1.0
p. Geropsychiatry Fellow	0.5
q. Director of Health System Data and Information Services	1.0
r. Research Manager	1.0
s. Research Mentor/ Investigator (Psychiatrist or Psychologist	0.15 SFY2020, 1.15 SFY 2021, 1.0 SFY 2022

3.4. Specific Staffing Requirements – Service Area #2 – Glencliff Home

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3.4.1. **Medical Director**

3.4.1.1. The Contractor shall, for the term of the contract, provide the part-time services of one (1) geropsychiatrist to serve at the Glencliff Home as the Medical Director. This position shall be a 0.4 Full-Time Equivalent.

3.5. Specific Staffing Requirements – Service Area #3 – Medicaid Program

3.5.1. **Department of Health and Human Services Chief Medical Officer –**

3.5.1.1. The Contractor shall, for the term of the contract, provide the full-time services of a designated physician, identified by the Department to serve as the Chief Medical Officer. This position shall be a 1.0 Full-Time Equivalent.

3.5.1.2. The Contractor shall ensure that the Chief Medical Officer provided under this contract is subject to the Contractor's normal and customary employee benefits and policies, including leave provisions for a senior executive level position. However, the Contractor and DHHS agree that the continuous provision of services is essential, and in addition to any required approvals by the Contractor for its employees, the Chief Medical Officer shall provide timely, prior notification to the DHHS Designee of any leave time taken. Absences due to vacation and continuing education shall be planned in advance, in consideration of the business needs of the Medicaid program – including ensuring appropriate coverage for any clinical and/or operational responsibilities or tasks that need oversight while the Chief Medical Officer is on leave.

3.5.1.3. The Chief Medical Officer shall possess the following qualifications:

a. Possess a medical degree (MD or DO);

b. Maintain an unrestricted license as a physician by the New Hampshire Board of Medicine;

c. A graduate degree in public health or health care administration with demonstrated experience in public health or healthcare administration systems development;

d. Have a minimum of five years of experience in a position of clinical leadership for a major public sector program, government authority or other organization involved in the delivery of public Medicaid services;

e. Have work experience in managed care settings focused on improved health outcomes;

f. Have fellowship and/or work experience in research in health services, outcomes and/or policy, as well as the ability to work collaboratively with team members and the provider

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community;

g. Have extensive experience and judgment to plan and accomplish goals working in a team environment;

h. Demonstrate strong verbal and written communication skills;

i. Work collaboratively with Medicaid staff to achieve program goals in an efficient and timely manner;

j. Have Board certification in either Family Medicine, Preventive Medicine/Community Health, Internal Medicine, Pediatrics, or Obstetrics and Gynecology, and with a strong working knowledge of primary care medicine;

k. Must be well versed in the regulations governing the federal Title XIX Medicaid and Title XXI Medicaid and CHIP programs and how those programs are administered in New Hampshire;

l. Possess a high degree of creativity and initiative;

m. Have expertise in clinical, policy, or outcomes research; and

n. Have work experience in project management, grant writing, contract management, and program evaluation.

3.6. Specific Staffing Requirements – Service Area #4 – Children, Youth and Families

3.6.1. Staff Psychologist

3.6.1.1. The Staff Psychologist shall possess the following qualifications:

a. Possess a Doctor of Philosophy (Ph.D.) or Doctor of Psychology (Psy.D.) degree from a college or university accredited by the American Psychological Association.

b. Experience and interest in both child psychology and criminal justice;

c. Certification by NH Board of Psychologists.

d. Maintain an unrestricted license to practice Psychology

e. Possess at least five (5) years of experience in community mental health, criminal justice, or similar training.

3.6.2. Staff Psychiatrist

3.6.2.1. The Contractor shall, provide the services of a designated psychiatrist, who is a faculty member and/or employee of the Contractor, to provide psychiatric services to the programs within the Children, Youth and Families service area. This position shall be a .25 Full-Time Equivalent.

3.6.2.2. DHHS reserves the right to jointly, with the Contractor, or separately, interview, research or otherwise screen and consider candidates the

Contractor designates for the Staff Psychiatrist.

3.6.2.3. The Staff Psychiatrist shall possess the following qualifications:

a. Possess a medical degree (MD or DO);

b. Specialty in child psychiatry and an interest in criminal justice;

c. Completion of both an ACGME approved residency program in psychiatry and a 2-year ACGME approved fellowship in child/adolescent psychiatry;

d. Board certification by the American Board of Psychiatry and Neurology in Psychiatry;

e. Maintain an unrestricted license as a physician by the New Hampshire Board of Medicine; and

f. Possess post-fellowship experience in public sector psychiatry, community mental health, criminal justice, or similar training.

3.6.3. Psychiatric Consultant

3.6.3.1. The Contractor shall provide a part-time psychiatric consultant (.25 FTE), to work two (2) days each week for five (5) hours each day, and who meets the following criteria:

3.6.3.2. Has interest and clinical experience in addiction treatment and criminal justice.

3.6.3.3. Has completed a fellowship training and/or board certification in Child Psychiatry.

3.7. Specific Staffing Requirements – Service Area #5 – Behavioral Health

3.7.1. Medical Director

3.7.1.1. The Contractor shall, for the term of the contract, provide a part-time Medical Director to the Behavioral Health service area, as identified by the Department. This position shall be available on-site at a DHHS designated location for twenty (20) hours per week (0.5 FTE).

3.7.1.2. The Medical Director shall possess the following qualifications:

a. Possess a medical degree (MD or DO);

b. Board certification by the American Board of Psychiatry and Neurology in Psychiatry;

c. Maintain an unrestricted license as a physician by the New Hampshire Board of Medicine; and

d. Have at least five (5) years of experience in public mental

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health and services for people with mental illness.

3.7.2. Support Staff CPHS

3.7.2.1. The Contractor shall, for the term of the contract, provide a part-time Support Staff to support the Committee for the Protection of Human Services. This position shall be allocated at 0.15 FTE.

3.7.2.2. The Contractor shall, for the term of the contract, provide a part-time Research Assistant. This position shall be allocated at 0.5 FTE.

3.7.3. Evidence-Based Practice Trainer/Consultant

3.7.3.1. The Contractor shall, for the term of the contract, provide part-time Evidence-Based Practice Trainers/Consultants. These positions shall be allocated, in total, at 2 FTE.

3.7.4. Behavioral Health Policy Institute

3.7.4.1. The Contractor shall, for the term of the contract, provide a part-time Behavioral Health Policy Institute Consultant. This position shall be allocated at 0.1 FTE.

3.8. Specific Staffing Requirements – Service Area #6 – Elderly and Adult Services

3.8.1. Medical Director

3.8.1.1. The Contractor shall, for the term of the contract, provide a part-time Medical Director to the Elderly and Adult Services service area. This position shall be allocated at a 0.03 Full-Time Equivalent.

3.8.1.2. The Medical Director shall possess the following qualifications:

a. Possess a medical degree (MD or DO);

b. Maintain board certification in Gerontology or Preventive Medicine/Community Health;

c. Possess expertise in clinical, policy or outcomes research; and

d. Be well versed in the regulations governing the federal Title XIX Medicaid program, including requirements for the operation of waiver and State Plan services, and Title XX, the Social Service Block Program and services provided under the Older Americans Act.

3.9. Specific Staffing Requirements – Service Area #7 – Developmental Services

3.9.1. Medical Director

3.9.1.1. The Contractor shall, for the term of the contract, provide a part-time Medical Director to the Developmental Services service area. This

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position shall be allocated at 0.4 Full-Time Equivalent.

3.9.1.2. The Medical Director shall possess the following qualifications:

a. Possess a medical degree (MD or DO);

b. Maintain board certification in Child and Adult Psychiatry; and

c. Possess expertise and experience in developmental disability, including Autism Spectrum Disorders.

3.9.2. Developmental Services Interdisciplinary Clinic Team

3.9.2.1. The Contractor shall, for the term of the contract, provide the following part-time positions to the Adult Developmental Services Interdisciplinary Clinic Team. These positions shall be allocated, as specified below in Full-Time Equivalent (FTE):

3.9.2.2. a. Child Psychiatrist 0.1 FTE

3.9.2.3. b. Psychiatrist 0.1 FTE

3.9.2.4. c. Neuropsychologist 0.1 FTE

3.9.2.5. d. Neuropsychology Fellow 0.1 FTE

3.9.2.6. e. Neurologist 0.05 FTE

3.9.2.7. f. Primary Care Physician 0.05 FTE

3.9.2.8. g. Occupational Therapist 0.05 FTE

3.9.2.9. h. Administrative Support 0.05 FTE

4. Performance Standards and Outcomes

4.1. Service Area #1 – Chief Medical Officer – NHH

4.1.1. Within forty-five (45) days of the assignment of the Chief Medical Officer, and at each contract anniversary thereafter, the Contractor and the NHH CEO, in consultation with the Chief Medical Officer, shall develop a list of performance metrics based upon the deliverables, functions and responsibilities of the Chief Medical Officer. The performance metrics shall be approved by the NHH CEO prior to being effective. The performance metrics shall be reviewed by the NHH CEO on at least a quarterly basis with the Chief Medical Officer.

4.1.2. The Contractor shall ensure the services provided by the Chief Medical Officer at NHH are satisfactory to the Department. As part of this responsibility, the Contractor shall, no less than annually and more frequently if required by DHHS, provide an evaluation tool to solicit input from the NHH CEO regarding the Chief Medical Officer's provision of services under the contract.

4.1.3. The Contractor shall develop a corrective action plan to address any concerns raised by the NHH CEO in the evaluation tool, and provide a copy of such plan to the NHH CEO for review. If the NHH CEO disagrees

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with the Contractor's proposed resolutions within the corrective action plan, the dispute shall be referred to the DHHS Commissioner for resolution with the Contractor.

4.2. Service Area #1 – Clinical Staff – NHH

4.2.1. Staffing levels shall be maintained at all times throughout the contract, with the exception of the leave provisions and approval processes described in the subsections applicable to each staffing need.

4.2.1.1. DHHS' expectation is that staffing will be at the a level of 100% ensures that inthat ensures no case shall Contractor staffing affect impact to the number of NHH beds available, and that NHH units will not stop admissions due to the lack of coverage for Contractor staff. All positions allocated in this contract are to be 100% filled or in active recruitment. In the event that a position remains vacant (due to the need to fill the position or recruit for the position) for more than 30 days, the contractor shall reduce the monthly invoice by amount budgeted for that position until the position is filled. The Contractor shall provider DHHS with monthly updates on the recruitment process for all unfilled positions.

4.2.2. The Contractor shall ensure the following performance standards are met by all clinical staff provided by the Contractor to provide services at NHH:

4.2.3. In providing services, DHMC providers shall at all times during the term comply with the Key Performance Indicators (KPI) defined below. Key Performance Indicators may be revised by mutual agreement of the parties. In the event that DHMC providers fail to satisfy any KPI's, in addition to any other rights available to NHH hereunder, DHMC shall cooperate with NHH to remedy such shortfalls and take appropriate action to alleviate the unsatisfactory performance, as determined by the Department.

Key Performance Indicators

4.2.3.1. 1. Psychiatric Progress Notes

(i) Completion daily on children and adults who are certified as acute inpatient level of care.

(ii) Completion of not less than four (4) times per week on children and adult patients that are no longer acute level of care.

(iii) Content as it pertains to CMS local coverage determinations for NHH and NHH Policy.

2. Patient Length of Stay

(i) Evaluation by through data collection and case review

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of active treatment during patient stay.

3. CMS Certification Guidelines
   (i) Certifications/re-certification conducted in accordance to required CMS and NHH timeframes.
   (ii) Assigned certification status is clearly supported in psychiatric progress notes.
4. Standardized Process
   (i) Compliance with all existing and future standardized work processes with the goal of reducing variation in care.
   (ii) Individual metrics will be developed based on the target outcomes of the standardized work.
5. Treatment Plans
   (i) Completed timely and comprehensively.
   (ii) Performance measured by random monthly audits which are provided to the Chief Medical Officer and Chief Executive Officer of NHH.
6. Annual Reviews
   (i) Annual reviews are documented on all DHMC staff by the Chief Medical Officer or designee. Performance evaluation shall be in compliance with professional standards for evaluations per CMS/Joint Commission guidelines.

4.3. Service Area #3 – Chief Medical Officer – Medicaid

4.3.1. Within forty-five (45) days of the assignment of the Chief Medical Officer, and at each contract anniversary thereafter, the Contractor and the DHHS Designee, in consultation with the Chief Medical Officer, shall develop a list of performance metrics based upon the deliverables, functions and responsibilities of the Chief Medical Officer. The performance metrics shall be approved by the DHHS Designee prior to being effective. The performance metrics shall be reviewed by the DHHS Designee on at least a quarterly basis with the Chief Medical Officer. These meetings shall be documented with written progress notes by the DHHS Designee.

4.3.2. The Contractor shall ensure the services provided by the Chief Medical Officer are satisfactory to the Department. As part of this responsibility, the Contractor shall, no less than annually and more frequently if required by DHHS, provide an evaluation tool, that is based on the agreed upon performance metrics for the previous year, to solicit input from the DHHS Designee regarding the Chief Medical Officer's provision of services

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under the contract.

4.3.3. Goals for the upcoming year will be established at the time of the Contractor's evaluation of the Chief Medical Officer, in collaboration with the DHHS Designee. In the case of a newly hired Chief Medical Officer, the evaluation tool shall be completed upon six (6) months of employment and then again at one (1) year, and thereafter on the contract anniversary date.

4.4. Service Area #4 – Staff Psychiatrist – Children, Youth and Families

4.4.1. Within forty-five (45) days of the assignment of the Staff Psychiatrist, and at each contract anniversary thereafter, the Contractor and the DHHS designee, in consultation with the Staff Psychiatrist, shall develop a list of performance metrics based upon the deliverables, functions and responsibilities of the Staff Psychiatrist. The performance metrics shall be approved by the DHHS designee prior to being effective. The performance metrics shall be reviewed by the DHHS designee on at least a quarterly basis with the Staff Psychiatrist. These meetings shall be documented with written progress notes by the DHHS designee.

4.4.2. The Contractor shall ensure the services provided by the Staff Psychiatrist are satisfactory to the Department. As part of this responsibility, the Contractor shall, no less than annually and more frequently if needed, provide an evaluation tool, that is based on the agreed upon performance metrics for the previous year, to solicit input from the DHHS designee regarding the Staff Psychiatrist's provision of services under the contract.

Goals for the upcoming year will be established at the time of the Contractor's evaluation of the Staff Psychiatrist, in collaboration with the DHHS designee. In the case of a newly hired Staff Psychiatrist, the evaluation tool shall be completed upon six (6) months of employment and then again at one (1) year, and thereafter on the contract anniversary date.

4.5. Quality Assurance Plan and Monitoring

The following Quality Assurance Plan and Monitoring shall be provided by the Contractor, subject to modification and/or augmentation as required by DHHS:

4.5.1. Service Area #1 – New Hampshire Hospital – Chief Medical Officer

4.5.1.1. The Contractor shall provide oversight of the performance of the Chief Medical Officer toward these Performance Standards and Quality Assurance Monitoring goals.

In addition to performance metrics and in partnership with the NHH CEO, the Chief Medical Officer shall be responsible for the following program outcomes:

a. Ensuring the program is staffed adequately to operate NHH

beds at full utilization;

b. Ensuring that Contractor staff receive necessary supervision and training to perform the tasks they are assigned;

c. Assuring that patients receive care consistent with evidence-based care;

d. Creation and implementation of highest standard practices to protect the safety of patients, staff, and visitors; and

e. Other responsibilities detailed herein at subsection 2.3.1.

4.5.1.2. The Chief Medical Officer shall be responsible for monitoring progress toward these goals and providing regular reports, at minimum on a quarterly basis or more frequently if needed, to the NHH CEO and to the Chair of the Department of Psychiatry or his designee. The Chief Medical Officer will meet at minimum on a quarterly basis or more frequently if needed, with the Chair of the Department of Psychiatry (or his or her designee) and the NHH CEO to review progress toward these metrics. The metrics above shall be considered preliminary metrics, subject to refinement, as described herein at subsection 4.2.2., and shall be reviewed and modified by DHHS during the term to assure that they continue to be the best metrics to use to assure contract compliance.

4.5.2. Monitoring – Service Area #1 – New Hampshire Hospital – Chief Medical Officer:

4.5.2.1. The findings from Key Performance Indicators shall be discussed in scheduled meetings between the NHH CEO and the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry (or his or her designee) at meetings that shall take place on a quarterly basis or more frequently if needed.

4.5.2.2. The Key Performance Indicators and feedback solicited from the NHH CEO shall be part of the Chief Medical Officer's annual performance review. The Contractor shall document the annual performance review on the Department's standard annual evaluation tool.

a. If there are performance difficulties that require a corrective action plan, the Contractor shall develop a proposed corrective action plan and shall share and discuss the plan with the NHH CEO prior to issuance to the Chief Medical Officer. If the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry and the NHH CEO disagree on the proposed corrective action plan, the dispute shall be referred to the DHHS Commissioner for resolution.

4.5.2.3. This plan shall be updated and revised at least annually, by the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, working with the NHH CEO and in consultation with the NHH Chief Medical Officer. New goals may be

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set at any time but shall be set at least annually. New goals may trigger new metrics.

4.5.3. Service Area #1 – New Hampshire Hospital – Clinical Staff

4.5.3.1. In providing services, DHMC providers shall at all times during the term comply with the Key Performance Indicators (KPI) defined below. Key Performance Indicators may be revised by mutual agreement of the parties. In the event that DHMC providers fail to satisfy any KPI's, in addition to any other rights available to NHH hereunder, DHMC shall cooperate with NHH to remedy such shortfalls and the parties shall agree on any appropriate action necessary to alleviate the unsatisfactory performance.

Key Performance Indicators

1. Psychiatric Progress Notes
   - (i) Completion daily on children and adults who are certified as acute inpatient level of care.
   - (ii) Completion of not less than four (4) times per week on children and adult patients that are no longer acute level of care.
   - (iii) Content as it pertains to CMS local coverage determinations for NHH and NHH Policy.
2. Patient Length of Stay
   - (i) Evaluation by through data collection and case review of active treatment during patient stay.
3. CMS Certification Guidelines
   - (i) Certifications/re-certification conducted in accordance to required CMS and NHH timeframes.
   - (ii) Assigned certification status is clearly supported in psychiatric progress notes.
4. Standardized Process
   - (i) Compliance with all existing and future standardized work processes with the goal of reducing variation in care.
   - (ii) Individual metrics will be developed based on the target outcomes of the standardized work.
5. Treatment Plans
   - (i) Completed timely and comprehensively.
   - (ii) Performance measured by random monthly audits which are provided to the Chief Medical Officer and

Chief Executive Officer of NHH.

6. Annual Reviews

(i) Annual reviews are documented on all DHMC staff by the Chief Medical Officer or designee. Performance evaluation shall be in compliance with professional standards for evaluations per CMS/Joint Commission guidelines.

4.5.4. Service Area #3 – Medicaid – Chief Medical Officer

4.5.4.1. Within 45 days of the contract effective date, the Contractor shall work with the DHHS designee overseeing the Medicaid service area to develop a list of performance metrics based on the deliverables, functions, and responsibilities, as described herein at subsection 2.5. Together, these metrics shall form an evaluation tool. The Chief Medical Officer shall be consulted in this process and the metrics shall be subject to approval by the DHHS Designee overseeing the Medicaid service area. The selection of metrics shall be reviewed over time to assure that they are the best metrics to use to assure contract compliance.

4.5.4.2. The DHHS designee shall review the findings from monitoring of these metrics at least quarterly with the Chief Medical Officer.

4.5.4.3. The Chief Medical Officer role requires initiative, relationship building, and high level leadership. The following metrics are relevant to the Chief Medical Officer's fulfillment of his or her responsibilities and shall be part of the plan for monitoring contract fulfillment:

a. Attendance records of Medicaid Management Team meetings; and

b. A checklist of core duties and expectations, as described herein at subsection 2.5, with feedback solicited on a quarterly or semi-annual basis from the members of the Medicaid Management Team and/or other key informants, designed to monitor performance. The checklist shall rate performance and allow for comments that will help guide improvement.

4.5.5. Monitoring – Service Area #3 – Medicaid – Chief Medical Officer

4.5.5.1. Resources for monitoring the performance metrics shall be identified when the performance plan is developed and may require Contractor or State resources to perform such tasks. Performance metric data may include but not be limited to:

a. Checklist feedback from the Medicaid Management Team. Source: Medicaid Management Team members; and

b. Collection and collating of attendance records from the Medicaid Management Team meetings. Source: DHHS

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administrative support staff.

4.5.5.2. At least twice yearly, or more frequently if needed:

a. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, and the DHHS designee shall review the data collected in the performance metrics, and discuss these with the Chief Medical Officer;

b. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall solicit information from the DHHS designee and shall discuss twice yearly with the DHHS designee, or more frequently if needed, the Chief Medical Officer's performance on the metrics.

c. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, and the DHHS designee shall maintain notes of their meetings. The annual performance review shall be documented on the Department's standard annual evaluation tool.

4.5.5.3. The findings collected in the evaluation tool, as well as verbal information solicited from the DHHS designee, shall form the core of the Chief Medical Officer's annual performance review. This review shall be conducted at six months for a new Chief Medical Officer then annually thereafter.

4.5.5.4. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, the DHHS designee, and the Chief Medical Officer shall collaborate to establish goals for the upcoming year as part of the performance evaluation process. New goals may be set at any time but shall be set at least annually.

4.5.5.5. If there are performance difficulties that require a corrective action plan, the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall develop a proposed corrective action plan, and shall discuss and share the plan with the DHHS designee. If the DHHS designee and the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, disagree on the proposed resolutions, the dispute will be referred to the DHHS Commissioner for resolution.

4.5.6. Service Area #4 – Children, Youth and Families – Staff Psychiatrist

4.5.6.1. Within 45 days of the contract effective date, the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall work with the DHHS designee overseeing the Children, Youth and Families service area to develop a list of performance metrics based on the deliverables, functions, and responsibilities, as described herein at Subsection 2.6. Together, these metrics shall form an evaluation tool. The Staff Psychologist shall be consulted in this process and the metrics shall be subject to

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approval by the DHHS Designee overseeing the Children, Youth and Families service area. The selection of metrics shall be reviewed over time to assure that they are the best metrics to use to assure contract compliance.

4.5.6.2. The content of performance metrics developed shall be such that they assure the Staff Psychologist is fulfilling his or her administrative and clinical responsibilities as described herein at subsection 2.6. The following metrics are relevant to the Staff Psychologist and shall be part of the plan for monitoring contract fulfillment:

a. Monitoring of work hours;

Regular checks of the Staff Psychologist's electronic calendar to be sure it includes proposed leave time, conferences, and trainings;

Clinical documentation monitoring to be sure it meets standards of timeliness and completeness established by Children, Youth, and Families;

Counts of activities such as the number of treatment team meetings and clinical consultations provided, types and numbers of evidence-based practices provided, number of teaching and supervision contacts with interns, residents, and fellows at SYSC; and

Checklist feedback on effectiveness in establishing interagency collaboration between Juvenile Justice Services, area mental health services, and NHH.

4.5.7. Monitoring – Services Area #4 – Children, Youth & Families – Staff Psychologist

4.5.7.1. Resources for monitoring the performance metrics shall be identified when the performance plan is developed and may require Contractor or State resources to perform such tasks. Performance metric data may include but not be limited to:

a. Counts of Activities. Source: Staff Psychologist; and

b. Clinical documentation monitoring. Source: DHHS staff.

4.5.7.2. At least twice yearly, or more frequently if needed:

a. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, and the DHHS designee shall review the data collected in the performance metrics, and discuss these with the Staff Psychologist;

b. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall solicit information from the DHHS designee and shall discuss twice yearly with the DHHS designee, or more frequently if needed, the Staff

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Psychiatrist's performance on the metrics.

c. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, and the DHHS designee shall maintain notes of their meetings. The annual performance review shall be documented on the Department's standard annual evaluation tool.

4.5.7.3. The findings collected in the evaluation tool, as well as verbal information solicited from the DHHS designee, shall form the core of the Staff Psychologist's annual performance review. This review shall be conducted at six months for a new Staff Psychologist, then annually thereafter.

4.5.7.4. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, the DHHS designee, and the Staff Psychologist shall collaborate to establish goals for the upcoming year as part of the performance evaluation process. New goals may be set at any time but shall be set at least annually.

4.5.7.5. If there are performance difficulties that require a corrective action plan, the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall develop a proposed corrective action plan, and shall discuss and share the plan with the DHHS designee. If the DHHS designee and the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, disagree on the proposed resolutions, the dispute will be referred to the DHHS Commissioner for resolution.

4.5.8. Service Areas #2, 3, 5, 6 and 7

4.5.8.1. Upon DHHS request, the Contractor shall identify performance metrics, develop performance goals, establish monitoring processes and engage in collaborative performance evaluation processes, similar to those described herein at subsection 4.5. For Service Areas 2, 3, 5, 6 and 7.

4.5.9. All Other Positions

4.5.9.1. All staff provided by the Contractor, not otherwise addressed herein at subsection 4.5, shall have annual performance reviews. The Contractor shall conduct such reviews and first obtain feedback from the applicable DHHS designee for the service area in which the staff is assigned to provide services. This feedback shall be a core element of the annual performance review process. The Contractor shall ensure that goal development is responsive to the evolving needs of DHHS over the course of the contract period.

5. Reporting

5.1. Service Area #1 – New Hampshire Hospital

5.1.1. In addition to other reports as agreed to by the parties, on an annual

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basis, the Contractor shall make a report in writing to DHHS that is descriptive of the Chief Medical Officers' and the clinicians' services provided by the Contractor and the Contractor's performance under this contract during the preceding contract year, the research activities provided during the preceding contract year, and planned research activities for the current contract year.

5.1.2. On an annual basis, DHHS shall submit to the Contractor a report in writing containing DHHS' evaluation of the Contractor's performance pursuant to this contract during the preceding year.

5.1.3. On a quarterly basis, or as otherwise more frequently required by the United States Department of Health and Human Services regulations, DHHS and in a form specified by DHHS, the Contractor shall provide a written report to DHHS documenting the services provided by the Contractor's staff in sufficient form and with sufficient detail to satisfy the reporting requirements of Medicare, Medicaid, and other third-party providers.

5.2. All Service Areas

5.2.1. The Contractor shall maintain and provide the DHHS designee(s) identified by the Department with up-to-date detailed personnel listings for all Contractor staff performing services under this contract. The listings shall include information, including, but not limited to; the names, titles, position costs (including salary and fringe benefit costs, direct and indirect rates), for each position for each service area for each state fiscal year, or more frequently as required by DHHS, to ensure the accuracy of information contained therein and to ensure proper cost allocation. The listings shall be in a format as determined and approved by DHHS.

6. Compliance

6.1. Continuity of Services

6.1.1. The Contractor and the Department agree that:

6.1.1.1. It will be extremely impracticable and difficult to determine actual damages that the Department will sustain in the event that the Contractor breaches this Agreement by failing to maintain the required staffing levels or by failing to deliver the required services, as described in this Exhibit A Amendment #2, Sections 2 through 5;

6.1.1.2. Any breach by the Contractor will delay and disrupt the Department's operations and impact its ability to meet its obligations and lead to significant damages of an uncertain amount as well as a reduction of services; The Contractor's failure to provide Required Staffing, Required Services, or meet the Performance Standards and Outcomes and Reporting Requirements, all as specified in this Exhibit A Amendment #2, Sections 2 through 5, shall result in the assessment of liquidated damages as specified in Exhibit B

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Amendment #2; and

6.1.1.3. The liquidated damages as specified in Exhibit B Amendment #2 are reasonable and fair and not intended as a penalty.

Definitions

CMS – Centers for Medicare and Medicaid Services
CPHS – Committee for the Protection of Human Subjects.
Department – New Hampshire Department of Health and Human Services
DHHS – New Hampshire Department of Health and Human Services
HIPAA – Health Insurance Portability and Accountability Act
TJC – The Joint Commission

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Method and Conditions Precedent to Payment

1. The State shall pay the Contractor an amount not to exceed the Price Limitation, Block 1.8, in consideration for the Contractor's compliance with the terms and conditions of this Agreement and for the services provided by the Contractor pursuant to Exhibit A Amendment #2, Scope of Services.
2. Agreement Period: Effective July 1, 2019, or the date of Governor and Executive Council approval, whichever date is later, through June 30, 2022.
3. Funding Sources: The services described in Exhibit A Amendment #2, Scope of Services, are funded with:
   - 40% Other Funds (Medicare, Medicaid & third party insurance);
   - 28% Federal Funds from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medical Assistance Program, Code of Federal Domestic Assistance Number (CFDA) 93.778; and
   - 32% General Funds.

   3.1 DHHS reserves the right to adjust funding sources throughout the Agreement Period and will provide the Contractor reasonable notice of any such changes. Adjustments made may require a mutually agreed upon contract amendment.

   3.2 Funds must be used in accordance with the provisions of the specified CFDA numbers.
4. This is a firm, fixed price contract. The Contractor shall provide services under this Agreement based on the Budget specified below per applicable Service Area and State Fiscal Year. The Contractor shall be compensated, for providing and delivering the services described in Exhibit A Amendment #2, Scope of Services, on the basis of this Budget.

Budget			
Agreement Period by State Fiscal Year			
Service Area	7/1/2019-6/30/2020	7/1/2020-6/30/2021	7/1/2021-6/30/2022
1: New Hampshire Hospital	$11,640,759	$12,717,827	$13,366,111
2: Glencliff Home	$139,309	$148,447	$156,475
3: Medicaid	$408,628	$432,119	$455,192
4: Children, Youth & Families	$396,688	$392,445	$413,867
5: Behavioral Health	$517,056	$544,803	$572,319
6: Elderly and Adult Services	$39,197	$41,809	$44,110
7: Developmental Services	$284,893	$310,264	$327,751

   4.1 Any amendments to this budget will require a written agreement by the parties in the form of a contract amendment, which may be subject to Governor and Executive Council approval and at minimum shall be subject to Attorney General approval.
5. **Invoicing**: The Contractor shall invoice DHHS monthly for services performed in accordance with the contract on invoices the format of which will be identified and approved by DHHS. The Contractor shall ensure that DHHS receives within thirty (30) days following

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the end of the month in which services were provided, the applicable invoice. The State shall make payment to the Contractor within thirty (30) days of receipt of an accurate invoice for Contractor services provided pursuant to this Agreement. Should a discrepancy in an invoice be identified by DHHS, it shall promptly notify the designated individual identified in Section 7, below, prior to the due date for payment. DHHS shall not be required to pay an invoice until any discrepancy with the invoice is resolved to the satisfaction of DHHS.

5.1 Invoices must be submitted to the attention of the DHHS designee at:

ATTN: [DHHS designee]
Financial Manager
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

5.2 Each monthly invoice shall distinctly identify and differentiate the expenses as charged according to each of the seven (7) Service Areas for which services are provided. The seven (7) Service Areas are as follows:

Service Area #1 – New Hampshire Hospital (NHH)
Service Area #2 – Glencliff Home
Service Area #3 – Medicaid Program
Service Area #4 – Children, Youth and Families
Service Area #5 – Behavioral Health
Service Area #6 – Elderly and Adult Services
Service Area #7 – Developmental Services

6. **Payment:** Compensation paid by DHHS shall be accepted by the Contractor as payment in full for the services provided under the Agreement. Notwithstanding anything to the contrary contained in the Agreement or in any other document, contract or understanding, it is expressly understood and agreed by the parties hereto that no payments will be made hereunder to reimburse the Contractor for costs incurred for any purpose or for any services provided to any individual prior to the effective date of the Contract.

7. **Financial Management:** The Contractor shall designate a contact person to resolve any questions or discrepancies regarding invoices. The Contractor shall provide DHHS with the name, title, telephone number, fax number and email address of the contact person. The Contractor shall also notify DHHS in the event of a change of the designated contact person. DHHS shall provide the Contractor with the name, title, mailing address, and telephone number of the corresponding DHHS contact person. DHHS shall notify the Contractor in the event of a change in the designated contact person.

7.1 Contingent upon additional state or federal funding and pursuant to a mutually agreed upon contract amendment, the Contractor may be asked to provide additional services appropriate for inclusion in the contract's scope, if such services are not otherwise detailed in this Agreement.

8. **Liquidated Damages**

9.1 **Continuity of Services:** As specified and described in Exhibit A Amendment #2, Scope of Services Subsection 6.1, Continuity of Services, the Contractor's failure to

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provide required staffing, required services, or meet the performance standards and reporting requirements as described in Exhibit A Amendment #2, Scope of Services, Sections 2 through 5, shall result in liquidated damages.

9.2 The Contractor and DHHS agree that:

9.2.1. It will be extremely impracticable and difficult to determine actual damages that DHHS will sustain in the event that the Contractor breaches this Agreement by failing to maintain the required staffing levels or by failing to deliver the required services, as described in Exhibit A Amendment #2, Scope of Services, Sections 2 through 5;

9.2.2. Any breach by the Contractor will delay and disrupt DHHS's operations and impact its ability to meet its obligations and lead to significant damages of an uncertain amount as well as a reduction of services;

9.2.3. The Contractor's failure to provide Required Staffing, Required Services, or meet the Performance Standards and Outcomes and Reporting Requirements, all as specified in Exhibit A Amendment #2, Scope of Services, Sections 2 through 5, shall result in the assessment of liquidated damages as specified in this Exhibit B Amendment #2;

9.2.4. The liquidated damages as specified in this Exhibit B Amendment #2 are reasonable and fair and not intended as a penalty; and

9.2.5. Assessment and recovery of liquidated damages by DHHS shall be in addition to, and not exclusive of, any other remedies, including actual damages, as may be available to DHHS for breach of contract, both at law and in equity, and shall not preclude DHHS from recovering damages related to other acts or omissions by the Contractor under this Agreement. Imposition of liquidated damages shall not limit the right of DHHS to terminate the Contract for default as provided in Paragraph 8 of the General Provisions (P-37).

9.3 **Notification**: DHHS shall make all assessments of liquidated damages. Prior to the imposition of liquidated damages, as described herein, DHHS shall issue a written notice of remedies that will include, as applicable, the following:

- A citation of the contract provision violated;
- The remedies to be applied, and the date the remedies shall be imposed (cure period);
- The basis for DHHS' determination that the remedies shall be imposed;
- A request for a Corrective Action Plan from the Contractor; and
- The timeframe and procedure for the Contractor to dispute DHHS' determination.

9.3.1 If the failure to perform by the Contractor is not resolved within the cure period identified by DHHS, liquidated damages may be imposed retroactively to the date of failure to perform and will continue until the failure is cured or any resulting dispute is resolved in the Contractor's favor.

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9.3.2 The Contractor's dispute of liquidated damages or remedies shall not stay the effective date of the proposed liquidated damages or remedies.

9.4 **Corrective Action Plan:** The Contractor shall submit a written Corrective Action Plan to DHHS within five (5) business days of receiving notification as specified in subsection 9.3. Notification, for DHHS review. The Corrective Action Plan shall be subject to DHHS approval prior to its implementation.

9.5 **Liquidated Damages:**

9.5.1 Liquidated damages, if assessed, shall be in the amount of $1,000 per day for each day the Contractor fails to meet the general and specific service requirements for each Service Area as identified in Exhibit A Amendment #2, Scope of Services, Section 2, Scope of Services.

9.5.2 Liquidated damages, if assessed, shall be in the amount of $1,000 per day for each day the Contractor fails to meet and maintain the staffing levels identified in Exhibit A Amendment #2, Scope of Services, Section 3, Staffing.

9.5.3 Liquidated damages, if assessed, shall be in the amount of $1,000 per day for each day the Contractor fails to meet the Performance Standards identified in Exhibit A Amendment #2, Scope of Services, Section 4, Performance Standards and Outcomes.

9.5.4 Liquidated damages, if assessed, shall be in the amount of $1,000 per day for each day the Contractor fails to meet the Reporting Requirements identified in Exhibit A Amendment #2, Scope of Services, Section 5, Reporting.

9.5.5 Liquidated damages, if assessed, shall apply until the Contractor cures the failure cited in the Notification described in Subsection 9.3, or until the resulting dispute is resolved in the Contractor's favor.

9.5.6 The amount of liquidated damages assessed by DHHS shall not exceed the price limitation in Form P-37, General Provisions, Block 1.8 – Price Limitation.

9.6 **Assessment:** DHHS shall be entitled to assess and recover liquidated damages cumulatively under each section applicable to any given incident. Assessment and recovery of liquidated damages by DHHS shall be in addition to, and not exclusive of, any other remedies, including actual damages, as may be available to DHHS for breach of contract, both at law and in equity, and shall not preclude DHHS from recovering damages related to other acts or omissions by the Contractor under this Agreement. Imposition of liquidated damages shall not limit the right of DHHS to terminate the Contract for default as provided in Paragraph 8 of the General Provisions (P-37).

9.7 **Damages Related to Failure to Document Medical Necessity**: The Contractor shall be liable to DHHS for any losses incurred by DHHS which arise out of the failure of Contractor staff to provide the required documentation to support medical necessity as identified in Exhibit A Amendment #2, Scope of Services, Section 2.3.3.1. (j) and Section 2.3.5.4.

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Jeffrey A. Meyers
Commissioner

Lori A. Shibinette
Chief Executive Officer

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION FOR BEHAVIORAL HEALTH
NEW HAMPSHIRE HOSPITAL
36 CLINTON STREET, CONCORD, NH 03301
603-271-5300 1-800-852-3345 Ext. 5300
Fax: 603-271-5395 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

December 7, 2018

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services to amend an existing agreement with Mary Hitchcock Memorial Hospital (a component of Dartmouth-Hitchcock), (Vendor #177160) of One Medical Center Drive, Lebanon, New Hampshire, 03756 for the provision of Physician Clinical and Administrative Services to meet the specialized health and related clinical and administrative needs of the residents of the State of New Hampshire by modifying the scope of services to support the continued delivery of these services, with no change to the contract price limitation of $36,554,042 and no change to the contract completion date of June 30, 2019, effective upon approval by the Governor and Executive Council. 28% Federal Funds, 32% General Funds, 40% Other Funds from Medicare, Medicaid and third party insurance.

The original agreement was approved by the Governor and Executive Council on August 24, 2016 (Item # 6A).

EXPLANATION

The purpose of this request is to modify existing physician, clinical and administrative services provided by the Contractor at New Hampshire Hospital (NHH).

The Contractor provides clinical and administrative services to the Department and specifically to New Hampshire Hospital through staffing all inpatient care units with medical staff, Advanced Practice Registered Nurses, research and general hospital clinical support. New Hampshire Hospital achieved Joint Commission Accreditation in September 2018 as an Acute Psychiatric Hospital. The hospital is executing strategic initiatives that focus on safety culture, efficiency and effectiveness of work flow and becoming a data driven organization.

This request, if approved, will modify the scope of services provided by the Contract by eliminating the requirement to retain a Neuropsychologist and a Public Psychiatry Fellow while adding the following positions:

- Director of Quality Systems and APRN Services
- Director of Health System Data and Information Services.

These new positions reallocate resources to New Hampshire Hospital's most critical areas of need. The Director of Quality Systems and APRN Services will establish and implement a comprehensive Quality Assurance program that ensures New Hampshire Hospital is meeting regulatory performance metrics that focus on excellence of patient care and prioritizes a culture of safety. Additionally, this position provides oversight and supervision to the Advanced Practice Registered Nurses, ensuring standardized practice in line with established practice guidelines in psychiatric medicine.

The Director of Health Systems Data and Information Services serves as the conduit for data collection within New Hampshire Hospital. This position will oversee Health Information Services, Information Technology, the Electronic Health Record and the strategic movement of New Hampshire Hospital becoming a data driven organization.

Should the Governor and Executive Council determine to not authorize this request, the Department may not be able to provide essential services at NHH to ensure compliance with regulatory and safety requirements required to maintain accreditation with The Joint Commission, and may increase risk for many of the State's most vulnerable residents.

Area Served: New Hampshire Hospital, Concord NH

Source of Funds: 28% Federal Funds from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medical Assistance Program, Code of Federal Domestic Assistance Number (CFDA) 93.778; 32% General Funds, and; 40% Other Funds (Medicare, Medicaid & third party insurance).

In the event that the Federal Funds become no longer available, additional General Funds will not be requested to support this contract.

Respectfully submitted,

Lori A. Shibinette
Chief Executive Officer

Approved by:

Jeffrey A. Meyers
Commissioner

State of New Hampshire
Department of Health and Human Services

Amendment #1 to the Physician Clinical and Administrative Services Contract

This 1st Amendment to the Physician Clinical and Administrative Services contract (hereinafter referred to as "Amendment #1") dated this 20th day of November 2018, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Mary Hitchcock Memorial Hospital, (hereinafter referred to as "the Contractor"), a corporation with a place of business at One Medical Center Drive, Lebanon, New Hampshire 03756.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on August 24, 2016, (Item #6A), the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract and in consideration of certain sums specified; and

WHEREAS, the State and the Contractor have agreed to make changes to the scope of work, payment schedules and terms and conditions of the contract; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 18, the State may modify the scope of work and the payment schedule of the contract upon written agreement of the parties and approval from the Governor and Executive Council; and

WHEREAS, the parties agree to modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Form P-37, General Provisions, Block 1.9, Contracting Officer for State Agency, to read:

   Nathan D. White, Director.

2. Form P-37, General Provisions, Block 1.10, State Agency Telephone Number, to read:

   603-271-9631.

3. Delete Exhibit A, Scope of Services in its entirety and replace with Exhibit A Amendment #1.

4. Add Exhibit K, DHHS Information Security Requirements.

This amendment shall be effective upon the date of Governor and Executive Council approval.
IN WITNESS WHEREOF, the parties have set their hands as of the date written below.

State of New Hampshire
Department of Health and Human Services

12/12/18
Date

Name:
Title:

Mary Hitchcock Memorial Hospital

11/21/18
Date

Name: Daniel P. Jantzen
Title: Chief Financial Officer

Acknowledgement of Contractor's signature:

State of New Hampshire, County of Grafton on November 21 2018, before the undersigned officer, personally appeared the person identified directly above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.

Signature of Notary Public or Justice of the Peace

LAURA K. RONDEAU
STATE OF
- MY -
COMMISSION
EXPIRES
APRIL 19,
2022
NEW HAMPSHIRE
NOTARY PUBLIC

Laura Rondeau - Notary Public
Name and Title of Notary or Justice of the Peace

My Commission Expires: April 19, 2022

The preceding Amendment, having been reviewed by this office, is approved as to form, substance, and execution.

OFFICE OF THE ATTORNEY GENERAL

12/10/18
Date

Name: Megan A. Lord
Title: Attorney

I hereby certify that the foregoing Amendment was approved by the Governor and Executive Council of the State of New Hampshire at the Meeting on: _____ (date of meeting)

OFFICE OF THE SECRETARY OF STATE

Date

Name:
Title:

Scope of Services

1. Provisions Applicable to All Services

1.1. The Contractor will submit a detailed description of the language assistance services they will provide to persons with limited English proficiency to ensure meaningful access to their programs and/or services within ten (10) days of the contract effective date.

1.2. The Contractor agrees that, to the extent future legislative action by the New Hampshire General Court or federal or state court orders may have an impact on the Services described herein, the State has the right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance therewith.

2. Scope of Services

2.1. Covered Populations and Services

The Contractor shall provide physician clinical and administrative services to various populations served by DHHS, in all seven (7) Service Areas identified below and as described herein:

2.1.1. Service Area #1 – New Hampshire Hospital (NHH)

2.1.2. Service Area #2 – Glencliff Home

2.1.3. Service Area #3 – Medicaid

2.1.4. Service Area #4 – Children, Youth and Families

2.1.5. Service Area #5 – Behavioral Health

2.1.6. Service Area #6 – Elderly and Adult Services

2.1.7. Service Area #7 – Developmental Services

2.2. General Requirements Applicable to All Service Areas

2.2.1. The Contractor shall provide psychiatric and other professional services to all service areas through the employment of appropriate Contractor staff described in the following sections, and requiring such staff to perform required services.

2.2.2. The Contractor shall work with DHHS to continue to develop and refine an integrated mental health care system applying principles of managed care for clinical treatment, educational and training programs, and related research.

2.2.3. The Contractor shall work with DHHS to jointly maintain and develop an applied research and evaluation capacity, the general purpose of which shall be to identify and address medical research issues relative to the DHHS mission under RSA 135-C. The activities shall be directed at enhancing applied research resources, capacities and activities within the State mental health services system and implementing a program of applied research relative to that system.

2.2.4. All personnel provided by the Contractor under this contract shall be employees or consultants of the Contractor. No personnel provided by

the Contractor under this contract shall be considered an employee of the State of New Hampshire.

2.3. Specific Service Requirements for Service Area #1 – New Hampshire Hospital

2.3.1. Chief Medical Officer's Administrative/Clinical Responsibilities

2.3.1.1. Subject to (1) the statutory authority of the DHHS Commissioner or designee, and (2) the authority of the NHH CEO (NHH CEO) with respect to administrative/clinical matters, the Chief Medical Officer shall be responsible for the following:

a. To coordinate with the NHH CEO all clinical activities in order to accomplish the day-to-day clinical operation of NHH in a manner consistent with RSA Chapter 135-C and the rules adopted pursuant thereto, all NHH policies, and all standards of TJC and CMS;
b. To participate in the formulation, implementation, and supervision of all clinical programs for the diagnosis, assessment, treatment, care, and management of patients of NHH, and all clinical personnel engaged in said programs to participate in the formulation, implementation, and supervision of all clinical educational, clinical research, and clinical training programs within NHH;
c. To supervise all documentation requirements of all staff psychiatrists and other clinical personnel employed by the Contractor and providing services under this contract at NHH;
d. To perform annual performance evaluations and discipline as necessary for all staff psychiatrists and other clinical personnel employed by the Contractor and providing services under this contract at NHH. In preparing these evaluations, the Chief Medical Officer shall consult with and seek input from the NHH CEO as to the Department's satisfaction with the services provided by any such individual under review;
e. To perform an annual administrative review of all clinical personnel employed by the Contractor and providing services under this contract at NHH to assure compliance with NHH policy, including but not limited to: training, record keeping, matters of medical records, CPR and CMP training/retraining, TJC requirements, customer service responsibilities, and HIPAA compliance and attendance at mandated in-service training. The Chief Medical Officer shall take whatever action necessary to assure compliance with these requirements and take whatever disciplinary action necessary in instances of non-compliance of NHH policy or NHH Medical Staff Organization bylaws;
f. To comply with all applicable performance standards set forth in this contract pertaining to staff psychiatrists;
g. To provide consultation to DHHS relative to the development of the State mental health service system;
h. To support NHH's customer service culture by adhering to and assuring that psychiatrists under his/her direction, adhere to the

established Customer Service Guidelines for Physicians;

i. To report to the NHH CEO issues known to him/her regarding all admissions, patient care or any other situation that may pose a significant risk to patients or the community or that may result in adverse publicity or in any way undermine public confidence in the clinical care provided by NHH;
j. To participate as a member of the NHH's Administrative Executive Committee;
k. To participate as an ex officio non-voting member of the Executive Committee of the Medical Staff Organization of NHH who represents the NHH CEO;
l. To participate with the NHH CEO in the development of the clinical budget of NHH;
m. To participate in the recruitment of other clinical DHHS personnel, upon the request of the NHH CEO;
n. To establish, subject to the NHH CEO approval, an employment schedule for all clinical personnel employed by the Contractor to provide services at NHH;
o. To assist the NHH Chief Executive Office with the clinical supervision and education of all other clinical staff at NHH; and
p. To provide clinical coverage of Contractor staff as necessary.

2.3.2. Associate Medical Director Responsibilities

2.3.2.1. Subject to (1) the statutory authority of the DHHS Commissioner or designee, and (2) the authority of the NHH CEO with respect to administrative/clinical matters, the Associate Medical Director shall be responsible for the following:

a. To coordinate with the NHH Chief Medical Officer and NHH CEO all clinical activities in order to accomplish the day-to-day clinical operation of NHH in a manner consistent with RSA Chapter 135-C and the rules adopted pursuant thereto, all NHH policies, and all standards of TJC and CMS;
b. Serves in the capacity of the chief medical officer during his/her absence;
c. To participate with the Chief Medical Officer in the formulation, implementation, and supervision of all clinical programs for the diagnosis, assessment, treatment, care, and management of patients of NHH, and all clinical personnel engaged in said programs to participate in the formulation, implementation, and supervision of all clinical educational, clinical research, and clinical training programs within NHH;
d. To supervise all documentation requirements of all staff psychiatrists and other clinical personnel employed by the Contractor and providing services under this contract at NHH;
e. To participate with the Chief Medical Officer in performing annual performance evaluations and discipline as necessary for all staff psychiatrists and other clinical personnel employed by the Contractor and providing services under this contract at NHH. In preparing these evaluations, the Associate Medical Director shall assist the Chief Medical Officer who shall consult with and seek

input from the NHH CEO as to the Department's satisfaction with the services provided by any such individual under review;

f. To work with the CMO to perform an annual administrative review of all clinical personnel employed by the Contractor and providing services under this contract at NHH to assure compliance with NHH policy, including but not limited to: training, record keeping, matters of medical records, CPR and CMP training/retraining, TJC requirements, customer service responsibilities, and HIPAA compliance and attendance at mandated in-service training. The Associate Medical Director shall assist the Chief Medical Officer who shall take whatever action necessary to assure compliance with these requirements and take whatever disciplinary action necessary in instances of non-compliance of NHH policy or Medical Staff Organization bylaws;
g. To comply with all applicable performance standards set forth in this contract pertaining to staff psychiatrists;
h. To provide consultation to DHHS relative to the development of the State mental health service system;
i. To support NHH's customer service culture by adhering to and assuring that psychiatrists under his/her direction, adhere to the established Customer Service Guidelines for Physicians;
j. To report to the NHH Chief Medical Officer and to the CEO issues known to him/her regarding all admissions, patient care or any other situation that may pose a significant risk to patients or the community or that may result in adverse publicity or in any way undermine public confidence in the clinical care provided by NHH;
k. To participate as a member of the NHH's Administrative Executive Committee;
l. In the absence of the Chief Medical Officer, participates as an ex officio non-voting member of the Executive Committee of the Medical Staff Organization of NHH representing the NHH CEO;
m. To participate with the NHH Chief Medical Officer and the NHH CEO in the development of the clinical budget of NHH;
n. To participate in the recruitment of other clinical DHHS personnel, upon the request of the NHH CEO;
o. To assist in establishing, subject to the NHH Chief Medical Officer and NHH CEO approval, an employment schedule for all clinical personnel employed by the Contractor to provide services at NHH; and
p. To assist the NHH Chief Medical Officer and the NHH CEO with the clinical supervision and education of all other clinical staff at NHH; and
q. To provide clinical coverage as necessary and to the extent possible when there are vacancies with the staff psychiatrists or advanced psychiatric nurse practitioners.

2.3.3. General Psychiatrist Responsibilities

2.3.3.1. The following responsibilities are applicable to all psychiatrists the Contractor provides to NHH under this contract. Staff psychiatrists shall be responsible for the following:

a. The formulation and implementation of individual treatment plans and clinical services, in cooperation with treatment teams, for the diagnosis, assessment, treatment, care and management of patients of NHH;
b. Maintaining and directing a clinically appropriate treatment plan for assigned cases in concert with the multidisciplinary staff consistent with NHH norms;
c. Determination, consistent with RSA 135-C, of the appropriateness of admissions, transfers and discharges;
d. Participation with other staff physicians, the NHH Chief Medical Officer, and the Associate Medical Director to provide on-call after hours coverage and serve as on-site, after hours coverage, on a 24-hour a day, 7-day a week, year round basis when necessary as determined by the NHH CEO, the NHH Chief Medical Officer, and/or the Associate Medical Director;
e. Participation in research and education activities consistent with the mission of NHH and subject to the approval of the NHH CEO;
f. Participation in the Medical Staff Organization and other administrative committees of NHH, assigned committees and task forces;
g. Performance of medical/psychiatric consultation on patients from facilities other than NHH, consistent with current NHH policy;
h. Timely completion of all necessary documentation as required by TJC and CMS standards;
i. Responsibility for completing NHH's Incident Reports in compliance with NHH policy;
j. Completion of all medical record documentation in the timeframes required by the NHH's Policy and Procedure "Medical Record Documentation" and other relevant policies and procedures, including ongoing and timely documentation of clinical care regarding medical necessity, including daily progress notes to document and support medical necessity;
k. Adherence to all NHH policies, including, but not limited to policies on Medical Records Documentation and Progress Notes;
l. Ensuring that documentation is consistent with normative data collected by the NHH compliance officer and NHH utilization review manager;
m. Provision of other services as required, which are consistent with the mission of NHH and the intent of this contract;
n. Appearing and testifying in all court and administrative hearings as required by the Department;
o. Developing and maintaining positive relationships with NHH staff, patients, families, advocates, community providers and other interest groups vital to the functioning of NHH and the DHHS system of care, including for the purpose of transition planning. In accomplishing this requirement, psychiatrists shall adhere to the standards set forth in NHH's Customer Service Guidelines for Physicians;
p. Meaningfully participating in utilization review processes, including appeals and other processes, as required by the NHH Chief

Medical Officer, the Associate Medical Director, and the NHH CEO; and

q. Demonstrating value added achievements with academic and scholarly activities including, but not limited to: teaching (clinical and didactic); attendance and participation in case conferences; engagement with the profession with presentation and/or publication; hospital in-services; and service to the hospital and community through committee work, task force work, community service with advocacy groups; and involvement with the work of DHHS, as well as other public and private agencies that serve the mentally ill, e.g. law enforcement, corrections, the court, the legislature, colleges and universities and other related entities.

2.3.3.2. All psychiatrists shall provide services on a full-time basis, and limit their practice to treating NHH patients only.

2.3.3.3. Notwithstanding the above, psychiatrists serving under this contract may perform occasional outside practice duties, with the advance written approval of the Chief Medical Officer and the NHH CEO, but only if said duties do not, in the sole judgment of the NHH CEO, interfere with the psychiatrists' duties at the NHH.

2.3.3.4. For subsection 2.3.3.2., the term "full-time" shall mean that each psychiatrist shall be required to account, through appropriate record-keeping as specified by NHH, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities, subject to the Contractor's normal and customary employee leave policies.

a. Said minimum hours must be satisfied through hours devoted to clinical activities onsite at NHH.
b. Psychiatrists may be permitted, subject to prior notice and the approval of both the Chief Medical Officer and the NHH CEO; to work up to a maximum of 4 hours per week devoted to educational or research activities so long as those activities further the mission and goals of NHH. Psychiatrists approved for such activities shall provide documentation to the Chief Medical Officer and the NHH CEO that time spent devoted to educational or research activities furthers the mission and goals of NHH.

2.3.3.5. Notwithstanding the foregoing allowance for educational or research activities specified in subsection 2.3.3.4.a., psychiatrists shall be physically present onsite at NHH not less than 36 hours per week, unless otherwise accommodated for through the Contractor's normal and customary employee leave policies.

2.3.4. Residents/Post Graduate Fellows Responsibilities

2.3.4.1. The responsibilities of all residents and post graduate fellows (PGY) shall be outlined, monitored, and reviewed by the Chief Medical Officer or the Associate Medical Director, and the appropriate attending psychiatrist.

2.3.4.2. Responsibilities for Residents/Post Graduate Fellows shall involve the advancement of the clinical initiatives underway at NHH under the

supervision of the Chief Medical Officer.

a. General Psychiatry Residents (PGY II and PGY IV) – The Contractor shall ensure that Residents are an integral part of the Contractor's ACGME approved psychiatric residency program. Additionally, the Contractor shall provide faculty oversight, clinical supervision, didactic education and appropriate research opportunities in the field of public psychiatry.
b. Child/Adolescent Fellows – The Contractor shall ensure that Fellows are an integral part of the Contractor's ACGME approved child/adolescent training program. The Contractor shall incorporate a full spectrum of child/adolescent coursework and clinical experience to facilitate the NHH rotation, emphasizing areas of child welfare, family intervention, wraparound services and the juvenile justice system. Fellows shall provide coverage for the entire calendar year.
c. Geropsychiatry Fellow – The Contractor shall ensure that the Fellow is an integral part of an ACGME approved fellowship program in geriatric psychiatry. Additionally, the Contractor shall provide faculty oversight, clinical supervision, didactic education and appropriate research opportunities in the care of the elderly.

2.3.5. Psychiatric Advanced Practice Registered Nurses (APRN) Responsibilities

2.3.5.1. Psychiatric Advanced Practice Registered Nurses shall provide clinical services in extended care and admissions areas with patients with severe mental illness and medical co-morbidity morbidity in accordance with the scope of practice described in RSA 326-B:11.

2.3.5.2. The responsibilities for Psychiatric APRNs shall include but not be limited to: performing advanced assessments; diagnosing; prescribing; administering and developing treatment regimens; and providing consultation as appropriate.

2.3.5.3. APRNs shall independently prescribe, dispense, and distribute psychopharmacologic drugs within the formulary and act as treatment team leaders in accordance with State law and medical staff by-laws.

2.3.5.4. APRNs shall provide the same level of documentation as required of psychiatrists as outlined in subsection 2.3.3.1.

2.3.6. NHH Research Manager Responsibilities

2.3.6.1. The Research Manager shall be responsible for assisting in the development and management of all research at NHH. The Research Manager shall play a pivotal role in initiating and cultivating research that is efficient and responsive to the needs of the NHH CEO, psychiatrists, nursing staff, clinical investigators, administration, and patient community, and works with the Chief Medical Officer to market the research opportunities at NHH while tracking and reporting the growth and development of research activities.

2.3.6.2. The Research Manager shall develop policies and procedures to ensure that research endeavors function effectively and manages and

trains support staff in studies as the research program continues to grow and develop.

2.3.6.3. The Research Manager shall serve as the primary contact for all incoming and proposed studies, assesses feasibility and potential use of resources and guides potential projects through the process from initial proposal to planning for staffing, finding resources, reviewing budgets, and providing guidance with hospital, state and federal regulations through to completion of the project.

2.3.7. After Hours Coverage

2.3.7.1. The Contractor shall provide on-call after-hours coverage, 24 hours per day, 7 days per week, year round. Coverage shall be provided by one or more full-time psychiatrists who are certified or eligible for certification by the American Board of Psychiatry and Neurology. The coverage will be assigned in one-week increments in rotation among the full-time New Hampshire Hospital psychiatric staff. The after-hours coverage will include back-up to the psychiatry residents who provide in-house after-hours coverage and will cover in-house in the event that the assigned in-house physician is not able to provide the service.

2.3.7.2. The Contractor shall provide on-site after hours coverage, 16 hours per day, Monday through Friday, and 24 hours per day on weekends and holidays, year round.

a. The on-site after-hours coverage on weekdays, weekends and holidays shall be provided by a physician who is certified or eligible for certification by the American Board of Psychiatry and Neurology, or, is in training in an accredited psychiatry residency program with at least three years of training experience.
b. The Contractor shall maintain a pool of psychiatric physicians or resident physicians who are credentialed with New Hampshire Hospital for the after-hours work, and the after-hours physicians will be assigned to in-house after-hours coverage by the Chief Medical Officer or Associate Medical Officer with a six (6) month rolling calendar. The pool shall be of sufficient size and appropriate qualifications to ensure the Contractor's ability to meet 100% staffing level requirements and performance standards specified herein at section 4. Performance Standards and Outcomes.

2.3.8. Applied Clinical Research

2.3.8.1. The Contractor, working jointly with DHHS, shall identify and perform applied clinical research for the purpose of advancing the goals of the public mental health services system. All clinical research projects shall be approved by DHHS in advance. This shall include assessing the system's capacity, developing and/or refining clinical strategies, and training clinical staff in emerging treatment technology. The Contractor shall work jointly with DHHS to seek and obtain appropriate financial support (federal, State and foundation) to continue to build on the existing research projects. The Contractor

shall, subject to DHHS approval, ensure that publication of the findings of this research shall receive the widest possible dissemination in the services delivery system in New Hampshire and through conferences and special reports nationally and internationally.

2.3.9. **Additional Requirements**

2.3.9.1. The Contractor shall provide clinical personnel to perform the services required for clinical, educational, research, and training programs at NHH. The Contractor shall provide psychiatrists and other clinical personnel with sufficient professional skills and qualifications to provide the educational and research services needed by NHH.

2.3.9.2. At the direction of the NHH CEO, Contractor staff may be assigned to conduct telepsychiatry or offsite consultation not arising from the clinical operation and administration of New Hampshire Hospital or any other public health or clinical service offered by the Department. Contractor staff assigned to telepsychiatry shall have professional malpractice insurance in effect in an amount satisfactory to the Department. The Contractor shall be responsible for ensuring that staff members have malpractice insurance in effect and in amounts satisfactory to DHHS.

2.4. Specific Service Requirements for Service Area #2 – Glencliff Home

2.4.1. **General Requirements**

2.4.1.1. The Contractor shall provide routine or emergency telephone consultation by the Medical Director (described below) or an equally qualified physician at no additional cost, twenty-four (24) hours per day, seven (7) days per week, fifty-two (52) weeks per year, to clinical and administrative staff at the Glencliff Home.

2.4.2. **Medical Director Responsibilities**

2.4.2.1. The Contractor shall provide a geropsychiatrist to serve as the Medical Director. The Medical Director shall be responsible for the following:

a. Coordination of all medical care and direct psychiatric services, treatment and associated follow up to all residents of Glencliff Home;
b. Provide administrative functions, including but not limited to policy review and establishment that reflect current standards of practice; oversight of physicians; attendance at mandatory committee meetings, including but not limited to continuous quality improvement, infection control, and admissions; regularly review the use of psychotropic medications for compliance with the Omnibus Budget Reconciliation Act (OBRA) regulations; and the provision of other assistance in meeting standards for annual State inspections and Federal regulations;
c. Deliver expert testimony in probate court as needed (e.g. guardianship cases, electroconvulsive therapy, do not resuscitate orders). Preparation may include consultation with legal counsel,

records review, and travel;

d. Provide written patient evaluations on each patient as frequently as required by the Department but in no case less than once per calendar year;
e. Serve as liaison with other organizations, such as NHH or Dartmouth-Hitchcock Medical Center, when a Glencliff Home resident is receiving services at another healthcare institution; and
f. Provide the applicable services as described herein at subsection 2.3.3.1. and its subparagraphs.

2.5. Specific Service Requirements – Service Area #3 – Medicaid

2.5.1. Department of Health and Human Services Chief Medical Officer Responsibilities

2.5.1.1. The Contractor shall provide for the term of the contract, the full-time services of a designated physician, to serve as the Department's Chief Medical Officer.

2.5.1.2. For the Chief Medical Officer, the term "full-time" shall mean that the Chief Medical Officer shall be required to account, through appropriate record-keeping as determined by DHHS, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities, subject to the Contractor's normal and customary employee leave policies.

2.5.1.3. The Chief Medical Officer shall maintain regular office hours consistent with DHHS' regular business hours for senior executive team members. The Contractor shall ensure that the Chief Medical Officer is provided a flexible work schedule that is consistent with the expectations of a senior executive manager at DHHS, subject to the approval of the DHHS Designee.

2.5.1.4. The Chief Medical Officer shall maintain his or her professional calendar electronically, in a format subject to DHHS approval, and make same available to the DHHS Designee as necessary. The Contractor shall ensure the calendar is kept up to date and includes approved leave time, conferences, trainings, etc.

2.5.1.5. The Contractor shall ensure that any out of state travel for conferences and/or trainings for the Chief Medical Officer shall be subject to the prior approval of the DHHS Designee.

2.5.1.6. The Chief Medical Officer's primary workspace shall be located in Concord, New Hampshire, in a DHHS designated facility. DHHS shall provide office space, furniture, a computer with access to DHHS shared network drives as necessary, the usual and customary office supplies, a cell phone for business use and administrative and clerical support. The Contractor shall ensure the Chief Medical Officer utilizes DHHS-provided information and technology resources consistent with applicable State policies.

2.5.1.7. The Chief Medical Officer shall plan and direct all aspects of DHHS'

medical policies and programs to ensure the provision of integrated primary care services to individuals eligible for the Medicaid program, in collaboration with the DHHS Designee.

2.5.1.8. The responsibilities of the Chief Medical Officer shall include but not be limited to the following:

a. Developing strategic clinical relationships with physicians and in growing public/private partnerships with academic institutions and federal agencies with a focus on quality improvement and the implementation of federal health care reforms, such as but not limited to the Patient Protection Affordable Care Act (ACA), and any amendments thereto;
b. Overseeing the development of the clinical content in marketing and educational materials and ensures all clinical programs are in compliance with state and federal regulations;
c. Participating in the writing of research publications to support clinical service offerings;
d. Providing medical oversight of the state's publicly funded health insurance programs, making key policy decisions, and shaping administrative planning strategies to enhance the operating efficiency of Medicaid and CHIP and related healthcare initiatives across the state;
e. In collaboration with the DHHS Designee, directs the day-to-day operations of the DHHS program area responsible for clinical programs, benefit management, and quality improvement activities. Also serves as chief clinical liaison to other state program units, insurance providers, and professional organizations;
f. Serving as the clinical authority in reviewing and determining requests for covered and uncovered medical services and pharmacy services;
g. Participating in the development of procedural reimbursement policy;
h. Promoting and assures effective and efficient utilization of facilities and services using quality improvement methodologies. Oversees the development of a formal quality assurance and quality improvement function within the NH Medicaid program;
i. Identifying new developments and emerging trends in clinical practices and research that would have an impact on medical policy and/or costs, and recommends options and courses of action;
j. Within the context of implementation of federal health care reforms, such as but not limited to the Affordable Care Act and any amendments thereto, provides leadership in the planning, Medicaid program response, development of health care delivery systems, clinical quality initiatives, and related policy issues;
k. Representing the DHHS Designee at meetings and other events and serving as DHHS designee for any committees, boards, and commissions as requested;

l. Analyzing proposed and new federal legislation related to benefits management and recommends options and courses of action;
m. Maintaining and enforces policies, procedures, administrative rules, and State plan provisions that govern Medicaid medical benefits; and
n. Overseeing the implementation of contracted services, maintaining working relationships with contractors, managing contractor deliverables and services, and measuring contractor performance; and
o. Regularly attending Medicaid Management Team meetings.

2.5.1.9. Additionally, the Chief Medical Officer shall assist the DHHS Designee with managing the operations of the clinical and benefits management functions within the Medicaid program. This may include providing to the DHHS Designee input and making recommendations on staffing needs, performance standards, and other matters applicable to DHHS staff.

2.5.1.10. The Chief Medical Officer shall also provide executive team office coverage as needed and requested by the DHHS Designee.

2.6. Specific Service Requirements – Service Area #4 – Children, Youth and Families

2.6.1. DCYF Staff Psychiatrist Responsibilities

2.6.1.1. The Contractor shall provide for the term of the contract, the full-time services of a designated psychiatrist, who is a faculty member and/or employee of the Contractor, to provide psychiatric services to the programs within the Children, Youth and Families service area. For purposes of this paragraph, the term "full-time" shall mean that the Staff Psychiatrist shall be required to account, through appropriate record-keeping as determined by the DHHS designee, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities, subject to the Contractor's normal and customary employee leave policies.

2.6.1.2. The Staff Psychiatrist is expected to work additional hours, including attending non-business hour meetings as required in order to meet the business needs of DHHS without additional cost to DHHS.

2.6.1.3. The Staff Psychiatrist shall maintain regular office hours consistent with those of DHHS senior executive team members.

2.6.1.4. The Staff Psychiatrist shall maintain his or her professional calendar electronically, in a form subject to DHHS approval, and make it available to the DHHS designee as necessary, and will keep it up to date to include leave time, conferences and trainings.

2.6.1.5. The Contractor shall ensure that the Staff Psychiatrist provided under this contract is subject to the Contractor's normal and customary employee benefits and policies, including leave provisions for a senior executive level position. However, the Contractor and DHHS agree that the continuous provision of services is essential, and in addition

to any required approvals by the Contractor for its employees, the Staff Psychiatrist shall provide timely, prior notification to the designated DHHS representative of any leave time taken. Absences due to vacation and continuing education shall be planned in advanced, in consideration of the business needs of the DHHS designated program areas.

2.6.1.6. The Contractor shall ensure that any out of state travel for conferences and/or trainings for the Staff Psychiatrist shall be subject to the prior approval of the DHHS designee.

2.6.1.7. The Contractor shall ensure that any vacation or continuing education leave time by the Staff Psychiatrist shall be planned in advance and consider the business needs of DHHS, including ensuring appropriate coverage for any clinical and/or operational responsibilities or tasks that need oversight.

2.6.1.8. The Staff Psychiatrist's primary workspace shall be located in Manchester, New Hampshire, in a DHHS designated facility. DHHS shall provide office space, furniture, a computer with access to DHHS shared network drives as necessary, the usual and customary office supplies, a cell phone for business use and administrative and clerical support. The Contractor shall ensure the Staff Psychiatrist utilizes DHHS-provided information and technology resources consistent with applicable State policies

2.6.1.9. The Contractor shall work directly with the DHHS designee for the Sununu Youth Services Center (SYSC), and shall ensure the following services are provided by the Staff Psychiatrist under the contract:

a. Provide medical and psychiatric services at SYSC;
b. Provide treatment planning oversight, clinical consultations, and assessments to treatment coordinators and Juvenile Probation and Parole Officers. Documents the number of comprehensive psychiatric evaluations and units of psychiatric services provided annually in direct care to youths in SYSC and the Juvenile Justice System. Documents the number of treatment team meetings and clinical consultations attended annually with multi-disciplinary team members at SYSC;
c. Provides program development at SYSC, using a resiliency-building framework, and implementation of evidence-based practices to include interpersonal problem-solving skills, trauma-focused cognitive behavioral therapy, and dialectical behavioral therapy. Documents specific types and numbers of evidence-based treatment interventions implemented annually at SYSC;
d. Provides clinical supervision and teaching of child psychiatry residents and fellows at SYSC. Documents the number of teaching and supervision contacts annually with interns, residents, and fellows at SYSC;
e. Oversees implementation of research initiatives on the effectiveness and outcomes of services and programs within and for JJS;

f. Documents on an aggregate level, through web-based outcome measures, the efficacy of services targeting Post Traumatic Stress Disorder, depression, substance abuse, and behavioral disorders among New Hampshire youth; and
g. Fosters improved interagency collaboration between JJS services, the area mental health agencies, and NHH to enhance mental health services for adjudicated youths, and to improve transitional processes between residential and community-based programs for court involved youths. Documents the number of youths consulted on annually by Juvenile Probation and Parole Officers and interagency collaborative teams.

2.7. Specific Service Requirements – Service Area #5 – Behavioral Health

2.7.1. Medical Director Responsibilities

2.7.1.1. The Contractor shall provide a part-time Medical Director and the necessary personnel to fulfill four major service components, in addition to a time study requirement in the area of behavioral health services. The four components are:

a. Medical Director for the Behavioral Health program;
b. Evidence-Based Practices Training and Consultation;
c. Behavioral Health Policy Institute (BHPI); and
d. Committee for the Protection of Human Subjects (CPHS).

2.7.1.2. The Medical Director shall be available on-site, at a DHHS designated location, for twenty (20) hours per week to provide services to the Behavioral Health service area. The Medical Director shall be available via telephone, email, and in person by appointment during that time.

2.7.1.3. The Medical Director shall, in collaboration with the DHHS designee be responsible for the following:

a. Meet weekly with the DHHS designee;
b. Address Behavioral Health clinical issues;
c. Address Behavioral Health policy issues;
d. Enhance housing support capacity planning;
e. Address Medicaid and state rule issues;
f. Address designated receiving facility maintenance and development;
g. Assist in developing Telemedicine capacity;
h. Utilizes electronic medical records;
i. Coordinate between NHH and CMHC care;
j. Evidence Based Practices (EBP) implementation;
k. Develop funding and reimbursement strategies;
l. Assist in sustainability of the "In Shape" program
m. Assess the needs of patients in NHH and Transitional Housing Services who might be served in the community; and
n. Attend meetings between the Behavioral Health program and various community stakeholder groups, such as the Community Behavioral Health Association and the Disabilities Rights Center,

to communicate about and also garner support for and input regarding Behavioral Health initiatives.

2.7.1.4. The Medical Director shall fulfill the additional following responsibilities:

a. Participate on key departmental and legislative committees, as required by DHHS, including the Mental Health Commission, the Mental Health Council, the Drug Utilization and Review Board, and the DHHS Institutional Review Board;
b. Serve as secretary for the Mental Health Council, to ensure that the work of the council supports the goals of DHHS;
c. Serve as a member of the Drug Utilization and Review Board to ensure that the Medicaid Preferred Drug List and work of the Board addresses the needs of consumers with mental illness disabilities;
d. Attend regular case conferences and sentinel event reviews. Analyze challenging clinical cases or events and recommend improvements in policy or services to address problem areas;
e. Attend monthly Institutional Review Board meetings, review research protocols as needed each month to ensure safety of DHHS research participants;
f. Participate on several Behavioral Health System Transformation Workgroups, including the EBP Steering Committee, Programmatic Workgroup, and Quality Assurance Group;
g. Coordinate and meet with DHHS leadership as required by DHHS;
h. Conduct bi-monthly or more frequent Behavioral Health Medical Director's meeting to coordinate efforts, between Behavioral Health and CMHCs, regarding medical/treatment issues related to both hospital and outpatient care of people with serious mental illness and to consult on other relevant issues or concerns, including: preferred drug list issues, coordination with NHH admissions and treatment, Medicaid interruption during institutionalization, enhancement of community housing supports, use of information technology, medical director administrative issues, use of best practices, implementation of EBP's, documentation burden, integration of mental and physical health care, smoking cessation, coordinating local, state and national agendas regarding public mental health care, electronic health records, health information exchange, education and training for CMHC prescribers regarding evidence-based use of antipsychotic medications and monitoring for cardio metabolic side effects;
i. Monitor the effectiveness of the preferred drug list in enhancing cost effective and safe psychotropic medication prescribing in NH including engaging in ongoing discussions with CMHC leaders regarding the Preferred Drug List and direct education and training for CMHC prescribers regarding evidence-based use of antipsychotic medications and monitoring for cardio-metabolic side effects;
j. Communicate regularly with, and provide clinical consultation (including potential site visits, conference calls, and written

reports) to all Behavioral Health management staff regarding current, challenging clinical issues, including conditional discharges; Medicaid consumer cases, and suicide monitoring;

k. Collaborate with the other DHHS Medical Directors, on a regular basis to monitor medical care and related patient care issues throughout New Hampshire, including drug choice for the Preferred Drug List, performance and impact of the Preferred Drug List on clinical care, Medicaid interruption during hospitalization and incarceration, integration of medical, mental health, and substance abuse services, and enhancement of addiction treatment capacity; and

l. Provide oversight and continuing implementation of Evidence Based Practices, including practices as part of the Medicaid Program for Community Mental Health Services as well as those practices specifically required in the Community Mental Health Agreement.

2.7.2. Evidence-Based Practices Training and Consultation

2.7.2.1. The Contractor shall provide Evidence-Based Practices Training and Consultation services as described in Appendix I, of RFP-2017-OCOM-01-PHYSI, for the purpose of sustaining and continuously improving the quality of three (3) Evidence-Based Practices (EBP) that are implemented across the New Hampshire Community Mental Health Centers (CMHC) system. The EBPs are: Illness Management and Recovery (IMR), Evidence-Based Supported Employment (EBSE), and Assertive Community Treatment Teams (ACT). Additional EBPs may take the place of these based on the availability of federal funding to support the implementation of additional EBPs in New Hampshire.

2.7.2.2. The Contractor shall provide education, training, technical assistance and consultation to the DHHS Behavioral Health service area and the CMHCs. The deliverables described below shall be provided directly to DHHS-designated Behavioral Health program staff and CMHCs designated by DHHS.

2.7.2.3. DHHS shall designate a specific DHHS Behavioral Health staff member to oversee the deliverables specified herein. The Contractor shall designate a specific representative of the Contractor to work directly with the DHHS designee in the fulfillment of these deliverables.

2.7.2.4. **Training the CMHC Workforce:** To sustain and improve the quality of IMR and EBSE services, the Contractor shall provide education and training to DHHS designated CMHCs staff.

a. The Contractor shall ensure that the training and education is provided in central locations and in a manner that best facilitates the learning of key skills and strategies that are necessary to provide IMR and EBSE in ways that support the most effective outcomes for consumers at each of the CMHCs. The training shall be designed to fulfill the specifications described in He-M

426 for CMHC providers of EBPs in NH.

b. Each training event shall include, at a minimum:
   i. Invitations provided to CMHC staff before the training event;
   ii. A description of who should attend the training;
   iii. Outcomes for participants attending the training;
   iv. Sufficient time to provide instruction and practice for skills;
   v. Content designed to improve the fidelity of the practice at CMHC's;
   vi. Documentation of all participants attending the training; and
   vii. Certificates of attendance for all participants completing the training.

c. Each training event shall be staffed by Contractor staff or other qualified professionals; such individuals shall be subject to approval of the DHHS designee.

2.7.2.5. **Illness Management and Recovery (IMR):** The Contractor shall develop, in collaboration with the DHHS designee, specific topic areas for CMHC staff providing IMR services. The topic areas shall be subject to the DHHS designee's approval.

a. The Contractor shall provide the IMR trainings in the following formats:
   i. A minimum of one two-day training for new IMR practitioners to fulfill the specifications described in He-M 426 to provide IMR services. The capacity for each of these training events shall be twenty participants and up to thirty participants depending on the availability of the training space;
   ii. A minimum of four half-day trainings for experienced IMR practitioners, of which the combination of attending any two of these events shall fulfill the specifications described in He-M 426 for ongoing providers of IMR services. The capacity for each of these training events shall be at least twenty participants and up to thirty participants depending on the availability of the training space.
   iii. A minimum of one full-day training for IMR supervisors that shall fulfill the specifications in He-M 426 for ongoing providers of IMR services. The content shall include information on supporting the learning of IMR skills for colleagues and improving the quality and outcomes of IMR services through practice-specific supervision. The capacity for this training event shall be twenty participants.

2.7.2.6. **Evidence Based Supported Employment (EBSE):** The Contractor shall develop, in collaboration with the DHHS designee, specific topic areas for CMHC staff providing EBSE services. The topic areas shall be subject to the DHHS designee's approval.

a. The Contractor shall provide the EBSE trainings in the following formats:
   i. A minimum of two two-day trainings for new EBSE practitioners to fulfill the specifications described in He-M 426 to provide EBSE services. The capacity for each of these

training events shall be twenty participants.

ii. A minimum of two half-day trainings for experienced EBSE practitioners, the combination of attending these two events shall fulfill the specifications described in He-M 426 for ongoing providers of EBSE services. The capacity for each of these training events shall be twenty participants.

iii. A minimum of two half-day trainings for experienced EBSE practitioners and EBSE supervisors. The combination of attending these two events shall fulfill the specifications described in He-M 426 for ongoing providers of EBSE services. The content shall include information on developing and improving collaboration with the New Hampshire Department of Vocational Rehabilitation and other important community partners in providing effective EBSE services. The capacity for each of these training events will be twenty participants.

2.7.2.7. **Assertive Community Treatment Teams (ACT)**: The Contractor shall develop, in collaboration with the DHHS designee, specific topic areas for CMHC staff providing ACT services. The topic areas shall be subject to the DHHS designee's approval.

b. The Contractor shall provide the ACT trainings in the following formats:

i. A minimum of two two-day trainings for new ACT practitioners to fulfill the specifications described in He-M 426 to provide EBSE services. The capacity for each of these training events shall be twenty participants.

ii. A minimum of two half-day trainings for experienced ACT practitioners, the combination of attending these two events shall fulfill the specifications described in He-M 426 for ongoing providers of ACT services. The capacity for each of these training events shall be twenty participants.

iii. A minimum of two half-day trainings for experienced ACT practitioners and ACT supervisors. The combination of attending these two events shall fulfill the specifications described in He-M 426 for ongoing providers of ACT services. The capacity for each of these training events will be twenty participants.

2.7.2.8. **Assessing Fidelity to Evidence Based Practices (EBPs)**: The Contractor shall assess the fidelity (organizational faithfulness to the principles of the practice) of IMR, ACT and EBSE for all CMHCs, as designated by the DHHS designee, with the exception of those CMHCs where the DHHS designee has approved a limited scope of review through the submission of an approved Quality Improvement Plan (QIP). In those organizations utilizing a QIP, the Contractor shall review those fidelity items described in the QIP.

a. In either case, fidelity assessments shall be conducted for the purpose of monitoring the implementation of IMR, ACT and EBSE and for providing information about the capacity, strengths and areas in need of improvement in providing the practice at the

designated CMHCs.

b. The Contractor shall develop, in collaboration with the DHHS designee, a specific schedule designating specific time periods for each CMHC IMR, ACT and EBSE fidelity or QIP review. The schedule shall be subject to the advanced approval of the DHHS designee.
c. The Contractor shall ensure that each fidelity or QIP assessment includes, at a minimum:
   i. Written instructions to the CMHC regarding necessary observations, interviews, data access and other activities for the assessment;
   ii. A description of CMHC staff, other community providers, consumers and family members who will need to be interviewed for the assessment;
   iii. A specific written assessment schedule jointly developed by the Contractor and the CMHC;
   iv. Sufficient time to assess and evaluate the CMHC's delivery of IMR, ACT or EBSE;
   v. A debriefing at the end of the assessment to review themes from the review with CMHC leadership; and
   vi. Documentation of the assessment process, findings and scoring of fidelity items for CMHC leadership and the Department no later than four weeks following the assessment.

2.7.2.9. **Consultation to CMHC Leadership and Workforce Development:** The Contractor shall provide agency-based consultations to all CMHCs as designated by the DHHS designee to assist agencies in sustaining and providing continuous quality improvement for IMR, ACT and EBSE services. The Contractor shall ensure that CMHC leadership has access to consultations at their agencies after they have received the written documentation of the findings of each fidelity assessment described herein at subsection 2.7.2.8. Consultations shall include the development of ideas, strategies and interventions that each individual CMHC may utilize to most effectively sustain and improve IMR, ACT and EBSE services.

a. In cases where CMHCs would benefit from specific agency-based workforce development interventions from the Contractor's staff, the Contractor shall ensure that such further interventions are provided only when collaboratively agreed upon by the DHHS designee, the Contractor and CMHC leadership. These interventions shall be time-limited (customarily one half-day, single events) and specifically tailored to improving designated fidelity areas that are identified as a result of agency-based post fidelity consultations.

2.7.2.10. **NH Behavioral Health Service Area Consultations and Collaboration:** In order to most effectively fulfill the deliverables described in this document for the purposes of sustaining and improving the quality of IMR, ACT and EBSE services in the NH Community Mental Health system, the Contractor shall work in a highly integrated fashion with the DHHS designee and additional

DHHS Behavioral Health resources identified by the DHHS designee. This integrated alliance shall also be extended to other state and community agencies as collaboratively agreed upon by the DHHS designee and the Contractor.

a. In addition to attending designated meeting or events, the Contractor shall prepare research information, specific ideas, interventions, feedback, data and strategies, as collaboratively agreed upon by the DHHS designee and the Contractor. Specific activities for consultation and collaboration shall include:
   i. The Contractor's attendance at the State EBP advisory committee bi-monthly meetings by the Contractor and/or designees;
   ii. The Contractor's attendance at weekly meetings with the DHHS designee;
   iii. Attendance of Contractor staff at monthly meetings with the DHHS designee and any additional DHHS Behavioral Health resources identified by the DHHS designee;
   iv. The Contractor's attendance at quarterly meetings with the DHHS designee, and any additional DHHS Behavioral Health resources identified by the DHHS designee, to review progress of these deliverables and make any necessary resource allocations within the scope based, as collaboratively agreed upon by the DHHS designee and the Contractor;
   v. The Contractor's attendance at DHHS designated meetings with NH Bureau of Vocational Rehabilitation (NHBVR) personnel to improve collaboration between EBSE services and NHBVR at both state-wide and regional levels to better assist CMHC consumers in achieving their vocational goals;
   vi. The Contractor's attendance at DHHS designated meetings with Granite State Employment Project (Medicaid Infrastructure Grant) personnel to improve collaboration between EBSE services and the Granite State Employment Project at both state-wide and regional levels to better assist CMHC consumers in achieving their vocational goals;
   vii. The Contractor's attendance at DHHS designated meetings with DHHS Behavioral Health personnel regarding Behavioral Health strategies and interventions, including proposed rule or policy and procedure changes, to better facilitate the sustaining and improvement of IMR, ACT and EBSE services in the NH Community Mental Health system;
   viii. The Contractor's attendance at designated meetings with key CMHC personnel, including monthly meetings of CMHC Community Support Program directors, regarding the Contractor's activities and to better facilitate the sustaining and improvement of IMR, ACT and EBSE services; and
   ix. The Contractor's attendance at other events, as collaboratively agreed upon by the DHHS designee and the Contractor, for the purposes of sustaining and improving the quality of IMR, ACT and EBSE services.

2.7.3. **Behavioral Health Policy Institute (BHPI)**

2.7.3.1. Under the direction of the DHHS designee and the Behavioral Health Medical Director providing services to the Behavioral Health program, the Contractor shall conduct periodic analyses, the frequency of which shall be determined by DHHS, of Medicaid claims to address policy issues and questions under consideration from the Behavioral Health program. The Contractor shall participate in regular meetings with the DHHS designee and the Behavioral Health Medical Director to review these analyses, and associated policy implications.

2.7.4. **Committee for the Protection of Human Services (CPHS)**

2.7.4.1. The Contractor shall achieve the following CPHS related deliverables for the purpose of sustaining and supporting a committee to oversee research funded by federal agencies and other non-state sources, and conducted in New Hampshire DHHS-funded programs that serve people with mental illness, developmental disabilities, and substance abuse or dependence disorders, in fulfillment of NH RSA 171-A:19-a. Because of federal regulations governing the composition and operation of such committees, a certain number of scientific experts must be present on the committee. The Contractor shall provide research, scientific and human subject's expertise to the CPHS under the contract.

2.7.4.2. The Contractor shall provide staff to support the CPHS who shall:

a. Attend and fully participate in CPHS full committee meetings (once per month);
b. Conduct expedited reviews as requested by the CPHS Administrator (averaging about three per month);
c. Provide consultation, support, and guidance to the CPHS Administrator, Chairperson, and Committee members regarding the interpretation of federal regulations and human subject's protections (e.g., pre-reviewing materials, reviewing requirements for exempt and expedited determinations, reviewing significant adverse event reports);
d. Serve on the Consent Form Template and Forms sub-committees, or others as requested by the CPHS Chairperson; and
e. Serve as the Co-Vice Chair to the CPHS.

2.7.4.3. Revision of the aforementioned deliverables may be done by mutual agreement of the Contractor and the DHHS designee. The availability of additional federal funds to support the implementation of additional Evidence Based Practices may also necessitate a renegotiation of priorities outlined in this deliverables plan, and a reallocation of the Contractor's time in order to assist with the construction of federal grant applications. Changes agreed upon may be subject to Governor and Executive Council approval.

2.7.5. **Time Studies**

2.7.5.1. The Contractor shall be responsible for performing regular time studies in accordance with CMS and DHHS Medicaid Cost Allocation

procedures in order to document activities, relating directly to the administration of the Medicaid program, to draw down federal matching revenues, which will be utilized to support costs associated with the Behavioral Health Medical Director's salary, benefits, and indirect expenses. These studies shall be provided in and documented in a format approved by DHHS.

2.8. Specific Service Requirements – Service Area #6 – Elderly and Adult Services

2.8.1. Medical Director Responsibilities

2.8.1.1. The Contractor shall provide a part-time Medical Director to the Elderly and Adult Services service area who shall provide services for the purposes of sustaining and improving the quality of services for the elderly and adults with disabilities in NH.

2.8.1.2. The Medical Director shall, in collaboration with the DHHS designee:

a. Assist in the planning and direction of the organization's medical policies and programs;
b. Strategically develop public/private partnerships with community providers, academic institutions and state/federal agencies with a focus on quality improvement;
c. Serve as a resource for chronic disease self-management or other wellness/prevention initiatives to improve the lives of individuals served by the Elderly and Adult Services service area;
d. Perform a variety of complex tasks that include the provision of medical consultation, clinical oversight, educational instruction, benefits management and quality assurance within the Elderly and Adult Services service area;
e. Provide medical oversight for all aspects of the Medicaid Program managed by the Elderly and Adult Services service area, including the waiver program for seniors and adults with disabilities, assisting in key policy decisions, identifying partnering opportunities with other program areas, and shaping administrative planning strategies to enhance the program's operating efficiency and cost effectiveness;
f. Serve as the clinical authority in reviewing requests for coverage of services not routinely offered, and providing clinical guidance to the Elderly and Adult Services service area on all such responses, as well as collaborating on developing new service coverage to respond to needs or practices identified;
g. Promote and assures effective and efficient utilization of facilities and services using quality improvement methodologies. Oversees the development of a formal quality assurance and quality improvement function within the Elderly and Adult Service area;
h. Identify new developments and emerging trends in clinical practice and research that would have an impact on clinical policy and/or costs and recommend options and courses of action;
i. Identify program development opportunities within federal health care reforms, such as but not limited to the implementation of the Patient Protection Affordable Care Act (ACA) and any

amendments thereto;

j. Leads planning and development of program and policy changes within the Elderly and Adult Services service area throughout the implementation of federal health care reforms, such as but not limited to the ACA and any amendments thereto;
k. Participate in the Technical Assistance Committee (TAC) that reviews clinical issues and initiatives within New Hampshire Nursing Facilities;
l. Participate in the quality assurance initiative, Sentinel Event Reviews;
m. Assist in the implementation of ACA by providing leadership in the planning and development of health care delivery systems, clinical quality initiatives and related policy issues;
n. Provide educational training to DHHS Elderly and Adult Services service area personnel, and external stakeholders;
o. Provide clinical expertise and medical consultation in Elderly and Adult Services service area grant writing and program evaluation;
p. Attend a minimum of two (2) Technical Advisor Committee meetings per annum;
q. Attend Sentinel Event Review Meetings; and
r. Meet, two times per month with the DHHS designee to review initiatives and provide consultation services.

2.9. Specific Service Requirements – Service Area #7 – Developmental Services

2.9.1. Medical Director Responsibilities

2.9.1.1. The Contractor shall provide a part-time Medical Director to the Developmental Services service area. The Medical Director shall provide services that includes two days of psychiatric consultation services per week, and is allocated at 0.4 Full-Time Equivalent.

2.9.1.2. The Medical Director shall:

a. Weekly dedicate one day to referrals from the ten Area Agencies and another day to referrals from Special Medical Services (SMS) and its child development clinics. These referrals may include the Medical Director performing evaluations, consultations and medication reviews;
b. Based on He-M 1201, chair Developmental Services' Medication Committee meetings and provide expert opinion and leadership to facilitate effective functioning of the Committee;
c. Assist the DHHS Developmental Services service area staff in addressing medical issues related to quality assurance activities or Sentinel Event Reviews;
d. Provide educational training to DHHS Developmental Services service area staff, Area Agencies, and subcontract agencies and other stakeholders, as identified by Developmental Services;
e. Provide expertise and assistance in efforts to improve New Hampshire's developmental services system; and
f. Respond to all referrals for evaluations and consultations made through the Area Agencies, SMS, and child development clinics.

2.9.2. Adult Developmental Services Interdisciplinary Clinic Team

2.9.2.1. The Contractor shall provide an Interdisciplinary Clinic Team for Adults. The Contractor shall provide the following staffing and fulfill the following responsibilities for the Interdisciplinary Clinic Team for Adults.

a. **Psychiatrist** – the psychiatrist shall serve as the clinic director, coordinating the team / providers involved in this clinic. The psychiatrist shall conduct a comprehensive psychiatric examination; including reviewing the client's entire past psychiatric treatment and medical history. The psychiatrist shall make recommendations as part of the comprehensive report regarding evidence based treatment for optimal care for each client;
b. **Neuropsychologist** – the neuropsychologist shall review all past psychiatric, medical records, neuropsychological testing and behavioral incidents. The neuropsychologist shall document their recommendations as part of the comprehensive report. The neuropsychologist shall supervise the neuropsychology fellow and shall oversee the documentation of historical information regarding the client;
c. **Neuropsychology fellow** – the neuropsychology fellow shall review all past medical, past psychiatric records, neuropsychological testing, behavioral incidents and document pertinent historical information regarding each person as part of the comprehensive report;
d. **Neurologist** – the neurologist shall review past medical records, conduct a physical examination, and document their findings and recommendations as part of the comprehensive report;
e. **Primary Care Physician** – the primary care physician shall review past medical records, conduct a physical examination, and document their findings and recommendations as part of the comprehensive report;
f. **Occupational Therapist** – the occupational therapist shall review past medical records, conduct an occupational therapy evaluation, document their findings and recommendations as part of the comprehensive report; and
g. **Administrative Support** – the administrative support will schedule the appointment, review received documents and checklist of requested documents, copy records for providers and fax completed reports.

2.9.2.2. The Interdisciplinary Clinic Team for Adults shall provide the following services:

a. The Contractor shall ensure the Team accepts adults being referred from the Area Agencies needing this service. Should the number of referrals exceed the number of clients able to be seen, then the Contractor shall prioritize clients based on the most immediate need and critical situation;
b. The Contractor shall support the goal of this Interdisciplinary Clinic Team by providing high quality interdisciplinary evaluations to adults with developmental disabilities and acquired brain injuries.

The Contractor shall provide a comprehensive understanding of the client with a focus on a biological, psychological, social/environmental approach and the interaction of these factors as they relate to the clients strengths, skills, and interests. The Contractor shall generate one comprehensive report with recommendations that can be utilized by the Systemic – Therapeutic – Assessment – Resources – and Treatment (START) Coordinators, Area Agencies and medical providers to provide the best quality of care for each person. The Contractor shall serve as one point of access to a team of expert providers to reduce each client's number of medical appointments and reduce each clients need to travel to multiple appointments;

c. The Contractor shall convene the Interdisciplinary Clinic Team one time per month and shall conduct a face-to-face appointment with one client per month, for a total of 12 clients per year. The Interdisciplinary Clinic Team meetings and face-to-face client appointments shall take place at a location designated by DHHS. The Contractor shall review all previous records of each client prior to each face-to-face appointment. The Contractor's Interdisciplinary Clinic Team of providers shall meet with the client and the client's team of caregivers as part of the evaluation to obtain history / concerns and examine the client. After meeting and examining the client, the Interdisciplinary Clinic Team shall meet to discuss recommendations. The Interdisciplinary Clinic Team shall generate a comprehensive report regarding the visit and recommendations. The report shall be made available within 15 business days from the date of the last meeting of the Interdisciplinary Clinic Team; and
d. The Contractor shall have the client or the client's authorized representative sign a release form identifying the parties to whom the Contractor may distribute the comprehensive reports.

2.9.3. Child Developmental Services Interdisciplinary Clinic Team

2.9.3.1. The Contractor shall provide an Interdisciplinary Clinic Team for Children. The Contractor shall provide the following staffing and fulfill the following responsibilities for the Interdisciplinary Clinic Team for Children.

a. **Child Psychiatrist** – the psychiatrist shall serve as the clinic director, coordinating the team / providers involved in this clinic. The psychiatrist shall conduct a comprehensive psychiatric examination, including reviewing the client's entire past psychiatric treatment history. The psychiatrist shall make recommendations as part of the comprehensive report regarding evidence based treatment for optimal care for each patient;
b. **Neuropsychologist** – the neuropsychologist shall review all past medical records, neuropsychological testing, and behavioral incidents; document their recommendations as part of the comprehensive report. The neuropsychologist shall supervise the neuropsychology fellow and shall oversee writing the historical information regarding the child;

c. **Neuropsychology fellow** – the neuropsychology fellow shall review all past medical records, neuropsychological testing, behavioral incidents and document pertinent historical information regarding each person as part of the comprehensive report;
d. **Neurologist** – the neurologist shall review past medical records, conduct a physical examination, and document their findings and recommendations as part of the comprehensive report;
e. **Primary Care Physician** – the primary care physician shall review past medical records, conduct a physical examination, and document their findings and recommendations as part of the comprehensive report;
f. **Occupational Therapist** – the occupational therapist shall review past medical records, conduct an occupational therapy evaluation, document their findings and recommendations as part of the comprehensive report; and
g. **Administrative Support** – the administrative support shall schedule the appointment, review received documents and checklist of requested documents, copy records for providers and fax completed reports.

2.9.3.2. The Interdisciplinary Clinic Team for Children shall provide the following services:

a. The Contractor shall ensure the Team accepts children being referred from the Area Agencies needing this service. Should the number of referrals exceed the number of clients able to be seen, then the Contractor shall prioritize clients based on the most immediate need and critical situation;
b. The Contractor shall support the goal of this Interdisciplinary Clinic Team by providing high quality interdisciplinary evaluations to children and adolescents with developmental disabilities. The Contractor shall provide a comprehensive understanding of the child with a focus on a biological, psychological, social/environmental approach and the interaction of these factors as they relate to the child's strengths, skills, and interests. The Contractor shall generate one comprehensive report with recommendations that can be utilized by the Systemic – Therapeutic – Assessment – Resources – and Treatment (START) Coordinators, area agencies and medical providers to provide the best quality of care for each child. The Contractor shall serve as one point of access to a team of expert providers to reduce each client's number of medical appointments and reduce each clients need to travel to multiple appointments;
c. The Contractor shall convene the Interdisciplinary Clinic Team one time per month and shall conduct a face-to-face appointment with one client per month, for a total of 12 client appointments per year. The Interdisciplinary Clinic Team meetings and face-to-face client appointments shall take place at a location designated by DHHS. The Contractor shall review all previous records prior to each client's appointment. The Interdisciplinary Clinic Team of providers shall meet with the client and the client's team of

caregivers as part of the evaluation to obtain history / concerns and examine the client. After meeting and examining the client, the Interdisciplinary Clinic Team shall meet to discuss recommendations. The Interdisciplinary Clinic Team shall generate a comprehensive report regarding the client's appointment and resulting team recommendations. The report shall be made available within 15 business days from the date of the last meeting of the Interdisciplinary Clinic Team; and

d. The Contractor shall have the client or the client's authorized representative sign a release form identifying the parties to whom the Contractor may distribute the comprehensive reports.

3. Staffing

3.1. General Requirements Applicable to All Service Areas:

3.1.1. The following requirements apply to all personnel provided under the contract:

3.1.1.1. The Contractor shall recruit and retain qualified individuals for the staffing needs specified herein at subsections 3.3 through 3.9, and as otherwise necessary to fulfill the requirements described herein at: Section 2, Scope of Services; Section 4, Performance Standards and Outcomes; and Section 5, Reporting.

3.1.1.2. All such individuals shall be subject to DHHS approval prior to the Contractor notifying candidates of assignment/hire to fulfill a specified staffing role. DHHS shall inform the Contractor of its applicable designee for this purpose per position or service area. The designee, at his or her discretion, shall be entitled to interview any such candidate; the Contractor shall facilitate coordinating such interviews upon the DHHS designee's request.

3.1.1.3. DHHS, at its sole discretion, may rescind, either permanently or temporarily, its approval of any Contractor personnel providing any services under this contract for any of the following reasons:

a. Suspension, revocation or other loss of a required license, certification or other contractual requirement to perform such services under the contract;
b. Providing unsatisfactory service based on malfeasance, misfeasance, insubordination or failure to satisfactorily provide required services;
c. Arrest or conviction of any felony, misdemeanor, or drug or alcohol related offense;
d. Abolition of the role due to a change in organizational structure, lack of sufficient funds or like reasons; or
e. Any other reason which includes, but is not limited to: misconduct, violation of DHHS policy, or violation of state or federal laws and regulations pertaining to the applicable DHHS service area, or a determination that the individual presents a risk to the health and safety of any staff member or any individual served by the Department.

In the event of such rescission, the Contractor's applicable staff member shall be prohibited from providing services under the contract for the period of time that DHHS exercises this right. In the event DHHS chooses to exercise this right, DHHS shall provide reasonable advance notice to the Contractor.

3.1.1.4. DHHS shall provide the Contractor with prior notice of exercising its right under subsection 3.1.1.3. and the reason for which DHHS has exercised its right. If DHHS removes Contractor personnel for any reason, no additional payments shall be paid by the State for any staff removed from duty by the Department

3.1.1.5. In the event that DHHS exercises its right under subsection 3.1.1.3.

a. The Contractor shall provide replacement personnel who shall meet all of the applicable requirements under the contract, including but not limited to being subject to the DHHS approval specified in 3.1.1.2.;
b. The Contractor shall be responsible for providing transition services to the applicable DHHS service area to avoid the interruption of services and administrative responsibilities at no additional cost to DHHS;
c. DHHS shall inform the Contractor of the anticipated duration for which approval will remain rescinded. If the position is assigned to NHH, and if the duration of a temporarily rescinded approval is greater than seven (7) calendar days, the Contractor shall furnish within ten (10) business days replacement Contractor staff who shall meet all of the requirements for the applicable position under the contract. The Contractor shall be responsible for providing, at no additional cost to the Department, transition services to NHH to avoid service interruption;
d. It shall be at the Contractor's sole discretion whether to initiate any internal personnel actions against its own employees. However, nothing herein shall prohibit the Contractor from seeking information from DHHS regarding DHHS' decision, unless such information is otherwise restricted from disclosure by DHHS based on internal DHHS policies or rules, State of New Hampshire personnel policies, rules, collective bargaining agreements, or other state or federal laws.

3.1.1.6. The Contractor shall ensure that, prior to providing the applicable services for the applicable DHHS service area or facility, all required licenses, certifications, privileges, or other specified minimum qualifications are met for all staff, and where applicable, are maintained throughout the provision of services for the full term of the contract. The Contractor shall provide the applicable DHHS designee with a copy of all such documents. The Contractor acknowledges and agrees that DHHS shall not be held financially liable for any fees or costs for any licenses, certifications or renewal of same, nor for any fees or costs incurred for providing copies of said licenses or certifications.

3.1.1.7. The Contractor shall ensure that all staff provided under this contract

are subject to the Contractor's normal and customary employee benefits and policies, including leave provisions. However, whereas the Contractor and DHHS agree that the continuity of operations and continuous provision of the staffing described in this contract at the level of 100%, is of paramount importance to the State, in addition to any required approvals by the Contractor for its employees, Contractor staff providing services shall provide timely, prior notification to the applicable DHHS designee for any anticipated leave time, unless otherwise stated herein for a specific position or service area.

3.1.1.8. All personnel provided by the Contractor shall be subject to the identified criminal background, registry, screening and medical examinations, as specified in the table below, for the applicable Service Area to which the individual is assigned contractual service responsibilities. The Contractor shall ensure the successful completion of these requirements for each individual assigned by the Contractor to perform contractual services prior to commencing work and shall ensure that such requirements are kept up to date as required; the Department shall receive copies of all documentation prior to the commencement of services and shall not be responsible for any costs incurred in obtaining the documentation described below:

Service Area		Required Background, Registry, Screening, and Medical Examinations
1	New Hampshire Hospital	Criminal Background, BEAS State Registry, DCYF Central Registry, Health Assessment (including TB testing and physical capacity examination).
2	Glencliff Home	Criminal Background (including RSO and OIG), BEAS State Registry, DCYF Central Registry, TB Testing
3	Medicaid Program	Criminal Background, BEAS State Registry, DCYF Central Registry
4	Children, Youth & Families	Criminal Background, DCYF Central Registry, TB Testing
5	Behavioral Health	Criminal Background, BEAS State Registry, DCYF Central Registry
6	Elderly and Adult Services	Criminal Background, BEAS State Registry
7	Developmental Services	Criminal Background, BEAS State Registry, DCYF Central Registry

3.2. General Staffing Requirements Applicable to Service Area #1 – New Hampshire Hospital

3.2.1. The following additional requirements shall apply specifically to personnel provided to fulfill the contractual requirements applicable to Service Area #1 – NHH, for the duration of the contract:

3.2.1.1. The Contractor shall ensure that the Chief Medical Officer actively participates in the recruitment of all other staffing needs required

under the contract for the provision of services at NHH.

3.2.1.2. The Contractor shall ensure that, prior to commencing practice at NHH, all psychiatrists are licensed to practice medicine in the State of New Hampshire, as well as boarded in their particular specialty or are board eligible, and shall commence the privileging process of the Medical Staff Organization of NHH as authorized by its by-laws. Such licenses and clinical privileges must be maintained throughout the term of the contract.

3.2.1.3. The Contractor shall ensure that all clinical personnel maintain appropriate licensure/certification relevant to the practice of their clinical disciplines.

3.2.1.4. DHHS reserves the right to jointly, with the Contractor, or separately, interview, research or otherwise screen and consider candidates the Contractor designates for the Chief Medical Officer role.

3.2.1.5. In addition to the provisions stated herein at subsection 3.1.1.7., staff providing services to NHH shall provide timely, prior notification to the Chief Medical Officer and the NHH CEO for any anticipated leave time. The Contractor shall be solely responsible for providing, at no additional cost to DHHS, qualified, sufficient staff coverage to fill any gap in coverage during any anticipated leave time, including sick leave, lasting more than three (3) consecutive days unless otherwise agreed upon by the NHH CEO on a case-by-case basis, and for providing appropriate transition between staff members covering for those on leave. Qualified sufficient staff coverage shall mean personnel who meet or exceed the qualifications of the vacating staff member.

3.2.1.6. The Contractor acknowledges and understands that DHHS' expectation is that staffing at the level of 100% ensures that in no case shall Contractor staffing affect the number of NHH beds available, and that NHH units will not stop admissions due to the lack of coverage for Contractor staff.

3.2.2. DHHS reserves the right, through its NHH CEO, or other designee in the absence of the NHH CEO or a vacancy in that position, at its sole discretion to rescind, either temporarily or permanently, its approval of any Contractor staff member providing services at NHH for any of the following reasons:

3.2.2.1. Loss of medical staff privileges at NHH pursuant to medical staff by-laws;

3.2.2.2. Revocation or suspension of the Chief Medical Officer's New Hampshire medical license;

3.2.2.3. Arrest or conviction of a felony, misdemeanor or drug or alcohol related offense; or

3.2.2.4. Any other reason, which includes, but is not limited to: misconduct, violation of NHH or DHHS policy or state or federal laws or regulations, malfeasance, unsatisfactory work performance, or a

determination that the individual presents a risk to the health and safety of any staff member or any individual served by the Department.

3.2.3. Should DHHS exercise this right, the applicable staff member shall be prohibited from providing services under the contract for any period of time DHHS chooses.

3.2.4. If the NHH CEO removes Contractor staff assigned to this service area, including the Chief Medical Officer, for any reason, the Contractor shall not be entitled to payment for the staff member during the period of removal.

3.2.5. If approval of the Chief Medical Officer is temporarily rescinded, pursuant to subsection 3.1.1.3., the Contractor shall furnish within ten (10) business days a psychiatrist to serve full-time as interim NHH Chief Medical Officer, until such time as the existing Chief Medical Officer either resumes duty full-time or is replaced by a new Chief Medical Officer. The interim Chief Medical Officer shall meet all of the requirements for the Chief Medical Officer as set forth under the contract. The Contractor shall be responsible for providing transition services to NHH, at no additional cost, to avoid the interruption of services and administrative responsibilities.

3.2.6. DHHS shall provide Contractor staff at NHH with adequate facilities and DHHS-employed administrative support staff. Facilities shall include, but not be limited to, office space, equipment, and furnishings. Sufficient space to accomplish educational, training, and research missions shall also be made available. Administrative support staff shall include, but not be limited to, secretarial assistance, including one full-time executive secretary to support the Chief Medical Officer.

3.2.7. The Contractor, the Chief Medical Officer and all other clinical staff provided by the Contractor shall execute their responsibilities pursuant to this contract consistent with RSA Chapter 135-C, any applicable administrative rules, the by-laws of the NHH's Medical Staff Organization, The Joint Commission (TJC), Centers for Medicare and Medicaid Services (CMS), and in accordance with generally accepted medical standards and practices.

3.3. Specific Staffing Requirements – Service Area #1 – New Hampshire Hospital

3.3.1. Chief Medical Officer

3.3.1.1. The Contractor shall provide for the term of the contract, the full-time services of a qualified physician to serve as the Chief Medical Officer for NHH. The Chief Medical Officer shall possess the following qualifications and meet the following requirements:

a. The Chief Medical Officer shall be a Board Certified Psychiatrist licensed to practice in the State of New Hampshire. The Chief Medical Officer shall, at all times, maintain both a license to practice medicine in the State of New Hampshire and clinical privileges at NHH.

b. The Chief Medical Officer shall be a senior administrative psychiatrist having a minimum of five (5) years of experience in a position of clinical leadership for a major public sector program, psychiatric hospital, governmental authority, state or national medical/psychiatric society organization involved in the delivery of public sector psychiatric services. The Chief Medical Officer shall have completed an ACGME approved residency program with board certification in Psychiatry by the American Board of Psychiatry and Neurology. Additional subspecialty certification in forensic, geriatric or child/adolescent psychiatry may be substituted for 2 years of administrative leadership. Completion of a graduate curriculum in medical administration preferred.

c. For purposes of this paragraph, the term "full-time" shall mean that the Chief Medical Officer shall be required to account, through appropriate record-keeping as determined by NHH, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities pursuant to the contract, subject to the Contractor's normal and customary employee leave policies. Said minimum hours must be satisfied through hours devoted to clinical activities onsite at NHH.

3.3.1.2. The Chief Medical Officer may be permitted with prior notice and approval of the NHH CEO to work up to a maximum of 4 hours per week devoted to educational or research activities so long as those activities further the mission and goals of NHH. The Chief Medical Officer shall be responsible for providing documentation to the NHH CEO that time spent devoted to educational or research activities furthers the mission and goals of NHH.

3.3.1.3. Notwithstanding the foregoing allowance for educational or research activities, the Chief Medical Officer shall be physically present onsite at NHH not less than 36 hours per week. The Chief Medical Officer shall also participate with staff psychiatrists in on call, after-hours coverage above the 40 hour week to ensure a 24-hour a day, 7 day per week provision of Psychiatrist-On-Call services without additional compensation to the Contractor or the Chief Medical Officer.

3.3.1.4. In the event the Chief Medical Officer resigns, or is otherwise removed from providing services to NHH under this contract, the Contractor shall furnish within ten (10) business days, not including holidays, a psychiatrist to serve full-time as interim NHH Chief Medical Officer, until such time as the existing Chief Medical Officer either resumes duty full-time or is replaced by a new Chief Medical Officer. The interim Chief Medical Officer shall meet all of the requirements for the Chief Medical Officer as set forth under the contract. The Contractor shall be responsible for providing transition services to NHH, at no additional cost, to avoid the interruption of services and administrative responsibilities.

3.3.1.5. The Chief Medical Officer shall demonstrate:

a. Clear success in the fields of clinical psychiatry and psychiatric education at the graduate or undergraduate level;

b. Development of innovative clinical programs specific to the needs of the severely and persistently mentally ill, (SPMI) population;
c. Successful collaboration with state government leadership in the areas of program planning, budget, personnel policies, staffing levels, and the legislative process;
d. Cooperation with consumer organizations; and
e. Competence in program evaluation and evidence based outcomes related clinical practice. Research experience; particularly in public sector relevant research as a principal investigator or co-principal investigator is preferred.

3.3.1.6. On an annual basis, the Chief Medical Officer and the NHH CEO shall establish staffing needs for NHH, which shall include psychiatric, research and related clinical personnel. A schedule of personnel shall be developed and written notice shall be provided to the Contractor prior to commencement of the applicable contract year.

3.3.2. Associate Medical Director

3.3.2.1. The Contractor shall provide for the term of the contract, the full-time services of a qualified physician to serve as the Associate Medical Director for NHH. The Associate Medical Director shall possess the following qualifications and meet the following requirements:

a. The Associate Medical Director shall be a Board Certified Psychiatrist licensed to practice in the State of New Hampshire. The Associate Medical Director shall, at all times, maintain both a license to practice medicine in the State of New Hampshire and clinical privileges at NHH.
b. The Associate Medical Director shall be a senior administrative psychiatrist having a minimum of five (5) years of experience in a position of clinical leadership for a major public sector program, psychiatric hospital, governmental authority, state or national medical/psychiatric society organization involved in the delivery of public sector psychiatric services. The Associate Medical Director shall have completed an ACGME approved residency program with board certification in Psychiatry by the American Board of Psychiatry and Neurology. Additional subspecialty certification in forensic, addiction, geriatric or child/adolescent psychiatry may be substituted for 2 years of administrative leadership. Completion of a graduate curriculum in medical administration preferred.
c. For purposes of this paragraph, the term "full-time" shall mean that the Associate Medical Director shall be required to account, through appropriate record-keeping as determined by NHH, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities pursuant to the contract, subject to the Contractor's normal and customary employee leave policies. Said minimum hours must be satisfied through hours devoted to clinical activities onsite at NHH.

3.3.2.2. The Associate Medical Director may be permitted with prior notice and approval of the NHH CEO to work up to a maximum of 4 hours per week devoted to educational or research activities so long as those

activities further the mission and goals of NHH. The Associate Medical Director shall be responsible for providing documentation to the NHH CEO that time spent devoted to educational or research activities furthers the mission and goals of NHH.

3.3.2.3. Notwithstanding the foregoing allowance for educational or research activities, the Associate Medical Director shall be physically present onsite at NHH not less than 36 hours per week. The Associate Medical Director shall also participate with staff psychiatrists in on call, after-hours coverage above the 40 hour week to ensure a 24-hour a day, 7 day per week provision of Psychiatrist-On-Call services without additional compensation to the Contractor or the Chief Medical Officer.

3.3.2.4. In the event the Associate Medical Director resigns, or is otherwise removed from providing services to NHH under this contract, the Contractor shall furnish, within 10 business days, not including holidays, a psychiatrist to serve full-time as interim NHH Associate Medical Director, until such time as the existing Associate Medical Director either resumes duty full-time or is replaced by a new Associate Medical Director. The interim Associate Medical Director shall meet all of the requirements for the Chief Medical Officer as set forth under the contract. The Contractor shall be responsible for providing transition services to NHH, at no additional cost, to avoid the interruption of services and administrative responsibilities.

3.3.2.5. The Associate Medical Director shall demonstrate:

a. Clear success in the fields of clinical psychiatry and psychiatric education at the graduate or undergraduate level;
b. Development of innovative clinical programs specific to the needs of the severely and persistently mentally ill, (SPMI) population;
c. Successful collaboration with state government leadership in the areas of program planning, budget, personnel policies, staffing levels, and the legislative process;
d. Cooperation with consumer organizations; and
e. Competence in program evaluation and evidence based outcomes related clinical practice. Research experience; particularly in public sector relevant research as a principal investigator or co-principal investigator is preferred.

3.3.2.6. On an annual basis, the Associate Medical Director, together with the Chief Medical Officer and the NHH CEO, shall establish staffing needs for NHH, which shall include psychiatric, research and related clinical personnel. A schedule of personnel shall be developed and written notice shall be provided to the Contractor prior to commencement of the applicable contract year.

3.3.3. Psychiatrists

3.3.3.1. The Contractor shall provide eleven (11) General Psychiatrists for the adult units at NHH:

a. All psychiatrists shall have appropriate experience in the specialty they are boarded or board eligible in;

b. All psychiatrists shall have completed an ACGME approved residency program in psychiatry;
c. At least one psychiatrist shall be dedicated full-time to provide services to the Inpatient Stabilization Unit (ISU); and
d. At least one psychiatrist shall be certified in addiction treatment this psychiatrist shall be a physician who is certified in general psychiatry and has significant clinical experience in addiction medicine. A fellowship training and/or board certification in Addiction Medicine or Addiction Psychiatry is highly desirable.

3.3.4. Child/Adolescent Psychiatrists

3.3.4.1. The Contractor shall provide four (4) Child/Adolescent Psychiatrists who have successfully completed their fellowship.

a. All psychiatrists shall have completed both an ACGME approved residency program in psychiatry and a 2-year ACGME approved fellowship in child/adolescent psychiatry.

3.3.5. Geropsychiatrist

3.3.5.1. The Contractor shall provide one (1) geropsychiatrist who has:

a. Completed an ACGME approved residency program in psychiatry, and be board certified by the American Board of Psychiatry and Neurology in Psychiatry; and
b. Completed a 1-year geropsychiatry fellowship and is specialty certified by the American Board of Psychiatry and Neurology in geriatric psychiatry. Two years of additional clinical experience in geriatric psychiatry may be substituted for fellowship training.

3.3.6. Director of Neuropsychology Laboratory

3.3.6.1. The Contractor shall provide a senior neuropsychologist who has:

a. Past experience shall include leadership responsibilities in MRI operations and the ability to integrate cognitive test results with data from structural and functional brain imaging;
b. A Ph.D. or Psy.D. in clinical psychology or neuropsychology and shall have completed a neuropsychology postdoctoral fellowship (Houston guidelines); and
c. Evidence of scientific productivity in relation to the SPMI population and the ability to generate proposals for federal and foundation support is preferred.

3.3.7. Neuropsychologist Trainees

3.3.7.1. The Contractor shall provide three neuropsychologist trainees who:

a. Shall be clinical psychology graduate students who are obtaining specialty training in neuropsychology; and
b. Shall have three to four years of graduate instruction and training, including training experience in general psychology.

3.3.8. General Medical Director

3.3.8.1. The Contractor shall provide one full-time physician to fulfill the role of General Medical Director who shall be a primary care or internal

medicine physician who has completed residency with at least three years of experience in supervising primary care clinicians. A board certification in a primary care field is preferred.

3.3.9. General Medical Physician

3.3.9.1. The Contractor shall provide one full-time physician who is a primary care or internal medicine physician who has completed residency with at least three years of experience. A board certification in a primary care field is preferred.

3.3.10. Forensic Psychologist

3.3.10.1. Beginning in SFY 2018, the Contractor shall provide a full-time forensic psychologist. The forensic psychologist shall be a clinical psychologist (PhD or Psy.D.) with significant clinical experience in forensic psychology. A certification in forensic psychology is preferred.

3.3.11. Residents/Post Graduate Fellows

3.3.11.1. For all residents/post graduate fellows the Contractor provides to NHH under this contract, the responsibilities shall be outlined, monitored and reviewed by the Chief Medical Officer and the appropriate, attending psychiatrist.

a. General Psychiatry Residents (PGY II and PGY IV) – The Contractor shall rotate PGY II residents and a PGY IV (chief resident) through NHH.
b. Child/Adolescent Fellows – The Contractor shall rotate three (3) child/adolescent fellows (combined 1 FTE) apportioned through the PGY IV and PGY V years or PGY V and VI years (1st and 2nd year fellows) through NHH.
c. Geropsychiatry Fellow – The Contractor shall rotate a geropsychiatry fellow (PGY V) through the NHH.

3.3.12. Psychiatric Advanced Practice Registered Nurses (APRN)

3.3.12.1. The Contractor shall provide six full-time Psychiatric Advanced Practice Registered Nurses.

a. Psychiatric APRNs shall possess an APRN degree and have board certification as Psychiatric–Mental Health Nurse Practitioner-Board.
b. At least one Psychiatric APRN with specialty in addiction or the requisite number of hours of experience in addiction treatment shall be provided.
c. At least one Psychiatric APRN shall be dedicated full-time to provide services to the ISU.

3.3.13. NHH Research Manager

3.3.13.1. The Contractor shall provide a full-time NHH Research Manager, as described below:

a. The Research Manager requires a thorough knowledge and understanding of clinical research, research protocols, and clinical operations, knowledge of GCPs and federal regulations related to

human subject research, knowledge of patient privacy and confidentiality, ability to manage teams of professionals, maintain meticulous study records, laboratory data and other information related to research protocols, and manage complex schedules and competing priorities.

b. The Research Manager shall meet the following minimum experience and education requirements:
   i. Master's degree in management or health or research related area;
   ii. Five or more years of relevant experience in clinical trials research support;
   iii. Experience with industry sponsored, federally sponsored and investigator initiated clinical research;
   iv. Experience with clinical trial budgets and billing;
   v. Through knowledge of clinical research, research protocols and clinical operations; and
   vi. Knowledge of Good Clinical Practices (GCP's) and federal regulations related to research.

3.3.14. Director of Quality Systems and APRN Services

3.3.14.1. The Contractor shall provide a full time Director of Quality and APRN Services, as described below:

a. Licensed as an Advance Practice Registered Nurse
b. Two of more years of relevant experience in a psychiatric setting.
c. Experience with quality systems, development and enhancement of organizational systems and processes.
d. Serves as Chair of the Quality Council.
e. Provides clinical standards and provides leadership for all Psychiatric APRNs.
f. Builds community relationships with professional organizations to enhance both the quality programs and APRN programs.
g. Five or more years of experience in leadership of teams.
h. May supervise clinical and non-clinical NHH staff as directed by the Chief Medical Officer and/or the Chief Executive Officer.

3.3.15. Director of Health Systems Data and Information Services

3.3.15.1. The Contractor shall provide a full time Director of Health Systems Data and Information Services, as described below:

a. Five or more years of experience with collecting, analyzing, documenting and reporting hospital and/or health systems data.
b. Five or more years of experience with Electronic Health Records and development of Health Services Data Program.
c. Five or more years of experience in leadership of teams.
d. May supervise clinical and non-clinical NHH staff as directed by the Chief Medical Officer and/or the Chief Executive Officer.

3.3.16. Schedule and Allocation of Positions – Service Area #1 – NHH

3.3.16.1. The following schedule shall reflect the full (100%) staffing complement for which the Contractor shall provide the required staff,

consistent with the requirements described in the Contract for the full term of the contract.

Position Title	Full-Time Equivalent
a. Chief Medical Officer	1.0
b. Associate Medical Director	1.0
c. General Psychiatrists	11.0
d. Psychiatric APRNs	6.0
e. Child/Adolescent Psychiatrists	4.0
f. Geropsychiatrist	1.0
g. Director of Neuropsychology Laboratory	0.5
h. Director of Quality Systems and APRN Services.	1.0
i. Neuropsychologist Trainees	3.0
j. General Medical Director	1.0
k. General Medical Physician	1.0
l. Forensic Psychologist	1.0
m.. PGY IV Residents	1.0
n. PGY II Residents	1.5
o. Child/Adolescent Fellow	1.0
p. Geropsychiatry Fellow	0.5
q. Director of Health System Data and Information Services	1.0
r. Research Manager	1.0

3.4. Specific Staffing Requirements – Service Area #2 – Glencliff Home

3.4.1. Medical Director

3.4.1.1. The Contractor shall, for the term of the contract, provide the part-time services of one (1) geropsychiatrist to serve at the Glencliff Home as the Medical Director. This position shall be a 0.4 Full-Time Equivalent.

3.5. Specific Staffing Requirements – Service Area #3 – Medicaid Program

3.5.1. **Department of Health and Human Services Chief Medical Officer –**

3.5.1.1. The Contractor shall, for the term of the contract, provide the full-time services of a designated physician, identified by the Department to serve as the Chief Medical Officer. This position shall be a 1.0 Full-Time Equivalent.

3.5.1.2. The Contractor shall ensure that the Chief Medical Officer provided under this contract is subject to the Contractor's normal and customary employee benefits and policies, including leave provisions for a senior executive level position. However, the Contractor and DHHS agree that the continuous provision of services is essential, and in addition to any required approvals by the Contractor for its employees, the Chief Medical Officer shall provide timely, prior notification to the DHHS Designee of any leave time taken. Absences due to vacation and continuing education shall be planned in advance, in consideration of the business needs of the Medicaid program – including ensuring appropriate coverage for any clinical and/or operational responsibilities or tasks that need oversight while the Chief Medical Officer is on leave.

3.5.1.3. The Chief Medical Officer shall possess the following qualifications:

a. Possess a medical degree (MD or DO);
b. Maintain an unrestricted license as a physician by the New Hampshire Board of Medicine;
c. A graduate degree in public health or health care administration with demonstrated experience in public health or healthcare administration systems development;
d. Have a minimum of five years of experience in a position of clinical leadership for a major public sector program, government authority or other organization involved in the delivery of public Medicaid services;
e. Have work experience in managed care settings focused on improved health outcomes;
f. Have fellowship and/or work experience in research in health services, outcomes and/or policy, as well as the ability to work collaboratively with team members and the provider community;
g. Have extensive experience and judgment to plan and accomplish goals working in a team environment;
h. Demonstrate strong verbal and written communication skills;
i. Work collaboratively with Medicaid staff to achieve program goals in an efficient and timely manner;
j. Have Board certification in either Family Medicine, Preventive Medicine/Community Health, Internal Medicine, Pediatrics, or Obstetrics and Gynecology, and with a strong working knowledge of primary care medicine;
k. Must be well versed in the regulations governing the federal Title XIX Medicaid and Title XXI Medicaid and CHIP programs and how those programs are administered in New Hampshire;
l. Possess a high degree of creativity and initiative;
m. Have expertise in clinical, policy, or outcomes research; and

n. Have work experience in project management, grant writing, contract management, and program evaluation.

3.6. Specific Staffing Requirements – Service Area #4 – Children, Youth and Families

3.6.1. Staff Psychiatrist

3.6.1.1. The Contractor shall, for the term of the contract, provide the full-time services of a designated psychiatrist, who is a faculty member and/or employee of the Contractor, to provide psychiatric services to the programs within the Children, Youth and Families service area. This position shall be a 1.0 Full-Time Equivalent.

3.6.1.2. DHHS reserves the right to jointly, with the Contractor, or separately, interview, research or otherwise screen and consider candidates the Contractor designates for the Staff Psychiatrist.

3.6.1.3. The Staff Psychiatrist shall possess the following qualifications:

a. Possess a medical degree (MD or DO);
b. Specialty in both child psychiatry and criminal justice;
c. Completion of both an ACGME approved residency program in psychiatry and a 2-year ACGME approved fellowship in child/adolescent psychiatry;
d. Board certification by the American Board of Psychiatry and Neurology in Psychiatry;
e. Maintain an unrestricted license as a physician by the New Hampshire Board of Medicine; and
f. Possess at least five (5) years post-fellowship experience in public sector psychiatry, community mental health, criminal justice, or similar training.

3.7. Specific Staffing Requirements – Service Area #5 – Behavioral Health

3.7.1. Medical Director

3.7.1.1. The Contractor shall, for the term of the contract, provide a part-time Medical Director to the Behavioral Health service area, as identified by the Department. This position shall be available on-site at a DHHS designated location for twenty (20) hours per week (0.5 FTE).

3.7.1.2. The Medical Director shall possess the following qualifications:

a. Possess a medical degree (MD or DO);
b. Board certification by the American Board of Psychiatry and Neurology in Psychiatry;
c. Maintain an unrestricted license as a physician by the New Hampshire Board of Medicine; and
d. Have at least five (5) years of experience in public mental health and services for people with mental illness.

3.7.2. Support Staff CPHS

3.7.2.1. The Contractor shall, for the term of the contract, provide a part-time Support Staff to support the Committee for the Protection of Human

Services. This position shall be allocated at 0.15 FTE.

3.7.2.2. The Contractor shall, for the term of the contract, provide a part-time Research Assistant. This position shall be allocated at 0.5 FTE.

3.7.3. Evidence-Based Practice Trainer/Consultant

3.7.3.1. The Contractor shall, for the term of the contract, provide part-time Evidence-Based Practice Trainers/Consultants. These positions shall be allocated, in total, at 1.5 FTE.

3.7.4. Behavioral Health Policy Institute

3.7.4.1. The Contractor shall, for the term of the contract, provide a part-time Behavioral Health Policy Institute Consultant. This position shall be allocated at 0.1 FTE.

3.8. Specific Staffing Requirements – Service Area #6 – Elderly and Adult Services

3.8.1. Medical Director

3.8.1.1. The Contractor shall, for the term of the contract, provide a part-time Medical Director to the Elderly and Adult Services service area. This position shall be allocated at a 0.03 Full-Time Equivalent.

3.8.1.2. The Medical Director shall possess the following qualifications:

a. Possess a medical degree (MD or DO);
b. Maintain board certification in Gerontology or Preventive Medicine/Community Health;
c. Possess expertise in clinical, policy or outcomes research; and
d. Be well versed in the regulations governing the federal Title XIX Medicaid program, including requirements for the operation of waiver and State Plan services, and Title XX, the Social Service Block Program and services provided under the Older Americans Act.

3.9. Specific Staffing Requirements – Service Area #7 – Developmental Services

3.9.1. Medical Director

3.9.1.1. The Contractor shall, for the term of the contract, provide a part-time Medical Director to the Developmental Services service area. This position shall be allocated at 0.4 Full-Time Equivalent.

3.9.1.2. The Medical Director shall possess the following qualifications:

a. Possess a medical degree (MD or DO);
b. Maintain board certification in Child and Adult Psychiatry; and
c. Possess expertise and experience in developmental disability, including Autism Spectrum Disorders.

3.9.2. Adult Developmental Services Interdisciplinary Clinic Team

3.9.2.1. The Contractor shall, for the term of the contract, provide the following part-time positions to the Adult Developmental Services Interdisciplinary Clinic Team. These positions shall be allocated, as

specified below in Full-Time Equivalent (FTE):

a. Psychiatrist	0.1 FTE
b. Neuropsychologist	0.05 FTE
c. Neuropsychology Fellow	0.05 FTE
d. Neurologist	0.025 FTE
e. Primary Care Physician	0.025 FTE
f. Occupational Therapist	0.025 FTE
g. Administrative Support	0.025 FTE

3.9.3. Child Developmental Services Interdisciplinary Clinic Team

3.9.3.1. The Contractor shall, for the term of the contract, provide the following part-time positions to the Child Developmental Services Interdisciplinary Clinic Team. These positions shall be allocated, as specified below in Full-Time Equivalent (FTE):

a. Child Psychiatrist	0.10 FTE
b. Neuropsychologist	0.05 FTE
c. Neuropsychology Fellow	0.05 FTE
d. Neurologist	0.025 FTE
e. Primary Care Physician	0.025 FTE
f. Occupational Therapist	0.025 FTE
g. Administrative Support	0.025 FTE

4. Performance Standards and Outcomes

4.1. Service Area #1 – Chief Medical Officer – NHH

4.1.1. Within forty-five (45) days of the assignment of the Chief Medical Officer, and at each contract anniversary thereafter, the Contractor and the NHH CEO, in consultation with the Chief Medical Officer, shall develop a list of performance metrics based upon the deliverables, functions and responsibilities of the Chief Medical Officer. The performance metrics shall be approved by the NHH CEO prior to being effective. The performance metrics shall be reviewed by the NHH CEO on at least a quarterly basis with the Chief Medical Officer. These meetings shall be documented with written progress notes by the NHH CEO.

4.1.2. The Contractor shall ensure the services provided by the Chief Medical Officer at NHH are satisfactory to the Department. As part of this responsibility, the Contractor shall, no less than annually and more frequently if required by DHHS, provide an evaluation tool to solicit input from the NHH CEO regarding the Chief Medical Officer's provision of services under the contract.

4.1.3. The Contractor shall develop a corrective action plan to address any concerns raised by the NHH CEO in the evaluation tool, and provide a copy of such plan to the NHH CEO for review. If the NHH CEO disagrees with the Contractor's proposed resolutions within the corrective action plan, the dispute shall be referred to the DHHS Commissioner for resolution with the Contractor.

4.2. Service Area #1 – Clinical Staff – NHH

4.2.1. Staffing levels shall be maintained at 100% at all times throughout the

contract, with the exception of the leave provisions and approval processes described in the subsections applicable to each staffing need.

4.2.1.1. DHHS' expectation is that staffing at the level of 100% ensures that in no case shall Contractor staffing affect the number of NHH beds available, and that NHH units will not stop admissions due to the lack of coverage for Contractor staff.

4.2.2. The Contractor shall ensure the following performance standards are met by all clinical staff provided by the Contractor to provide services at NHH:

4.2.2.1. Clinical staff shall support the optimum functioning of the Medical Staff Organization as evidenced by attendance of Medical Staff Organization meetings and participation in assigned committees and task forces at a rate of no less than 80% participation, excluding approved absences;

4.2.2.2. Clinical staff shall support the completion of all required documentation regarding patients as evidenced by satisfactorily completing documentation regarding patient admission, discharge and during the inpatient stay – in compliance with hospital policy – within twelve (12) months of beginning the provision of services at NHH under the contract; and by satisfactorily completing all required documentation consistent with normative data collected by the compliance officer and utilization review manager.

4.2.2.3. Clinical staff shall provide clear treatment plans with specific interventions and regular updates as required by NHH policy;

4.2.2.4. Clinical staff shall provide daily progress notes with sufficient detail to meet medical necessity and level of care criteria;

4.2.2.5. Clinical staff shall provide regular progress notes focused on specific reasons for admission and plan towards discharge; and

4.2.2.6. Clinical staff shall provide written explanation of medication decisions and reasons for change when not effective.

4.3. Service Area #3 – Chief Medical Officer – Medicaid

4.3.1. Within forty-five (45) days of the assignment of the Chief Medical Officer, and at each contract anniversary thereafter, the Contractor and the DHHS Designee, in consultation with the Chief Medical Officer, shall develop a list of performance metrics based upon the deliverables, functions and responsibilities of the Chief Medical Officer. The performance metrics shall be approved by the DHHS Designee prior to being effective. The performance metrics shall be reviewed by the DHHS Designee on at least a quarterly basis with the Chief Medical Officer. These meetings shall be documented with written progress notes by the DHHS Designee.

4.3.2. The Contractor shall ensure the services provided by the Chief Medical Officer are satisfactory to the Department. As part of this responsibility, the Contractor shall, no less than annually and more frequently if required by DHHS, provide an evaluation tool, that is based on the agreed upon performance metrics for the previous year, to solicit input from the DHHS Designee regarding the Chief Medical Officer's provision of services

under the contract.

4.3.3. Goals for the upcoming year will be established at the time of the Contractor's evaluation of the Chief Medical Officer, in collaboration with the DHHS Designee. In the case of a newly hired Chief Medical Officer, the evaluation tool shall be completed upon six (6) months of employment and then again at one (1) year, and thereafter on the contract anniversary date.

4.4. Service Area #4 – Staff Psychiatrist – Children, Youth and Families

4.4.1. Within forty-five (45) days of the assignment of the Staff Psychiatrist, and at each contract anniversary thereafter, the Contractor and the DHHS designee, in consultation with the Staff Psychiatrist, shall develop a list of performance metrics based upon the deliverables, functions and responsibilities of the Staff Psychiatrist. The performance metrics shall be approved by the DHHS designee prior to being effective. The performance metrics shall be reviewed by the DHHS designee on at least a quarterly basis with the Staff Psychiatrist. These meetings shall be documented with written progress notes by the DHHS designee.

4.4.2. The Contractor shall ensure the services provided by the Staff Psychiatrist are satisfactory to the Department. As part of this responsibility, the Contractor shall, no less than annually and more frequently if needed, provide an evaluation tool, that is based on the agreed upon performance metrics for the previous year, to solicit input from the DHHS designee regarding the Staff Psychiatrist's provision of services under the contract.

Goals for the upcoming year will be established at the time of the Contractor's evaluation of the Staff Psychiatrist, in collaboration with the DHHS designee. In the case of a newly hired Staff Psychiatrist, the evaluation tool shall be completed upon six (6) months of employment and then again at one (1) year, and thereafter on the contract anniversary date.

4.5. Quality Assurance Plan and Monitoring

The following Quality Assurance Plan and Monitoring shall be provided by the Contractor, subject to modification and/or augmentation as required by DHHS:

4.5.1. Service Area #1 – New Hampshire Hospital – Chief Medical Officer

4.5.1.1. The Contractor shall provide oversight of the performance of the Chief Medical Officer toward these Performance Standards and Quality Assurance Monitoring goals.

4.5.1.2. Pending development of final program metrics as required herein at subsection 4.1.1., in partnership with the NHH CEO, the Chief Medical Officer shall be responsible for the following program outcomes:

a. Ensuring the program is staffed adequately to operate NHH beds at full utilization;
b. Ensuring that Contractor staff receive necessary supervision and training to perform the tasks they are assigned;
c. Assuring that patients receive care consistent with evidence-

based care;

d. Creation and implementation of highest standard practices to protect the safety of patients, staff, and visitors; and
e. Other responsibilities detailed herein at subsection 2.3.1.

4.5.1.3. The Chief Medical Officer shall be responsible for monitoring progress toward these goals and providing regular reports, at minimum on a quarterly basis or more frequently if needed, to the NHH CEO and to the Chair of the Department of Psychiatry or his designee. The Chief Medical Officer will meet at minimum on a quarterly basis or more frequently if needed, with the Chair of the Department of Psychiatry (or his or her designee) and the NHH CEO to review progress toward these metrics. The metrics above shall be considered preliminary metrics, subject to refinement, as described herein at subsection 4.1.1., and shall be reviewed over time to assure that they are the best metrics to use to assure contract compliance.

4.5.1.4. The content of the performance metrics to be measured shall be such that they assure that the Chief Medical Officer is fulfilling his or her administrative/clinical responsibilities as detailed herein at subsection 2.3.1. The following metrics shall be relevant to the Chief Medical Officer's fulfillment of his or her responsibilities:

a. The results of all Joint Commission, CMS, and other surveys pertaining to NHH;
b. Reports on clinical documentation by clinical staff;
c. Lists demonstrating completion of annual reviews of all Contractor-provided NHH clinicians to demonstrate active management, oversight, and discipline (when needed) of clinicians. The annual reviews shall include evidence of input from the NHH CEO (or their designee) on performance;
d. Records of attendance at meetings with:
    i. The NHH CEO indicating participation in formulation, implementation and supervision of all clinical programs, participation in budgeting, recruiting, plan for employment schedule, and supervision and educational plan for all Contractor-provided NHH clinical staff;
    ii. Other DHHS representatives - showing consultation in the development of the State mental health system;
    iii. NHH Executive Committee – showing executive participation; and
    iv. Executive Committee of the NHH Medical Staff Organization – showing participation in oversight of physician work; and
e. Report on availability of beds in NHH that are open for care – indicating adequate provider staffing to operate at full capacity.

4.5.1.5. The NHH CEO shall review these metrics at least quarterly with the NHH Chief Medical Officer.

4.5.2. Monitoring – Service Area #1 – New Hampshire Hospital – Chief Medical Officer:

4.5.2.1. The NHH Director of Quality Management and his or her staff shall

conduct medical record and quality compliance monitoring. Monitoring shall take place through:

a. The routine reviews of The Joint Commission, CMS, and other overseeing groups;
b. The routine NHH documentation monitoring reports produced at NHH;
c. Department of Psychiatry tracking of Annual Review completion that is a routine process of the Department;
d. Use of attendance sheets that can be developed for this purpose; and
e. Routine monitoring of bed availability.

4.5.2.2. NHH support staff shall gather information regarding meeting attendance. The NHH Director of Quality Management and his or her staff shall gather the balance of collected metrics into a report. The collected data shall be provided to the NHH CEO and the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry (or his or her designee) on a quarterly basis.

4.5.2.3. The findings from this monitoring shall be discussed in scheduled meetings between the NHH CEO and the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry (or his or her designee) at meetings that shall take place on a quarterly basis or more frequently if needed. Both parties shall maintain their notes from each quarterly meeting to support the annual performance review process.

4.5.2.4. The monitoring data, including the notes described herein at subsection 4.5.2.3., and feedback solicited from the NHH CEO shall be part of the Chief Medical Officer's annual performance review. The Contractor shall document the annual performance review on the Department's standard annual evaluation tool.

a. If there are performance difficulties that require a corrective action plan, the Contractor shall develop a proposed corrective action plan and shall share and discuss the plan with the NHH CEO prior to issuance to the Chief Medical Officer. If the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry and the NHH CEO disagree on the proposed corrective action plan, the dispute shall be referred to the DHHS Commissioner for resolution.

4.5.2.5. This plan shall be updated and revised at least annually, by the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, working with the NHH CEO and in consultation with the NHH Chief Medical Officer. New goals may be set at any time but shall be set at least annually. New goals may trigger new metrics.

4.5.3. Service Area #1 – New Hampshire Hospital – Clinical Staff

4.5.3.1. Within 45 days of the contract effective date, the Chief Medical Officer, or his or her designee, shall work with the NHH CEO and the NHH Director of Quality Management to develop a list of performance metrics based on the expected deliverables, functions and

responsibilities for each staff member as described herein at the applicable subsection in Section 2. The metrics shall monitor, at a minimum, the performance standards describe herein at subsection 4.2. The NHH CEO shall review these metrics at least quarterly with the Chief Medical Officer. This selection of metrics shall be reviewed over time to assure that they are the best metrics to use to assure contract compliance.

4.5.3.2. The content of the performance metrics to be measured shall be such that they assure the Clinical Staff are fulfilling their administrative/clinical responsibilities as described herein at Section 2 for the applicable position. The following metrics are relevant to the Clinical Staff's fulfillment of their responsibilities and shall be part of the plan for monitoring contract fulfillment:

a. Attendance lists of Medical Staff Organization (and assigned committees and task forces) that show who is expected to attend and who did attend;
b. Measurements of compliance with documentation policies;
c. Measurement of adherence with treatment plan policies;
d. Measurement of progress note adherence to policies including showing medical necessity and need for level of care and demonstration of reason for admission and progress towards discharge, and explanation of medical decisions and reasons for change when the plan is not effective.

4.5.4. Monitoring – Service Area #1 – New Hampshire Hospital – Clinical Staff

4.5.4.1. Monitoring of the metrics for the NHH Clinical Staff shall take place as part of the routine data collection of the NHH Quality Management Staff. The collected data shall be provided to the Chief Medical Officer and the NHH CEO on a quarterly basis.

a. The performance metrics that are developed shall involve measurements and documentation that must be collected, including meeting attendance records. Other NHH staff may be involved in data collection efforts, including staff within the information technology, health information and utilization management sections depending on the content of the developed performance metrics.

4.5.4.2. The NHH CEO, the NHH Director of Quality Management, and the Chief Medical Officer shall speak at least quarterly about the performance of the NHH Clinical Staff. Each individual shall maintain notes of every quarterly meeting; these notes shall be used to support the annual performance review process for NHH Clinical Staff. If there are performance difficulties that require a corrective action plan, the identified issues shall be discussed with the Chief Medical Officer in order to initiate an appropriate course of action to address the identified difficulty or difficulties.

4.5.4.3. Annual reviews of Clinical Staff shall be documented by the Chief Medical Officer, or his or her designee, on the Contractor's Department of Psychiatry Annual Review form. Annual reviews shall

include findings for quality assurance monitoring and feedback on performance from DHHS leaders.

4.5.5. **Service Area #3 – Medicaid – Chief Medical Officer**

4.5.5.1. Within 45 days of the contract effective date, the Contractor shall work with the DHHS designee overseeing the Medicaid service area to develop a list of performance metrics based on the deliverables, functions, and responsibilities, as described herein at subsection 2.5. Together, these metrics shall form an evaluation tool. The Chief Medical Officer shall be consulted in this process and the metrics shall be subject to approval by the DHHS Designee overseeing the Medicaid service area. The selection of metrics shall be reviewed over time to assure that they are the best metrics to use to assure contract compliance.

4.5.5.2. The DHHS designee shall review the findings from monitoring of these metrics at least quarterly with the Chief Medical Officer.

4.5.5.3. The Chief Medical Officer role requires initiative, relationship building, and high level leadership. The following metrics are relevant to the Chief Medical Officer's fulfillment of his or her responsibilities and shall be part of the plan for monitoring contract fulfillment:

a. Attendance records of Medicaid Management Team meetings; and
b. A checklist of core duties and expectations, as described herein at subsection 2.5, with feedback solicited on a quarterly or semi-annual basis from the members of the Medicaid Management Team and/or other key informants, designed to monitor performance. The checklist shall rate performance and allow for comments that will help guide improvement.

4.5.6. **Monitoring – Service Area #3 – Medicaid – Chief Medical Officer**

4.5.6.1. Resources for monitoring the performance metrics shall be identified when the performance plan is developed and may require Contractor or State resources to perform such tasks. Performance metric data may include but not be limited to:

a. Checklist feedback from the Medicaid Management Team. Source: Medicaid Management Team members; and
b. Collection and collating of attendance records from the Medicaid Management Team meetings. Source: DHHS administrative support staff.

4.5.6.2. At least twice yearly, or more frequently if needed:

a. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, and the DHHS designee shall review the data collected in the performance metrics, and discuss these with the Chief Medical Officer;
b. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall solicit information from the DHHS designee and shall discuss twice yearly with the DHHS designee, or more frequently if needed, the Chief Medical Officer's

performance on the metrics.

c. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, and the DHHS designee shall maintain notes of their meetings. The annual performance review shall be documented on the Department's standard annual on evaluation tool.

4.5.6.3. The findings collected in the evaluation tool, as well as verbal information solicited from the DHHS designee, shall form the core of the Chief Medical Officer's annual performance review. This review shall be conducted at six months for a new Chief Medical Officer then annually thereafter.

4.5.6.4. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, the DHHS designee, and the Chief Medical Officer shall collaborate to establish goals for the upcoming year as part of the performance evaluation process. New goals may be set at any time but shall be set at least annually.

4.5.6.5. If there are performance difficulties that require a corrective action plan, the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall develop a proposed corrective action plan, and shall discuss and share the plan with the DHHS designee. If the DHHS designee and the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, disagree on the proposed resolutions, the dispute will be referred to the DHHS Commissioner for resolution.

4.5.7. Service Area #4 – Children, Youth and Families – Staff Psychiatrist

4.5.7.1. Within 45 days of the contract effective date, the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall work with the DHHS designee overseeing the Children, Youth and Families service area to develop a list of performance metrics based on the deliverables, functions, and responsibilities, as described herein at subsection 2.6. Together, these metrics shall form an evaluation tool. The Staff Psychiatrist shall be consulted in this process and the metrics shall be subject to approval by the DHHS Designee overseeing the Children, Youth and Families service area. The selection of metrics shall be reviewed over time to assure that they are the best metrics to use to assure contract compliance.

4.5.7.2. The content of performance metrics developed shall be such that they assure the Staff Psychiatrist is fulfilling his or her administrative and clinical responsibilities as described herein at subsection 2.6. The following metrics are relevant to the Staff Psychiatrist and shall be part of the plan for monitoring contract fulfillment:

a. Monitoring of work hours;
   i. Regular checks of the Staff Psychiatrist's electronic calendar to be sure it includes proposed leave time, conferences, and trainings;
   ii. Clinical documentation monitoring to be sure it meets

standards of timeliness and completeness established by Children, Youth, and Families;

iii. Counts of activities such as the number of treatment team meetings and clinical consultations provided, types and numbers of evidence-based practices provided, number of teaching and supervision contacts with interns, residents, and fellows at SYSC; and

iv. Checklist feedback on effectiveness in establishing interagency collaboration between Juvenile Justice Services, area mental health services, and NHH.

4.5.8. Monitoring – Services Area #4 – Children, Youth & Families – Staff Psychiatrist

4.5.8.1. Resources for monitoring the performance metrics shall be identified when the performance plan is developed and may require Contractor or State resources to perform such tasks. Performance metric data may include but not be limited to:

a. Counts of Activities. Source: Staff Psychiatrist; and
b. Clinical documentation monitoring. Source: DHHS staff.

4.5.8.2. At least twice yearly, or more frequently if needed:

a. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, and the DHHS designee shall review the data collected in the performance metrics, and discuss these with the Staff Psychiatrist;
b. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall solicit information from the DHHS designee and shall discuss twice yearly with the DHHS designee, or more frequently if needed, the Staff Psychiatrist's performance on the metrics.
c. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, and the DHHS designee shall maintain notes of their meetings. The annual performance review shall be documented on the Department's standard annual evaluation tool.

4.5.8.3. The findings collected in the evaluation tool, as well as verbal information solicited from the DHHS designee, shall form the core of the Staff Psychiatrist's annual performance review. This review shall be conducted at six months for a new Staff Psychiatrist then annually thereafter.

4.5.8.4. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, the DHHS designee, and the Staff Psychiatrist shall collaborate to establish goals for the upcoming year as part of the performance evaluation process. New goals may be set at any time but shall be set at least annually.

4.5.8.5. If there are performance difficulties that require a corrective action plan, the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall develop a proposed corrective action plan, and shall discuss and share the plan with the

DHHS designee. If the DHHS designee and the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, disagree on the proposed resolutions, the dispute will be referred to the DHHS Commissioner for resolution.

4.5.9. Service Areas #2, 3, 5, 6 and 7

4.5.9.1. Upon DHHS request, the Contractor shall identify performance metrics, develop performance goals, establish monitoring processes and engage in collaborative performance evaluation processes, similar to those described herein at subsection 4.5. For Service Areas 2, 3, 5, 6 and 7.

4.5.10. All Other Positions

4.5.10.1. All staff provided by the Contractor, not otherwise addressed herein at subsection 4.5, shall have annual performance reviews. The Contractor shall conduct such reviews and first obtain feedback from the applicable DHHS designee for the service area in which the staff is assigned to provide services. This feedback shall be a core element of the annual performance review process. The Contractor shall ensure that goal development is responsive to the evolving needs of DHHS over the course of the contract period.

5. Reporting

5.1. Service Area #1 – New Hampshire Hospital

5.1.1. In addition to other reports as agreed to by the parties, on an annual basis, the Contractor shall make a report in writing to DHHS that is descriptive of the Chief Medical Officers' and the clinicians' services provided by the Contractor and the Contractor's performance under this contract during the preceding contract year, the research activities provided during the preceding contract year, and planned research activities for the current contract year.

5.1.2. On an annual basis, DHHS shall submit to the Contractor a report in writing containing DHHS' evaluation of the Contractor's performance pursuant to this contract during the preceding year.

5.1.3. On a quarterly basis, or as otherwise more frequently required by the United States Department of Health and Human Services regulations, DHHS and in a form specified by DHHS, the Contractor shall provide a written report to DHHS documenting the services provided by the Contractor's staff in sufficient form and with sufficient detail to satisfy the reporting requirements of Medicare, Medicaid, and other third-party providers.

5.2. All Service Areas

5.2.1. The Contractor shall maintain and provide the DHHS designee(s) identified by the Department with up-to-date detailed personnel listings for all Contractor staff performing services under this contract. The listings shall include information, including, but not limited to; the names, titles, position costs (including salary and fringe benefit costs, direct and indirect rates), for each position for each service area for each state fiscal year.

or more frequently as required by DHHS, to ensure the accuracy of information contained therein and to ensure proper cost allocation. The listings shall be in a format as determined and approved by DHHS.

6. Compliance

6.1. Continuity of Services

6.1.1. The Contractor and the Department agree that:

6.1.1.1. It will be extremely impracticable and difficult to determine actual damages that the Department will sustain in the event that the Contractor breaches this Agreement by failing to maintain the required staffing levels or by failing to deliver the required services, as described in Exhibit A, Sections 2 through 5;

6.1.1.2. Any breach by the Contractor will delay and disrupt the Department's operations and impact its ability to meet its obligations and lead to significant damages of an uncertain amount as well as a reduction of services; The Contractor's failure to provide Required Staffing, Required Services, or meet the Performance Standards and Outcomes and Reporting Requirements, all as specified in this Exhibit A, Sections 2 through 5, shall result in the assessment of liquidated damages as specified in Exhibit B; and

6.1.1.3. The liquidated damages as specified in Exhibit B are reasonable and fair and not intended as a penalty.

7. Definitions

CMS – Centers for Medicare and Medicaid Services
CPHS – Committee for the Protection of Human Subjects.
Department – New Hampshire Department of Health and Human Services
DHHS – New Hampshire Department of Health and Human Services
HIPAA – Health Insurance Portability and Accountability Act
TJC – The Joint Commission

A. Definitions

The following terms may be reflected and have the described meaning in this document:

1. "Breach" means the loss of control, compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, or any similar term referring to situations where persons other than authorized users and for an other than authorized purpose have access or potential access to personally identifiable information, whether physical or electronic. With regard to Protected Health Information, "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

2. "Computer Security Incident" shall have the same meaning "Computer Security Incident" in section two (2) of NIST Publication 800-61, Computer Security Incident Handling Guide, National Institute of Standards and Technology, U.S. Department of Commerce.

3. "Confidential Information," "Confidential Data," or "Data" (as defined in Exhibit K), means all confidential information disclosed by one party to the other such as all medical, health, financial, public assistance benefits and personal information including without limitation, Substance Abuse Treatment Records, Case Records, Protected Health Information and Personally Identifiable Information.

   Confidential Information also includes any and all information owned or managed by the State of NH - created, received from or on behalf of the Department of Health and Human Services (DHHS) or accessed in the course of performing contracted services - of which collection, disclosure, protection, and disposition is governed by state or federal law or regulation. This information includes, but is not limited to Protected Health Information (PHI), Personal Information (PI), Personal Financial Information (PFI), Federal Tax Information (FTI), Social Security Numbers (SSN), Payment Card Industry (PCI), and or other sensitive and confidential information.

4. "End User" means any person or entity (e.g., contractor's employee, business associate, subcontractor, other downstream user, etc.) that receives DHHS data or derivative data in accordance with the terms of this Contract.

5. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.

6. "Incident" means an act that potentially violates a security policy, which includes successful attempts) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or

storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent. Incidents include the loss of data through theft or device misplacement, loss or misplacement of hardcopy documents, and misrouting of physical or electronic documents or mail.

7. "Open Wireless Network" means any network or segment of a network that is not designated by the State of New Hampshire's Department of Information Technology or delegate as a protected network (designed, tested, and approved, by means of the State, to transmit) will be considered an open network and not adequately secure for the transmission of unencrypted PI, PFI, PHI or confidential DHHS data.

8. "Personal Information" (or "PI") means information which can be used to distinguish or trace an individual's identity, such as their name, social security number, personal information as defined in New Hampshire RSA 359-C:19, biometric records, etc., alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc.

9. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

10. "Protected Health Information" (or "PHI") has the same meaning as provided in the definition of "Protected Health Information" in the HIPAA Privacy Rule at 45 C.F.R. § 160.103.

11. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. Part 164, Subpart C, and amendments thereto.

12. "Unsecured Protected Health Information" means Protected Health Information that is not secured by a technology standard that renders Protected Health Information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

I. RESPONSIBILITIES OF DHHS AND THE CONTRACTOR

A. Business Use and Disclosure of Confidential Information.

1. The Contractor must not use, disclose, maintain or transmit Confidential Information

except as required or permitted under this Contract or required by law. Further, Contractor, including but not limited to all its directors, officers, employees and agents, must not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

2. The Contractor must not disclose any Confidential Information in response to a request for disclosure on the basis that it is required by law, in response to a subpoena, etc., without first notifying DHHS so that DHHS has an opportunity to consent or object to the disclosure.
3. The Contractor agrees that DHHS Data or derivative there from disclosed to an End User must only be used pursuant to the terms of this Contract.

II. METHODS OF SECURE TRANSMISSION OF DATA

1. Application Encryption. If Contractor is transmitting DHHS Data containing Confidential Data between applications, the Contractor attests the applications have been evaluated by an expert knowledgeable in cyber security and that said application's encryption capabilities ensure secure transmission via the internet.
2. Computer Disks and Portable Storage Devices. Contractor may not use computer disks or portable storage devices, such as a thumb drive, as a method of transmitting DHHS Data.
3. Encrypted Email. Contractor may only employ email to transmit Confidential Data if email is encrypted and being sent to and being received by email addresses of persons authorized to receive such information.
4. Encrypted Web Site. If Contractor is employing the Web to transmit Confidential Data, the secure socket layers (SSL) must be used and the web site must be secure. SSL encrypts data transmitted via a Web site.
5. File Hosting Services, also known as File Sharing Sites. Contractor may not use file hosting services, such as Dropbox or Google Cloud Storage, to transmit Confidential Data.
6. Ground Mail Service. Contractor may only transmit Confidential Data via *certified* ground mail within the continental U.S. and when sent to a named individual.
7. Laptops and PDA. If Contractor is employing portable devices to transmit Confidential Data said devices must be encrypted and password-protected.
8. Open Wireless Networks. Contractor may not transmit Confidential Data via an open wireless network. End User must employ a virtual private network (VPN) when remotely transmitting via an open wireless network.

9. Remote User Communication. If Contractor is employing remote communication to access or transmit Confidential Data, a secure method of transmission or remote access, which complies with the terms and conditions of Exhibit K, must be used.
10. SSH File Transfer Protocol (SFTP), also known as Secure File Transfer Protocol. If Contractor is employing an SFTP to transmit Confidential Data, End User will structure the Folder and access privileges to prevent inappropriate disclosure of information. SFTP folders and sub-folders used for transmitting Confidential Data will be coded for 24-hour auto-deletion cycle (i.e. Confidential Data will be deleted every 24 hours).
11. Wireless Devices. If Contractor is transmitting Confidential Data via wireless devices, all data must be encrypted to prevent inappropriate disclosure of information.

III. RETENTION AND DISPOSITION OF IDENTIFIABLE RECORDS

The Contractor will only retain DHHS Data and any derivative of the data for the duration of this Contract. After such time, the Contractor will have thirty (30) days to destroy the data and any derivative in whatever form it may exist, unless, otherwise required by law or, if it is infeasible to return or destroy DHHS Data, protections are extended to such information, in accordance with the termination provisions in this Section. To this end, the parties must:

A. Retention

1. The Contractor agrees it will not store, transfer or process data collected in connection with the services rendered under this Contract outside of the United States. This physical location requirement shall also apply in the implementation of cloud computing, cloud service or cloud storage capabilities, and includes backup data and Disaster Recovery locations.
2. The Contractor agrees to ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems accessed or utilized for purposes of carrying out this contract.
3. The Contractor agrees to provide security awareness and education for its End Users in support of protecting DHHS Confidential information.
4. The Contractor agrees to retain all electronic and hard copies of Confidential Data in a secure location and identified in section IV. A.2
5. The Contractor agrees Confidential Data stored in a Cloud must be in a FedRAMP/HITECH compliant solution and comply with all applicable statutes and regulations regarding the privacy and security. All servers and devices must have

currently-supported and hardened operating systems, current, updated, and maintained anti-malware (e.g. anti-viral, anti-hacker, anti-spam, anti-spyware) utilities. The environment, as a whole, must have aggressive intrusion-detection and firewall protection.

6. The Contractor agrees to and ensures its complete cooperation with the State's Chief Information Officer in the detection of any security vulnerability of the hosting infrastructure.

B. Disposition

If the Contractor maintains any Confidential Information on its systems (or its sub-contractor systems) and it has not done so previously, the Contractor will implement policies and procedures to ensure that any storage media on which such data maybe recorded will be rendered unreadable and that the data will be un-recoverable when the storage media is disposed of. Upon request, the Contractor will provide the Department with copies of these policies and with written documentation demonstrating compliance with the policies. The written documentation will include all details necessary to demonstrate data contained in the storage media has been rendered unreadable and un-recoverable. Where applicable, regulatory and professional standards for retention requirements may be jointly evaluated by the State and Contractor prior to destruction.

1. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to destroy all hard copies of Confidential Data using a secure method such as shredding.
2. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to completely destroy all electronic Confidential Data by means of data erasure, also known as secure data wiping.

IV. PROCEDURES FOR SECURITY

A. Contractor agrees to safeguard the DHHS Data received under this Contract, and any derivative data or files, as follows:

1. The Contractor will maintain proper security controls to protect Department confidential information collected, processed, managed, and/or stored in the delivery of contracted services.
2. The Contractor will maintain policies and procedures to protect Department confidential information throughout the information lifecycle, where applicable, (from

creation, transformation, use, storage and secure destruction) regardless of the media used to store the data (i.e., tape, disk, paper, etc.).

3. The Contractor will maintain appropriate authentication and access controls to contractor systems that collect, transmit, or store Department confidential information where applicable.

4. If the Contractor will be sub-contracting any core functions of the engagement supporting the services for State of New Hampshire, the Contractor will ensure End-User will maintain an internal process or processes that defines specific security expectations, and monitoring compliance to security requirements that at a minimum match those for the Contractor, including breach notification requirements.

5. The Contractor will work with the Department to sign and comply with all applicable State of New Hampshire and Department system access and authorization policies and procedures, systems access forms, and computer use agreements as part of obtaining and maintaining access to any Department system(s). Agreements will be completed and signed by the Contractor and any applicable sub-contractors prior to system access being authorized.

6. If the Department determines the Contractor is a Business Associate pursuant to 45 CFR 160.103, the Contractor will execute a HIPAA Business Associate Agreement (BAA) with the Department and is responsible for maintaining compliance with the agreement.

7. The Contractor will not store any State of New Hampshire or Department data offshore or outside the boundaries of the United States unless prior express written consent is obtained from the Information Security Office leadership member within the Department.

8. Data Security Breach Liability. In the event of any computer security incident, incident, or breach Contractor shall make efforts to investigate the causes of the breach, promptly take measures to prevent future breach and minimize any damage or loss resulting from the breach. The State shall recover from the Contractor all costs of response and recovery from the breach, including but not limited to: credit monitoring services, mailing costs and costs associated with website and telephone call center services necessary due to the breach.

9. Contractor must, comply with all applicable statutes and regulations regarding the privacy and security of Confidential Information, and must in all other respects maintain the privacy and security of PI and PHI at a level and scope that is not less than the level and scope of, HIPAA Privacy and Security Rules (45 C.F.R. Parts 160

and 164) and 42 C.F.R. Part 2 that govern protections for individually identifiable health information and as applicable under State law.

10. Contractor agrees to establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality of the Confidential Data and to prevent unauthorized use or access to it. The safeguards must provide a level and scope of security that is not less than the level and scope of security requirements established by the State of New Hampshire, Department of Information Technology. Refer to Vendor Resources/Procurement at https://www.nh.gov/doit/vendor/index.htm for the Department of Information Technology policies, guidelines, standards, and procurement information relating to vendors.

11. Contractor agrees to maintain a documented breach notification and incident response process. The Contractor will notify the State's Privacy Officer, and additional email addresses provided in Section VI, of any security breach within 24-hours of the time that the Contractor learns of its occurrence. This includes a confidential information breach, computer security incident, or suspected breach which affects or includes any State of New Hampshire systems that connect to the State of New Hampshire network.

12. Contractor must restrict access to the Confidential Data obtained under this Contract to only those authorized End Users who need such DHHS Data to perform their official duties in connection with purposes identified in this Contract.

13. The Contractor is responsible for End User oversight and compliance with the terms and conditions of the contract and Exhibit K.

DHHS reserves the right to conduct onsite inspections to monitor compliance with this Contract, including the privacy and security requirements provided in herein, HIPAA, and other applicable laws and Federal regulations until such time the Confidential Data is disposed of in accordance with this Contract.

V. LOSS REPORTING

The Contractor must notify the State's Privacy Officer, Information Security Office and Program Manager of any Security Incidents and Breaches within 24- hours of the time that the Contractor learns of their occurrence.

The Contractor must further handle and report Incidents and Breaches involving PHI in accordance with DHHS's documented Incident Handling and Breach Notification procedures and in accordance with– the HIPAA, Privacy and Security Rules. In addition to, and notwithstanding, Contractor's compliance with all applicable obligations and

procedures, Contractor's procedures must also address how the Contractor will:

1. Identify Incidents;
2. Determine if personally identifiable information is involved in Incidents;
3. Report suspected or confirmed Incidents as required in this Exhibit or P-37;
4. Identify and convene a core response group to determine the risk level of Incidents and determine risk-based responses to Incidents; and
5. Determine whether Breach notification is required, and, if so, identify appropriate Breach notification methods, timing, source, and contents from among different options, and bear costs associated with the Breach notice as well as any mitigation measures.

Incidents and/or Breaches that implicate PI must be addressed and reported, as applicable, in accordance with NH RSA 359-C:20.

VI. PERSONS TO CONTACT

A. DHHS contact for Data Management or Data Exchange issues:
DHHSInformationSecurityOffice@dhhs.nh.gov

B. DHHS contacts for Privacy issues:
DHHSPrivacyOfficer@dhhs.nh.gov

C. DHHS contact for Information Security issues:
DHHSInformationSecurityOffice@dhhs.nh.gov

D. DHHS contact for Breach notifications:
DHHSInformationSecurityOffice@dhhs.nh.gov
DHHSPrivacyOfficer@dhhs.nh.gov

6A new

State of New Hampshire

DEPARTMENT OF HEALTH AND HUMAN SERVICES
129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-9200 FAX: 603-271-4912 TDD ACCESS: RELAY NH 1-800-735-2964

JEFFREY A. MEYERS
COMMISSIONER

August 19, 2016

Her Excellency, Governor Margaret Wood Hassan
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services to enter into an agreement with Mary Hitchcock Memorial Hospital (a component of Dartmouth-Hitchcock), (Vendor #177160) of One Medical Center Drive, Lebanon, New Hampshire, 03756 to provide Physician Clinical and Administrative Services to meet the specialized health and related clinical and administrative needs of the residents of the State of New Hampshire in an amount not to exceed $38,554,042 effective November 1, 2016, or upon Governor and Executive Council approval, whichever is later, through June 30, 2019. This contract includes renewal options for up to two (2) three year periods, subject to Governor and Council approval. The funding for this contract will be from the following sources:

- 40% Other Funds (Medicare, Medicaid & third party insurance);
- 28% Federal Funds from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medical Assistance Program, Code of Federal Domestic Assistance Number (CFDA) 93.778; and
- 32% General Funds.

Funds to support this request are available in the following accounts for State Fiscal Years 2017, 2018, and 2019, with authority to adjust encumbrances in the State Fiscal Year through the Budget Office, if needed and justified without further approval from Governor and Executive Council:

05-95-48-481010-33170000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: ELDERLY AND ADULT SERVICES, GRANTS TO LOCALS, ADMIN ON AGING SVCS GRANT-SMPP

Fiscal Year	Class/Account	Class/Title	Activity Code	Current Modified Budget
2017	102-500731	Contracts for Program Services	48130284	$21,000
2018	102-500731	Contracts for Program Services	48130284	$28,153
2019	102-500731	Contracts for Program Services	48130284	$29,199
			Sub-Total	$78,352

05-95-42-421510-79150000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: SUNUNU YOUTH SERVICE CENTER, HEALTH SERVICES

Fiscal Year	Class/Account	Class/Title	Activity Code	Current Modified Budget
2017	102-500730	Medical Payments to Providers	42151501	$325,491
2018	102-500730	Medical Payments to Providers	42151501	$392,391
2019	102-500730	Medical Payments to Providers	42151501	$407,002
			Sub-Total	1,124,884

05-95-47-470010-79370000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS:OFC OF MEDICAID & BUS. PLCY, OFF. OF MEDICAID & BUS. POLICY, MEDICAID

Fiscal Year	Class/Account	Class/Title	Activity Code	Current Modified Budget
2017	102-500731	Contracts for Program Services	47000021	$278,300
2018	102-500731	Contracts for Program Services	47000021	$374,358
2019	102-500731	Contracts for Program Services	47000021	$388,407
			Sub-Total	$1,041,065

05-95-94-940010-87500000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: NEW HAMPSHIRE HOSPITAL, NEW HAMPSHIRE HOSPITAL, ACUTE PSYCHIATRIC

Fiscal Year	Class/Account	Class/Title	Activity Code	Current Modified Budget
2017	102-500731	Contracts for Program Services	494058000	$8,407,616
2018	102-500731	Contracts for Program Services	494058000	$11,471,661
2019	102-500731	Contracts for Program Services	494058000	$11,862,758
			Sub-Total	$31,742,035

05-95-94-940010-87500000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: NEW HAMPSHIRE HOSPITAL, NEW HAMPSHIRE HOSPITAL, BEHAVIORAL HEALTH

Fiscal Year	Class/Account	Class/Title	Activity Code	Current Modified Budget
2017	102-500731	Contracts for Program Services	494058000	$351,661
2018	102-500731	Contracts for Program Services	494058000	$477,825
2019	102-500731	Contracts for Program Services	494058000	$494,500
			Sub-Total	**$1,323,986**

05-95-94-940010-87500000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: NEW HAMPSHIRE HOSPITAL, NEW HAMPSHIRE HOSPITAL, GLENCLIFF

Fiscal Year	Class/Account	Class/Title	Activity Code	Current Modified Budget
2017	102-500731	Contracts for Program Services	494058000	$114,511
2018	102-500731	Contracts for Program Services	494058000	$152,935
2019	102-500731	Contracts for Program Services	494058000	$158,555
			Sub-Total	**$426,001**

05-95-93-930010-51910000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: DEVELOPMENTAL SERV DIV OF, DIV OF DEVELOPMENTAL SVCS, SPECIAL MEDICAL SERVICES

Fiscal Year	Class/Account	Class/Title	Activity Code	Current Modified Budget
2017	561-500911	Specialty Services	93001000	$20,000
2018	561-500911	Specialty Services	93001000	$30,000
2019	561-500911	Specialty Services	93001000	$30,000
			Sub-Total	**$80,000**

05-95-93-930010-59470000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: DEVELOPMENTAL SERV DIV OF, DIV OF DEVELOPMENTAL SVCS, PROGRAM SUPPORT

Fiscal Year	Class/Account	Class/Title	Activity Code	Current Modified Budget
2017	102-500731	Contracts for Program Services	93005947	$93,096
2018	102-500731	Contracts for Program Services	93005947	$119,981
2019	102-500731	Contracts for Program Services	93005947	$125,376
			Sub-Total	**$338,453**

05-95-93-930010-59470000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF HHS: DEVELOPMENTAL SERV DIV OF, DIV OF DEVELOPMENTAL SVCS, PROGRAM SUPPORT

Fiscal Year	Class/Account	Class/Title	Activity Code	Current Modified Budget
2017	103-502664	Contracts for Operational Svcs	93015947	$106,480
2018	103-502664	Contracts for Operational Svcs	93015947	$143,673
2019	103-502664	Contracts for Operational Svcs	93015947	$149,113
			Sub-Total	**$399,266**

EXPLANATION

The purpose of this request is to provide physician clinical and administrative services to specific populations served by the Department. The services identified will be provided across the following seven service areas:

Service Area #1 – New Hampshire Hospital
Service Area #2 – Glencliff Home
Service Area #3 – Medicaid
Service Area #4 – Children, Youth and Families
Service Area #5 – Behavioral Health
Service Area #6 – Elderly and Adult Services
Service Area #7 – Developmental Services

Presently, the Department, contracts with an academic medical center to meet the specialized health, clinical, and administrative needs identified in these service areas. Clinical focus areas include the provision of psychiatric care at New Hampshire Hospital, clinical and administrative leadership to the State's Medicaid program, and clinical leadership to behavioral health services. In addition, the Department receives physician consultation services in the area of elderly and adult services, juvenile justice services, and developmental services for children and adults.

Service Area #1 – New Hampshire Hospital

The Contractor will provide the Department, through a Chief Medical Officer, in collaboration with the Hospital's Chief Executive Officer, clinical and administrative services to best meet the evolving needs of New Hampshire residents with mental illness. This will include staffing of the newly opened Inpatient Stabilization Unit (ISU) as well as staffing for adult units, the Anna Philbrook Center for children, and the Geropsychiatry Unit. Additionally, the Contractor will work with the Department to continue to maintain and develop an applied research and evaluation capacity which shall identify and address medical research issues relative to the Department's mission. The Contractor will also provide the necessary physician and allied health care personnel, including staff certified in addiction treatment, required to deliver quality health services to patients at New Hampshire Hospital. The services provided are intended to achieve innovative and cost-effective acute psychiatric care that is oriented toward appropriate treatment, stabilization, and rapid return to the community. A recovery model will continue to be emphasized.

Service Area #2 – Glencliff Home

The Department operates the Glencliff Home to provide a continuum of services for New Hampshire's developmentally disabled, and/or mentally ill population in a home-like setting, with an emphasis on independence, dignity, and acceptance. The Contractor will provide the Department, through the expertise a Medical Director, direct psychiatric services, treatment, and associated services to all residents of the Glencliff Home. The Medical Director will serve other functions including, but not limited to, oversight of physicians, as well as other administrative duties, including review of medication use for compliance with federal law and serving as the liaison with other healthcare organizations.

Service Area #3 – Medicaid

The Department is responsible for the administration of the Medicaid medical assistance program and is dedicated to the identification of New Hampshire's health care needs through the assessment and implementation of health care and social services delivery systems. To assist the Department in the furtherance of these responsibilities, the Contractor will provide the services of a full time Chief Medical Officer. The Chief Medical Officer's responsibilities will include developing strategic clinical relationships with physicians as well as growing partnerships with academic institutions and federal agencies with a focus on quality improvement and the implementation of federal health care reforms. Additionally, the Chief Medical Officer will provide medical oversight of the state's publicly funded health insurance programs, assist in making policy decisions, and shape administrative planning strategies to enhance the operating efficiency of Medicaid and related healthcare initiatives across the state.

Service Area #4 – Children, Youth, and Families

The Department is responsible for providing supervision and rehabilitative services to youth adjudicated under state law as delinquent or as children in need of services (CHINS). The Department provides supervision, case management, and an array of rehabilitative services to youth through its staff of Juvenile Probation and Parole Officers (JPPOs) and a network of community based providers. In order to provide additional clinical expertise to the Department, the Contractor will provide the services of a full-time psychiatrist to provide psychiatric services to youth served by the Department. The psychiatrist will provide treatment planning oversight, clinical consultations, and assessments to treatment coordinators and JPPOs as well as providing psychiatric evaluations and direct care to youth served by the Department. Additionally, the psychiatrist will provide program development at the Sununu Youth Services Center (SYSC) and foster improved interagency collaboration between Juvenile Justice Services, area mental health agencies, and New Hampshire Hospital to enhance mental health services for adjudicated youth.

Service Area #5 – Behavioral Health

Through its integrated behavioral health services, the Department promotes respect, recovery, and full community inclusion for adults who experience a mental illness and children with emotional disturbances. The Department, through its behavioral health program, seeks to sustain the development and implementation of evidence based practices through the provision of technical assistance and training made possible through this contract, as well as through state and federal grant opportunities. The Contractor will provide the personnel needed to help the Department achieve positive outcomes for individuals served by the behavioral health program. Personnel include a Medical Director who will provide direction and expertise on key policy initiatives as well as evidence-based practices training consultants who will provide support in sustaining and fostering continuous quality improvement of the evidence-based practices that are implemented across the New Hampshire Community Mental Health Centers system.

Service Area #6 – Elderly and Adult Services

A critical component of the Department's statewide delivery system is its community-based provider network. The Department coordinates long-term care support services through contracts at the local level, thus reflecting the commitment of the Department to strengthen the autonomy of local communities and to direct resources to where they are needed most. In order to assist the Department in the provision of social and long-term supports to adults aged 60 and older and to adults between the ages of 18 and 60 who have a chronic illness or disability, the Contractor will provide the services of a Medical Director. The Medical Director will assist in the planning and direction of the Department's policies and programs for the purpose of sustaining and improving the quality of services for those elderly and adults served by the Department.

Service Area #7 – Developmental Services

The developmental services system offers individuals with developmental disabilities and acquired brain disorders a wide range of supports and services through partnerships with community based service networks developed through the leadership and oversight of the Department. The Contractor will provide the services of a Medical Director who will provide psychiatric consultation services as well as expert guidance and training to the Department's developmental services staff. The Contractor will also provide the services of two Developmental Services Interdisciplinary Clinic Teams with the clinical expertise needed to conduct evaluations of both adults and children with developmental disabilities and acquired brain injuries. These evaluations will be conducted based on referrals from Area Agencies.

The Contractor was selected through a competitive bidding process. The Department published a Request for Proposals for Physician Clinical and Administrative Services (RFP-2017-OCOM-01-PHYSI) on the Department of Health and Human Services website on February 25, 2016, and also notified several potentially interested vendors of the release. The Department received one proposal in response. The proposal was evaluated and scored by a team of individuals with comprehensive knowledge of the service areas addressed in the RFP. Based on this evaluation, the Department selected Mary Hitchcock Memorial Hospital to provide these services. The proposal summary score sheet is attached.

Should the Governor and Executive Council determine to not authorize this request the Department will be severely limited in its ability to provide essential services in the service areas identified above, thereby putting at risk many of the State's most vulnerable residents.

Area Served: Statewide

- Source of Funds: 40% Other Funds (Medicare, Medicaid & third party insurance);
- 28% Federal Funds from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medical Assistance Program, Code of Federal Domestic Assistance Number (CFDA) 93.778; and
- 32% General Funds.

In the event that the Federal Funds become no longer available, additional General Funds will not be requested to support this contract.

Respectfully submitted,

Approved by:
Jeffrey A. Meyers
Commissioner

New Hampshire Department of Health and Human Services
Office of Business Operations
Contracts & Procurement Unit
Summary Scoring Sheet

Physician Clinical and Administrative Services
RFP Name

RFP-2017-OCOM-01-PHYSI
RFP Number

Bidder Name	Pass/Fail	Maximum Points	Actual Points
1. Mary Hitchcock Memorial Hospital	Pass	1000	857
2. 0		1000	0
3. 0		1000	0
4. 0		1000	0
5. 0		1000	0
6. 0		1000	0
7. 0		1000	0

Reviewer Names

1. Katie Dunn, Director OMBP, Deputy Commissioner
2. Michele Harlan
3. Diane Langley
4. Bob MacLeod, CEO NH Hospital
5. Dawn Touzin, DHHS, Department Controller
6.
7.
8.
9.

Subject: Physician Clinical and Administrative Services/REP-2017-OCOM-01-PHYSI-01

Notice: This agreement and all of its attachments shall become public upon submission to Governor and Executive Council for approval. Any information that is private, confidential or proprietary must be clearly identified to the agency and agreed to in writing prior to signing the contract.

AGREEMENT

The State of New Hampshire and the Contractor hereby mutually agree as follows:

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name NH Department of Health and Human Services		1.2 State Agency Address 129 Pleasant Street Concord, NH 03301-3857	
1.3 Contractor Name ~~Mayr~~ Hitchcock Memorial Hospital Dary		1.4 Contractor Address One Medical Center Drive, Lebanon, New Hampshire 03756	
1.5 Contractor Phone Number 603-650-7815	1.6 Account Number	1.7 Completion Date June 30, 2019	1.8 Price Limitation $36,554,042
1.9 Contracting Officer for State Agency Eric Borrin, Director of Contracts and Procurement		1.10 State Agency Telephone Number 603-271-9558	
1.11 Contractor Signature MD		1.12 Name and Title of Contractor Signatory Robert Greene, MD EVP Chief Population Health Management officer	

1.13 Acknowledgement: State of New Hampshire County of Grafton

On 8/19/16, before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.

1.13.1 Signature of Notary Public or Justice of the Peace

1.13.2 Name and Title of Notary or Justice of the Peace

Laura K. Rogers - Notary Public

1.14 State Agency Signature Date: 8/19/16	1.15 Name and Title of State Agency Signatory Katja S. Fox, Director
1.16 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)* By:	Director, On:
1.17 Approval by the Attorney General (Form, Substance and Execution) *(if applicable)* By:	On: 8/19/16
1.18 Approval by the Governor and Executive Council *(if applicable)* By:	On:

2. EMPLOYMENT OF CONTRACTOR/SERVICES TO BE PERFORMED. The State of New Hampshire, acting through the agency identified in block 1.1 ("State"), engages contractor identified in block 1.3 ("Contractor") to perform, and the Contractor shall perform, the work or sale of goods, or both, identified and more particularly described in the attached EXHIBIT A which is incorporated herein by reference ("Services").

3. EFFECTIVE DATE/COMPLETION OF SERVICES.
3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, if applicable, this Agreement, and all obligations of the parties hereunder, shall become effective on the date the Governor and Executive Council approve this Agreement as indicated in block 1.18, unless no such approval is required, in which case the Agreement shall become effective on the date the Agreement is signed by the State Agency as shown in block 1.14 ("Effective Date").
3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

4. CONDITIONAL NATURE OF AGREEMENT.
Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including, without limitation, the continuance of payments hereunder, are contingent upon the availability and continued appropriation of funds, and in no event shall the State be liable for any payments hereunder in excess of such available appropriated funds. In the event of a reduction or termination of appropriated funds, the State shall have the right to withhold payment until such funds become available, if ever, and shall have the right to terminate this Agreement immediately upon giving the Contractor notice of such termination. The State shall not be required to transfer funds from any other account to the Account identified in block 1.6 in the event funds in that Account are reduced or unavailable.

5. CONTRACT PRICE/PRICE LIMITATION/ PAYMENT.
5.1 The contract price, method of payment, and terms of payment are identified and more particularly described in EXHIBIT B which is incorporated herein by reference.
5.2 The payment by the State of the contract price shall be the only and the complete reimbursement to the Contractor for all expenses, of whatever nature incurred by the Contractor in the performance hereof, and shall be the only and the complete compensation to the Contractor for the Services. The State shall have no liability to the Contractor other than the contract price.
5.3 The State reserves the right to offset from any amounts otherwise payable to the Contractor under this Agreement those liquidated amounts required or permitted by N.H. RSA 80:7 through RSA 80:7-c or any other provision of law.
5.4 Notwithstanding any provision in this Agreement to the contrary, and notwithstanding unexpected circumstances, in no event shall the total of all payments authorized, or actually made hereunder, exceed the Price Limitation set forth in block 1.8.

6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/ EQUAL EMPLOYMENT OPPORTUNITY.
6.1 In connection with the performance of the Services, the Contractor shall comply with all statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal opportunity laws. This may include the requirement to utilize auxiliary aids and services to ensure that persons with communication disabilities, including vision, hearing and speech, can communicate with, receive information from, and convey information to the Contractor. In addition, the Contractor shall comply with all applicable copyright laws.
6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.
6.3 If this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all the provisions of Executive Order No. 11246 ("Equal Employment Opportunity"), as supplemented by the regulations of the United States Department of Labor (41 C.F.R. Part 60), and with any rules, regulations and guidelines as the State of New Hampshire or the United States issue to implement these regulations. The Contractor further agrees to permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

7. PERSONNEL.
7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.
7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this

Contractor Initials _____
Date 8/18/2016

Agreement. This provision shall survive termination of this Agreement.
7.3 The Contracting Officer specified in block 1.9, or his or her successor, shall be the State's representative. In the event of any dispute concerning the interpretation of this Agreement, the Contracting Officer's decision shall be final for the State.

8. EVENT OF DEFAULT/REMEDIES.
8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"):
8.1.1 failure to perform the Services satisfactorily or on schedule;
8.1.2 failure to submit any report required hereunder; and/or
8.1.3 failure to perform any other covenant, term or condition of this Agreement.
8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:
8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely remedied, terminate this Agreement, effective two (2) days after giving the Contractor notice of termination;
8.2.2 give the Contractor a written notice specifying the Event of Default and suspending all payments to be made under this Agreement and ordering that the portion of the contract price which would otherwise accrue to the Contractor during the period from the date of such notice until such time as the State determines that the Contractor has cured the Event of Default shall never be paid to the Contractor;
8.2.3 set off against any other obligations the State may owe to the Contractor any damages the State suffers by reason of any Event of Default; and/or
8.2.4 treat the Agreement as breached and pursue any of its remedies at law or in equity, or both.

9. DATA/ACCESS/CONFIDENTIALITY/ PRESERVATION.
9.1 As used in this Agreement, the word "data" shall mean all information and things developed or obtained during the performance of, or acquired or developed by reason of, this Agreement, including, but not limited to, all studies, reports, files, formulae, surveys, maps, charts, sound recordings, video recordings, pictorial reproductions, drawings, analyses, graphic representations, computer programs, computer printouts, notes, letters, memoranda, papers, and documents, all whether finished or unfinished.
9.2 All data and any property which has been received from the State or purchased with funds provided for that purpose under this Agreement, shall be the property of the State, and shall be returned to the State upon demand or upon termination of this Agreement for any reason.
9.3 Confidentiality of data shall be governed by N.H. RSA chapter 91-A or other existing law. Disclosure of data requires prior written approval of the State.

10. TERMINATION. In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall deliver to the Contracting Officer, not later than fifteen (15) days after the date of termination, a report ("Termination Report") describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination Report shall be identical to those of any Final Report described in the attached EXHIBIT A.

11. CONTRACTOR'S RELATION TO THE STATE. In the performance of this Agreement the Contractor is in all respects an independent contractor, and is neither an agent nor an employee of the State. Neither the Contractor nor any of its officers, employees, agents or members shall have authority to bind the State or receive any benefits, workers' compensation or other emoluments provided by the State to its employees.

12. ASSIGNMENT/DELEGATION/SUBCONTRACTS.
The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written notice and consent of the State. None of the Services shall be subcontracted by the Contractor without the prior written notice and consent of the State.

13. INDEMNIFICATION. The Contractor shall defend, indemnify and hold harmless the State, its officers and employees, from and against any and all losses suffered by the State, its officers and employees, and any and all claims, liabilities or penalties asserted against the State, its officers and employees, by or on behalf of any person, on account of, based or resulting from, arising out of (or which may be claimed to arise out of) the acts or omissions of the Contractor. Notwithstanding the foregoing, nothing herein contained shall be deemed to constitute a waiver of the sovereign immunity of the State, which immunity is hereby reserved to the State. This covenant in paragraph 13 shall survive the termination of this Agreement.

14. INSURANCE.
14.1 The Contractor shall, at its sole expense, obtain and maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:
14.1.1 comprehensive general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $1,000,000per occurrence and $2,000,000 aggregate ; and
14.1.2 special cause of loss coverage form covering all property subject to subparagraph 9.2 herein, in an amount not less than 80% of the whole replacement value of the property.
14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.

Contractor Initials RM
Date 9/18/2014

14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than thirty (30) days prior to the expiration date of each of the insurance policies. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference. Each certificate(s) of insurance shall contain a clause requiring the insurer to provide the Contracting Officer identified in block 1.9, or his or her successor, no less than thirty (30) days prior written notice of cancellation or modification of the policy.

15. WORKERS' COMPENSATION.

15.1 By signing this agreement, the Contractor agrees, certifies and warrants that the Contractor is in compliance with or exempt from, the requirements of N.H. RSA chapter 281-A *("Workers' Compensation")*.

15.2 To the extent the Contractor is subject to the requirements of N.H. RSA chapter 281-A, Contractor shall maintain, and require any subcontractor or assignee to secure and maintain, payment of Workers' Compensation in connection with activities which the person proposes to undertake pursuant to this Agreement. Contractor shall furnish the Contracting Officer identified in block 1.9, or his or her successor, proof of Workers' Compensation in the manner described in N.H. RSA chapter 281-A and any applicable renewal(s) thereof, which shall be attached and are incorporated herein by reference. The State shall not be responsible for payment of any Workers' Compensation premiums or for any other claim or benefit for Contractor, or any subcontractor or employee of Contractor, which might arise under applicable State of New Hampshire Workers' Compensation laws in connection with the performance of the Services under this Agreement.

16. WAIVER OF BREACH. No failure by the State to enforce any provisions hereof after any Event of Default shall be deemed a waiver of its rights with regard to that Event of Default, or any subsequent Event of Default. No express failure to enforce any Event of Default shall be deemed a waiver of the right of the State to enforce each and all of the provisions hereof upon any further or other Event of Default on the part of the Contractor.

17. NOTICE. Any notice by a party hereto to the other party shall be deemed to have been duly delivered or given at the time of mailing by certified mail, postage prepaid, in a United States Post Office addressed to the parties at the addresses given in blocks 1.2 and 1.4, herein.

18. AMENDMENT. This Agreement may be amended, waived or discharged only by an instrument in writing signed by the parties hereto and only after approval of such amendment, waiver or discharge by the Governor and Executive Council of the State of New Hampshire unless no such approval is required under the circumstances pursuant to State law, rule or policy.

19. CONSTRUCTION OF AGREEMENT AND TERMS. This Agreement shall be construed in accordance with the laws of the State of New Hampshire, and is binding upon and inures to the benefit of the parties and their respective successors and assigns. The wording used in this Agreement is the wording chosen by the parties to express their mutual intent, and no rule of construction shall be applied against or in favor of any party.

20. THIRD PARTIES. The parties hereto do not intend to benefit any third parties and this Agreement shall not be construed to confer any such benefit.

21. HEADINGS. The headings throughout the Agreement are for reference purposes only, and the words contained therein shall in no way be held to explain, modify, amplify or aid in the interpretation, construction or meaning of the provisions of this Agreement.

22. SPECIAL PROVISIONS. Additional provisions set forth in the attached EXHIBIT C are incorporated herein by reference.

23. SEVERABILITY. In the event any of the provisions of this Agreement are held by a court of competent jurisdiction to be contrary to any state or federal law, the remaining provisions of this Agreement will remain in full force and effect.

24. ENTIRE AGREEMENT. This Agreement, which may be executed in a number of counterparts, each of which shall be deemed an original, constitutes the entire Agreement and understanding between the parties, and supersedes all prior Agreements and understandings relating hereto.

Contractor Initials RAL
Date 8/18/2016

Scope of Services

1. Provisions Applicable to All Services

1.1. The Contractor will submit a detailed description of the language assistance services they will provide to persons with limited English proficiency to ensure meaningful access to their programs and/or services within ten (10) days of the contract effective date.

1.2. The Contractor agrees that, to the extent future legislative action by the New Hampshire General Court or federal or state court orders may have an impact on the Services described herein, the State has the right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance therewith.

2. Scope of Services

2.1. Covered Populations and Services

The Contractor shall provide physician clinical and administrative services to various populations served by DHHS, in all seven (7) Service Areas identified below and as described herein:

2.1.1. Service Area #1 – New Hampshire Hospital (NHH)

2.1.2. Service Area #2 – Glencliff Home

2.1.3. Service Area #3 – Medicaid

2.1.4. Service Area #4 – Children, Youth and Families

2.1.5. Service Area #5 – Behavioral Health

2.1.6. Service Area #6 – Elderly and Adult Services

2.1.7. Service Area #7 – Developmental Services

2.2. General Requirements Applicable to All Service Areas

2.2.1. The Contractor shall provide psychiatric and other professional services to all service areas through the employment of appropriate Contractor staff described in the following sections, and requiring such staff to perform required services.

2.2.2. The Contractor shall work with DHHS to continue to develop and refine an integrated mental health care system applying principles of managed care for clinical treatment, educational and training programs, and related research.

2.2.3. The Contractor shall work with DHHS to jointly maintain and develop an applied research and evaluation capacity, the general purpose of which shall be to identify and address medical research issues relative to the DHHS mission under RSA 135-C. The activities shall be directed at enhancing applied research resources, capacities and activities within the State mental health services system and implementing a program of applied research relative to that system.

2.2.4. All personnel provided by the Contractor under this contract shall be employees or consultants of the Contractor. No personnel provided by the Contractor under this contract shall be considered an employee of the State of New Hampshire.

2.3. Specific Service Requirements for Service Area #1 – New Hampshire Hospital

2.3.1. Chief Medical Officer's Administrative/Clinical Responsibilities

2.3.1.1. Subject to (1) the statutory authority of the DHHS Commissioner or designee, and (2) the authority of the NHH CEO (NHH CEO) with respect to administrative/clinical matters, the Chief Medical Officer shall be responsible for the following:

a. To coordinate with the NHH CEO all clinical activities in order to accomplish the day-to-day clinical operation of NHH in a manner consistent with RSA Chapter 135-C and the rules adopted pursuant thereto, all NHH policies, and all standards of TJC and CMS;
b. To participate in the formulation, implementation, and supervision of all clinical programs for the diagnosis, assessment, treatment, care, and management of patients of NHH, and all clinical personnel engaged in said programs to participate in the formulation, implementation, and supervision of all clinical, educational, clinical research, and clinical training programs within NHH;
c. To supervise all documentation requirements of all staff psychiatrists and other clinical personnel employed by the Contractor and providing services under this contract at NHH;
d. To perform annual performance evaluations and discipline as necessary for all staff psychiatrists and other clinical personnel employed by the Contractor and providing services under this contract at NHH. In preparing these evaluations, the Chief Medical Officer shall consult with and seek input from the NHH CEO as to the Department's satisfaction with the services provided by any such individual under review;
e. To perform an annual administrative review of all clinical personnel employed by the Contractor and providing services under this contract at NHH to assure compliance with NHH policy, including but not limited to: training, record keeping, matters of medical records, CPR and CMP training/retraining, TJC requirements, customer service responsibilities, and HIPAA compliance and attendance at mandated in-service training. The Chief Medical Officer shall take whatever action necessary to assure compliance with these requirements and take whatever disciplinary action necessary in instances of non-compliance of NHH policy or NHH Medical Staff Organization bylaws;
f. To comply with all applicable performance standards set forth in this contract pertaining to staff psychiatrists;
g. To provide consultation to DHHS relative to the development of the State mental health service system;

h. To support NHH's customer service culture by adhering to and assuring that psychiatrists under his/her direction, adhere to the established Customer Service Guidelines for Physicians;
i. To report to the NHH CEO issues known to him/her regarding all admissions, patient care or any other situation that may pose a significant risk to patients or the community or that may result in adverse publicity or in any way undermine public confidence in the clinical care provided by NHH;
j. To participate as a member of the NHH's Administrative Executive Committee;
k. To participate as an ex officio non-voting member of the Executive Committee of the Medical Staff Organization of NHH who represents the NHH CEO;
l. To participate with the NHH CEO in the development of the clinical budget of NHH;
m. To participate in the recruitment of other clinical DHHS personnel, upon the request of the NHH CEO;
n. To establish, subject to the NHH CEO approval, an employment schedule for all clinical personnel employed by the Contractor to provide services at NHH;
o. To assist the NHH Chief Executive Office with the clinical supervision and education of all other clinical staff at NHH; and
p. To provide clinical coverage of Contractor staff as necessary.

2.3.2. Associate Medical Director Responsibilities

2.3.2.1. Subject to (1) the statutory authority of the DHHS Commissioner or designee, and (2) the authority of the NHH CEO with respect to administrative/clinical matters, the Associate Medical Director shall be responsible for the following:

a. To coordinate with the NHH Chief Medical Officer and NHH CEO all clinical activities in order to accomplish the day-to-day clinical operation of NHH in a manner consistent with RSA Chapter 135-C and the rules adopted pursuant thereto, all NHH policies, and all standards of TJC and CMS;
b. Serves in the capacity of the chief medical officer during his/her absence;
c. To participate with the Chief Medical Officer in the formulation, implementation, and supervision of all clinical programs for the diagnosis, assessment, treatment, care, and management of patients of NHH, and all clinical personnel engaged in said programs to participate in the formulation, implementation, and supervision of all clinical educational, clinical research, and clinical training programs within NHH;
d. To supervise all documentation requirements of all staff psychiatrists and other clinical personnel employed by the Contractor and providing services under this contract at NHH;
e. To participate with the Chief Medical Officer in performing annual performance evaluations and discipline as necessary for all staff psychiatrists and other clinical personnel employed by the Contractor and providing services under this contract at NHH. In

preparing these evaluations, the Associate Medical Director shall assist the Chief Medical Officer who shall consult with and seek input from the NHH CEO as to the Department's satisfaction with the services provided by any such individual under review;

f. To work with the CMO to perform an annual administrative review of all clinical personnel employed by the Contractor and providing services under this contract at NHH to assure compliance with NHH policy, including but not limited to: training, record keeping, matters of medical records, CPR and CMP training/retraining, TJC requirements, customer service responsibilities, and HIPAA compliance and attendance at mandated in-service training. The Associate Medical Director shall assist the Chief Medical Officer who shall take whatever action necessary to assure compliance with these requirements and take whatever disciplinary action necessary in instances of non-compliance of NHH policy or Medical Staff Organization bylaws;
g. To comply with all applicable performance standards set forth in this contract pertaining to staff psychiatrists;
h. To provide consultation to DHHS relative to the development of the State mental health service system;
i. To support NHH's customer service culture by adhering to and assuring that psychiatrists under his/her direction, adhere to the established Customer Service Guidelines for Physicians;
j. To report to the NHH Chief Medical Officer and to the CEO issues known to him/her regarding all admissions, patient care or any other situation that may pose a significant risk to patients or the community or that may result in adverse publicity or in any way undermine public confidence in the clinical care provided by NHH;
k. To participate as a member of the NHH's Administrative Executive Committee;
l. In the absence of the Chief Medical Officer, participates as an ex officio non-voting member of the Executive Committee of the Medical Staff Organization of NHH representing the NHH CEO;
m. To participate with the NHH Chief Medical Officer and the NHH CEO in the development of the clinical budget of NHH;
n. To participate in the recruitment of other clinical DHHS personnel, upon the request of the NHH CEO;
o. To assist in establishing, subject to the NHH Chief Medical Officer and NHH CEO approval, an employment schedule for all clinical personnel employed by the Contractor to provide services at NHH; and
p. To assist the NHH Chief Medical Officer and the NHH CEO with the clinical supervision and education of all other clinical staff at NHH; and
q. To provide clinical coverage as necessary and to the extent possible when there are vacancies with the staff psychiatrists or advanced psychiatric nurse practitioners.

2.3.3. General Psychiatrist Responsibilities

2.3.3.1. The following responsibilities are applicable to all psychiatrists the Contractor provides to NHH under this contract. Staff psychiatrists shall be responsible for the following:

a. The formulation and implementation of individual treatment plans and clinical services, in cooperation with treatment teams, for the diagnosis, assessment, treatment, care and management of patients of NHH;
b. Maintaining and directing a clinically appropriate treatment plan for assigned cases in concert with the multidisciplinary staff consistent with NHH norms;
c. Determination, consistent with RSA 135-C, of the appropriateness of admissions, transfers and discharges;
d. Participation with other staff physicians, the NHH Chief Medical Officer, and the Associate Medical Director to provide on-call after hours coverage and serve as on-site, after hours coverage, on a 24-hour a day, 7-day a week, year round basis when necessary as determined by the NHH CEO, the NHH Chief Medical Officer, and/or the Associate Medical Director;
e. Participation in research and education activities consistent with the mission of NHH and subject to the approval of the NHH CEO;
f. Participation in the Medical Staff Organization and other administrative committees of NHH, assigned committees and task forces;
g. Performance of medical/psychiatric consultation on patients from facilities other than NHH, consistent with current NHH policy;
h. Timely completion of all necessary documentation as required by TJC and CMS standards;
i. Responsibility for completing NHH's Incident Reports in compliance with NHH policy;
j. Completion of all medical record documentation in the timeframes required by the NHH's Policy and Procedure "Medical Record Documentation" and other relevant policies and procedures, including ongoing and timely documentation of clinical care regarding medical necessity, including daily progress notes to document and support medical necessity;
k. Adherence to all NHH policies, including, but not limited to policies on Medical Records Documentation and Progress Notes;
l. Ensuring that documentation is consistent with normative data collected by the NHH compliance officer and NHH utilization review manager;
m. Provision of other services as required, which are consistent with the mission of NHH and the intent of this contract;
n. Appearing and testifying in all court and administrative hearings as required by the Department;
o. Developing and maintaining positive relationships with NHH staff, patients, families, advocates, community providers and other interest groups vital to the functioning of NHH and the DHHS system of care, including for the purpose of transition planning. In

accomplishing this requirement, psychiatrists shall adhere to the standards set forth in NHH's Customer Service Guidelines for Physicians;

p. Meaningfully participating in utilization review processes, including appeals and other processes, as required by the NHH Chief Medical Officer, the Associate Medical Director, and the NHH CEO; and

q. Demonstrating value added achievements with academic and scholarly activities including, but not limited to: teaching (clinical and didactic); attendance and participation in case conferences; engagement with the profession with presentation and/or publication; hospital in-services; and service to the hospital and community through committee work, task force work, community service with advocacy groups; and involvement with the work of DHHS, as well as other public and private agencies that serve the mentally ill, e.g. law enforcement, corrections, the court, the legislature, colleges and universities and other related entities.

2.3.3.2. All psychiatrists shall provide services on a full-time basis, and limit their practice to treating NHH patients only.

2.3.3.3. Notwithstanding the above, psychiatrists serving under this contract may perform occasional outside practice duties, with the advance written approval of the Chief Medical Officer and the NHH CEO, but only if said duties do not, in the sole judgment of the NHH CEO, interfere with the psychiatrists' duties at the NHH.

2.3.3.4. For subsection 2.3.3.2., the term "full-time" shall mean that each psychiatrist shall be required to account, through appropriate record-keeping as specified by NHH, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities, subject to the Contractor's normal and customary employee leave policies.

a. Said minimum hours must be satisfied through hours devoted to clinical activities onsite at NHH. Psychiatrists may be permitted, subject to prior notice and the approval of both the Chief Medical Officer and the NHH CEO; to work up to a maximum of 4 hours per week devoted to educational or research activities so long as those activities further the mission and goals of NHH. Psychiatrists approved for such activities shall provide documentation to the Chief Medical Officer and the NHH CEO that time spent devoted to educational or research activities furthers the mission and goals of NHH.

2.3.3.5. Notwithstanding the foregoing allowance for educational or research activities specified in subsection 2.3.3.4.a., psychiatrists shall be physically present onsite at NHH not less than 36 hours per week, unless otherwise accommodated for through the Contractor's normal and customary employee leave policies.

2.3.4. **Residents/Post Graduate Fellows Responsibilities**

2.3.4.1. The responsibilities of all residents and post graduate fellows (PGY) shall be outlined, monitored, and reviewed by the Chief Medical Officer or the Associate Medical Director, and the appropriate attending psychiatrist.

2.3.4.2. Responsibilities for Residents/Post Graduate Fellows shall involve the advancement of the clinical initiatives underway at NHH under the supervision of the Chief Medical Officer.

a. General Psychiatry Residents (PGY II and PGY IV) – The Contractor shall ensure that Residents are an integral part of the Contractor's ACGME approved psychiatric residency program. Additionally, the Contractor shall provide faculty oversight, clinical supervision, didactic education and appropriate research opportunities in the field of public psychiatry.

b. Child/Adolescent Fellows – The Contractor shall ensure that Fellows are an integral part of the Contractor's ACGME approved child/adolescent training program. The Contractor shall incorporate a full spectrum of child/adolescent coursework and clinical experience to facilitate the NHH rotation, emphasizing areas of child welfare, family intervention, wraparound services and the juvenile justice system. Fellows shall provide coverage for the entire calendar year.

c. Geropsychiatry Fellow – The Contractor shall ensure that the Fellow is an integral part of an ACGME approved fellowship program in geriatric psychiatry. Additionally, the Contractor shall provide faculty oversight, clinical supervision, didactic education and appropriate research opportunities in the care of the elderly.

d. Public Psychiatry Fellow – This program shall begin in SFY 2018. The Contractor shall ensure that the Fellow is an integral part of an approved fellowship program in public sector psychiatry. The Contractor shall provide faculty oversight, clinical supervision, didactic education and appropriate research opportunities in the care of patients with severe and persistent mental illness with the Public Psychiatry Fellowship Program elements as follows:
   i. Academic Curriculum;
   ii. Presentations and consultations outlining principles in the field;
   iii. Guest speakers with topics including mental health administration;
   iv. Weekly meeting with a faculty preceptor;
   v. Lifelong mentorship; and
   vi. Contact and work with advocacy groups and other organizations dedicated to public and community psychiatry.

2.3.5. **Psychiatric Advanced Practice Registered Nurses (APRN) Responsibilities**

2.3.5.1. Psychiatric Advanced Practice Registered Nurses shall provide clinical services in extended care and admissions areas with patients with severe mental illness and medical co-morbidity morbidity in accordance with the scope of practice described in RSA 326-B:11.

2.3.5.2. The responsibilities for Psychiatric APRNs shall include but not be limited to: performing advanced assessments; diagnosing; prescribing; administering and developing treatment regimens; and providing consultation as appropriate.

2.3.5.3. APRNs shall independently prescribe, dispense, and distribute psychopharmacologic drugs within the formulary and act as treatment team leaders in accordance with State law and medical staff by-laws.

2.3.5.4. APRNs shall provide the same level of documentation as required of psychiatrists as outlined in subsection 2.3.3.1.

2.3.6. **NHH Research Manager Responsibilities**

2.3.6.1. The Research Manager shall be responsible for assisting in the development and management of all research at NHH. The Research Manager shall play a pivotal role in initiating and cultivating research that is efficient and responsive to the needs of the NHH CEO, psychiatrists, nursing staff, clinical investigators, administration, and patient community, and works with the Chief Medical Officer to market the research opportunities at NHH while tracking and reporting the growth and development of research activities.

2.3.6.2. The Research Manager shall develop policies and procedures to ensure that research endeavors function effectively and manages and trains support staff in studies as the research program continues to grow and develop.

2.3.6.3. The Research Manager shall serve as the primary contact for all incoming and proposed studies, assesses feasibility and potential use of resources and guides potential projects through the process from initial proposal to planning for staffing, finding resources, reviewing budgets, and providing guidance with hospital, state and federal regulations through to completion of the project.

2.3.7. **After Hours Coverage**

2.3.7.1. The Contractor shall provide on-call after-hours coverage, 24 hours per day, 7 days per week, year round. Coverage shall be provided by one or more full-time psychiatrists who are certified or eligible for certification by the American Board of Psychiatry and Neurology. The coverage will be assigned in one-week increments in rotation among the full-time New Hampshire Hospital psychiatric staff. The after-hours coverage will include back-up to the psychiatry residents who provide in-house after-hours coverage and will cover in-house in the event that the assigned in-house physician is not able to provide the service.

2.3.7.2. The Contractor shall provide on-site after hours coverage, 16 hours per day, Monday through Friday, and 24 hours per day on weekends and holidays, year round.

a. The on-site after-hours coverage on weekdays, weekends and holidays shall be provided by a physician who is certified or eligible for certification by the American Board of Psychiatry and Neurology, or, is in training in an accredited psychiatry residency program with at least three years of training experience.
b. The Contractor shall maintain a pool of psychiatric physicians or resident physicians who are credentialed with New Hampshire Hospital for the after-hours work, and the after-hours physicians will be assigned to in-house after-hours coverage by the Chief Medical Officer or Associate Medical Officer with a six (6) month rolling calendar. The pool shall be of sufficient size and appropriate qualifications to ensure the Contractor's ability to meet 100% staffing level requirements and performance standards specified herein at section 4. Performance Standards and Outcomes.

2.3.8. Applied Clinical Research

2.3.8.1. The Contractor, working jointly with DHHS, shall identify and perform applied clinical research for the purpose of advancing the goals of the public mental health services system. All clinical research projects shall be approved by DHHS in advance. This shall include assessing the system's capacity, developing and/or refining clinical strategies, and training clinical staff in emerging treatment technology. The Contractor shall work jointly with DHHS to seek and obtain appropriate financial support (federal, State and foundation) to continue to build on the existing research projects. The Contractor shall, subject to DHHS approval, ensure that publication of the findings of this research shall receive the widest possible dissemination in the services delivery system in New Hampshire and, through conferences and special reports nationally and internationally.

2.3.9. Additional Requirements

2.3.9.1. The Contractor shall provide clinical personnel to perform the services required for clinical, educational, research, and training programs at NHH. The Contractor shall provide psychiatrists and other clinical personnel with sufficient professional skills and qualifications to provide the educational and research services needed by NHH.

2.3.9.2. At the direction of the NHH CEO, Contractor staff may be assigned to conduct telepsychiatry or offsite consultation not arising from the clinical operation and administration of New Hampshire Hospital or any other public health or clinical service offered by the Department. Contractor staff assigned to telepsychiatry shall have professional malpractice insurance in effect in an amount satisfactory to the Department. The Contractor shall be responsible for ensuring that staff members have malpractice insurance in effect and in amounts satisfactory to DHHS.

2.4. Specific Service Requirements for Service Area #2 – Glencliff Home

2.4.1. General Requirements

2.4.1.1. The Contractor shall provide routine or emergency telephone consultation by the Medical Director (described below) or an equally qualified physician at no additional cost, twenty-four (24) hours per day, seven (7) days per week, fifty-two (52) weeks per year, to clinical and administrative staff at the Glencliff Home.

2.4.2. Medical Director Responsibilities

2.4.2.1. The Contractor shall provide a geropsychiatrist to serve as the Medical Director. The Medical Director shall be responsible for the following:

a. Coordination of all medical care and direct psychiatric services, treatment and associated follow up to all residents of Glencliff Home;
b. Provide administrative functions, including but not limited to policy review and establishment that reflect current standards of practice; oversight of physicians; attendance at mandatory committee meetings, including but not limited to continuous quality improvement, infection control, and admissions; regularly review the use of psychotropic medications for compliance with the Omnibus Budget Reconciliation Act (OBRA) regulations; and the provision of other assistance in meeting standards for annual State inspections and Federal regulations;
c. Deliver expert testimony in probate court as needed (e.g. guardianship cases, electroconvulsive therapy, do not resuscitate orders). Preparation may include consultation with legal counsel, records review, and travel;
d. Provide written patient evaluations on each patient as frequently as required by the Department but in no case less than once per calendar year;
e. Serve as liaison with other organizations, such as NHH or Dartmouth-Hitchcock Medical Center, when a Glencliff Home resident is receiving services at another healthcare institution; and
f. Provide the applicable services as described herein at subsection 2.3.3.1. and its subparagraphs.

2.5. Specific Service Requirements – Service Area #3 – Medicaid

2.5.1. Department of Health and Human Services Chief Medical Officer Responsibilities

2.5.1.1. The Contractor shall provide for the term of the contract, the full-time services of a designated physician, to serve as the Department's Chief Medical Officer.

2.5.1.2. For the Chief Medical Officer, the term "full-time" shall mean that the Chief Medical Officer shall be required to account, through appropriate record-keeping as determined by DHHS, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities, subject to the Contractor's normal and customary employee leave policies.

2.5.1.3. The Chief Medical Officer shall maintain regular office hours consistent with DHHS' regular business hours for senior executive team members. The Contractor shall ensure that the Chief Medical Officer is provided a flexible work schedule that is consistent with the expectations of a senior executive manager at DHHS, subject to the approval of the DHHS Designee.

2.5.1.4. The Chief Medical Officer shall maintain his or her professional calendar electronically, in a format subject to DHHS approval, and make same available to the DHHS Designee as necessary. The Contractor shall ensure the calendar is kept up to date and includes approved leave time, conferences, trainings, etc.

2.5.1.5. The Contractor shall ensure that any out of state travel for conferences and/or trainings for the Chief Medical Officer shall be subject to the prior approval of the DHHS Designee.

2.5.1.6. The Chief Medical Officer's primary workspace shall be located in Concord, New Hampshire, in a DHHS designated facility. DHHS shall provide office space, furniture, a computer with access to DHHS shared network drives as necessary, the usual and customary office supplies, a cell phone for business use and administrative and clerical support. The Contractor shall ensure the Chief Medical Officer utilizes DHHS-provided information and technology resources consistent with applicable State policies.

2.5.1.7. The Chief Medical Officer shall plan and direct all aspects of DHHS' medical policies and programs to ensure the provision of integrated primary care services to individuals eligible for the Medicaid program, in collaboration with the DHHS Designee.

2.5.1.8. The responsibilities of the Chief Medical Officer shall include but not be limited to the following:

a. Developing strategic clinical relationships with physicians and in growing public/private partnerships with academic institutions and federal agencies with a focus on quality improvement and the implementation of federal health care reforms, such as but not limited to the Patient Protection Affordable Care Act (ACA), and any amendments thereto;
b. Overseeing the development of the clinical content in marketing and educational materials and ensures all clinical programs are in compliance with state and federal regulations;
c. Participating in the writing of research publications to support clinical service offerings;
d. Providing medical oversight of the state's publicly funded health insurance programs, making key policy decisions, and shaping

administrative planning strategies to enhance the operating efficiency of Medicaid and CHIP and related healthcare initiatives across the state;

e. In collaboration with the DHHS Designee, directs the day-to-day operations of the DHHS program area responsible for clinical programs, benefit management, and quality improvement activities. Also serves as chief clinical liaison to other state program units, insurance providers, and professional organizations;
f. Serving as the clinical authority in reviewing and determining requests for covered and uncovered medical services and pharmacy services;
g. Participating in the development of procedural reimbursement policy;
h. Promoting and assures effective and efficient utilization of facilities and services using quality improvement methodologies. Oversees the development of a formal quality assurance and quality improvement function within the NH Medicaid program;
i. Identifying new developments and emerging trends in clinical practices and research that would have an impact on medical policy and/or costs, and recommends options and courses of action;
j. Within the context of implementation of federal health care reforms, such as but not limited to the Affordable Care Act and any amendments thereto, provides leadership in the planning, Medicaid program response, development of health care delivery systems, clinical quality initiatives, and related policy issues;
k. Representing the DHHS Designee at meetings and other events and serving as DHHS designee for any committees, boards, and commissions as requested;
l. Analyzing proposed and new federal legislation related to benefits management and recommends options and courses of action;
m. Maintaining and enforces policies, procedures, administrative rules, and State plan provisions that govern Medicaid medical benefits; and
n. Overseeing the implementation of contracted services, maintaining working relationships with contractors, managing contractor deliverables and services, and measuring contractor performance; and
o. Regularly attending Medicaid Management Team meetings.

2.5.1.9. Additionally, the Chief Medical Officer shall assist the DHHS Designee with managing the operations of the clinical and benefits management functions within the Medicaid program. This may include providing to the DHHS Designee input and making recommendations on staffing needs, performance standards, and other matters applicable to DHHS staff.

2.5.1.10. The Chief Medical Officer shall also provide executive team office coverage as needed and requested by the DHHS Designee.

2.6. Specific Service Requirements – Service Area #4 – Children, Youth and Families

2.6.1. DCYF Staff Psychiatrist Responsibilities

2.6.1.1. The Contractor shall provide for the term of the contract, the full-time services of a designated psychiatrist, who is a faculty member and/or employee of the Contractor, to provide psychiatric services to the programs within the Children, Youth and Families service area. For purposes of this paragraph, the term "full-time" shall mean that the Staff Psychiatrist shall be required to account, through appropriate record-keeping as determined by the DHHS designee, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities, subject to the Contractor's normal and customary employee leave policies.

2.6.1.2. The Staff Psychiatrist is expected to work additional hours, including attending non-business hour meetings as required in order to meet the business needs of DHHS without additional cost to DHHS.

2.6.1.3. The Staff Psychiatrist shall maintain regular office hours consistent with those of DHHS senior executive team members.

2.6.1.4. The Staff Psychiatrist shall maintain his or her professional calendar electronically, in a form subject to DHHS approval, and make it available to the DHHS designee as necessary, and will keep it up to date to include leave time, conferences and trainings.

2.6.1.5. The Contractor shall ensure that the Staff Psychiatrist provided under this contract is subject to the Contractor's normal and customary employee benefits and policies, including leave provisions for a senior executive level position. However, the Contractor and DHHS agree that the continuous provision of services is essential, and in addition to any required approvals by the Contractor for its employees, the Staff Psychiatrist shall provide timely, prior notification to the designated DHHS representative of any leave time taken. Absences due to vacation and continuing education shall be planned in advanced, in consideration of the business needs of the DHHS designated program areas.

2.6.1.6. The Contractor shall ensure that any out of state travel for conferences and/or trainings for the Staff Psychiatrist shall be subject to the prior approval of the DHHS designee.

2.6.1.7. The Contractor shall ensure that any vacation or continuing education leave time by the Staff Psychiatrist shall be planned in advance and consider the business needs of DHHS, including ensuring appropriate coverage for any clinical and/or operational responsibilities or tasks that need oversight.

2.6.1.8. The Staff Psychiatrist's primary workspace shall be located in Manchester, New Hampshire, in a DHHS designated facility. DHHS shall provide office space, furniture, a computer with access to DHHS shared network drives as necessary, the usual and customary office supplies, a cell phone for business use and administrative and clerical support. The Contractor shall ensure the Staff Psychiatrist utilizes DHHS-provided information and technology resources consistent with applicable State policies

2.6.1.9. The Contractor shall work directly with the DHHS designee for the Sununu Youth Services Center (SYSC), and shall ensure the following services are provided by the Staff Psychiatrist under the contract:

a. Provide medical and psychiatric services at SYSC;
b. Provide treatment planning oversight, clinical consultations, and assessments to treatment coordinators and Juvenile Probation and Parole Officers. Documents the number of comprehensive psychiatric evaluations and units of psychiatric services provided annually in direct care to youths in SYSC and the Juvenile Justice System. Documents the number of treatment team meetings and clinical consultations attended annually with multi-disciplinary team members at SYSC;
c. Provides program development at SYSC, using a resiliency-building framework, and implementation of evidence-based practices to include interpersonal problem-solving skills, trauma-focused cognitive behavioral therapy, and dialectical behavioral therapy. Documents specific types and numbers of evidence-based treatment interventions implemented annually at SYSC;
d. Provides clinical supervision and teaching of child psychiatry residents and fellows at SYSC. Documents the number of teaching and supervision contacts annually with interns, residents, and fellows at SYSC;
e. Oversees implementation of research initiatives on the effectiveness and outcomes of services and programs within and for JJS;
f. Documents on an aggregate level, through web-based outcome measures, the efficacy of services targeting Post Traumatic Stress Disorder, depression, substance abuse, and behavioral disorders among New Hampshire youth; and
g. Fosters improved interagency collaboration between JJS services, the area mental health agencies, and NHH to enhance mental health services for adjudicated youths, and to improve transitional processes between residential and community-based programs for court involved youths. Documents the number of youths consulted on annually by Juvenile Probation and Parole Officers and interagency collaborative teams.

2.7. Specific Service Requirements – Service Area #5 – Behavioral Health

2.7.1. Medical Director Responsibilities

2.7.1.1. The Contractor shall provide a part-time Medical Director and the necessary personnel to fulfill four major service components, in addition to a time study requirement in the area of behavioral health services. The four components are:

a. Medical Director for the Behavioral Health program;
b. Evidence-Based Practices Training and Consultation;
c. Behavioral Health Policy Institute (BHPI); and
d. Committee for the Protection of Human Subjects (CPHS).

2.7.1.2. The Medical Director shall be available on-site, at a DHHS designated location, for twenty (20) hours per week to provide services to the Behavioral Health service area. The Medical Director shall be available via telephone, email, and in person by appointment during that time.

2.7.1.3. The Medical Director shall, in collaboration with the DHHS designee be responsible for the following:

a. Meet weekly with the DHHS designee;
b. Address Behavioral Health clinical issues;
c. Address Behavioral Health policy issues;
d. Enhance housing support capacity planning;
e. Address Medicaid and state rule issues;
f. Address designated receiving facility maintenance and development;
g. Assist in developing Telemedicine capacity;
h. Utilizes electronic medical records;
i. Coordinate between NHH and CMHC care;
j. Evidence Based Practices (EBP) implementation;
k. Develop funding and reimbursement strategies;
l. Assist in sustainability of the "In Shape" program
m. Assess the needs of patients in NHH and Transitional Housing Services who might be served in the community; and
n. Attend meetings between the Behavioral Health program and various community stakeholder groups, such as the Community Behavioral Health Association and the Disabilities Rights Center, to communicate about and also garner support for and input regarding Behavioral Health initiatives.

2.7.1.4. The Medical Director shall fulfill the additional following responsibilities:

a. Participate on key departmental and legislative committees, as required by DHHS, including the Mental Health Commission, the Mental Health Council, the Drug Utilization and Review Board, and the DHHS Institutional Review Board;
b. Serve as secretary for the Mental Health Council, to ensure that the work of the council supports the goals of DHHS;

c. Serve as a member of the Drug Utilization and Review Board to ensure that the Medicaid Preferred Drug List and work of the Board addresses the needs of consumers with mental illness disabilities;
d. Attend regular case conferences and sentinel event reviews. Analyze challenging clinical cases or events and recommend improvements in policy or services to address problem areas;
e. Attend monthly Institutional Review Board meetings, review research protocols as needed each month to ensure safety of DHHS research participants;
f. Participate on several Behavioral Health System Transformation Workgroups, including the EBP Steering Committee, Programmatic Workgroup, and Quality Assurance Group;
g. Coordinate and meet with DHHS leadership as required by DHHS;
h. Conduct bi-monthly or more frequent Behavioral Health Medical Director's meeting to coordinate efforts, between Behavioral Health and CMHCs, regarding medical/treatment issues related to both hospital and outpatient care of people with serious mental illness and to consult on other relevant issues or concerns, including: preferred drug list issues, coordination with NHH admissions and treatment; Medicaid interruption during institutionalization, enhancement of community housing supports, use of information technology, medical director administrative issues, use of best practices, implementation of EBP's, documentation burden, integration of mental and physical health care, smoking cessation, coordinating local, state and national agendas regarding public mental health care, electronic health records, health information exchange, education and training for CMHC prescribers regarding evidence-based use of antipsychotic medications and monitoring for cardio metabolic side effects;
i. Monitor the effectiveness of the preferred drug list in enhancing cost effective and safe psychotropic medication prescribing in NH including engaging in ongoing discussions with CMHC leaders regarding the Preferred Drug List and direct education and training for CMHC prescribers regarding evidence-based use of antipsychotic medications and monitoring for cardio metabolic side effects;
j. Communicate regularly with, and provide clinical consultation (including potential site visits, conference calls, and written reports) to all Behavioral Health management staff regarding current, challenging clinical issues, including conditional discharges, Medicaid consumer cases, and suicide monitoring;
k. Collaborate with the other DHHS Medical Directors, on a regular basis to monitor medical care and related patient care issues throughout New Hampshire, including drug choice for the Preferred Drug List, performance and impact of the Preferred Drug List on clinical care, Medicaid interruption during hospitalization and incarceration, integration of medical, mental health, and substance abuse services, and enhancement of addiction treatment capacity; and

l. Provide oversight and continuing implementation of Evidence Based Practices, including practices as part of the Medicaid Program for Community Mental Health Services as well as those practices specifically required in the Community Mental Health Agreement.

2.7.2. Evidence-Based Practices Training and Consultation

2.7.2.1. The Contractor shall provide Evidence-Based Practices Training and Consultation services as described in Appendix I, of RFP-2017-OCOM-01-PHYSI, for the purpose of sustaining and continuously improving the quality of three (3) Evidence-Based Practices (EBP) that are implemented across the New Hampshire Community Mental Health Centers (CMHC) system. The EBPs are: Illness Management and Recovery (IMR), Evidence-Based Supported Employment (EBSE), and Assertive Community Treatment Teams (ACT). Additional EBPs may take the place of these based on the availability of federal funding to support the implementation of additional EBPs in New Hampshire.

2.7.2.2. The Contractor shall provide education, training, technical assistance and consultation to the DHHS Behavioral Health service area and the CMHCs. The deliverables described below shall be provided directly to DHHS-designated Behavioral Health program staff and CMHCs designated by DHHS.

2.7.2.3. DHHS shall designate a specific DHHS Behavioral Health staff member to oversee the deliverables specified herein. The Contractor shall designate a specific representative of the Contractor to work directly with the DHHS designee in the fulfillment of these deliverables.

2.7.2.4. **Training the CMHC Workforce:** To sustain and improve the quality of IMR and EBSE services, the Contractor shall provide education and training to DHHS designated CMHCs staff.

a. The Contractor shall ensure that the training and education is provided in central locations and in a manner that best facilitates the learning of key skills and strategies that are necessary to provide IMR and EBSE in ways that support the most effective outcomes for consumers at each of the CMHCs. The training shall be designed to fulfill the specifications described in He-M 426 for CMHC providers of EBPs in NH.

b. Each training event shall include, at a minimum:
   i. Invitations provided to CMHC staff before the training event;
   ii. A description of who should attend the training;
   iii. Outcomes for participants attending the training;
   iv. Sufficient time to provide instruction and practice for skills;
   v. Content designed to improve the fidelity of the practice at CMHC's;
   vi. Documentation of all participants attending the training; and
   vii. Certificates of attendance for all participants completing the training.

c. Each training event shall be staffed by Contractor staff or other qualified professionals; such individuals shall be subject to approval of the DHHS designee.

2.7.2.5. **Illness Management and Recovery (IMR):** The Contractor shall develop, in collaboration with the DHHS designee, specific topic areas for CMHC staff providing IMR services. The topic areas shall be subject to the DHHS designee's approval.

a. The Contractor shall provide the IMR trainings in the following formats:
   i. A minimum of one two-day training for new IMR practitioners to fulfill the specifications described in He-M 426 to provide IMR services. The capacity for each of these training events shall be twenty participants and up to thirty participants depending on the availability of the training space;
   ii. A minimum of four half-day trainings for experienced IMR practitioners, of which the combination of attending any two of these events shall fulfill the specifications described in He-M 426 for ongoing providers of IMR services. The capacity for each of these training events shall be at least twenty participants and up to thirty participants depending on the availability of the training space.
   iii. A minimum of one full-day training for IMR supervisors that shall fulfill the specifications in He-M 426 for ongoing providers of IMR services. The content shall include information on supporting the learning of IMR skills for colleagues and improving the quality and outcomes of IMR services through practice-specific supervision. The capacity for this training event shall be twenty participants.

2.7.2.6. **Evidence Based Supported Employment (EBSE):** The Contractor shall develop, in collaboration with the DHHS designee, specific topic areas for CMHC staff providing EBSE services. The topic areas shall be subject to the DHHS designee's approval.

a. The Contractor shall provide the EBSE trainings in the following formats:
   i. A minimum of two two-day trainings for new EBSE practitioners to fulfill the specifications described in He-M 426 to provide EBSE services. The capacity for each of these training events shall be twenty participants.
   ii. A minimum of two half-day trainings for experienced EBSE practitioners, the combination of attending these two events shall fulfill the specifications described in He-M 426 for ongoing providers of EBSE services. The capacity for each of these training events shall be twenty participants.
   iii. A minimum of two half-day trainings for experienced EBSE practitioners and EBSE supervisors. The combination of attending these two events shall fulfill the specifications described in He-M 426 for ongoing providers of EBSE services. The content shall include information on developing and improving collaboration with the New Hampshire Department

of Vocational Rehabilitation and other important community partners in providing effective EBSE services. The capacity for each of these training events will be twenty participants.

2.7.2.7. **Assertive Community Treatment Teams (ACT):** The Contractor shall develop, in collaboration with the DHHS designee, specific topic areas for CMHC staff providing ACT services. The topic areas shall be subject to the DHHS designee's approval.

b. The Contractor shall provide the ACT trainings in the following formats:
   i. A minimum of two two-day trainings for new ACT practitioners to fulfill the specifications described in He-M 426 to provide EBSE services. The capacity for each of these training events shall be twenty participants.
   ii. A minimum of two half-day trainings for experienced ACT practitioners, the combination of attending these two events shall fulfill the specifications described in He-M 426 for ongoing providers of ACT services. The capacity for each of these training events shall be twenty participants.
   iii. A minimum of two half-day trainings for experienced ACT practitioners and ACT supervisors. The combination of attending these two events shall fulfill the specifications described in He-M 426 for ongoing providers of ACT services. The capacity for each of these training events will be twenty participants.

2.7.2.8. **Assessing Fidelity to Evidence Based Practices (EBPs):** The Contractor shall assess the fidelity (organizational faithfulness to the principles of the practice) of IMR, ACT and EBSE for all CMHCs, as designated by the DHHS designee, with the exception of those CMHCs where the DHHS designee has approved a limited scope of review through the submission of an approved Quality Improvement Plan (QIP). In those organizations utilizing a QIP, the Contractor shall review those fidelity items described in the QIP.

a. In either case, fidelity assessments shall be conducted for the purpose of monitoring the implementation of IMR, ACT and EBSE and for providing information about the capacity, strengths and areas in need of improvement in providing the practice at the designated CMHCs.
b. The Contractor shall develop, in collaboration with the DHHS designee, a specific schedule designating specific time periods for each CMHC IMR, ACT and EBSE fidelity or QIP review. The schedule shall be subject to the advanced approval of the DHHS designee.
c. The Contractor shall ensure that each fidelity or QIP assessment includes, at a minimum:
   i. Written instructions to the CMHC regarding necessary observations, interviews, data access and other activities for the assessment;

ii. A description of CMHC staff, other community providers, consumers and family members who will need to be interviewed for the assessment;
iii. A specific written assessment schedule jointly developed by the Contractor and the CMHC;
iv. Sufficient time to assess and evaluate the CMHC's delivery of IMR, ACT or EBSE;
v. A debriefing at the end of the assessment to review themes from the review with CMHC leadership; and
vi. Documentation of the assessment process, findings and scoring of fidelity items for CMHC leadership and the Department no later than four weeks following the assessment.

2.7.2.9. **Consultation to CMHC Leadership and Workforce Development:** The Contractor shall provide agency-based consultations to all CMHCs as designated by the DHHS designee to assist agencies in sustaining and providing continuous quality improvement for IMR, ACT and EBSE services. The Contractor shall ensure that CMHC leadership has access to consultations at their agencies after they have received the written documentation of the findings of each fidelity assessment described herein at subsection 2.7.2.8. Consultations shall include the development of ideas, strategies and interventions that each individual CMHC may utilize to most effectively sustain and improve IMR, ACT and EBSE services.

a. In cases where CMHCs would benefit from specific agency-based workforce development interventions from the Contractor's staff, the Contractor shall ensure that such further interventions are provided only when collaboratively agreed upon by the DHHS designee, the Contractor and CMHC leadership. These interventions shall be time-limited (customarily one half-day, single events) and specifically tailored to improving designated fidelity areas that are identified as a result of agency-based post fidelity consultations.

2.7.2.10. **NH Behavioral Health Service Area Consultations and Collaboration:** In order to most effectively fulfill the deliverables described in this document for the purposes of sustaining and improving the quality of IMR, ACT and EBSE services in the NH Community Mental Health system, the Contractor shall work in a highly integrated fashion with the DHHS designee and additional DHHS Behavioral Health resources identified by the DHHS designee. This integrated alliance shall also be extended to other state and community agencies as collaboratively agreed upon by the DHHS designee and the Contractor.

a. In addition to attending designated meeting or events, the Contractor shall prepare research information, specific ideas, interventions, feedback, data and strategies, as collaboratively agreed upon by the DHHS designee and the Contractor. Specific activities for consultation and collaboration shall include:

i. The Contractor's attendance at the State EBP advisory committee bi-monthly meetings by the Contractor and/or designees;
ii. The Contractor's attendance at weekly meetings with the DHHS designee;
iii. Attendance of Contractor staff at monthly meetings with the DHHS designee and any additional DHHS Behavioral Health resources identified by the DHHS designee;
iv. The Contractor's attendance at quarterly meetings with the DHHS designee, and any additional DHHS Behavioral Health resources identified by the DHHS designee, to review progress of these deliverables and make any necessary resource allocations within the scope based, as collaboratively agreed upon by the DHHS designee and the Contractor;
v. The Contractor's attendance at DHHS designated meetings with NH Bureau of Vocational Rehabilitation (NHBVR) personnel to improve collaboration between EBSE services and NHBVR at both state-wide and regional levels to better assist CMHC consumers in achieving their vocational goals;
vi. The Contractor's attendance at DHHS designated meetings with Granite State Employment Project (Medicaid Infrastructure Grant) personnel to improve collaboration between EBSE services and the Granite State Employment Project at both state-wide and regional levels to better assist CMHC consumers in achieving their vocational goals;
vii. The Contractor's attendance at DHHS designated meetings with DHHS Behavioral Health personnel regarding Behavioral Health strategies and interventions, including proposed rule or policy and procedure changes, to better facilitate the sustaining and improvement of IMR, ACT and EBSE services in the NH Community Mental Health system;
viii. The Contractor's attendance at designated meetings with key CMHC personnel, including monthly meetings of CMHC Community Support Program directors, regarding the Contractor's activities and to better facilitate the sustaining and improvement of IMR, ACT and EBSE services; and
ix. The Contractor's attendance at other events, as collaboratively agreed upon by the DHHS designee and the Contractor, for the purposes of sustaining and improving the quality of IMR, ACT and EBSE services.

2.7.3. Behavioral Health Policy Institute (BHPI)

2.7.3.1. Under the direction of the DHHS designee and the Behavioral Health Medical Director providing services to the Behavioral Health program, the Contractor shall conduct periodic analyses, the frequency of which shall be determined by DHHS, of Medicaid claims to address policy issues and questions under consideration from the Behavioral Health program. The Contractor shall participate in regular meetings with the DHHS designee and the Behavioral Health Medical Director to review these analyses, and associated policy implications.

2.7.4. Committee for the Protection of Human Services (CPHS)

2.7.4.1. The Contractor shall achieve the following CPHS related deliverables for the purpose of sustaining and supporting a committee to oversee research funded by federal agencies and other non-state sources, and conducted in New Hampshire DHHS-funded programs that serve people with mental illness, developmental disabilities, and substance abuse or dependence disorders, in fulfillment of NH RSA 171-A:19-a. Because of federal regulations governing the composition and operation of such committees, a certain number of scientific experts must be present on the committee. The Contractor shall provide research, scientific and human subject's expertise to the CPHS under the contract.

2.7.4.2. The Contractor shall provide staff to support the CPHS who shall:

a. Attend and fully participate in CPHS full committee meetings (once per month);
b. Conduct expedited reviews as requested by the CPHS Administrator (averaging about three per month);
c. Provide consultation, support, and guidance to the CPHS Administrator, Chairperson, and Committee members regarding the interpretation of federal regulations and human subject's protections (e.g., pre-reviewing materials, reviewing requirements for exempt and expedited determinations, reviewing significant adverse event reports);
d. Serve on the Consent Form Template and Forms sub-committees, or others as requested by the CPHS Chairperson; and
e. Serve as the Co-Vice Chair to the CPHS.

2.7.4.3. Revision of the aforementioned deliverables may be done by mutual agreement of the Contractor and the DHHS designee. The availability of additional federal funds to support the implementation of additional Evidence Based Practices may also necessitate a renegotiation of priorities outlined in this deliverables plan, and a reallocation of the Contractor's time in order to assist with the construction of federal grant applications. Changes agreed upon may be subject to Governor and Executive Council approval.

2.7.5. Time Studies

2.7.5.1. The Contractor shall be responsible for performing regular time studies in accordance with CMS and DHHS Medicaid Cost Allocation procedures in order to document activities, relating directly to the administration of the Medicaid program, to draw down federal matching revenues, which will be utilized to support costs associated with the Behavioral Health Medical Director's salary, benefits, and indirect expenses. These studies shall be provided in and documented in a format approved by DHHS.

2.8. Specific Service Requirements – Service Area #6 – Elderly and Adult Services

2.8.1. Medical Director Responsibilities

2.8.1.1. The Contractor shall provide a part-time Medical Director to the Elderly and Adult Services service area who shall provide services for the purposes of sustaining and improving the quality of services for the elderly and adults with disabilities in NH.

2.8.1.2. The Medical Director shall, in collaboration with the DHHS designee:

a. Assist in the planning and direction of the organization's medical policies and programs;
b. Strategically develop public/private partnerships with community providers, academic institutions and state/federal agencies with a focus on quality improvement;
c. Serve as a resource for chronic disease self-management or other wellness/prevention initiatives to improve the lives of individuals served by the Elderly and Adult Services service area;
d. Perform a variety of complex tasks that include the provision of medical consultation, clinical oversight, educational instruction, benefits management and quality assurance within the Elderly and Adult Services service area;
e. Provide medical oversight for all aspects of the Medicaid Program managed by the Elderly and Adult Services service area, including the waiver program for seniors and adults with disabilities, assisting in key policy decisions, identifying partnering opportunities with other program areas, and shaping administrative planning strategies to enhance the program's operating efficiency and cost effectiveness;
f. Serve as the clinical authority in reviewing requests for coverage of services not routinely offered, and providing clinical guidance to the Elderly and Adult Services service area on all such responses, as well as collaborating on developing new service coverage to respond to needs or practices identified;
g. Promote and assures effective and efficient utilization of facilities and services using quality improvement methodologies. Oversees the development of a formal quality assurance and quality improvement function within the Elderly and Adult Service area;
h. Identify new developments and emerging trends in clinical practice and research that would have an impact on clinical policy and/or costs and recommend options and courses of action;
i. Identify program development opportunities within federal health care reforms, such as but not limited to the implementation of the Patient Protection Affordable Care Act (ACA) and any amendments thereto;
j. Leads planning and development of program and policy changes within the Elderly and Adult Services service area throughout the implementation of federal health care reforms, such as but not limited to the ACA and any amendments thereto;

k. Participate in the Technical Assistance Committee (TAC) that reviews clinical issues and initiatives within New Hampshire Nursing Facilities;
l. Participate in the quality assurance initiative, Sentinel Event Reviews;
m. Assist in the implementation of ACA by providing leadership in the planning and development of health care delivery systems, clinical quality initiatives and related policy issues;
n. Provide educational training to DHHS Elderly and Adult Services service area personnel, and external stakeholders;
o. Provide clinical expertise and medical consultation in Elderly and Adult Services service area grant writing and program evaluation;
p. Attend a minimum of two (2) Technical Advisor Committee meetings per annum;
q. Attend Sentinel Event Review Meetings; and
r. Meet, two times per month with the DHHS designee to review initiatives and provide consultation services.

2.9. Specific Service Requirements – Service Area #7 – Developmental Services

2.9.1. Medical Director Responsibilities

2.9.1.1. The Contractor shall provide a part-time Medical Director to the Developmental Services service area. The Medical Director shall provide services that includes two days of psychiatric consultation services per week, and is allocated at 0.4 Full-Time Equivalent.

2.9.1.2. The Medical Director shall:

a. Weekly dedicate one day to referrals from the ten Area Agencies and another day to referrals from Special Medical Services (SMS) and its child development clinics. These referrals may include the Medical Director performing evaluations, consultations and medication reviews;
b. Based on He-M 1201, chair Developmental Services' Medication Committee meetings and provide expert opinion and leadership to facilitate effective functioning of the Committee;
c. Assist the DHHS Developmental Services service area staff in addressing medical issues related to quality assurance activities or Sentinel Event Reviews;
d. Provide educational training to DHHS Developmental Services service area staff, Area Agencies, and subcontract agencies and other stakeholders, as identified by Developmental Services;
e. Provide expertise and assistance in efforts to improve New Hampshire's developmental services system; and
f. Respond to all referrals for evaluations and consultations made through the Area Agencies, SMS, and child development clinics.

2.9.2. **Adult Developmental Services Interdisciplinary Clinic Team**

2.9.2.1. The Contractor shall provide an Interdisciplinary Clinic Team for Adults. The Contractor shall provide the following staffing and fulfill the following responsibilities for the Interdisciplinary Clinic Team for Adults.

a. **Psychiatrist** – the psychiatrist shall serve as the clinic director, coordinating the team / providers involved in this clinic. The psychiatrist shall conduct a comprehensive psychiatric examination; including reviewing the client's entire past psychiatric treatment and medical history. The psychiatrist shall make recommendations as part of the comprehensive report regarding evidence based treatment for optimal care for each client;
b. **Neuropsychologist** – the neuropsychologist shall review all past psychiatric, medical records, neuropsychological testing and behavioral incidents. The neuropsychologist shall document their recommendations as part of the comprehensive report. The neuropsychologist shall supervise the neuropsychology fellow and shall oversee the documentation of historical information regarding the client;
c. **Neuropsychology fellow** – the neuropsychology fellow shall review all past medical, past psychiatric records, neuropsychological testing, behavioral incidents and document pertinent historical information regarding each person as part of the comprehensive report;
d. **Neurologist** – the neurologist shall review past medical records, conduct a physical examination, and document their findings and recommendations as part of the comprehensive report;
e. **Primary Care Physician** – the primary care physician shall review past medical records, conduct a physical examination, and document their findings and recommendations as part of the comprehensive report;
f. **Occupational Therapist** – the occupational therapist shall review past medical records, conduct an occupational therapy evaluation, document their findings and recommendations as part of the comprehensive report; and
g. **Administrative Support** – the administrative support will schedule the appointment, review received documents and checklist of requested documents, copy records for providers and fax completed reports.

2.9.2.2. The Interdisciplinary Clinic Team for Adults shall provide the following services:

a. The Contractor shall ensure the Team accepts adults being referred from the Area Agencies needing this service. Should the number of referrals exceed the number of clients able to be seen, then the Contractor shall prioritize clients based on the most immediate need and critical situation;
b. The Contractor shall support the goal of this Interdisciplinary Clinic Team by providing high-quality interdisciplinary evaluations to adults with developmental disabilities and acquired brain injuries.

The Contractor shall provide a comprehensive understanding of the client with a focus on a biological, psychological, social/environmental approach and the interaction of these factors as they relate to the clients strengths, skills, and interests. The Contractor shall generate one comprehensive report with recommendations that can be utilized by the Systemic – Therapeutic – Assessment – Resources – and Treatment (START) Coordinators, Area Agencies and medical providers to provide the best quality of care for each person. The Contractor shall serve as one point of access to a team of expert providers to reduce each client's number of medical appointments and reduce each clients need to travel to multiple appointments;

c. The Contractor shall convene the Interdisciplinary Clinic Team one time per month and shall conduct a face-to-face appointment with one client per month, for a total of 12 clients per year. The Interdisciplinary Clinic Team meetings and face-to-face client appointments shall take place at a location designated by DHHS. The Contractor shall review all previous records of each client prior to each face-to-face appointment. The Contractor's Interdisciplinary Clinic Team of providers shall meet with the client and the client's team of caregivers as part of the evaluation to obtain history / concerns and examine the client. After meeting and examining the client, the Interdisciplinary Clinic Team shall meet to discuss recommendations. The Interdisciplinary Clinic Team shall generate a comprehensive report regarding the visit and recommendations. The report shall be made available within 15 business days from the date of the last meeting of the Interdisciplinary Clinic Team; and

d. The Contractor shall have the client or the client's authorized representative sign a release form identifying the parties to whom the Contractor may distribute the comprehensive reports.

2.9.3. Child Developmental Services Interdisciplinary Clinic Team

2.9.3.1. The Contractor shall provide an Interdisciplinary Clinic Team for Children. The Contractor shall provide the following staffing and fulfill the following responsibilities for the Interdisciplinary Clinic Team for Children.

a. **Child Psychiatrist** – the psychiatrist shall serve as the clinic director, coordinating the team / providers involved in this clinic. The psychiatrist shall conduct a comprehensive psychiatric examination, including reviewing the client's entire past psychiatric treatment history. The psychiatrist shall make recommendations as part of the comprehensive report regarding evidence based treatment for optimal care for each patient;

b. **Neuropsychologist** – the neuropsychologist shall review all past medical records, neuropsychological testing, and behavioral incidents; document their recommendations as part of the comprehensive report. The neuropsychologist shall supervise the neuropsychology fellow and shall oversee writing the historical information regarding the child;

c. **Neuropsychology fellow** – the neuropsychology fellow shall review all past medical records, neuropsychological testing, behavioral incidents and document pertinent historical information regarding each person as part of the comprehensive report;
d. **Neurologist** – the neurologist shall review past medical records, conduct a physical examination, and document their findings and recommendations as part of the comprehensive report;
e. **Primary Care Physician** – the primary care physician shall review past medical records, conduct a physical examination, and document their findings and recommendations as part of the comprehensive report;
f. **Occupational Therapist** – the occupational therapist shall review past medical records, conduct an occupational therapy evaluation, document their findings and recommendations as part of the comprehensive report; and
g. **Administrative Support** – the administrative support shall schedule the appointment, review received documents and checklist of requested documents, copy records for providers and fax completed reports.

2.9.3.2. The Interdisciplinary Clinic Team for Children shall provide the following services:

a. The Contractor shall ensure the Team accepts children being referred from the Area Agencies needing this service. Should the number of referrals exceed the number of clients able to be seen, then the Contractor shall prioritize clients based on the most immediate need and critical situation;
b. The Contractor shall support the goal of this Interdisciplinary Clinic Team by providing high quality interdisciplinary evaluations to children and adolescents with developmental disabilities. The Contractor shall provide a comprehensive understanding of the child with a focus on a biological, psychological, social/environmental approach and the interaction of these factors as they relate to the child's strengths, skills, and interests. The Contractor shall generate one comprehensive report with recommendations that can be utilized by the Systemic – Therapeutic – Assessment – Resources – and Treatment (START) Coordinators, area agencies and medical providers to provide the best quality of care for each child. The Contractor shall serve as one point of access to a team of expert providers to reduce each client's number of medical appointments and reduce each clients need to travel to multiple appointments;
c. The Contractor shall convene the Interdisciplinary Clinic Team one time per month and shall conduct a face-to-face appointment with one client per month, for a total of 12 client appointments per year. The Interdisciplinary Clinic Team meetings and face-to-face client appointments shall take place at a location designated by DHHS. The Contractor shall review all previous records prior to each client's appointment. The Interdisciplinary Clinic Team of providers shall meet with the client and the client's team of

caregivers as part of the evaluation to obtain history / concerns and examine the client. After meeting and examining the client, the Interdisciplinary Clinic Team shall meet to discuss recommendations. The Interdisciplinary Clinic Team shall generate a comprehensive report regarding the client's appointment and resulting team recommendations. The report shall be made available within 15 business days from the date of the last meeting of the Interdisciplinary Clinic Team; and

d. The Contractor shall have the client or the client's authorized representative sign a release form identifying the parties to whom the Contractor may distribute the comprehensive reports.

3. Staffing

3.1. General Requirements Applicable to All Service Areas:

3.1.1. The following requirements apply to all personnel provided under the contract:

3.1.1.1. The Contractor shall recruit and retain qualified individuals for the staffing needs specified herein at subsections 3.3 through 3.9, and as otherwise necessary to fulfill the requirements described herein at: Section 2, Scope of Services; Section 4, Performance Standards and Outcomes; and Section 5, Reporting.

3.1.1.2. All such individuals shall be subject to DHHS approval prior to the Contractor notifying candidates of assignment/hire to fulfill a specified staffing role; DHHS shall inform the Contractor of its applicable designee for this purpose per position or service area. The designee, at his or her discretion, shall be entitled to interview any such candidate; the Contractor shall facilitate coordinating such interviews upon the DHHS designee's request.

3.1.1.3. DHHS, at its sole discretion, may rescind, either permanently or temporarily, its approval of any Contractor personnel providing any services under this contract for any of the following reasons:

a. Suspension, revocation or other loss of a required license, certification or other contractual requirement to perform such services under the contract;
b. Providing unsatisfactory service based on malfeasance, misfeasance, insubordination or failure to satisfactorily provide required services;
c. Arrest or conviction of any felony, misdemeanor, or drug or alcohol related offense;
d. Abolition of the role due to a change in organizational structure, lack of sufficient funds or like reasons; or
e. Any other reason which includes, but is not limited to: misconduct, violation of DHHS policy, or violation of state or federal laws and regulations pertaining to the applicable DHHS service area, or a determination that the individual presents a risk to the health and safety of any staff member or any individual served by the Department.

In the event of such rescission, the Contractor's applicable staff member shall be prohibited from providing services under the contract for the period of time that DHHS exercises this right. In the event DHHS chooses to exercise this right, DHHS shall provide reasonable advance notice to the Contractor.

3.1.1.4. DHHS shall provide the Contractor with prior notice of exercising its right under subsection 3.1.1.3. and the reason for which DHHS has exercised its right. If DHHS removes Contractor personnel for any reason, no additional payments shall be paid by the State for any staff removed from duty by the Department

3.1.1.5. In the event that DHHS exercises its right under subsection 3.1.1.3.:

a. The Contractor shall provide replacement personnel who shall meet all of the applicable requirements under the contract, including but not limited to being subject to the DHHS approval specified in 3.1.1.2.;
b. The Contractor shall be responsible for providing transition services to the applicable DHHS service area to avoid the interruption of services and administrative responsibilities at no additional cost to DHHS;
c. DHHS shall inform the Contractor of the anticipated duration for which approval will remain rescinded. If the position is assigned to NHH, and if the duration of a temporarily rescinded approval is greater than seven (7) calendar days, the Contractor shall furnish within ten (10) business days replacement Contractor staff who shall meet all of the requirements for the applicable position under the contract. The Contractor shall be responsible for providing, at no additional cost to the Department, transition services to NHH to avoid service interruption;
d. It shall be at the Contractor's sole discretion whether to initiate any internal personnel actions against its own employees. However, nothing herein shall prohibit the Contractor from seeking information from DHHS regarding DHHS' decision, unless such information is otherwise restricted from disclosure by DHHS based on internal DHHS policies or rules, State of New Hampshire personnel policies, rules, collective bargaining agreements, or other state or federal laws.

3.1.1.6. The Contractor shall ensure that, prior to providing the applicable services for the applicable DHHS service area or facility, all required licenses, certifications, privileges, or other specified minimum qualifications are met for all staff, and where applicable, are maintained throughout the provision of services for the full term of the contract. The Contractor shall provide the applicable DHHS designee with a copy of all such documents. The Contractor acknowledges and agrees that DHHS shall not be held financially liable for any fees or costs for any licenses, certifications or renewal of same, nor for any fees or costs incurred for providing copies of said licenses or certifications.

3.1.1.7. The Contractor shall ensure that all staff provided under this contract are subject to the Contractor's normal and customary employee benefits and policies, including leave provisions. However, whereas the Contractor and DHHS agree that the continuity of operations and continuous provision of the staffing described in this contract at the level of 100%, is of paramount importance to the State, in addition to any required approvals by the Contractor for its employees, Contractor staff providing services shall provide timely, prior notification to the applicable DHHS designee for any anticipated leave time, unless otherwise stated herein for a specific position or service area.

3.1.1.8. All personnel provided by the Contractor shall be subject to the identified criminal background, registry, screening and medical examinations, as specified in the table below, for the applicable Service Area to which the individual is assigned contractual service responsibilities. The Contractor shall ensure the successful completion of these requirements for each individual assigned by the Contractor to perform contractual services prior to commencing work and shall ensure that such requirements are kept up to date as required; the Department shall receive copies of all documentation prior to the commencement of services and shall not be responsible for any costs incurred in obtaining the documentation described below:

Service Area		Required Background, Registry, Screening, and Medical Examinations
1	New Hampshire Hospital	Criminal Background, BEAS State Registry, DCYF Central Registry, Health Assessment (including TB testing and physical capacity examination).
2	Glencliff Home	Criminal Background (including RSO and OIG), BEAS State Registry, DCYF Central Registry, TB Testing
3	Medicaid Program	Criminal Background, BEAS State Registry, DCYF Central Registry
4	Children, Youth & Families	Criminal Background, DCYF Central Registry, TB Testing
5	Behavioral Health	Criminal Background, BEAS State Registry, DCYF Central Registry
6	Elderly and Adult Services	Criminal Background, BEAS State Registry
7	Developmental Services	Criminal Background, BEAS State Registry, DCYF Central Registry

3.2. General Staffing Requirements Applicable to Service Area #1 – New Hampshire Hospital

The following additional requirements shall apply specifically to personnel provided to fulfill the contractual requirements applicable to Service Area #1 – NHH, for the duration of the contract:

3.2.1. The Contractor shall ensure that the Chief Medical Officer actively participates in the recruitment of all other staffing needs required under the contract for the provision of services at NHH.

3.2.2. The Contractor shall ensure that, prior to commencing practice at NHH, all psychiatrists are licensed to practice medicine in the State of New Hampshire, as well as boarded in their particular specialty or are board eligible, and shall commence the privileging process of the Medical Staff Organization of NHH as authorized by its by-laws. Such licenses and clinical privileges must be maintained throughout the term of the contract.

3.2.3. The Contractor shall ensure that all clinical personnel maintain appropriate licensure/certification relevant to the practice of their clinical disciplines.

3.2.4. DHHS reserves the right to jointly, with the Contractor, or separately, interview, research or otherwise screen and consider candidates the Contractor designates for the Chief Medical Officer role.

3.2.5. In addition to the provisions stated herein at subsection 3.1.1.7., staff providing services to NHH shall provide timely, prior notification to the Chief Medical Officer and the NHH CEO for any anticipated leave time. The Contractor shall be solely responsible for providing, at no additional cost to DHHS, qualified, sufficient staff coverage to fill any gap in coverage during any anticipated leave time, including sick leave; lasting more than three (3) consecutive days unless otherwise agreed upon by the NHH CEO on a case-by-case basis, and for providing appropriate transition between staff members covering for those on leave. Qualified sufficient staff coverage shall mean personnel who meet or exceed the qualifications of the vacating staff member.

3.2.5.1. The Contractor acknowledges and understands that DHHS' expectation is that staffing at the level of 100% ensures that in no case shall Contractor staffing affect the number of NHH beds available, and that NHH units will not stop admissions due to the lack of coverage for Contractor staff.

3.2.6. DHHS reserves the right, through its NHH CEO, or other designee in the absence of the NHH CEO or a vacancy in that position, at its sole discretion to rescind, either temporarily or permanently, its approval of any Contractor staff member providing services at NHH for any of the following reasons:

3.2.6.1. Loss of medical staff privileges at NHH pursuant to medical staff by-laws;

3.2.6.2. Revocation or suspension of the Chief Medical Officer's New Hampshire medical license;

3.2.6.3. Arrest or conviction of a felony, misdemeanor or drug or alcohol related offense; or

3.2.6.4. Any other reason, which includes, but is not limited to: misconduct, violation of NHH or DHHS policy or state or federal laws or regulations, malfeasance, unsatisfactory work performance, or a determination that the individual presents a risk to the health and safety of any staff member or any individual served by the Department.

Should DHHS exercise this right, the applicable staff member shall be prohibited from providing services under the contract for any period of time DHHS chooses.

3.2.7. If the NHH CEO removes Contractor staff assigned to this service area, including the Chief Medical Officer, for any reason, the Contractor shall not be entitled to payment for the staff member during the period of removal.

3.2.8. If approval of the Chief Medical Officer is temporarily rescinded, pursuant to subsection 3.1.1.3., the Contractor shall furnish within ten (10) business days a psychiatrist to serve full-time as interim NHH Chief Medical Officer, until such time as the existing Chief Medical Officer either resumes duty full-time or is replaced by a new Chief Medical Officer. The Interim Chief Medical Officer shall meet all of the requirements for the Chief Medical Officer as set forth under the contract. The Contractor shall be responsible for providing transition services to NHH, at no additional cost, to avoid the interruption of services and administrative responsibilities.

3.2.9. DHHS shall provide Contractor staff at NHH with adequate facilities and DHHS-employed administrative support staff. Facilities shall include, but not be limited to, office space, equipment, and furnishings. Sufficient space to accomplish educational, training, and research missions shall also be made available. Administrative support staff shall include, but not be limited to, secretarial assistance, including one full-time executive secretary to support the Chief Medical Officer.

3.2.10. The Contractor, the Chief Medical Officer and all other clinical staff provided by the Contractor shall execute their responsibilities pursuant to this contract consistent with RSA Chapter 135-C, any applicable administrative rules, the by-laws of the NHH's Medical Staff Organization, The Joint Commission (TJC), Centers for Medicare and Medicaid Services (CMS); and in accordance with generally accepted medical standards and practices.

3.3. Specific Staffing Requirements – Service Area #1 – New Hampshire Hospital

3.3.1. Chief Medical Officer

3.3.1.1. The Contractor shall provide for the term of the contract, the full-time services of a qualified physician to serve as the Chief Medical Officer for NHH. The Chief Medical Officer shall possess the following qualifications and meet the following requirements:

a. The Chief Medical Officer shall be a Board Certified Psychiatrist licensed to practice in the State of New Hampshire. The Chief Medical Officer shall, at all times, maintain both a license to practice medicine in the State of New Hampshire and clinical privileges at NHH.

b. The Chief Medical Officer shall be a senior administrative psychiatrist having a minimum of five (5) years of experience in a position of clinical leadership for a major public sector program, psychiatric hospital, governmental authority, state or national medical/psychiatric society organization involved in the delivery of public sector psychiatric services. The Chief Medical Officer shall

have completed an ACGME approved residency program with board certification in Psychiatry by the American Board of Psychiatry and Neurology. Additional subspecialty certification in forensic, geriatric or child/adolescent psychiatry may be substituted for 2 years of administrative leadership. Completion of a graduate curriculum in medical administration preferred.

c. For purposes of this paragraph, the term "full-time" shall mean that the Chief Medical Officer shall be required to account, through appropriate record-keeping as determined by NHH, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities pursuant to the contract, subject to the Contractor's normal and customary employee leave policies. Said minimum hours must be satisfied through hours devoted to clinical activities onsite at NHH.

3.3.1.2. The Chief Medical Officer may be permitted with prior notice and approval of the NHH CEO to work up to a maximum of 4 hours per week devoted to educational or research activities so long as those activities further the mission and goals of NHH. The Chief Medical Officer shall be responsible for providing documentation to the NHH CEO that time spent devoted to educational or research activities furthers the mission and goals of NHH.

3.3.1.3. Notwithstanding the foregoing allowance for educational or research activities, the Chief Medical Officer shall be physically present onsite at NHH not less than 36 hours per week. The Chief Medical Officer shall also participate with staff psychiatrists in on call, after-hours coverage above the 40 hour week to ensure a 24-hour a day, 7 day per week provision of Psychiatrist-On-Call services without additional compensation to the Contractor or the Chief Medical Officer.

3.3.1.4. In the event the Chief Medical Officer resigns, or is otherwise removed from providing services to NHH under this contract, the Contractor shall furnish within ten (10) business days, not including holidays, a psychiatrist to serve full-time as interim NHH Chief Medical Officer, until such time as the existing Chief Medical Officer either resumes duty full-time or is replaced by a new Chief Medical Officer. The interim Chief Medical Officer shall meet all of the requirements for the Chief Medical Officer as set forth under the contract. The Contractor shall be responsible for providing transition services to NHH, at no additional cost, to avoid the interruption of services and administrative responsibilities.

3.3.1.5. The Chief Medical Officer shall demonstrate:

a. Clear success in the fields of clinical psychiatry and psychiatric education at the graduate or undergraduate level;
b. Development of innovative clinical programs specific to the needs of the severely and persistently mentally ill, (SPMI) population;
c. Successful collaboration with state government leadership in the areas of program planning, budget, personnel policies, staffing levels, and the legislative process;
d. Cooperation with consumer organizations; and

e. Competence in program evaluation and evidence based outcomes related clinical practice. Research experience; particularly in public sector relevant research as a principal investigator or co-principal investigator is preferred.

3.3.1.6. On an annual basis, the Chief Medical Officer and the NHH CEO shall establish staffing needs for NHH, which shall include psychiatric, research and related clinical personnel. A schedule of personnel shall be developed and written notice shall be provided to the Contractor prior to commencement of the applicable contract year.

3.3.2. Associate Medical Director

3.3.2.1. The Contractor shall provide for the term of the contract, the full-time services of a qualified physician to serve as the Associate Medical Director for NHH. The Associate Medical Director shall possess the following qualifications and meet the following requirements:

a. The Associate Medical Director shall be a Board Certified Psychiatrist licensed to practice in the State of New Hampshire. The Associate Medical Director shall, at all times, maintain both a license to practice medicine in the State of New Hampshire and clinical privileges at NHH.

b. The Associate Medical Director shall be a senior administrative psychiatrist having a minimum of five (5) years of experience in a position of clinical leadership for a major public sector program, psychiatric hospital, governmental authority, state or national medical/psychiatric society organization involved in the delivery of public sector psychiatric services. The Associate Medical Director shall have completed an ACGME approved residency program with board certification in Psychiatry by the American Board of Psychiatry and Neurology. Additional subspecialty certification in forensic, addiction, geriatric or child/adolescent psychiatry may be substituted for 2 years of administrative leadership. Completion of a graduate curriculum in medical administration preferred.

c. For purposes of this paragraph, the term "full-time" shall mean that the Associate Medical Director shall be required to account, through appropriate record-keeping as determined by NHH, for a minimum of 40 hours of work per week devoted to his or her duties and responsibilities pursuant to the contract, subject to the Contractor's normal and customary employee leave policies. Said minimum hours must be satisfied through hours devoted to clinical activities onsite at NHH.

3.3.2.2. The Associate Medical Director may be permitted with prior notice and approval of the NHH CEO to work up to a maximum of 4 hours per week devoted to educational or research activities so long as those activities further the mission and goals of NHH. The Associate Medical Director shall be responsible for providing documentation to the NHH CEO that time spent devoted to educational or research activities furthers the mission and goals of NHH.

3.3.2.3. Notwithstanding the foregoing allowance for educational or research activities, the Associate Medical Director shall be physically present onsite at NHH not less than 36 hours per week. The Associate Medical Director shall also participate with staff psychiatrists in on call, after-hours coverage above the 40 hour week to ensure a 24-hour a day, 7 day per week provision of Psychiatrist-On-Call services without additional compensation to the Contractor or the Chief Medical Officer.

3.3.2.4.. In the event the Associate Medical Director resigns, or is otherwise removed from providing services to NHH under this contract, the Contractor shall furnish, within 10 business days, not including holidays, a psychiatrist to serve full-time as interim NHH Associate Medical Director, until such time as the existing Associate Medical Director either resumes duty full-time or is replaced by a new Associate Medical Director. The interim Associate Medical Director shall meet all of the requirements for the Chief Medical Officer as set forth under the contract. The Contractor shall be responsible for providing transition services to NHH, at no additional cost, to avoid the interruption of services and administrative responsibilities.

3.3.2.5. The Associate Medical Director shall demonstrate:

a. Clear success in the fields of clinical psychiatry and psychiatric education at the graduate or undergraduate level;
b. Development of innovative clinical programs specific to the needs of the severely and persistently mentally ill, (SPMI) population;
c. Successful collaboration with state government leadership in the areas of program planning, budget, personnel policies, staffing levels, and the legislative process;
d. Cooperation with consumer organizations; and
e. Competence in program evaluation and evidence based outcomes related clinical practice. Research experience; particularly in public sector relevant research as a principal investigator or co-principal investigator is preferred.

3.3.2.6. On an annual basis, the Associate Medical Director, together with the Chief Medical Officer and the NHH CEO, shall establish staffing needs for NHH, which shall include psychiatric, research and related clinical personnel. A schedule of personnel shall be developed and written notice shall be provided to the Contractor prior to commencement of the applicable contract year.

3.3.3. Psychiatrists

3.3.3.1. The Contractor shall provide eleven (11) General Psychiatrists for the adult units at NHH:

a. All psychiatrists shall have appropriate experience in the specialty they are boarded or board eligible in;
b. All psychiatrists shall have completed an ACGME approved residency program in psychiatry;
c. At least one psychiatrist shall be dedicated full-time to provide services to the Inpatient Stabilization Unit (ISU); and

d. At least one psychiatrist shall be certified in addiction treatment this psychiatrist shall be a physician who is certified in general psychiatry and has significant clinical experience in addiction medicine. A fellowship training and/or board certification in Addiction Medicine or Addiction Psychiatry is highly desirable.

3.3.4. Child/Adolescent Psychiatrists

3.3.4.1. The Contractor shall provide four (4) Child/Adolescent Psychiatrists who have successfully completed their fellowship.

a. All psychiatrists shall have completed both an ACGME approved residency program in psychiatry and a 2-year ACGME approved fellowship in child/adolescent psychiatry.

3.3.5. Geropsychiatrist

3.3.5.1. The Contractor shall provide one (1) geropsychiatrist who has:

a. Completed an ACGME approved residency program in psychiatry, and be board certified by the American Board of Psychiatry and Neurology in Psychiatry; and
b. Completed a 1-year geropsychiatry fellowship and is specialty certified by the American Board of Psychiatry and Neurology in geriatric psychiatry. Two years of additional clinical experience in geriatric psychiatry may be substituted for fellowship training.

3.3.6. Director of Neuropsychology Laboratory

3.3.6.1. The Contractor shall provide a senior neuropsychologist who has:

a. Past experience shall include leadership responsibilities in MRI operations and the ability to integrate cognitive test results with data from structural and functional brain imaging;
b. A Ph.D. or Psy.D. in clinical psychology or neuropsychology and shall have completed a neuropsychology postdoctoral fellowship (Houston guidelines); and
c. Evidence of scientific productivity in relation to the SPMI population and the ability to generate proposals for federal and foundation support is preferred.

3.3.7. Neuropsychologist

3.3.7.1. The Contractor shall provide a neuropsychologist who has:

a. A minimum of 2 years of post-fellowship experience in neurocognitive screening and comprehensive neuropsychological assessment protocols appropriate to public sector severely mentally ill and behaviorally challenged populations;
b. Experience in the integration of cognitive test results with data from structural and functional brain imaging; and
c. A Ph.D. or Psy.D. in clinical psychology or neuropsychology and has completed a neuropsychology postdoctoral fellowship (Houston guidelines).

3.3.8. Neuropsychologist Trainees

3.3.8.1. The Contractor shall provide three neuropsychologist trainees who:

a. Shall be clinical psychology graduate students who are obtaining specialty training in neuropsychology; and
b. Shall have three to four years of graduate instruction and training, including training experience in general psychology.

3.3.9. General Medical Director

3.3.9.1. The Contractor shall provide one full-time physician to fulfill the role of General Medical Director who shall be a primary care or internal medicine physician who has completed residency with at least three years of experience in supervising primary care clinicians. A board certification in a primary care field is preferred.

3.3.10. General Medical Physician

3.3.10.1. The Contractor shall provide one full-time physician who is a primary care or internal medicine physician who has completed residency with at least three years of experience. A board certification in a primary care field is preferred.

3.3.11. Forensic Psychologist

3.3.11.1. Beginning in SFY 2018, the Contractor shall provide a full-time forensic psychologist. The forensic psychologist shall be a clinical psychologist (PhD or Psy.D.) with significant clinical experience in forensic psychology. A certification in forensic psychology is preferred.

3.3.12. Residents/Post Graduate Fellows

3.3.12.1. For all residents/post graduate fellows the Contractor provides to NHH under this contract, the responsibilities shall be outlined, monitored and reviewed by the Chief Medical Officer and the appropriate, attending psychiatrist.

a. General Psychiatry Residents (PGY II and PGY IV) – The Contractor shall rotate PGY II residents and a PGY IV (chief resident) through NHH.
b. Child/Adolescent Fellows – The Contractor shall rotate three (3) child/adolescent fellows (combined 1 FTE) apportioned through the PGY IV and PGY V years or PGY V and VI years (1st and 2nd year fellows) through NHH.
c. Geropsychiatry Fellow – The Contractor shall rotate a geropsychiatry fellow (PGY V) through the NHH.
d. Public Psychiatry Fellow – The Contractor shall rotate a public psychiatry fellow through the NHH.

3.3.13. Psychiatric Advanced Practice Registered Nurses (APRN)

3.3.13.1. The Contractor shall provide six full-time Psychiatric Advanced Practice Registered Nurses.

a. Psychiatric APRNs shall possess an APRN degree and have board certification as Psychiatric–Mental Health Nurse Practitioner-Board.

b. At least one Psychiatric APRN with specialty in addiction or the requisite number of hours of experience in addiction treatment shall be provided.
c. At least one Psychiatric APRN shall be dedicated full-time to provide services to the ISU.

3.3.14. NHH Research Manager

3.3.14.1. The Contractor shall provide a full-time NHH Research Manager, as described below:

a. The Research Manager requires a thorough knowledge and understanding of clinical research, research protocols, and clinical operations, knowledge of GCPs and federal regulations related to human subject research, knowledge of patient privacy and confidentiality, ability to manage teams of professionals, maintain meticulous study records, laboratory data and other information related to research protocols, and manage complex schedules and competing priorities.
b. The Research Manager shall meet the following minimum experience and education requirements:
   i. Master's degree in management or health or research related area;
   ii. Five or more years of relevant experience in clinical trials research support;
   iii. Experience with industry sponsored, federally sponsored and investigator initiated clinical research;
   iv. Experience with clinical trial budgets and billing;
   v. Through knowledge of clinical research, research protocols and clinical operations; and
   vi. Knowledge of Good Clinical Practices (GCP's) and federal regulations related to research.

3.3.15. Schedule and Allocation of Positions – Service Area #1 – NHH

3.3.15.1. The following schedule shall reflect the full (100%) staffing complement for which the Contractor shall provide the required staff, consistent with the requirements described in the Contract for the full term of the contract.

Position Title	Full-Time Equivalent
a. Chief Medical Officer	1.0
b. Associate Medical Director	1.0
c. General Psychiatrists	11.0
d. Psychiatric APRNs	6.0
e. Child/Adolescent Psychiatrists	4.0
f. Geropsychiatrist	1.0
g. Director of Neuropsychology Laboratory	0.5
h. Neuropsychologist	1.0
i. Neuropsychologist Trainees	3.0
j. General Medical Director	1.0
k. General Medical Physician	1.0

l. Forensic Psychologist	1.0
m. PGY IV Residents	1.0
n. PGY II Residents	1.5
o. Child/Adolescent Fellow	1.0
p. Geropsychiatry Fellow	0.5
q. Public Sector Psychiatry Fellow	1.0
r. Research Manager	1.0

3.4. Specific Staffing Requirements – Service Area #2 – Glencliff Home

3.4.1. Medical Director

3.4.1.1. The Contractor shall, for the term of the contract, provide the part-time services of one (1) geropsychiatrist to serve at the Glencliff Home as the Medical Director. This position shall be a 0.4 Full-Time Equivalent.

3.5. Specific Staffing Requirements – Service Area #3 – Medicaid Program

3.6.1. Department of Health and Human Services Chief Medical Officer –

3.5.1.1. The Contractor shall, for the term of the contract, provide the full-time services of a designated physician, identified by the Department to serve as the Chief Medical Officer. This position shall be a 1.0 Full-Time Equivalent.

3.5.1.2. The Contractor shall ensure that the Chief Medical Officer provided under this contract is subject to the Contractor's normal and customary employee benefits and policies, including leave provisions for a senior executive level position. However, the Contractor and DHHS agree that the continuous provision of services is essential, and in addition to any required approvals by the Contractor for its employees, the Chief Medical Officer shall provide timely, prior notification to the DHHS Designee of any leave time taken. Absences due to vacation and continuing education shall be planned in advance, in consideration of the business needs of the Medicaid program – including ensuring appropriate coverage for any clinical and/or operational responsibilities or tasks that need oversight while the Chief Medical Officer is on leave.

3.5.1.3. The Chief Medical Officer shall possess the following qualifications:

a. Possess a medical degree (MD or DO);
b. Maintain an unrestricted license as a physician by the New Hampshire Board of Medicine;
c. A graduate degree in public health or health care administration with demonstrated experience in public health or healthcare administration systems development;
d. Have a minimum of five years of experience in a position of clinical leadership for a major public sector program, government authority or other organization involved in the delivery of public Medicaid services;

e. Have work experience in managed care settings focused on improved health outcomes;
f. Have fellowship and/or work experience in research in health services, outcomes and/or policy, as well as the ability to work collaboratively with team members and the provider community;
g. Have extensive experience and judgment to plan and accomplish goals working in a team environment;
h. Demonstrate strong verbal and written communication skills;
i. Work collaboratively with Medicaid staff to achieve program goals in an efficient and timely manner;
j. Have Board certification in either Family Medicine, Preventive Medicine/Community Health, Internal Medicine, Pediatrics, or Obstetrics and Gynecology, and with a strong working knowledge of primary care medicine;
k. Must be well versed in the regulations governing the federal Title XIX Medicaid and Title XXI Medicaid and CHIP programs and how those programs are administered in New Hampshire;
l. Possess a high degree of creativity and initiative;
m. Have expertise in clinical, policy, or outcomes research; and
n. Have work experience in project management, grant writing, contract management, and program evaluation.

3.6. Specific Staffing Requirements – Service Area #4 – Children, Youth and Families

3.6.1. Staff Psychiatrist

3.6.1.1. The Contractor shall, for the term of the contract, provide the full-time services of a designated psychiatrist, who is a faculty member and/or employee of the Contractor, to provide psychiatric services to the programs within the Children, Youth and Families service area. This position shall be a 1.0 Full-Time Equivalent.

3.6.1.2. DHHS reserves the right to jointly, with the Contractor, or separately, interview, research or otherwise screen and consider candidates the Contractor designates for the Staff Psychiatrist.

3.6.1.3. The Staff Psychiatrist shall possess the following qualifications:

a. Possess a medical degree (MD or DO);
b. Specialty in both child psychiatry and criminal justice;
c. Completion of both an ACGME approved residency program in psychiatry and a 2-year ACGME approved fellowship in child/adolescent psychiatry;
d. Board certification by the American Board of Psychiatry and Neurology in Psychiatry;
e. Maintain an unrestricted license as a physician by the New Hampshire Board of Medicine; and
f. Possess at least five (5) years post-fellowship experience in public sector psychiatry, community mental health, criminal justice, or similar training.

3.7. Specific Staffing Requirements – Service Area #5 – Behavioral Health

3.7.1. Medical Director

3.7.1.1. The Contractor shall, for the term of the contract, provide a part-time Medical Director to the Behavioral Health service area, as identified by the Department. This position shall be available on-site at a DHHS designated location for twenty (20) hours per week (0.5 FTE).

3.7.1.2. The Medical Director shall possess the following qualifications:

a. Possess a medical degree (MD or DO);
b. Board certification by the American Board of Psychiatry and Neurology in Psychiatry;
c. Maintain an unrestricted license as a physician by the New Hampshire Board of Medicine; and
d. Have at least five (5) years of experience in public mental health and services for people with mental illness.

3.7.2. Support Staff CPHS

3.7.2.1. The Contractor shall, for the term of the contract, provide a part-time Support Staff to support the Committee for the Protection of Human Services. This position shall be allocated at 0.15 FTE.

3.7.2.2. The Contractor shall, for the term of the contract, provide a part-time Research Assistant. This position shall be allocated at 0.5 FTE.

3.7.3. Evidence-Based Practice Trainer/Consultant

3.7.3.1. The Contractor shall, for the term of the contract, provide part-time Evidence-Based Practice Trainers/Consultants. These positions shall be allocated, in total, at 1.5 FTE.

3.7.4. Behavioral Health Policy Institute

3.7.4.1. The Contractor shall, for the term of the contract, provide a part-time Behavioral Health Policy Institute Consultant. This position shall be allocated at 0.1 FTE.

3.8. Specific Staffing Requirements – Service Area #6 – Elderly and Adult Services

3.8.1. Medical Director

3.8.1.1. The Contractor shall, for the term of the contract, provide a part-time Medical Director to the Elderly and Adult Services service area. This position shall be allocated at a 0.03 Full-Time Equivalent.

3.8.1.2. The Medical Director shall possess the following qualifications:

a. Possess a medical degree (MD or DO);
b. Maintain board certification in Gerontology or Preventive Medicine/Community Health;
c. Possess expertise in clinical, policy or outcomes research; and
d. Be well versed in the regulations governing the federal Title XIX Medicaid program, including requirements for the operation of

waiver and State Plan services, and Title XX, the Social Service Block Program and services provided under the Older Americans Act.

3.9. Specific Staffing Requirements – Service Area #7 – Developmental Services

3.9.1. Medical Director

3.9.1.1. The Contractor shall, for the term of the contract, provide a part-time Medical Director to the Developmental Services service area. This position shall be allocated at 0.4 Full-Time Equivalent.

3.9.1.2. The Medical Director shall possess the following qualifications:

a. Possess a medical degree (MD or DO);
b. Maintain board certification in Child and Adult Psychiatry; and
c. Possess expertise and experience in developmental disability, including Autism Spectrum Disorders.

3.9.2. Adult Developmental Services Interdisciplinary Clinic Team

3.9.2.1. The Contractor shall, for the term of the contract, provide the following part-time positions to the Adult Developmental Services Interdisciplinary Clinic Team. These positions shall be allocated, as specified below in Full-Time Equivalent (FTE):

a. Psychiatrist ..... 0.1 FTE
b. Neuropsychologist ..... 0.05 FTE
c. Neuropsychology Fellow ..... 0.05 FTE
d. Neurologist ..... 0.025 FTE
e. Primary Care Physician ..... 0.025 FTE
f. Occupational Therapist ..... 0.025 FTE
g. Administrative Support ..... 0.025 FTE

3.9.3. Child Developmental Services Interdisciplinary Clinic Team

3.9.3.1. The Contractor shall, for the term of the contract, provide the following part-time positions to the Child Developmental Services Interdisciplinary Clinic Team. These positions shall be allocated, as specified below in Full-Time Equivalent (FTE):

a. Child Psychiatrist	0.10 FTE
b. Neuropsychologist	0.05 FTE
c. Neuropsychology Fellow	0.05 FTE
d. Neurologist	0.025 FTE
e. Primary Care Physician	0.025 FTE
f. Occupational Therapist	0.025 FTE
g. Administrative Support	0.025 FTE

4. Performance Standards and Outcomes

4.1. Service Area #1 – Chief Medical Officer – NHH

4.1.1. Within forty-five (45) days of the assignment of the Chief Medical Officer, and at each contract anniversary thereafter, the Contractor and the NHH CEO, in consultation with the Chief Medical Officer, shall develop a list of performance metrics based upon the deliverables, functions and responsibilities of the Chief Medical Officer. The performance metrics shall be approved by the NHH CEO prior to being effective. The performance metrics shall be reviewed by the NHH CEO on at least a quarterly basis with the Chief Medical Officer. These meetings shall be documented with written progress notes by the NHH CEO.

4.1.2. The Contractor shall ensure the services provided by the Chief Medical Officer at NHH are satisfactory to the Department. As part of this responsibility, the Contractor shall, no less than annually and more frequently if required by DHHS, provide an evaluation tool to solicit input from the NHH CEO regarding the Chief Medical Officer's provision of services under the contract.

4.1.3. The Contractor shall develop a corrective action plan to address any concerns raised by the NHH CEO in the evaluation tool, and provide a copy of such plan to the NHH CEO for review. If the NHH CEO disagrees with the Contractor's proposed resolutions within the corrective action plan, the dispute shall be referred to the DHHS Commissioner for resolution with the Contractor.

4.2. Service Area #1 – Clinical Staff – NHH

4.2.1. Staffing levels shall be maintained at 100% at all times throughout the contract, with the exception of the leave provisions and approval processes described in the subsections applicable to each staffing need.

4.2.1.1. DHHS' expectation is that staffing at the level of 100% ensures that in no case shall Contractor staffing affect the number of NHH beds available, and that NHH units will not stop admissions due to the lack of coverage for Contractor staff.

4.2.2. The Contractor shall ensure the following performance standards are met by all clinical staff provided by the Contractor to provide services at NHH:

4.2.2.1. Clinical staff shall support the optimum functioning of the Medical Staff Organization as evidenced by attendance of Medical Staff Organization meetings and participation in assigned committees and task forces at a rate of no less than 80% participation, excluding approved absences;

4.2.2.2. Clinical staff shall support the completion of all required documentation regarding patients as evidenced by satisfactorily completing documentation regarding patient admission, discharge and during the inpatient stay – in compliance with hospital policy – within twelve (12) months of beginning the provision of services at NHH under the contract; and by satisfactorily completing all required documentation consistent with normative data collected by the compliance officer and utilization review manager.

4.2.2.3. Clinical staff shall provide clear treatment plans with specific interventions and regular updates as required by NHH policy;

4.2.2.4. Clinical staff shall provide daily progress notes with sufficient detail to meet medical necessity and level of care criteria;

4.2.2.5. Clinical staff shall provide regular progress notes focused on specific reasons for admission and plan towards discharge; and

4.2.2.6. Clinical staff shall provide written explanation of medication decisions and reasons for change when not effective.

4.3. Service Area #3 – Chief Medical Officer – Medicaid

4.3.1. Within forty-five (45) days of the assignment of the Chief Medical Officer, and at each contract anniversary thereafter, the Contractor and the DHHS Designee, in consultation with the Chief Medical Officer, shall develop a list of performance metrics based upon the deliverables, functions and responsibilities of the Chief Medical Officer. The performance metrics shall be approved by the DHHS Designee prior to being effective. The performance metrics shall be reviewed by the DHHS Designee on at least a quarterly basis with the Chief Medical Officer. These meetings shall be documented with written progress notes by the DHHS Designee.

4.3.2. The Contractor shall ensure the services provided by the Chief Medical Officer are satisfactory to the Department. As part of this responsibility, the Contractor shall, no less than annually and more frequently if required by DHHS, provide an evaluation tool, that is based on the agreed upon performance metrics for the previous year, to solicit input from the DHHS Designee regarding the Chief Medical Officer's provision of services under the contract.

4.3.3. Goals for the upcoming year will be established at the time of the Contractor's evaluation of the Chief Medical Officer, in collaboration with the DHHS Designee. In the case of a newly hired Chief Medical Officer, the evaluation tool shall be completed upon six (6) months of employment and then again at one (1) year, and thereafter on the contract anniversary date.

4.4. Service Area #4 – Staff Psychiatrist – Children, Youth and Families

4.4.1. Within forty-five (45) days of the assignment of the Staff Psychiatrist, and at each contract anniversary thereafter, the Contractor and the DHHS designee, in consultation with the Staff Psychiatrist, shall develop a list of performance metrics based upon the deliverables, functions and responsibilities of the Staff Psychiatrist. The performance metrics shall be approved by the DHHS designee prior to being effective. The performance metrics shall be reviewed by the DHHS designee on at least a quarterly basis with the Staff Psychiatrist. These meetings shall be documented with written progress notes by the DHHS designee.

4.4.2. The Contractor shall ensure the services provided by the Staff Psychiatrist are satisfactory to the Department. As part of this responsibility, the Contractor shall, no less than annually and more frequently if needed, provide an evaluation tool, that is based on the agreed upon performance metrics for the previous year, to solicit input from the DHHS designee regarding the Staff Psychiatrist's provision of services under the contract.

Goals for the upcoming year will be established at the time of the Contractor's evaluation of the Staff Psychiatrist, in collaboration with the DHHS designee. In the case of a newly hired Staff Psychiatrist, the evaluation tool shall be completed upon six (6) months of employment and then again at one (1) year, and thereafter on the contract anniversary date.

4.5. Quality Assurance Plan and Monitoring

The following Quality Assurance Plan and Monitoring shall be provided by the Contractor, subject to modification and/or augmentation as required by DHHS:

4.5.1. Service Area #1 – New Hampshire Hospital – Chief Medical Officer

4.5.1.1. The Contractor shall provide oversight of the performance of the Chief Medical Officer toward these Performance Standards and Quality Assurance Monitoring goals.

4.5.1.2. Pending development of final program metrics as required herein at subsection 4.1.1., in partnership with the NHH CEO, the Chief Medical Officer shall be responsible for the following program outcomes:

a. Ensuring the program is staffed adequately to operate NHH beds at full utilization;
b. Ensuring that Contractor staff receive necessary supervision and training to perform the tasks they are assigned;
c. Assuring that patients receive care consistent with evidence-based care;
d. Creation and implementation of highest standard practices to protect the safety of patients, staff, and visitors; and
e. Other responsibilities detailed herein at subsection 2.3.1.

4.5.1.3. The Chief Medical Officer shall be responsible for monitoring progress toward these goals and providing regular reports, at minimum on a quarterly basis or more frequently if needed, to the NHH CEO and to the Chair of the Department of Psychiatry or his designee. The Chief Medical Officer will meet at minimum on a quarterly basis or more frequently if needed, with the Chair of the Department of Psychiatry (or his or her designee) and the NHH CEO to review progress toward these metrics. The metrics above shall be considered preliminary metrics, subject to refinement, as described herein at subsection 4.1.1., and shall be reviewed over time to assure that they are the best metrics to use to assure contract compliance.

4.5.1.4. The content of the performance metrics to be measured shall be such that they assure that the Chief Medical Officer is fulfilling his or her administrative/clinical responsibilities as detailed herein at subsection 2.3.1. The following metrics shall be relevant to the Chief Medical Officer's fulfillment of his or her responsibilities:

a. The results of all Joint Commission, CMS, and other surveys pertaining to NHH;
b. Reports on clinical documentation by clinical staff;
c. Lists demonstrating completion of annual reviews of all Contractor-provided NHH clinicians to demonstrate active management, oversight, and discipline (when needed) of clinicians. The annual reviews shall include evidence of input from the NHH CEO (or their designee) on performance;
d. Records of attendance at meetings with:
   i. The NHH CEO indicating participation in formulation, implementation and supervision of all clinical programs, participation in budgeting, recruiting, plan for employment schedule, and supervision and educational plan for all Contractor-provided NHH clinical staff;
   ii. Other DHHS representatives - showing consultation in the development of the State mental health system;
   iii. NHH Executive Committee – showing executive participation; and
   iv. Executive Committee of the NHH Medical Staff Organization – showing participation in oversight of physician work; and
e. Report on availability of beds in NHH that are open for care – indicating adequate provider staffing to operate at full capacity.

4.5.1.5. The NHH CEO shall review these metrics at least quarterly with the NHH Chief Medical Officer.

4.5.2. Monitoring – Service Area #1 – New Hampshire Hospital – Chief Medical Officer:

4.5.2.1. The NHH Director of Quality Management and his or her staff shall conduct medical record and quality compliance monitoring. Monitoring shall take place through:

a. The routine reviews of The Joint Commission, CMS, and other overseeing groups;
b. The routine NHH documentation monitoring reports produced at NHH;
c. Department of Psychiatry tracking of Annual Review completion that is a routine process of the Department;
d. Use of attendance sheets that can be developed for this purpose; and
e. Routine monitoring of bed availability.

4.5.2.2. NHH support staff shall gather information regarding meeting attendance. The NHH Director of Quality Management and his or her staff shall gather the balance of collected metrics into a report. The collected data shall be provided to the NHH CEO and the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry (or his or her designee) on a quarterly basis.

4.5.2.3. The findings from this monitoring shall be discussed in scheduled meetings between the NHH CEO and the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry (or his or her designee) at meetings that shall take place on a quarterly basis or more frequently if needed. Both parties shall maintain their notes from each quarterly meeting to support the annual performance review process.

4.5.2.4. The monitoring data, including the notes described herein at subsection 4.5.2.3., and feedback solicited from the NHH CEO shall be part of the Chief Medical Officer's annual performance review. The Contractor shall document the annual performance review on the Department's standard annual evaluation tool.

a. If there are performance difficulties that require a corrective action plan, the Contractor shall develop a proposed corrective action plan and shall share and discuss the plan with the NHH CEO prior to issuance to the Chief Medical Officer. If the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry and the NHH CEO disagree on the proposed corrective action plan, the dispute shall be referred to the DHHS Commissioner for resolution.

4.5.2.5. This plan shall be updated and revised at least annually, by the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, working with the NHH CEO and in consultation with the NHH Chief Medical Officer. New goals may be set at any time but shall be set at least annually. New goals may trigger new metrics.

4.5.3. Service Area #1 – New Hampshire Hospital – Clinical Staff

4.5.3.1. Within 45 days of the contract effective date, the Chief Medical Officer, or his or her designee, shall work with the NHH CEO and the NHH Director of Quality Management to develop a list of performance metrics based on the expected deliverables, functions and responsibilities for each staff member as described herein at the applicable subsection in Section 2. The metrics shall monitor, at a minimum, the performance standards describe herein at subsection 4.2. The NHH CEO shall review these metrics at least quarterly with the Chief Medical Officer. This selection of metrics shall be reviewed over time to assure that they are the best metrics to use to assure contract compliance.

4.5.3.2. The content of the performance metrics to be measured shall be such that they assure the Clinical Staff are fulfilling their administrative/clinical responsibilities as described herein at Section 2 for the applicable position. The following metrics are relevant to the Clinical Staff's fulfillment of their responsibilities and shall be part of the plan for monitoring contract fulfillment:

a. Attendance lists of Medical Staff Organization (and assigned committees and task forces) that show who is expected to attend and who did attend;
b. Measurements of compliance with documentation policies;

c. Measurement of adherence with treatment plan policies;
d. Measurement of progress note adherence to policies including showing medical necessity and need for level of care and demonstration of reason for admission and progress towards discharge, and explanation of medical decisions and reasons for change when the plan is not effective.

4.5.4. Monitoring – Service Area #1 – New Hampshire Hospital – Clinical Staff

4.5.4.1. Monitoring of the metrics for the NHH Clinical Staff shall take place as part of the routine data collection of the NHH Quality Management Staff. The collected data shall be provided to the Chief Medical Officer and the NHH CEO on a quarterly basis.

a. The performance metrics that are developed shall involve measurements and documentation that must be collected, including meeting attendance records. Other NHH staff may be involved in data collection efforts, including staff within the information technology, health information and utilization management sections depending on the content of the developed performance metrics.

4.5.4.2. The NHH CEO, the NHH Director of Quality Management, and the Chief Medical Officer shall speak at least quarterly about the performance of the NHH Clinical Staff. Each individual shall maintain notes of every quarterly meeting; these notes shall be used to support the annual performance review process for NHH Clinical Staff. If there are performance difficulties that require a corrective action plan, the identified issues shall be discussed with the Chief Medical Officer in order to initiate an appropriate course of action to address the identified difficulty or difficulties.

4.5.4.3. Annual reviews of Clinical Staff shall be documented by the Chief Medical Officer, or his or her designee, on the Contractor's Department of Psychiatry Annual Review form. Annual reviews shall include findings for quality assurance monitoring and feedback on performance from DHHS leaders.

4.5.5. Service Area #3 – Medicaid – Chief Medical Officer

4.5.5.1. Within 45 days of the contract effective date, the Contractor shall work with the DHHS designee overseeing the Medicaid service area to develop a list of performance metrics based on the deliverables, functions, and responsibilities, as described herein at subsection 2.5. Together, these metrics shall form an evaluation tool. The Chief Medical Officer shall be consulted in this process and the metrics shall be subject to approval by the DHHS Designee overseeing the Medicaid service area. The selection of metrics shall be reviewed over time to assure that they are the best metrics to use to assure contract compliance.

4.5.5.2. The DHHS designee shall review the findings from monitoring of these metrics at least quarterly with the Chief Medical Officer.

4.5.5.3. The Chief Medical Officer role requires initiative, relationship building, and high level leadership. The following metrics are relevant to the Chief Medical Officer's fulfillment of his or her responsibilities and shall be part of the plan for monitoring contract fulfillment:

a. Attendance records of Medicaid Management Team meetings; and
b. A checklist of core duties and expectations, as described herein at subsection 2.5, with feedback solicited on a quarterly or semi-annual basis from the members of the Medicaid Management Team and/or other key informants, designed to monitor performance. The checklist shall rate performance and allow for comments that will help guide improvement.

4.5.6. Monitoring – Service Area #3 – Medicaid – Chief Medical Officer

4.5.6.1. Resources for monitoring the performance metrics shall be identified when the performance plan is developed and may require Contractor or State resources to perform such tasks. Performance metric data may include but not be limited to:

a. Checklist feedback from the Medicaid Management Team. Source: Medicaid Management Team members; and
b. Collection and collating of attendance records from the Medicaid Management Team meetings. Source: DHHS administrative support staff.

4.5.6.2. At least twice yearly, or more frequently if needed:

a. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, and the DHHS designee shall review the data collected in the performance metrics, and discuss these with the Chief Medical Officer;
b. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall solicit information from the DHHS designee and shall discuss twice yearly with the DHHS designee, or more frequently if needed, the Chief Medical Officer's performance on the metrics.
c. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, and the DHHS designee shall maintain notes of their meetings. The annual performance review shall be documented on the Department's standard annual evaluation tool.

4.5.6.3. The findings collected in the evaluation tool, as well as verbal information solicited from the DHHS designee, shall form the core of the Chief Medical Officer's annual performance review. This review shall be conducted at six months for a new Chief Medical Officer then annually thereafter.

4.5.6.4. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, the DHHS designee, and the Chief Medical Officer shall collaborate to establish goals for the upcoming year as part of the performance evaluation process.

a. New goals may be set at any time but shall be set at least annually.

4.5.6.5. If there are performance difficulties that require a corrective action plan, the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall develop a proposed corrective action plan, and shall discuss and share the plan with the DHHS designee. If the DHHS designee and the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, disagree on the proposed resolutions, the dispute will be referred to the DHHS Commissioner for resolution.

4.5.7. Service Area #4 – Children, Youth and Families – Staff Psychiatrist

4.5.7.1. Within 45 days of the contract effective date, the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall work with the DHHS designee overseeing the Children, Youth and Families service area to develop a list of performance metrics based on the deliverables, functions, and responsibilities, as described herein at subsection 2.6. Together, these metrics shall form an evaluation tool. The Staff Psychiatrist shall be consulted in this process and the metrics shall be subject to approval by the DHHS Designee overseeing the Children, Youth and Families service area. The selection of metrics shall be reviewed over time to assure that they are the best metrics to use to assure contract compliance.

4.5.7.2. The content of performance metrics developed shall be such that they assure the Staff Psychiatrist is fulfilling his or her administrative and clinical responsibilities as described herein at subsection 2.6. The following metrics are relevant to the Staff Psychiatrist and shall be part of the plan for monitoring contract fulfillment:

a. Monitoring of work hours;
b. Regular checks of the Staff Psychiatrist's electronic calendar to be sure it includes proposed leave time, conferences, and trainings;
c. Clinical documentation monitoring to be sure it meets standards of timeliness and completeness established by Children, Youth, and Families;
d. Counts of activities such as the number of treatment team meetings and clinical consultations provided, types and numbers of evidence-based practices provided, number of teaching and supervision contacts with interns, residents, and fellows at SYSC; and
e. Checklist feedback on effectiveness in establishing interagency collaboration between Juvenile Justice Services, area mental health services, and NHH.

4.5.8. Monitoring – Services Area #4 – Children, Youth & Families – Staff Psychiatrist

4.5.8.1. Resources for monitoring the performance metrics shall be identified when the performance plan is developed and may require Contractor or State resources to perform such tasks. Performance metric data may include but not be limited to:

a. Counts of Activities. Source: Staff Psychiatrist; and
b. Clinical documentation monitoring. Source: DHHS staff.

4.5.8.2. At least twice yearly, or more frequently if needed:

a. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, and the DHHS designee shall review the data collected in the performance metrics, and discuss these with the Staff Psychiatrist;
b. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall solicit information from the DHHS designee and shall discuss twice yearly with the DHHS designee, or more frequently if needed, the Staff Psychiatrist's performance on the metrics.
c. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, and the DHHS designee shall maintain notes of their meetings. The annual performance review shall be documented on the Department's standard annual evaluation tool.

4.5.8.3. The findings collected in the evaluation tool, as well as verbal information solicited from the DHHS designee, shall form the core of the Staff Psychiatrist's annual performance review. This review shall be conducted at six months for a new Staff Psychiatrist then annually thereafter.

4.5.8.4. The Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, the DHHS designee, and the Staff Psychiatrist shall collaborate to establish goals for the upcoming year as part of the performance evaluation process.

a. New goals may be set at any time but shall be set at least annually.

4.5.8.5. If there are performance difficulties that require a corrective action plan, the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, shall develop a proposed corrective action plan, and shall discuss and share the plan with the DHHS designee. If the DHHS designee and the Contractor's Chair of the Dartmouth-Hitchcock Department of Psychiatry, or his or her designee, disagree on the proposed resolutions, the dispute will be referred to the DHHS Commissioner for resolution.

4.5.9. Service Areas #2, 3, 5, 6 and 7

4.5.9.1. Upon DHHS request, the Contractor shall identify performance metrics, develop performance goals, establish monitoring processes and engage in collaborative performance evaluation processes, similar to those described herein at subsection 4.5. For Service Areas 2, 3, 5, 6 and 7.

4.5.10. All Other Positions

4.5.10.1. All staff provided by the Contractor, not otherwise addressed herein at subsection 4.5, shall have annual performance reviews. The Contractor shall conduct such reviews and first obtain feedback from the applicable DHHS designee for the service area in which the staff is assigned to provide services. This feedback shall be a core element of the annual performance review process. The Contractor shall ensure that goal development is responsive to the evolving needs of DHHS over the course of the contract period.

5. Reporting

5.1. Service Area #1 – New Hampshire Hospital

5.1.1. In addition to other reports as agreed to by the parties, on an annual basis, the Contractor shall make a report in writing to DHHS that is descriptive of the Chief Medical Officers' and the clinicians' services provided by the Contractor and the Contractor's performance under this contract during the preceding contract year, the research activities provided during the preceding contract year, and planned research activities for the current contract year.

5.1.2. On an annual basis, DHHS shall submit to the Contractor a report in writing containing DHHS' evaluation of the Contractor's performance pursuant to this contract during the preceding year.

5.1.3. On a quarterly basis, or as otherwise more frequently required by the United States Department of Health and Human Services regulations, DHHS and in a form specified by DHHS, the Contractor shall provide a written report to DHHS documenting the services provided by the Contractor's staff in sufficient form and with sufficient detail to satisfy the reporting requirements of Medicare, Medicaid, and other third-party providers.

5.2. All Service Areas

5.2.1. The Contractor shall maintain and provide the DHHS designee(s) identified by the Department with up-to-date detailed personnel listings for all Contractor staff performing services under this contract. The listings shall include information, including, but not limited to; the names, titles, position costs (including salary and fringe benefit costs, direct and indirect rates), for each position for each service area for each state fiscal year, or more frequently as required by DHHS, to ensure the accuracy of information contained therein and to ensure proper cost allocation. The listings shall be in a format as determined and approved by DHHS.

6. Compliance

6.1. Continuity of Services

6.1.1. The Contractor and the Department agree that:

6.1.1.1. It will be extremely impracticable and difficult to determine actual damages that the Department will sustain in the event that the Contractor breaches this Agreement by failing to maintain the required staffing levels or by failing to deliver the required services, as described in Exhibit A, Sections 2 through 5;

6.1.1.2. Any breach by the Contractor will delay and disrupt the Department's operations and impact its ability to meet its obligations and lead to significant damages of an uncertain amount as well as a reduction of services; The Contractor's failure to provide Required Staffing, Required Services, or meet the Performance Standards and Outcomes and Reporting Requirements, all as specified in this Exhibit A, Sections 2 through 5, shall result in the assessment of liquidated damages as specified in Exhibit B; and

6.1.1.3. The liquidated damages as specified in Exhibit B are reasonable and fair and not intended as a penalty.

7. Definitions

CMS – Centers for Medicare and Medicaid Services

CPHS – Committee for the Protection of Human Subjects.

Department – New Hampshire Department of Health and Human Services

DHHS – New Hampshire Department of Health and Human Services

HIPAA – Health Insurance Portability and Accountability Act

TJC – The Joint Commission

Method and Conditions Precedent to Payment

1. The State shall pay the Contractor an amount not to exceed the Price Limitation, block 1.8, in consideration for the Contractor's compliance with the terms and conditions of this Agreement and for the services provided by the Contractor pursuant to Exhibit A, Scope of Services.
2. Agreement Period: Effective November 1, 2016, or the date of Governor and Executive Council approval, whichever date is later, through June 30, 2019.
3. Funding Sources: The services described in Exhibit A, Scope of Services, are funded with:
   - 40% Other Funds (Medicare, Medicaid & third party insurance);
   - 28% Federal Funds from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medical Assistance Program, Code of Federal Domestic Assistance Number (CFDA) 93.778; and
   - 32% General Funds.

   3.1 DHHS reserves the right to adjust funding sources throughout the Agreement Period and will provide the Contractor reasonable notice of any such changes. Adjustments made may require a mutually agreed upon contract amendment.

   3.2 Funds must be used in accordance with the provisions of the specified CFDA numbers.
4. This is a firm, fixed price contract. The Contractor shall provide services under this Agreement based on the Budget specified below per applicable Service Area and State Fiscal Year. The Contractor shall be compensated, for providing and delivering the services described in Exhibit A, Scope of Services, on the basis of this Budget.

Budget			
Agreement Period by State Fiscal Year			
Service Area	11/1/16-6/30/17	7/1/17-6/30/18	7/1/18-6/30/19
1: New Hampshire Hospital	$8,407,616	$11,471,681	$11,882,758
2: Glencliff Home	$114,511	$152,934	$158,544
3: Medicaid	$278,300	$374,358	$388,407
4: Children, Youth & Families	$325,491	$392,391	$407,002
5: Behavioral Health	$351,661	$477,825	$494,500
6: Elderly and Adult Services	$21,000	$28,152	$29,199
7: Developmental Services	$219,578	$293,655	$304,490

   4.1 Any amendments to this Budget will require a written agreement by the parties in the form of a contract amendment, which may be subject to Governor and Executive Council approval and at minimum shall be subject to Attorney General approval.
5. Invoicing: The Contractor shall invoice DHHS monthly for services performed in accordance with the contract on invoices the format of which will be identified and approved by DHHS. The Contractor shall ensure that DHHS receives within thirty (30) days following the end of the month in which services were provided, the applicable invoice. The State shall make payment to the Contractor within thirty (30) days of receipt of an accurate invoice for Contractor services provided pursuant to this Agreement. Should a discrepancy in an invoice be identified by DHHS, it shall promptly notify the designated individual identified in

Section 7, below, prior to the due date for payment. DHHS shall not be required to pay an invoice until any discrepancy with the invoice is resolved to the satisfaction of DHHS.

5.1 Invoices must be submitted to the attention of the DHHS designee at:

ATTN: [DHHS designee]
Financial Manager
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

5.2 Each monthly invoice shall distinctly identify and differentiate the expenses as charged according to each of the seven (7) Service Areas for which services are provided. The seven (7) Service Areas are as follows:

Service Area #1 – New Hampshire Hospital (NHH)
Service Area #2 – Glencliff Home
Service Area #3 – Medicaid Program
Service Area #4 – Children, Youth and Families
Service Area #5 – Behavioral Health
Service Area #6 – Elderly and Adult Services
Service Area #7 – Developmental Services

6. **Payment:** Compensation paid by DHHS shall be accepted by the Contractor as payment in full for the services provided under the Agreement. Notwithstanding anything to the contrary contained in the Agreement or in any other document, contract or understanding, it is expressly understood and agreed by the parties hereto that no payments will be made hereunder to reimburse the Contractor for costs incurred for any purpose or for any services provided to any individual prior to the effective date of the Contract.

7. **Financial Management:** The Contractor shall designate a contact person to resolve any questions or discrepancies regarding invoices. The Contractor shall provide DHHS with the name, title, telephone number, fax number and email address of the contact person. The Contractor shall also notify DHHS in the event of a change of the designated contact person. DHHS shall provide the Contractor with the name, title, mailing address, and telephone number of the corresponding DHHS contact person. DHHS shall notify the Contractor in the event of a change in the designated contact person.

7.1 Contingent upon additional state or federal funding and pursuant to a mutually agreed upon contract amendment, the Contractor may be asked to provide additional services appropriate for inclusion in the contract's scope, if such services are not otherwise detailed in this Agreement.

8. **Liquidated Damages**

9.1 **Continuity of Services:** As specified and described in Exhibit A, subsection 6.1, Continuity of Services, the Contractor's failure to provide required staffing, required services, or meet the performance standards and reporting requirements as described in Exhibit A, Sections 2 through 5, shall result in liquidated damages.

9.2 The Contractor and DHHS agree that:

9.2.1. It will be extremely impracticable and difficult to determine actual damages that DHHS will sustain in the event that the Contractor breaches this Agreement by

failing to maintain the required staffing levels or by failing to deliver the required services, as described in Exhibit A, Sections 2 through 5;

9.2.2. Any breach by the Contractor will delay and disrupt DHHS's operations and impact its ability to meet its obligations and lead to significant damages of an uncertain amount as well as a reduction of services;

9.2.3. The Contractor's failure to provide Required Staffing, Required Services, or meet the Performance Standards and Outcomes and Reporting Requirements, all as specified in Exhibit A, Sections 2 through 5, shall result in the assessment of liquidated damages as specified in this Exhibit B;

9.2.4. The liquidated damages as specified in this Exhibit B are reasonable and fair and not intended as a penalty; and

9.2.5. Assessment and recovery of liquidated damages by DHHS shall be in addition to, and not exclusive of, any other remedies, including actual damages, as may be available to DHHS for breach of contract, both at law and in equity, and shall not preclude DHHS from recovering damages related to other acts or omissions by the Contractor under this Agreement. Imposition of liquidated damages shall not limit the right of DHHS to terminate the Contract for default as provided in Paragraph 8 of the General Provisions (P-37).

9.3 **Notification:** DHHS shall make all assessments of liquidated damages. Prior to the imposition of liquidated damages, as described herein, DHHS shall issue a written notice of remedies that will include, as applicable, the following:

- A citation of the contract provision violated;
- The remedies to be applied, and the date the remedies shall be imposed (cure period);
- The basis for DHHS' determination that the remedies shall be imposed;
- A request for a Corrective Action Plan from the Contractor; and
- The timeframe and procedure for the Contractor to dispute DHHS' determination.

9.3.1 If the failure to perform by the Contractor is not resolved within the cure period identified by DHHS, liquidated damages may be imposed retroactively to the date of failure to perform and will continue until the failure is cured or any resulting dispute is resolved in the Contractor's favor.

9.3.2 The Contractor's dispute of liquidated damages or remedies shall not stay the effective date of the proposed liquidated damages or remedies.

9.4 **Corrective Action Plan:** The Contractor shall submit a written Corrective Action Plan to DHHS within five (5) business days of receiving notification as specified in subsection 9.3. Notification, for DHHS review. The Corrective Action Plan shall be subject to DHHS approval prior to its implementation.

9.5 **Liquidated Damages:**

9.5.1 Liquidated damages, if assessed, shall be in the amount of $1,000 per day for each day the Contractor fails to meet the general and specific service requirements for each Service Area as identified in Exhibit A, Section 2, Scope of Services.

9.5.2 Liquidated damages, if assessed, shall be in the amount of $1,000 per day for each day the Contractor fails to meet and maintain the staffing levels identified in Exhibit A, Section 3, Staffing.

9.5.3 Liquidated damages, if assessed, shall be in the amount of $1,000 per day for each day the Contractor fails to meet the Performance Standards identified in Exhibit A, Section 4, Performance Standards and Outcomes.

9.5.4 Liquidated damages, if assessed, shall be in the amount of $1,000 per day for each day the Contractor fails to meet the Reporting Requirements identified in Exhibit A, Section 5, Reporting.

9.5.5 Liquidated damages, if assessed, shall apply until the Contractor cures the failure cited in the Notification described in Subsection 9.3, or until the resulting dispute is resolved in the Contractor's favor.

9.5.6 The amount of liquidated damages assessed by DHHS shall not exceed the price limitation in Form P-37, General Provisions, Block 1.8 – Price Limitation.

9.6 **Assessment:** DHHS shall be entitled to assess and recover liquidated damages cumulatively under each section applicable to any given incident. Assessment and recovery of liquidated damages by DHHS shall be in addition to, and not exclusive of, any other remedies, including actual damages, as may be available to DHHS for breach of contract, both at law and in equity, and shall not preclude DHHS from recovering damages related to other acts or omissions by the Contractor under this Agreement. Imposition of liquidated damages shall not limit the right of DHHS to terminate the Contract for default as provided in Paragraph 8 of the General Provisions (P-37).

9.7 **Damages Related to Failure to Document Medical Necessity:** The Contractor shall be liable to DHHS for any losses incurred by DHHS which arise out of the failure of Contractor staff to provide the required documentation to support medical necessity as identified in Exhibit A, Section 2.3.3.1. (j) and Section 2.3.5.4.

SPECIAL PROVISIONS

Contractors Obligations: The Contractor covenants and agrees that all funds received by the Contractor under the Contract shall be used only as payment to the Contractor for services provided to eligible individuals and, in the furtherance of the aforesaid covenants, the Contractor hereby covenants and agrees as follows:

1. **Compliance with Federal and State Laws:** If the Contractor is permitted to determine the eligibility of individuals such eligibility determination shall be made in accordance with applicable federal and state laws, regulations, orders, guidelines, policies and procedures.

2. **Time and Manner of Determination:** Eligibility determinations shall be made on forms provided by the Department for that purpose and shall be made and remade at such times as are prescribed by the Department.

3. **Documentation:** In addition to the determination forms required by the Department, the Contractor shall maintain a data file on each recipient of services hereunder, which file shall include all information necessary to support an eligibility determination and such other information as the Department requests. The Contractor shall furnish the Department with all forms and documentation regarding eligibility determinations that the Department may request or require.

4. **Fair Hearings:** The Contractor understands that all applicants for services hereunder, as well as individuals declared ineligible have a right to a fair hearing regarding that determination. The Contractor hereby covenants and agrees that all applicants for services shall be permitted to fill out an application form and that each applicant or re-applicant shall be informed of his/her right to a fair hearing in accordance with Department regulations.

5. **Gratuities or Kickbacks:** The Contractor agrees that it is a breach of this Contract to accept or make a payment, gratuity or offer of employment on behalf of the Contractor, any Sub-Contractor or the State in order to influence the performance of the Scope of Work detailed in Exhibit A of this Contract. The State may terminate this Contract and any sub-contract or sub-agreement if it is determined that payments, gratuities or offers of employment of any kind were offered or received by any officials, officers, employees or agents of the Contractor or Sub-Contractor.

6. **Retroactive Payments:** Notwithstanding anything to the contrary contained in the Contract or in any other document, contract or understanding, it is expressly understood and agreed by the parties hereto, that no payments will be made hereunder to reimburse the Contractor for costs incurred for any purpose or for any services provided to any individual prior to the Effective Date of the Contract and no payments shall be made for expenses incurred by the Contractor for any services provided prior to the date on which the individual applies for services or (except as otherwise provided by the federal regulations) prior to a determination that the individual is eligible for such services.

7. **Conditions of Purchase:** Notwithstanding anything to the contrary contained in the Contract, nothing herein contained shall be deemed to obligate or require the Department to purchase services hereunder at a rate which reimburses the Contractor in excess of the Contractors costs, at a rate which exceeds the amounts reasonable and necessary to assure the quality of such service, or at a rate which exceeds the rate charged by the Contractor to ineligible individuals or other third party funders for such service. If at any time during the term of this Contract or after receipt of the Final Expenditure Report hereunder, the Department shall determine that the Contractor has used payments hereunder to reimburse items of expense other than such costs, or has received payment in excess of such costs or in excess of such rates charged by the Contractor to ineligible individuals or other third party funders, the Department may elect to:
   7.1. Renegotiate the rates for payment hereunder, in which event new rates shall be established;
   7.2. Deduct from any future payment to the Contractor the amount of any prior reimbursement in excess of costs;

7.3. Demand repayment of the excess payment by the Contractor in which event failure to make such repayment shall constitute an Event of Default hereunder. When the Contractor is permitted to determine the eligibility of individuals for services, the Contractor agrees to reimburse the Department for all funds paid by the Department to the Contractor for services provided to any individual who is found by the Department to be ineligible for such services at any time during the period of retention of records established herein.

RECORDS: MAINTENANCE, RETENTION, AUDIT, DISCLOSURE AND CONFIDENTIALITY:

8. **Maintenance of Records:** In addition to the eligibility records specified above, the Contractor covenants and agrees to maintain the following records during the Contract Period:
   8.1. Fiscal Records: books, records, documents and other data evidencing and reflecting all costs and other expenses incurred by the Contractor in the performance of the Contract, and all income received or collected by the Contractor during the Contract Period, said records to be maintained in accordance with accounting procedures and practices which sufficiently and properly reflect all such costs and expenses, and which are acceptable to the Department, and to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.
   8.2. Statistical Records: Statistical, enrollment, attendance or visit records for each recipient of services during the Contract Period, which records shall include all records of application and eligibility (including all forms required to determine eligibility for each such recipient), records regarding the provision of services and all invoices submitted to the Department to obtain payment for such services.
   8.3. Medical Records: Where appropriate and as prescribed by the Department regulations, the Contractor shall retain medical records on each patient/recipient of services.

9. **Audit:** Contractor shall submit an annual audit to the Department within 60 days after the close of the agency fiscal year. It is recommended that the report be prepared in accordance with the provision of Office of Management and Budget Circular A-133, "Audits of States, Local Governments, and Non Profit Organizations" and the provisions of Standards for Audit of Governmental Organizations, Programs, Activities and Functions, issued by the US General Accounting Office (GAO standards) as they pertain to financial compliance audits.
   9.1. Audit and Review: During the term of this Contract and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives shall have access to all reports and records maintained pursuant to the Contract for purposes of audit, examination, excerpts and transcripts.
   9.2. Audit Liabilities: In addition to and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions and shall return to the Department, all payments made under the Contract to which exception has been taken or which have been disallowed because of such an exception.

10. **Confidentiality of Records:** All information, reports, and records maintained hereunder or collected in connection with the performance of the services and the Contract shall be confidential and shall not be disclosed by the Contractor, provided however, that pursuant to state laws and the regulations of the Department regarding the use and disclosure of such information, disclosure may be made to public officials requiring such information in connection with their official duties and for purposes directly connected to the administration of the services and the Contract; and provided further, that the use or disclosure by any party of any information concerning a recipient for any purpose not directly connected with the administration of the Department or the Contractor's responsibilities with respect to purchased services hereunder is prohibited except on written consent of the recipient, his attorney or guardian.

Notwithstanding anything to the contrary contained herein the covenants and conditions contained in the Paragraph shall survive the termination of the Contract for any reason whatsoever.

11. **Reports:** Fiscal and Statistical: The Contractor agrees to submit the following reports at the following times if requested by the Department.
    11.1. Interim Financial Reports: Written interim financial reports containing a detailed description of all costs and non-allowable expenses incurred by the Contractor to the date of the report and containing such other information as shall be deemed satisfactory by the Department to justify the rate of payment hereunder. Such Financial Reports shall be submitted on the form designated by the Department or deemed satisfactory by the Department.
    11.2. Final Report: A final report shall be submitted within thirty (30) days after the end of the term of this Contract. The Final Report shall be in a form satisfactory to the Department and shall contain a summary statement of progress toward goals and objectives stated in the Proposal and other information required by the Department.

12. **Completion of Services:** Disallowance of Costs: Upon the purchase by the Department of the maximum number of units provided for in the Contract and upon payment of the price limitation hereunder, the Contract and all the obligations of the parties hereunder (except such obligations as, by the terms of the Contract are to be performed after the end of the term of this Contract and/or survive the termination of the Contract) shall terminate, provided however, that if, upon review of the Final Expenditure Report the Department shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

13. **Credits:** All documents, notices, press releases, research reports and other materials prepared during or resulting from the performance of the services of the Contract shall include the following statement:
    13.1. The preparation of this (report, document etc.) was financed under a Contract with the State of New Hampshire, Department of Health and Human Services, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services.

14. **Prior Approval and Copyright Ownership:** All materials (written, video, audio) produced or purchased under the contract shall have prior approval from DHHS before printing, production, distribution or use. The DHHS will retain copyright ownership for any and all original materials produced, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports. Contractor shall not reproduce any materials produced under the contract without prior written approval from DHHS.

15. **Operation of Facilities: Compliance with Laws and Regulations:** In the operation of any facilities for providing services, the Contractor shall comply with all laws, orders and regulations of federal, state, county and municipal authorities and with any direction of any Public Officer or officers pursuant to laws which shall impose an order or duty upon the contractor with respect to the operation of the facility or the provision of the services at such facility. If any governmental license or permit shall be required for the operation of the said facility or the performance of the said services, the Contractor will procure said license or permit, and will at all times comply with the terms and conditions of each such license or permit. In connection with the foregoing requirements, the Contractor hereby covenants and agrees that, during the term of this Contract the facilities shall comply with all rules, orders, regulations, and requirements of the State Office of the Fire Marshal and the local fire protection agency, and shall be in conformance with local building and zoning codes, by-laws and regulations.

16. **Equal Employment Opportunity Plan (EEOP):** The Contractor will provide an Equal Employment Opportunity Plan (EEOP) to the Office for Civil Rights, Office of Justice Programs (OCR), if it has received a single award of $500,000 or more. If the recipient receives $25,000 or more and has 50 or

more employees, it will maintain a current EEOP on file and submit an EEOP Certification Form to the OCR, certifying that its EEOP is on file. For recipients receiving less than $25,000, or public grantees with fewer than 50 employees, regardless of the amount of the award, the recipient will provide an EEOP Certification Form to the OCR certifying it is not required to submit or maintain an EEOP. Non-profit organizations, Indian Tribes, and medical and educational institutions are exempt from the EEOP requirement, but are required to submit a certification form to the OCR to claim the exemption. EEOP Certification Forms are available at: http://www.ojp.usdoj/about/ocr/pdfs/cert.pdf.

17. **Limited English Proficiency (LEP):** As clarified by Executive Order 13166, Improving Access to Services for persons with Limited English Proficiency, and resulting agency guidance, national origin discrimination includes discrimination on the basis of limited English proficiency (LEP). To ensure compliance with the Omnibus Crime Control and Safe Streets Act of 1968 and Title VI of the Civil Rights Act of 1964, Contractors must take reasonable steps to ensure that LEP persons have meaningful access to its programs.

18. **Pilot Program for Enhancement of Contractor Employee Whistleblower Protections:** The following shall apply to all contracts that exceed the Simplified Acquisition Threshold as defined in 48 CFR 2.101 (currently, $150,000)

CONTRACTOR EMPLOYEE WHISTLEBLOWER RIGHTS AND REQUIREMENT TO INFORM EMPLOYEES OF WHISTLEBLOWER RIGHTS (SEP 2013)

(a) This contract and employees working on this contract will be subject to the whistleblower rights and remedies in the pilot program on Contractor employee whistleblower protections established at 41 U.S.C. 4712 by section 828 of the National Defense Authorization Act for Fiscal Year 2013 (Pub. L. 112-239) and FAR 3.908.

(b) The Contractor shall inform its employees in writing, in the predominant language of the workforce, of employee whistleblower rights and protections under 41 U.S.C. 4712, as described in section 3.908 of the Federal Acquisition Regulation.

(c) The Contractor shall insert the substance of this clause, including this paragraph (c), in all subcontracts over the simplified acquisition threshold.

19. **Subcontractors:** DHHS recognizes that the Contractor may choose to use subcontractors with greater expertise to perform certain health care services or functions for efficiency or convenience, but the Contractor shall retain the responsibility and accountability for the function(s). Prior to subcontracting, the Contractor shall evaluate the subcontractor's ability to perform the delegated function(s). This is accomplished through a written agreement that specifies activities and reporting responsibilities of the subcontractor and provides for revoking the delegation or imposing sanctions if the subcontractor's performance is not adequate. Subcontractors are subject to the same contractual conditions as the Contractor and the Contractor is responsible to ensure subcontractor compliance with those conditions.
When the Contractor delegates a function to a subcontractor, the Contractor shall do the following:
    19.1. Evaluate the prospective subcontractor's ability to perform the activities, before delegating the function
    19.2. Have a written agreement with the subcontractor that specifies activities and reporting responsibilities and how sanctions/revocation will be managed if the subcontractor's performance is not adequate
    19.3. Monitor the subcontractor's performance on an ongoing basis

19.4. Provide to DHHS an annual schedule identifying all subcontractors, delegated functions and responsibilities, and when the subcontractor's performance will be reviewed

19.5. DHHS shall, at its discretion, review and approve all subcontracts.

If the Contractor identifies deficiencies or areas for improvement are identified, the Contractor shall take corrective action.

DEFINITIONS

As used in the Contract, the following terms shall have the following meanings:

COSTS: Shall mean those direct and indirect items of expense determined by the Department to be allowable and reimbursable in accordance with cost and accounting principles established in accordance with state and federal laws, regulations, rules and orders.

DEPARTMENT: NH Department of Health and Human Services.

FINANCIAL MANAGEMENT GUIDELINES: Shall mean that section of the Contractor Manual which is entitled "Financial Management Guidelines" and which contains the regulations governing the financial activities of contractor agencies which have contracted with the State of NH to receive funds.

PROPOSAL: If applicable, shall mean the document submitted by the Contractor on a form or forms required by the Department and containing a description of the Services to be provided to eligible individuals by the Contractor in accordance with the terms and conditions of the Contract and setting forth the total cost and sources of revenue for each service to be provided under the Contract.

UNIT: For each service that the Contractor is to provide to eligible individuals hereunder, shall mean that period of time or that specified activity determined by the Department and specified in Exhibit B of the Contract.

FEDERAL/STATE LAW: Wherever federal or state laws, regulations, rules, orders, and policies, etc. are referred to in the Contract, the said reference shall be deemed to mean all such laws, regulations, etc. as they may be amended or revised from the time to time.

CONTRACTOR MANUAL: Shall mean that document prepared by the NH Department of Administrative Services containing a compilation of all regulations promulgated pursuant to the New Hampshire Administrative Procedures Act. NH RSA Ch 541-A, for the purpose of implementing State of NH and federal regulations promulgated thereunder.

SUPPLANTING OTHER FEDERAL FUNDS: The Contractor guarantees that funds provided under this Contract will not supplant any existing federal funds available for these services.

REVISIONS TO GENERAL PROVISIONS

1. Subparagraph 4 of the General Provisions of this contract, Conditional Nature of Agreement, is replaced as follows:

   4. CONDITIONAL NATURE OF AGREEMENT.
   Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including without limitation, the continuance of payments, in whole or in part, under this Agreement are contingent upon continued appropriation or availability of funds, including any subsequent changes to the appropriation or availability of funds affected by any state or federal legislative or executive action that reduces, eliminates, or otherwise modifies the appropriation or availability of funding for this Agreement and the Scope of Services provided in Exhibit A, Scope of Services, in whole or in part. In no event shall the State be liable for any payments hereunder in excess of appropriated or available funds. In the event of a reduction, termination or modification of appropriated or available funds, the State shall have the right to withhold payment until such funds become available, if ever. The State shall have the right to reduce, terminate or modify services under this Agreement immediately upon giving the Contractor notice of such reduction, termination or modification. The State shall not be required to transfer funds from any other source or account into the Account(s) identified in block 1.6 of the General Provisions, Account Number, or any other account, in the event funds are reduced or unavailable.

2. Subparagraph 10 of the General Provisions of this contract, Termination, is amended by adding the following language:

   10.1 The State may terminate the Agreement at any time for any reason, at the sole discretion of the State, 30 days after giving the Contractor written notice that the State is exercising its option to terminate the Agreement.

   10.2 In the event of early termination, the Contractor shall, within 15 days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement, including but not limited to, identifying the present and future needs of clients receiving services under the Agreement and establishes a process to meet those needs.

   10.3 The Contractor shall fully cooperate with the State and shall promptly provide detailed information to support the Transition Plan including, but not limited to, any information or data requested by the State related to the termination of the Agreement and Transition Plan and shall provide ongoing communication and revisions of the Transition Plan to the State as requested.

   10.4 In the event that services under the Agreement, including but not limited to clients receiving services under the Agreement are transitioned to having services delivered by another entity including contracted providers or the State, the Contractor shall provide a process for uninterrupted delivery of services in the Transition Plan.

   10.5 The Contractor shall establish a method of notifying clients and other affected individuals about the transition. The Contractor shall include the proposed communications in its Transition Plan submitted to the State as described above.

3. The Department reserves the right to renew the Agreement for up to two (2) three-year periods, at the Department's sole discretion, considering contractor performance, and subject to the continued availability of funds and approval by the Governor and Executive Council.

4. **Disputes:** The Contractor and DHHS shall work together to accomplish the mission and goals of this Agreement. Disputes regarding the responsibilities under this Agreement between the Contractor and the Department shall be referred to the Department Commissioner or designee for resolution. Notwithstanding the foregoing, nothing herein shall affect the parties' legal or equitable rights or remedies otherwise available to them.

5. **Subcontractors:** Subparagraph 19.5 of the Special Provisions, Exhibit C, of this Agreement, Subcontractors, is deleted and replaced with the following:

19.5 If the Contractor wishes to use subcontractors to perform any services or functions required by this Agreement, the Contractor shall provide the Department with prior written notice and obtain prior written consent of the Department. Such requests shall be submitted by the Contractor to the Department Commissioner.

6. **Agreement Elements/Order of Precedence:**

6.1 RFP-2017-OCOM-01-PHYSI is hereby incorporated into this Agreement.

6.2 The Contractor's proposal submitted in response to RFP-2017-OCOM-01-PHYSI is hereby incorporated into this Agreement.

6.3 The Agreement between the parties shall consist of the following documents, and in the event of any conflict or ambiguity between the Agreement documents, the documents shall govern in the following order of precedence:

6.3.1 General Provisions (P-37);
6.3.2 Exhibit A Scope of Services;
6.3.3 Exhibit B Methods and Conditions Precedent to Payment;
6.3.4 Exhibit C Special Provisions;
6.3.5 Exhibit C-1 Revisions to Special Provisions;
6.3.6 Exhibit D Certification Regarding Drug-Free Workplace Requirements;
6.3.7 Exhibit E Certification Regarding Lobbying;
6.3.8 Exhibit F Certification Regarding Debarment, Suspension and Other Responsibility Matters;
6.3.9 Exhibit G Certification of Compliance with Requirements Pertaining to Federal Nondiscrimination, Equal Treatment of Faith-Based Organizations and Whistleblower Protections;
6.3.10 Exhibit H Certification Regarding Environmental Tobacco Smoke;
6.3.11 Exhibit I Health Insurance Portability Act Business Associate Agreement;
6.3.11 Exhibit J Certification Regarding the Federal Funding Accountability and Transparency Act (FFATA) Compliance;
6.3.12 RFP-2017-OCOM-01-PHYSI-01 and all issued addenda; and
6.3.13 Contractor's proposal submitted in response to RFP-2017-OCOM-01-PHYSI.

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

This certification is required by the regulations implementing Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.). The January 31, 1989 regulations were amended and published as Part II of the May 25, 1990 Federal Register (pages 21681-21691), and require certification by grantees (and by inference, sub-grantees and sub-contractors), prior to award, that they will maintain a drug-free workplace. Section 3017.630(c) of the regulation provides that a grantee (and by inference, sub-grantees and sub-contractors) that is a State may elect to make one certification to the Department in each federal fiscal year in lieu of certificates for each grant during the federal fiscal year covered by the certification. The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment. Contractors using this form should send it to:

Commissioner
NH Department of Health and Human Services
129 Pleasant Street,
Concord, NH 03301-6505

1. The grantee certifies that it will or will continue to provide a drug-free workplace by:
   - 1.1. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
   - 1.2. Establishing an ongoing drug-free awareness program to inform employees about
     - 1.2.1. The dangers of drug abuse in the workplace;
     - 1.2.2. The grantee's policy of maintaining a drug-free workplace;
     - 1.2.3. Any available drug counseling, rehabilitation, and employee assistance programs; and
     - 1.2.4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
   - 1.3. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);
   - 1.4. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will
     - 1.4.1. Abide by the terms of the statement; and
     - 1.4.2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
   - 1.5. Notifying the agency in writing, within ten calendar days after receiving notice under subparagraph 1.4.2 from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer on whose grant activity the convicted employee was working, unless the Federal agency

has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

1.6. Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph 1.4.2, with respect to any employee who is so convicted
   1.6.1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   1.6.2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

1.7. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs 1.1, 1.2, 1.3, 1.4, 1.5, and 1.6.

2. The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant.

Place of Performance (street address, city, county, state, zip code) (list each location)

Check ☐ if there are workplaces on file that are not identified here.

Contractor Name:

8/18/2016
Date

RAG MD
Name: Robert A. Greene, MD
Title: EVP
Chief, Population Health Management officer.

CERTIFICATION REGARDING LOBBYING

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Section 319 of Public Law 101-121, Government wide Guidance for New Restrictions on Lobbying, and 31 U.S.C. 1352, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

Programs (indicate applicable program covered):
*Temporary Assistance to Needy Families under Title IV-A
*Child Support Enforcement Program under Title IV-D
*Social Services Block Grant Program under Title XX
*Medicaid Program under Title XIX
*Community Services Block Grant under Title VI
*Child Care Development Block Grant under Title IV

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor).

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor), the undersigned shall complete and submit Standard Form LLL, (Disclosure Form to Report Lobbying, in accordance with its instructions, attached and identified as Standard Exhibit E-I.)

3. The undersigned shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Contractor Name:

8/18/2016
Date

RAG MD
Name: Robert A Greene, MD
Title: EVP
Chief Population Health Management officer

CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Executive Office of the President, Executive Order 12549 and 45 CFR Part 76 regarding Debarment, Suspension, and Other Responsibility Matters, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

INSTRUCTIONS FOR CERTIFICATION

1. By signing and submitting this proposal (contract), the prospective primary participant is providing the certification set out below.

2. The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. If necessary, the prospective participant shall submit an explanation of why it cannot provide the certification. The certification or explanation will be considered in connection with the NH Department of Health and Human Services' (DHHS) determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.

3. The certification in this clause is a material representation of fact upon which reliance was placed when DHHS determined to enter into this transaction. If it is later determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, DHHS may terminate this transaction for cause or default.

4. The prospective primary participant shall provide immediate written notice to the DHHS agency to whom this proposal (contract) is submitted if at any time the prospective primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

5. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549: 45 CFR Part 76. See the attached definitions.

6. The prospective primary participant agrees by submitting this proposal (contract) that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by DHHS.

7. The prospective primary participant further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions," provided by DHHS, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

8. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or involuntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List (of excluded parties).

9. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and

information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

10. Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal government, DHHS may terminate this transaction for cause or default.

PRIMARY COVERED TRANSACTIONS

11. The prospective primary participant certifies to the best of its knowledge and belief, that it and its principals:
    11.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;
    11.2. have not within a three-year period preceding this proposal (contract) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or a contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
    11.3. are not presently indicted for otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (l)(b) of this certification; and
    11.4. have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

12. Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal (contract).

LOWER TIER COVERED TRANSACTIONS

13. By signing and submitting this lower tier proposal (contract), the prospective lower tier participant, as defined in 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:
    13.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
    13.2. where the prospective lower tier participant is unable to certify to any of the above, such prospective participant shall attach an explanation to this proposal (contract).

14. The prospective lower tier participant further agrees by submitting this proposal (contract) that it will include this clause entitled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion - Lower Tier Covered Transactions," without modification in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

Contractor Name:

8/18/2016
Date

Name:
Title:

CERTIFICATION OF COMPLIANCE WITH REQUIREMENTS PERTAINING TO FEDERAL NONDISCRIMINATION, EQUAL TREATMENT OF FAITH-BASED ORGANIZATIONS AND WHISTLEBLOWER PROTECTIONS

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

Contractor will comply, and will require any subgrantees or subcontractors to comply, with any applicable federal nondiscrimination requirements, which may include:

- the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. Section 3789d) which prohibits recipients of federal funding under this statute from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act requires certain recipients to produce an Equal Employment Opportunity Plan;

- the Juvenile Justice Delinquency Prevention Act of 2002 (42 U.S.C. Section 5672(b)) which adopts by reference, the civil rights obligations of the Safe Streets Act. Recipients of federal funding under this statute are prohibited from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act includes Equal Employment Opportunity Plan requirements;

- the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, which prohibits recipients of federal financial assistance from discriminating on the basis of race, color, or national origin in any program or activity);

- the Rehabilitation Act of 1973 (29 U.S.C. Section 794), which prohibits recipients of Federal financial assistance from discriminating on the basis of disability, in regard to employment and the delivery of services or benefits, in any program or activity;

- the Americans with Disabilities Act of 1990 (42 U.S.C. Sections 12131-34), which prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation;

- the Education Amendments of 1972 (20 U.S.C. Sections 1681, 1683, 1685-86), which prohibits discrimination on the basis of sex in federally assisted education programs;

- the Age Discrimination Act of 1975 (42 U.S.C. Sections 6106-07), which prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance. It does not include employment discrimination;

- 28 C.F.R. pt. 31 (U.S. Department of Justice Regulations – OJJDP Grant Programs); 28 C.F.R. pt. 42 (U.S. Department of Justice Regulations – Nondiscrimination; Equal Employment Opportunity; Policies and Procedures); Executive Order No. 13279 (equal protection of the laws for faith-based and community organizations); Executive Order No. 13559, which provide fundamental principles and policy-making criteria for partnerships with faith-based and neighborhood organizations;

- 28 C.F.R. pt. 38 (U.S. Department of Justice Regulations – Equal Treatment for Faith-Based Organizations); and Whistleblower protections 41 U.S.C. §4712 and The National Defense Authorization Act (NDAA) for Fiscal Year 2013 (Pub. L. 112-239, enacted January 2, 2013) the Pilot Program for Enhancement of Contract Employee Whistleblower Protections, which protects employees against reprisal for certain whistle blowing activities in connection with federal grants and contracts.

The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment.

In the event a Federal or State court or Federal or State administrative agency makes a finding of discrimination after a due process hearing on the grounds of race, color, religion, national origin, or sex against a recipient of funds, the recipient will forward a copy of the finding to the Office for Civil Rights, to the applicable contracting agency or division within the Department of Health and Human Services, and to the Department of Health and Human Services Office of the Ombudsman.

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this proposal (contract) the Contractor agrees to comply with the provisions indicated above.

Contractor Name:

8/18/2016
Date

Name:
Title:

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, Part C - Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 per day and/or the imposition of an administrative compliance order on the responsible entity.

The Contractor identified in Section 1.3 of the General Provisions agrees, by signature of the Contractor's representative as identified in Section 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this contract, the Contractor agrees to make reasonable efforts to comply with all applicable provisions of Public Law 103-227, Part C, known as the Pro-Children Act of 1994.

Contractor Name:

8/18/2016
Date

[signature] MD
Name:
Title:

HEALTH INSURANCE PORTABLITY ACT
BUSINESS ASSOCIATE AGREEMENT

The Contractor identified in Section 1.3 of the General Provisions of the Agreement agrees to comply with the Health Insurance Portability and Accountability Act, Public Law 104-191 and with the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 applicable to business associates. As defined herein, "Business Associate" shall mean the Contractor and subcontractors and agents of the Contractor that receive, use or have access to protected health information under this Agreement and "Covered Entity" shall mean the State of New Hampshire, Department of Health and Human Services.

(1) Definitions.

a. "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

b. "Business Associate" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

c. "Covered Entity" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

d. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR Section 164.501.

e. "Data Aggregation" shall have the same meaning as the term "data aggregation" in 45 CFR Section 164.501.

f. "Health Care Operations" shall have the same meaning as the term "health care operations" in 45 CFR Section 164.501.

g. "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act, TitleXIII, Subtitle D, Part 1 & 2 of the American Recovery and Reinvestment Act of 2009.

h. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160, 162 and 164 and amendments thereto.

i. "Individual" shall have the same meaning as the term "individual" in 45 CFR Section 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.501(g).

j. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

k. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR Section 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

l. "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR Section 164.103.

m. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

n. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 164, Subpart C, and amendments thereto.

o. "Unsecured Protected Health Information" means protected health information that is not secured by a technology standard that renders protected health information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

p. Other Definitions - All terms not otherwise defined herein shall have the meaning established under 45 C.F.R. Parts 160, 162 and 164, as amended from time to time, and the HITECH
Act.

(2) Business Associate Use and Disclosure of Protected Health Information.

a. Business Associate shall not use, disclose, maintain or transmit Protected Health Information (PHI) except as reasonably necessary to provide the services outlined under Exhibit A of the Agreement. Further, Business Associate, including but not limited to all its directors, officers, employees and agents, shall not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

b. Business Associate may use or disclose PHI:
   I. For the proper management and administration of the Business Associate;
   II. As required by law, pursuant to the terms set forth in paragraph d. below; or
   III. For data aggregation purposes for the health care operations of Covered Entity.

c. To the extent Business Associate is permitted under the Agreement to disclose PHI to a third party, Business Associate must obtain, prior to making any such disclosure, (i) reasonable assurances from the third party that such PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (ii) an agreement from such third party to notify Business Associate, in accordance with the HIPAA Privacy, Security, and Breach Notification Rules of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.

d. The Business Associate shall not, unless such disclosure is reasonably necessary to provide services under Exhibit A of the Agreement, disclose any PHI in response to a request for disclosure on the basis that it is required by law, without first notifying Covered Entity so that Covered Entity has an opportunity to object to the disclosure and to seek appropriate relief. If Covered Entity objects to such disclosure, the Business

Associate shall refrain from disclosing the PHI until Covered Entity has exhausted all remedies.

e. If the Covered Entity notifies the Business Associate that Covered Entity has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Business Associate shall be bound by such additional restrictions and shall not disclose PHI in violation of such additional restrictions and shall abide by any additional security safeguards.

(3) Obligations and Activities of Business Associate.

a. The Business Associate shall notify the Covered Entity's Privacy Officer immediately after the Business Associate becomes aware of any use or disclosure of protected health information not provided for by the Agreement including breaches of unsecured protected health information and/or any security incident that may have an impact on the protected health information of the Covered Entity.

b. The Business Associate shall immediately perform a risk assessment when it becomes aware of any of the above situations. The risk assessment shall include, but not be limited to:

- The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person used the protected health information or to whom the disclosure was made;
- Whether the protected health information was actually acquired or viewed
- The extent to which the risk to the protected health information has been mitigated.

The Business Associate shall complete the risk assessment within 48 hours of the breach and immediately report the findings of the risk assessment in writing to the Covered Entity.

c. The Business Associate shall comply with all sections of the Privacy, Security, and Breach Notification Rule.

d. Business Associate shall make available all of its internal policies and procedures, books and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of Covered Entity to the Secretary for purposes of determining Covered Entity's compliance with HIPAA and the Privacy and Security Rule.

e. Business Associate shall require all of its business associates that receive, use or have access to PHI under the Agreement, to agree in writing to adhere to the same restrictions and conditions on the use and disclosure of PHI contained herein, including the duty to return or destroy the PHI as provided under Section 3 (l). The Covered Entity shall be considered a direct third party beneficiary of the Contractor's business associate agreements with Contractor's intended business associates, who will be receiving PHI

pursuant to this Agreement, with rights of enforcement and indemnification from such business associates who shall be governed by standard Paragraph #13 of the standard contract provisions (P-37) of this Agreement for the purpose of use and disclosure of protected health information.

f. Within five (5) business days of receipt of a written request from Covered Entity, Business Associate shall make available during normal business hours at its offices all records, books, agreements, policies and procedures relating to the use and disclosure of PHI to the Covered Entity, for purposes of enabling Covered Entity to determine Business Associate's compliance with the terms of the Agreement.

g. Within ten (10) business days of receiving a written request from Covered Entity, Business Associate shall provide access to PHI in a Designated Record Set to the Covered Entity, or as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR Section 164.524.

h. Within ten (10) business days of receiving a written request from Covered Entity for an amendment of PHI or a record about an individual contained in a Designated Record Set, the Business Associate shall make such PHI available to Covered Entity for amendment and incorporate any such amendment to enable Covered Entity to fulfill its obligations under 45 CFR Section 164.526.

i. Business Associate shall document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.

j. Within ten (10) business days of receiving a written request from Covered Entity for a request for an accounting of disclosures of PHI, Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill its obligations to provide an accounting of disclosures with respect to PHI in accordance with 45 CFR Section 164.528.

k. In the event any individual requests access to, amendment of, or accounting of PHI directly from the Business Associate, the Business Associate shall within two (2) business days forward such request to Covered Entity. Covered Entity shall have the responsibility of responding to forwarded requests. However, if forwarding the individual's request to Covered Entity would cause Covered Entity or the Business Associate to violate HIPAA and the Privacy and Security Rule, the Business Associate shall instead respond to the individual's request as required by such law and notify Covered Entity of such response as soon as practicable.

l. Within ten (10) business days of termination of the Agreement, for any reason, the Business Associate shall return or destroy, as specified by Covered Entity, all PHI received from, or created or received by the Business Associate in connection with the Agreement, and shall not retain any copies or back-up tapes of such PHI. If return or destruction is not feasible, or the disposition of the PHI has been otherwise agreed to in the Agreement, Business Associate shall continue to extend the protections of the Agreement, to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business

Associate maintains such PHI. If Covered Entity, in its sole discretion, requires that the Business Associate destroy any or all PHI, the Business Associate shall certify to Covered Entity that the PHI has been destroyed.

(4) Obligations of Covered Entity

a. Covered Entity shall notify Business Associate of any changes or limitation(s) in its Notice of Privacy Practices provided to individuals in accordance with 45 CFR Section 164.520, to the extent that such change or limitation may affect Business Associate's use or disclosure of PHI.

b. Covered Entity shall promptly notify Business Associate of any changes in, or revocation of permission provided to Covered Entity by individuals whose PHI may be used or disclosed by Business Associate under this Agreement, pursuant to 45 CFR Section 164.506 or 45 CFR Section 164.508.

c. Covered entity shall promptly notify Business Associate of any restrictions on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

(5) Termination for Cause

In addition to Paragraph 10 of the standard terms and conditions (P-37) of this Agreement the Covered Entity may immediately terminate the Agreement upon Covered Entity's knowledge of a breach by Business Associate of the Business Associate Agreement set forth herein as Exhibit I. The Covered Entity may either immediately terminate the Agreement or provide an opportunity for Business Associate to cure the alleged breach within a timeframe specified by Covered Entity. If Covered Entity determines that neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(6) Miscellaneous

a. Definitions and Regulatory References. All terms used, but not otherwise defined herein, shall have the same meaning as those terms in the Privacy and Security Rule, amended from time to time. A reference in the Agreement, as amended to include this Exhibit I, to a Section in the Privacy and Security Rule means the Section as in effect or as amended.

b. Amendment. Covered Entity and Business Associate agree to take such action as is necessary to amend the Agreement, from time to time as is necessary for Covered Entity to comply with the changes in the requirements of HIPAA, the Privacy and Security Rule, and applicable federal and state law.

c. Data Ownership. The Business Associate acknowledges that it has no ownership rights with respect to the PHI provided by or created on behalf of Covered Entity.

d. Interpretation. The parties agree that any ambiguity in the Agreement shall be resolved to permit Covered Entity to comply with HIPAA, the Privacy and Security Rule.

e. Segregation. If any term or condition of this Exhibit I or the application thereof to any person(s) or circumstance is held invalid, such invalidity shall not affect other terms or conditions which can be given effect without the invalid term or condition; to this end the terms and conditions of this Exhibit I are declared severable.

f. Survival. Provisions in this Exhibit I regarding the use and disclosure of PHI, return or destruction of PHI, extensions of the protections of the Agreement in section (3) I, the defense and indemnification provisions of section (3) e and Paragraph 13 of the standard terms and conditions (P-37), shall survive the termination of the Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Exhibit I.

Department of Health and Human Services	Mary Hitchcock Mem Hospital
The State	Name of the Contractor
Katja S. Fox	Robert A Greene MD
Signature of Authorized Representative	Signature of Authorized Representative
Katja S. Fox	Robert A. Greene, MD
Name of Authorized Representative	Name of Authorized Representative
Director	EVP Chief Population Health Management officer
Title of Authorized Representative	Title of Authorized Representative
8/19/16	8/18/2016
Date	Date

CERTIFICATION REGARDING THE FEDERAL FUNDING ACCOUNTABILITY AND TRANSPARENCY ACT (FFATA) COMPLIANCE

The Federal Funding Accountability and Transparency Act (FFATA) requires prime awardees of individual Federal grants equal to or greater than $25,000 and awarded on or after October 1, 2010, to report on data related to executive compensation and associated first-tier sub-grants of $25,000 or more. If the initial award is below $25,000 but subsequent grant modifications result in a total award equal to or over $25,000, the award is subject to the FFATA reporting requirements, as of the date of the award.
In accordance with 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), the Department of Health and Human Services (DHHS) must report the following information for any subaward or contract award subject to the FFATA reporting requirements:

1. Name of entity
2. Amount of award
3. Funding agency
4. NAICS code for contracts / CFDA program number for grants
5. Program source
6. Award title descriptive of the purpose of the funding action
7. Location of the entity
8. Principle place of performance
9. Unique identifier of the entity (DUNS #)
10. Total compensation and names of the top five executives if:
    - 10.1. More than 80% of annual gross revenues are from the Federal government, and those revenues are greater than $25M annually and
    - 10.2. Compensation information is not already available through reporting to the SEC.

Prime grant recipients must submit FFATA required data by the end of the month, plus 30 days, in which the award or award amendment is made.
The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of The Federal Funding Accountability and Transparency Act, Public Law 109-282 and Public Law 110-252, and 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions, execute the following Certification:
The below named Contractor agrees to provide needed information as outlined above to the NH Department of Health and Human Services and to comply with all applicable provisions of the Federal Financial Accountability and Transparency Act.

Contractor Name:

8/18/2016
Date

Name: Robert A. Greene, MD
Title: DVD Chief Population Health management officer

FORM A

As the Contractor identified in Section 1.3 of the General Provisions, I certify that the responses to the below listed questions are true and accurate.

1. The DUNS number for your entity is: 06-99102-97

2. In your business or organization's preceding completed fiscal year, did your business or organization receive (1) 80 percent or more of your annual gross revenue in U.S. federal contracts, subcontracts, loans, grants, sub-grants, and/or cooperative agreements; and (2) $25,000,000 or more in annual gross revenues from U.S. federal contracts, subcontracts, loans, grants, subgrants, and/or cooperative agreements?

   X NO _____ YES

   If the answer to #2 above is NO, stop here

   If the answer to #2 above is YES, please answer the following:

3. Does the public have access to information about the compensation of the executives in your business or organization through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C.78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986?

   _____ NO _____ YES

   If the answer to #3 above is YES, stop here

   If the answer to #3 above is NO, please answer the following:

4. The names and compensation of the five most highly compensated officers in your business or organization are as follows:

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____