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STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF THE COMMISSIONER

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-9200 1-800-852-3345 Ext. 9200
Fax: 603-271-4912 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

Lori A. Shibinette
Commissioner

Lori A. Weaver
Deputy Commissioner

February 12, 2021

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), Lebanon, New Hampshire to provide Physician, Clinical and Administrative Services to meet the specialized health and related clinical and administrative needs of New Hampshire residents, with no change to the price limitation of $80,594,711 and no change to the contract completion date of June 30, 2022 effective upon Governor and Council approval. 34% General Funds. 66% Other Funds (Medicare, Medicaid & third party insurance).

The original contract was approved by Governor and Council on September 7, 2016, item #6A. It was subsequently amended with Governor and Council approval on January 9, 2019, item #5A, June 19, 2019, (Item #10) and most recently amended with Governor and Council approval on June 24, 2020, item #10.

Funds are available in the following accounts for State Fiscal Year 2021, and are anticipated to be available in State Fiscal Year 2022, upon the availability and continued appropriation of funds in the future operating budget, with the authority to adjust budget line items within the price limitation and 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 modify the scope of services to specify monthly full-time equivalent (FTE) reporting as required documentation for contracted clinical staff in response to a recent Legislative Budget Assistant audit. This amendment is consistent with current practices.

The Contractor provides clinical and administrative services to New Hampshire Hospital and provides staffing for all inpatient care units with medical staff, research and general hospital clinical support. The Contractor also 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.

The Contractor provides expertise, direct psychiatric services, treatment and associated services for residents that include administrative duties and the review of medication use for compliance with federal law at Glencliff Home.

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The Contractor develops strategic clinical relationships with physicians as well as growing partnerships with academic institutions and deferral agencies, with a focus on quality improvement and the implementation of federal health care reforms to support the Departments responsibility to administer the Medicaid medical assistance program.

The Contractor provides psychiatric services to youth served by the Department that include treatment planning; clinical consultations; assessments to treatment coordinators; program development at the Sununu Youth Services Center and fosters improved interagency collaboration between Juvenile Justice Services, area mental health agencies and New Hampshire Hospital to enhance mental health services of adjudicated youth.

The Contractor provides the personnel needed to help the Department achieve positive outcomes for individuals serviced by the behavioral health program; coordinates long-term care support services and to direct resources where they are needed most; and to provide psychiatric and services and expert guidance and training to the Department's developmental services staff.

The Department will monitor contracted services using the following performance measures:

- Reviewing annual staff performance.
- Auditing Treatment plans
- Adherence to certification guidelines.

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 six (6) 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 Council not authorize this request, the Department will not be in compliance with the Legislative Budget Assistant Audit.

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 Federal Funds are no longer available and services are still needed.

Respectfully submitted,

Heather M. Moquin

Heather M. Moquin
Chief Executive Officer

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Dartmouth Contract Amendment #4

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 #4

This Amendment to the Physician Clinical and Administrative Services contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and Mary Hitchcock Memorial Hospital ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on September 7, 2016, (Item #6A), as amended on January 9, 2019, (Item #5A), June 19, 2019, (Item #10), and June 24, 2020, (Item #10) the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended and in consideration of certain sums specified; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 18, and Exhibit C-1, General Provisions, Paragraph 3, the Contract may be amended 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, or 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. Modify Exhibit A, Amendment #3, Scope of Services, Subsection 2.3., Specific Service Requirements for Service Area #1 – New Hampshire Hospital, Paragraph 2.3.3., General Psychiatrist Responsibilities, Subparagraph 2.3.3.4, to read:

   2.3.3.4. For Paragraph 2.3.3.2., the term "full-time" shall mean that each psychiatrist shall be required to work 40 hours per week, devoted to his or her duties and responsibilities, subject to the Contractor's normal and customary employee leave policies. It is understood that although psychiatrists will spend the majority of their workday at New Hampshire Hospital, there are times a psychiatrist may work outside of normal business hours to ensure timely care is rendered, or that documentation is completed in a timely fashion. For this reason, the Contractor shall provide reports summarizing full-time equivalent staffing rendered to the hospital for each invoicing period. The Contractor is not required to provide hourly timecards for clinical staff. For non-clinical staff, the Contactor shall provide hourly timecards summarizing hours worked for each invoicing period.

   a. Said required hours must be satisfied through hours devoted to clinical activities at NHH, including direct care and documentation of care.

   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. Modify Exhibit A, Amendment #3, Scope of Services, Subsection 3.3, Specific Staffing Requirements – Service Area #1 – New Hampshire Hospital, Paragraph 3.3.1., Chief Medical Officer, Subparagraph 3.3.1.1., Item c. to read:

   c. For purposes of this paragraph, the term "full-time" shall mean that each psychiatrist shall be required to work 40 hours per week, devoted to his or her

Contractor Initials
Date 5/18/21

clinical duties and responsibilities at NHH, subject to the Contractor's normal and customary employee leave policies. For this reason, the Contractor shall provide reports summarizing full-time equivalent staffing rendered to the hospital for each invoicing period, but is not required to provide hourly timecards for clinical staff. For non-clinical staff the Contactor shall provide hourly timecards summarizing hours worked for each invoicing period.

3. Modify Exhibit A, Amendment #3, Scope of Services, Subsection 3.3., Specific Staffing Requirements – Service Area #1 – New Hampshire Hospital, Paragraph 3.3.2., Associate Medical Director, Subparagraph 3.3.2.1., Item c. to read:

   c. For the purposes of this paragraph, the term "full-time" shall mean that each psychiatrist shall be required to work 40 hours per week, devoted to his or her clinical duties and responsibilities at NHH, subject to the Contractor's normal and customary employee leave policies. For this reason, the Contractor shall provide reports summarizing full-time equivalent staffing rendered to the hospital for each invoicing period. The Contractor is not required to provide hourly timecards for clinical staff. For non-clinical staff the Contactor shall provide hourly timecards summarizing hours worked for each invoicing period.

All terms and conditions of the Contract and prior amendments not modified by this Amendment 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

3/18/2021
Date

DocuSigned by:
Heather M. Moquin
46AF9C9C73B4D2...
Name: Heather M. Moquin
Title: Chief Executive Officer, New Hampshire Hospital

Mary Hitchcock Memorial Hospital

3/15/2021
Date

Name:
Title: EDWARD J. MERRENS
Chief Clinical Officer

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

OFFICE OF THE ATTORNEY GENERAL

3/18/2021
Date

DocuSigned by:
D6CA03303E23C4AE...
Name Catherine Pinos
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

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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 DARTMOUTH-HITCHCOCK CLINIC is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on March 01, 1983. 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: **69168**
Certificate Number: **0004905337**

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

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

Dartmouth-Hitchcock

CERTIFICATE OF VOTE/AUTHORITY

I, Edward H. Stansfield, III, of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital, do hereby certify that:

1. I am the duly elected Chair 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 Chair of the Board of Trustees of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital this 2nd day of March 2021.

Edward H. Stansfield, III, Board Chair

STATE OF NH

COUNTY OF GRAFTON

The foregoing instrument was acknowledged before me this 2 day of March 2021, by Edward H. Stansfield, III.

Notary Public
My Commission Expires: 9/21/2021

FAITH E. JOHNSTON
MY COMMISSION EXPIRES SEPT. 21, 2021
NOTARY PUBLIC
NEW HAMPSHIRE

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CERTIFICATE OF INSURANCE

DATE: July 1, 2020

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

INSURED
Dartmouth-Hitchcock Clinic
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		0002020-A	07/01/2020	07/01/2021	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	
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)

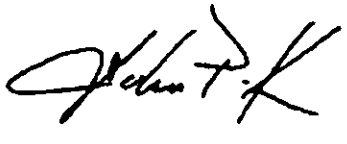
Certificate is issued as evidence of insurance only.

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



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DARTHIT-01 ASTOBERT

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 6/29/2020

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 275 US Route 1 Cumberland Foreside, ME 04110	CONTACT NAME: PHONE (A/C, No, Ext): (207) 829-3450 FAX (A/C, No): (207) 829-6350 E-MAIL ADDRESS:
INSURED Dartmouth-Hitchcock Health 1 Medical Center Dr. Lebanon, NH 03756	INSURER(S) AFFORDING COVERAGE / NAIC # 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						X PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y / N ☐	N / A		AG4061049	7/1/2020	7/1/2021	E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						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)

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, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

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Dartmouth-Hitchcock

Dartmouth-Hitchcock

Dartmouth-Hitchcock (D-H) is comprised of the Dartmouth-Hitchcock Medical Center and several clinics throughout New Hampshire and Vermont. Our physicians and researchers collaborate with Geisel School of Medicine scientists and faculty as well as other leading health care organizations to develop new treatments at the cutting edge of medical practice bringing the latest medical discoveries to the patient.

Dartmouth-Hitchcock includes:

Dartmouth-Hitchcock Medical Center (DHMC)

DHMC is the state's only academic medical center, and the only Level I Adult and Pediatric Trauma Center in New Hampshire. The Dartmouth-Hitchcock Advanced Response Team (DHART), based in Lebanon and Manchester, provides ground and air medical transportation to communities throughout northern New England. DHMC was named in 2020 as the #1 hospital in New Hampshire by U.S. News & World Report (https://health.usnews.com/best-hospitals/area/nh), and recognized for high performance in nine clinical specialties, procedures, and conditions.

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The Dartmouth-Hitchcock Clinic

The Dartmouth-Hitchcock Clinic is a network of primary and speciality care physicians located throughout New Hampshire and Vermont, with major community group practices in Lebanon, Concord, Manchester, Nashua, and Keene, NH, and Bennington, VT.

Mary Hitchcock Memorial Hospital

Mary Hitchcock Memorial Hospital is New Hampshire's only teaching hospital, with an inpatient capacity of 396 beds.

Children's Hospital at Dartmouth-Hitchcock (CHaD)

CHaD is New Hampshire's only children's hospital and a member of the Children's Hospital Association, providing advanced pediatric inpatient, outpatient and surgical services at DHMC in Lebanon as well as in Bedford, Concord, Manchester, Nashua, and Dover, NH.

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Norris Cotton Cancer Center (NCCC)

NCCC is a designated Comprehensive Cancer Center by the National Cancer Institute, and is one of the premier facilities for cancer treatment, research, prevention, and education. Interdisciplinary teams, devoted to the treatment of specific types of cancer, work together to care for patients of all ages in Lebanon, Manchester, Nashua, Keene, NH, and St. Johnsbury, VT.

Our mission, vision, and 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.

Our values

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

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Learn more about us

- Facts and Figures
- Community Outreach
- Collaborations
- Population Health
- Awards and Honors
- History

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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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June 30, 2019

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Part I

Financial Statements and Schedule of Expenditures of Federal Awards

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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.

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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

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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

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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.

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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

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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.

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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.

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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

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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.

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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

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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

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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.

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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.

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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

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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

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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

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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.

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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		

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	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

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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.

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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.

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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 %

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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

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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.

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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

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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

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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:

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(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.

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Consolidating Supplemental Information – Unaudited

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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

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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

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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

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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

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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	-	208,346	24,225	6,454	5,434	6,966	(3,763)	247,662	3,642	287	251,591
Medical supplies and medications	-	354,201	34,331	8,634	8,298	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

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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

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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

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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	7,406	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

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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.

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Schedule of Expenditures of Federal Awards

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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
Federal Program						
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	93.186	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	6K23MH116367-02	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	5,697	-
Mental Health Research Grants	93.242	R1156	Pass-Through	Trustees of Dartmouth College	4,721	-
					894,617	112,787

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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		135,887	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	1R01CA225782	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		14,675	-
Cancer Treatment Research	93.395	6U10CA180854-06	Direct		27,790	-
Cancer Treatment Research	93.395	DAC-194321	Pass-Through	Mayo Clinic	36,708	-

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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	2,683
Aging Research	93.866	R1102	Pass-Through	Trustees of Dartmouth College	8,285	-
					84,662	2,683
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

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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-DCOM-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	18,283	
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	-

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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		273,666	-
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	69,276	-
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

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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.

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Part II
Reports on Internal Control and Compliance

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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.

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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

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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.

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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

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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

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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

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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.

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DARTMOUTH-HITCHCOCK (D-H) | DARTMOUTH-HITCHCOCK HEALTH (D-HH)
BOARDS OF TRUSTEES AND OFFICERS

Effective: January 1, 2021

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Roberta L. Hines, MD MHMH/DHC Trustee *Surgeon-in-Chief, The John Hopkins Hospital*	

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CURRICULUM VITAE

Date prepared: March 1, 2021

Name: Kelly Anne Aschbrenner

Office Address: Dartmouth-Hitchcock Health System
294 Daniel Webster Highway
Merrimack, NH 03054

I. Education

1996-2000	Maryville University	B.A.
2000-2002	University of Chicago, School of Social Service Administration	M.A.
2002-2007	University of Wisconsin – Madison, School of Social Work	Ph.D.

II. Postdoctoral Training

2007-2009	Brown University	Health Services Research

III. Professional Development Activities

2015	Johns Hopkins School of Public Health	Mixed Methods Workshop
2015	Society of Behavioral Medicine	Maximizing Recruitment and Retention in Randomized Trials
2016	National Institutes of Health (NIH)	Mixed Methods Training Program for Health Sciences
2017	Harvard Medical School	Fundamentals of Clinical and Translational Research
2018	National Heart, Lung, and Blood Institute (NHLBI)	Leadership Workshop in Health Disparities and Implementation Science
2021	Qualitative Research Summer Intensive	Mixed Methods Research in Implementation Science

IV. Academic Appointments

2008-2009	Boston College School of Social Work	Instructor
2009-2010	Geisel School of Medicine at Dartmouth	Research Associate
2010-2019	Geisel School of Medicine at Dartmouth	Assistant Professor
2012-2019	The Dartmouth Institute for Health Policy & Clinical Practice	Adjunct Assistant Professor
2019-Present	Geisel School of Medicine at Dartmouth	Associate Professor
2012-Present	The Dartmouth Institute for Health Policy & Clinical Practice	Adjunct Associate Professor

V. Institutional Leadership Roles

Director of Psychiatry Research Forum (Dartmouth-Hitchcock Department of Psychiatry)

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Director of Research at New Hampshire Hospital

VI. Licensure and Certification

N/A

VII. Hospital Appointments

2016-present Dartmouth-Hitchcock Health System Senior Scientist

VIII. Other Professional Positions (Non-Dartmouth)

IX. Teaching Activities

A. Undergraduate (College) Education

Fall 2004
University of Wisconsin-Madison
Introduction to the Field of Social Work
Teaching Assistant
4 hours per week for 12 week semester

Spring 2015
Dartmouth College
Psychological Anthropology
Guest Lecturer
2 hours

B. Graduate Education

C. Undergraduate Medical Education

i. Classroom Teaching N/A
ii. Clerkship or Other Clinical UME Teaching N/A

D. Graduate Medical Education

Winter 2018
Dartmouth Hitchcock Medical Center
Leadership Preventive Medicine Residency
Guest Lecturer
2 hours

E. Other Clinical Education

N/A

X. Advising/Mentoring (Research)

2019-present	Jessica Salwen-Deremer, PhD Clinical Psychologist	Department of Psychiatry, Geisel School of Medicine at Dartmouth
2019-present	James T. Craig, PhD Clinical Psychologist	Department of Psychiatry, Geisel School of Medicine at Dartmouth

XI. Research Teaching/Mentoring

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A. Undergraduate Students

2014-2015	Terence Hughes, BA	Dartmouth College Presidential Scholar

B. Graduate Students

2013-2017	John Naslund, PhD	The Dartmouth Institute Doctor of Philosophy

C. Non-Degree Program Students

Summer 2014	Raleigh McElvery, BA	Summer Research Internship for Non-Dartmouth Undergraduates

D. Medical Students

2012-2013	Stephanie Rolin, MD	Tenney Fellow at Geisel School of Medicine at Dartmouth College

E. Residents/Fellows/Research Associates

XII. Community Service, Education, and Engagement

2013-present
Gate City Striders Running Club
College Scholarship Committee
Chair
10 hours per year

XIII. Research Funding

A. Current Support

R01MH110965 (Aschbrenner)
(NCE effective 6/1/20)
NIH/NIMH
Peer Support and Mobile Technology Targeting Cardiometabolic Risk Reduction in Young Adults with SMI
The objective of this R01 application is to evaluate the effectiveness of a group-based lifestyle intervention (PeerFIT) supported by mHealth technology and social media to promote weight loss and improved fitness in young adults with SMI. Role: Principal investigator.

PCS-2017C2-7724-IC (Pratt & Bartels)
6/01/18-5/31/24
PCORI
Integrated Physical and Mental Health Self-management Compared to Chronic Disease Self management
to Improve Outcomes and Reduce Early Mortality Risk in Persons with Serious Mental Illness.
Role: Co-Investigator

P50CA244433-02 (Emmons & Tavaris)
09/01/2019-08/31/2024
NIH/NCI
NCI The Implementation Science Center for Cancer Control Equity
The Methods Unit (MU) in this P50 will involve community-based participatory research and

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community engaged approaches to address the following: (1) critical methodological areas in equity-focused cancer screening and prevention implementation research (2) develop and support an *Implementation Research* Methods Incubator and (3) disseminate methodological advances and other center-generated resources.
Role: Co-Investigator on the P50 Methods Unit

UG1DA040309-06 (Marsch)
06/01/20-05/31/25
NIH/NIDA
Northeast Node of the National Drug Abuse Clinical Trials Network
In the renewal period, the Node will to enhance its activities and contributions to the national CTN to embrace advances in scientific discovery and research innovations that offer great promise for increasing the reach and effectiveness of treatments for SUDs. The Node will engage a broader group of investigators that bring additional expertise in data science (bioinformatics, predictive modeling, artificial intelligence, social media, data privacy/security) and experimental design (micro-randomized trials, adaptive designs, and implementation/systems science). With this expanded group of partners, it will support and grow a productive research agenda in the CTN with a focus on (a) digital health and data analytics, including research focused on providing personalized, science-based resources to individuals with SUD via digital technology and (b) expanding low threshold access to science-based SUD care, particularly in rural contexts (e.g., general medical settings; pharmacies; and community organizations). Role: Co-Investigator

Completed Research Support Past 5 Years
State of New Hampshire (Aschbrenner & Torrey)
07/01/2016-9/30/20
Department of Health and Human Services
First Episode Psychosis/Early Serious Mental Illness Program Planning
To engage stakeholers in selecting a statewide model of first episode psychosis care and developing a public awareness campaign to increase identification and referrals
Role: Co-PI

R01MH102325 (Bartels)
07/01/2014-06/20/2021
NIH/NIMH
RCT of a Learning Collaborative to Implement Health Promotion in Mental Health
To evaluate two different approaches to implementing evidence-based health promotion in mental health settings to decrease obesity and reduce cardiovascular risk for persons with mental illness.
Role: Co-I

1U48DP005018-01 (Bartels)
09/30/14-09/29/19
Centers for Disease Control and Prevention
Health Promotion and Disease Prevention Research Center
Role: Core Research Project Co-PI

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XIV. Program Development

Dartmouth-Hitchcock Psychiatry Research Forum (Co-Lead)

XV. Entrepreneurial Activities

XVI. Major Committee Assignments

National/International

2016	Mental Health Services Research Committee	Ad hoc grant reviewer	National Institute of Mental Health
2017	Effectiveness Trials for Treatment, Preventive, and Services Interventions	Ad hoc grant reviewer	National Institute of Mental Health
2017	Pilot Effectiveness Trials for Treatment, Preventive, and Services Interventions	Ad hoc grant reviewer	National Institute of Mental Health
2018	Biomedical Computing and Healthcare Informatics	Ad hoc grant reviewer	National Institute of Health Center for Scientific Review
2018	Pilot Effectiveness Trials for Treatment, Preventive, and Services Interventions	Ad hoc grant reviewer	National Institute of Mental Health
2019	Early Psychosis Intervention Network (EPINET): Practice-Based Research to Improve Treatment Outcomes (R01s) and Data Coordinating Centers (U24s)	Ad hoc grant reviewer	National Institute of Mental Health
2019	Research Leader Awards	Peer Reviewer	Health Research Board of Ireland
2019 – Present	Mental Health Services Research Committee	Standing Member	National Institute of Mental Health
2020 – Present	Data Safety Monitoring Board	Member	Johns Hopkins School of Medicine
2020	Clinical Research Career Development Fellowships	Reviewer	Wellcome Charitable Foundation (UK)

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2021 -- Present	Health Equity Task Force	Member	National Cancer Institute

Regional

2014-2016	Committee for the Protection of Human Subjects	Member	New Hampshire Department of Health and Human Services
2019-2020	Statewide First Episode Care Planning Steering Committee	Member	New Hampshire Department of Health & Human Services

Institutional

2015-2018	Community Engaged Research Advisory Board	Member	Dartmouth Clinical and Translational Sciences Institute
2015	SYNERGY Community Engaged Pilot Grants	Reviewer	Dartmouth Clinical and Translational Sciences Institute
2018	Tucker Junior Investigator Award	Reviewer	Department of Psychiatry
2018 –Present	Behavioral Health Research Seminar Planning Committee	Member	Center for Technology and Behavioral Health

XVII. Membership, Office and Committee Assignments in Professional Societies

2002-2014	Society for Social Work and Research	Member
2013-present	Mixed Methods International Research Association	Member
2014-present	Society of Behavioral Medicine	Member, Abstract Selection Committee

XVIII. Editorial Boards

2010-2017	Health & Social Work	Consulting Editor
2020-	Contemporary Clinical Trials	Review Editor
2020-	Frontiers in Public Health	Review Editor

XIX. Journal Referee Activity

2014-present	Acta Psychiatrica Scandinavica	Twice yearly
2016-present	Administration and Policy in Mental Health and Mental Health Services Research	Quarterly
2009-present	American Journal of Geriatric Psychiatry	Twice yearly
2009-present	BMC Health Services Research	Twice yearly
2016-present	BMC Psychiatry	Twice yearly
	Health Services & Outcomes Research	

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2010-present	Health & Social Work	Twice yearly
2015-present	Implementation Science	Twice yearly
2012-present	International Journal of Geriatric Psychiatry	Annually
2012-present	Journal of Dual Diagnosis	Twice yearly
2016-present	Journal of HIV/AIDS & Social Services	Annually
2010-present	Journal of Mental Health	Quarterly
2009-present	Journal of Nervous and Mental Disease	Quarterly
2009-present	Journal of the American Geriatrics Society	Annually
2014-present	Journal of the American Medical Directors Association	Annually
2015-present	PLoS ONE	Twice yearly
2010-present	Psychiatric Rehabilitation Journal	Quarterly
2013-present	Psychiatric Research	Twice yearly
2010-present	Psychiatric Services	Quarterly
2009present	Social Work in Mental Health	Quarterly
2015-present	Translational Behavioral Medicine: Practice, Policy, and Research	Quarterly

XX. Awards and Honors

2010	Gary Tucker Junior Clinical Investigator Award, Department of Psychiatry, Geisel School of Medicine at Dartmouth
2010	Student Loan Repayment Award for Clinical Investigators, National Institutes of Health
2012	NARSAD Young Investigator Award
2012	Fellow, NHLBI Summer Institute on Behavioral RCTs
2015	Fellow, NIH Mixed Methods Research Training for Health Sciences
2019	Best Poster Award in Methods and Measurements, 12th Annual Conference on Science of Dissemination and Implementation in Health
2021	Fellow, Leadership Institute, Society of Behavioral Medicine

XXI. Invited Presentations

A. International Meetings

2014	Feasibility of Family-based Social Support Intervention to Enhance Health Promotion in a Health Disparity Population International Mixed Methods International Research Association Boston, MA (#)
2019	Lifestyle Interventions for Reducing Cardiovascular Risk and Improving Health in People with Serious Mental Illness Royal College of Psychiatrists Northern Ireland Belfast, Ireland (#)

B. National Meetings

2008	Parenting an Adult Child with Bipolar Disorder in Later Life Society for Social Work and Research Annual Conference Washington D.C. (#)
2011	In SHAPE: RCT of a Fitness Intervention for People with SMI Society for Social Work and Research Annual Conference

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Tampa, FL (#)

2011 Family Contact and Health Status Among Older Adults with SMI
Society for Social Work and Research Annual Conference
Tampa, FL (#)

2012 Family Support for Health Promotion Among Older Adults with SMI
Grand Rounds – U.S. Department of Veterans Affairs
Houston, Texas (*)

2013 Social Influences on Health Behaviors in SMI
Department of Psychiatry
Columbia University
New York, NY (*)

2013 Social Support for Health Behavior Change Among Adults with SMI Enrolled in a Healthy Lifestyle Intervention
Society for Social Work and Research Annual Conference
San Diego, CA (#)

2014 Partner Support for Smoking Cessation in People with SMI
Mayo Clinic – Department of Psychology
Rochester, MN (*)

2014 The Other 23 Hours: Fitness Provider Perspectives on Engaging Support for Health Behavior Change for Persons with SMI
Society for Social Work and Research Annual Conference, San Antonio, TX (#)

2014 Feasibility a Peer and Technology Enhanced Health Promotion Intervention for Overweight and Obese Individuals with SMI
NIMH Conference on Mental Health Services Research
Bethesda, MD (#)

2014 Peer and Mobile Technology Enhanced Health Promotion for Adults with SMI
Science of Dissemination and Implementation Annual Meeting
Bethesda, MD (#)

2015 Implementing Evidence-based Health Promotion in Mental Health
National Council for Behavioral Health Annual Meeting
Orlando, FL (#)

2016 Using mHealth to Address Health Behaviors in High-risk Populations: Challenges and Opportunities to Advance a Research Agenda
Panel Chair (#)
Society of Behavioral Medicine Annual Meeting, Washington, DC

2019 Practical Strategies to Reduce Premature Mortality and Improve Health in People with Schizophrenia: Outcomes in Real World Settings
Schizophrenia International Research Society, Orlando, FL

2020 Mixed Methods in Intervention Research: Pilot Studies to Examine Feasibility
NIH Mixed Methods Research Training Program for the Health Sciences

2020 Advancing adaptation research: Evaluating stakeholder-led adaptations to an EBP in routine mental health service settings. oral presentation at the Virtual D&I Conference, December 15-17, 2020. The presentation was

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selected for the conference session: "The Leading Edge: Problems, Methods, and Findings that will Shape the Future of the Field"

2020 "Equitable implementation: Getting what works in health care to vulnerable patients," at the Implementation Learning Community for Massachusetts community health centers sponsored by the Implementation Science Center for Cancer Control Equity (ISCCCE) at Harvard T. H. Chan School of Public Health, December 11th, 2020, a virtual event.

2021 "Peer Support and Mobile Health Technology Lifestyle Intervention to Reduce Cardiometabolic Risk in Young Adults with Serious Mental Illness: A Randomized Controlled Trial," at the Johns Hopkins NIMH ALACRITY Center on January 13th, 2021.

Regional/Institutional

2012 Innovative Approaches to Health Behavior Change in Psychiatric Disabilities
Massachusetts Department of Mental Health
Boston, MA (*)

2013 Peer Enhanced Model of Health Promotion in SMI
Boston University Center for Psychiatric Rehabilitation
Boston, MA (*)

2013 Mixed Methods for Health Services Research
The Dartmouth Institute for Health Policy & Clinical Practice
Lebanon, NH (*)

2014 Family and Social Support for Health Promotion
National Alliance on Mental Illness
Concord, NH (*)

2015 Social Networks and Health Behavior Change Interventions
Dartmouth Psychiatric Research Center
Lebanon, NH (*,^)

2017 Partnering with NAMI to Develop and Test a Support Person Intervention to Promote Smoking Cessation
Behavioral Health Research Seminar
Lebanon, NH (*,^)

2017 Lifestyle Interventions for Young Adults with SMI
Invited Grand Rounds Presentation
Department of Psychiatry, Harvard Medical School
Boston, MA (*,^)

2018 Translating Social Network Science to Inform Smoking Cessation Interventions for Persons with Mental Illness
Invited Grand Rounds Presentation
Norris Cotton Cancer Center, Geisel School of Medicine
Lebanon, NH (*,^)

2018 Early Intervention with Mobile Health Coaching and Peer Support to Address Health Risks Among Young People with Serious Mental Illness
Invited Grand Rounds Presentation

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	Department of Psychiatry, Geisel School of Medicine Lebanon, NH (*,^)
2018	Health Promotion in Mental Health Settings: Using Peer Support, Digital Technology, and Social Media to Improve the Health of Young Adults with SMI (*) Invited seminar presentation University of Connecticut School of Social Work
2018	Treating Tobacco Use Disorder Among Young People with SMI in an Integrated Community Mental Health Primary Care Program Invited Seminar Presentation Dartmouth Center for Behavioral Health Technology
2018	Group-Based Health Promotion with Peer Support and Technology for Persons with Serious Mental Illness in Mental Health Settings Invited seminar presentation State of Connecticut Department of Mental Health and Addiction Services
2019	Harnessing Implementation Science to Promote Health Equity Invited seminar presentation Mongan Institute Massachusetts General Hospital Harvard Medical School
2019	Adaptation vs. Fidelity: Advancing the Goals of Equity and Sustainability in Implementation Science Harvard Catalyst Implementation Science Event Mongan Institute Massachusetts General Hospital Harvard Medical School
2021	Peer Support and Mobile Health Technology Lifestyle Intervention to Reduce Cardiometabolic Risk in Young Adults with Serious Mental Illness: A Randomized Controlled Trial," at the Dartmouth Center for Behavioral Health Technology on January 15th, 2021.

XXII. Bibliography

A. Peer-reviewed publications in print or other media

Original articles:

1. Greenberg JS, Knudsen KJ, and **Aschbrenner KA.** Prosocial family processes and the quality of life of persons with schizophrenia. Psychiatr Serv. 2006 Dec;57(12):1771-7. PMID:17158493

2. Grabowski DC, **Aschbrenner KA**, Zeng F, and Mor V. Mental illness in nursing homes: Variations across states. Health Aff (Millwood). 2009 May-Jun;28(3):689-700. PMID:19414877

3. **Aschbrenner KA**, Greenberg J, and Seltzer MM. Parenting an adult child with bipolar disorder in later-life. J Nerv Ment Dis. 2009 May;197(5):298-304. PMID:19440101

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4. Grabowski DC, **Aschbrenner KA**, Rome VF, and Bartels SJ. Quality of mental health care for nursing home residents: A literature review. Med Care Res Rev 2010 Dec;67(6):627-56. PMID:20223943

5. **Aschbrenner KA**, Greenberg JS, Allen SM, and Seltzer MM. Subjective burden and personal gains among older parents of adults with serious mental illness. Psychiatr Serv 2010 Jun;61(6): 605-11. PMID: 20513684

6. **Aschbrenner KA**, Mueser KT, Bartels SJ, and Pratt SI. Family contact and health status among older adults with serious mental illness. Psychiatr Rehabil J. 2011 Spring;34(4):295-303. PMID:21459745

7. **Aschbrenner KA,** Grabowski DC, Cai S, Bartels SJ, and Mor V. Nursing home admissions and long-stay conversions among persons with and without serious mental illness. J Aging and Soc Policy. 2011 Jul-Sep;23(3):286-304. PMID: 21740203

8. **Aschbrenner KA**, Cai S, Grabowski DC, Bartels SJ, and Mor V. Medical comorbidity and functional status in elderly vs. non-elderly persons with major mental illness newly admitted to nursing homes. Psychiatr Serv. 2011 Sep;62(9):1098-100. PMID:21885592

9. **Aschbrenner KA**, Carpenter-Song E, Mueser KT, Kinney A, Pratt S., and Bartels SJ. A qualitative study of social facilitators and barriers to health behavior change among persons with serious mental illness. Community Ment Health J. 2013 Apr;49(2):207-12. PMID:23054155

10. **Aschbrenner KA**, Bartels SJ, Mueser KT, Carpenter-Song E. and Kinney A. Consumer perspectives on involving family members and significant others in a healthy lifestyle intervention. Health Soc Work 2012 Nov;37(4):207-215. PMID: 23301434

11. **Aschbrenner KA**, Mueser KT, Bartels SJ, Pratt SI. (2013). Perceived social support for diet and exercise among persons with serious mental illness enrolled in a healthy lifestyle intervention. Psychiatr Rehab J. 2013 Jun;36(2):65-71. PMID:23647144

12. Bartels SJ, Pratt SI, **Aschbrenner KA,** Barre LK, Jue K, Wolfe RS, Xie H, McHugo GJ, Santos M, Williams GE, Naslund JA, and Mueser KT. Clinically significant improved fitness and weight loss among overweight persons with serious mental illness. Psychiatr Serv. 2013 Aug 1;64(8):729-736. PMID:23677386

13. Bartels SJ, Pratt SI, Mueser KT, Forester B, Wolfe RS, Cather C, Xie H, McHugo GJ, Bird B, **Aschbrenner KA,** and Naslund JA. Long-term outcomes of a randomized trial of integrated skills training and preventive health care for older adults with serious mental illness. Am J Geriatr Psychiatry. 2014 Nov;22(11):1251-61. PMID:23954039

14. Bartels SJ, **Aschbrenner KA,** Rolin S, Cimpean D, Naslund JA, and Faber M. Activating older adults with serious mental illness for collaborative primary care visits. Psychiatr Rehabil J. 2013 Dec;36(4):278-88. PMID: 24219769

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15. Naslund JA, Grande SW, **Aschbrenner KA**, and Elwyn G. Naturally occurring peer support through social media: the experiences of individuals with severe mental illness using YouTube. PLoS One. 2014 Oct 15;9(10):e110171. PMID: 25333470

16. **Aschbrenner KA**, Peppin R, Mueser KT, Naslund JA, Rolin SA, Faber MJ, and Bartels SJ. A mixed methods study of family involvement in medical care for older adults with serious mental illness and cardiovascular health risk. Int J of Psychiatry Med. 2014;48(2):121-33. PMID: 25377153

17. **Aschbrenner KA**, Ferron JC, Mueser KT, Bartels SJ, and Brunette MF. Social predictors of cessation treatment use among smokers with serious mental illness. Addict Behav. 2015 Feb;41:169-74. PMID: 25452062

18. Naslund JA, **Aschbrenner KA,** Barre LK, and Bartels SJ. Feasibility of popular mHealth technologies for activity tracking among individuals with serious mental illness. Telemed J E Health. 2015 Mar;21(3):213-6. PMID: 25536190

19. Jimenez DE, **Aschbrenner KA**, Burrows K, Pratt SI, Alegria M, and Bartels SJ. Perspectives of overweight Latinos with serious mental Illness on barriers and facilitators to health behavior change. J Lat Psychol. 2015 Feb;3(1):11-22. PMID: 25664227

20. Bartels SJ, Pratt SI, **Aschbrenner KA,** Naslund JA, Barre LK, Wolfe R, Xie H, McHugo GJ, Jimenez DE, Jue K, Feldman J, Bird BL. Pragmatic randomized trial of health promotion coaching for obesity in serious mental illness and maintenance of outcomes. Am J Psychiatry. 2015 Apr;172(4):344-52. PMID: 25827032

21. **Aschbrenner KA,** Mueser KT, Bartels SJ, Carpeter-Song E., Pratt SI, Barre L, Naslund J, and Kinney A. The other 23 hours: A qualitative study of fitness provider perspectives on social support for health behavior change among adults with serious mental illness. Health Soc Work. 2015 May;40(2):91-9. PMID: 26027417

22. **Aschbrenner KA,** Brunette MF, McElvery R, Naslund JA, Scherer EA, Pratt SI, and Bartels SJ. Cigarette smoking and interest in quitting among overweight and obese adults with serious mental illness enrolled in a fitness intervention. J Nerv Ment Dis. 2015 Jun;203(6):473-6. PMID: 26034872

23. Naslund, JA, **Aschbrenner KA.** McHugo G, Marsch L, and Bartels SJ. Crowdsourcing for conducting randomized trials of internet delivered interventions in people with serious mental illness: A systematic review. Contemp Clin Trials. 2015 Sep;44:77-88. PMID: 26188164

24. **Aschbrenner KA**, Naslund JA, Barre LK, Mueser KT, Kinney A, and Bartels SJ. Peer health coaching for overweight and obese individuals with serious mental illness: Intervention development and initial feasibility study. Transl Behav Med. 2015 Sep;5(3):277-84. PMID: 26327933

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25. Naslund JA, **Aschbrenner KA,** Scherer EA, Pratt SI, Wolfe R, and Bartels SJ. Lifestyle intervention for people with severe obesity and serious mental illness. Am J Prev Med. 2016 Feb;50(2):145-53. PMID: 26385164

26. Naslund JA, **Aschbrenner KA**, Pratt SI, and Bartels SJ. Comparison of people with serious mental illness and general population samples enrolled in lifestyle interventions for weight loss. Schizophr Res. 2015 Dec;169(1-3):486-488. PMID: 26427918

27. **Aschbrenner KA**, Naslund JA, Shevenell MD, Mueser KT, and Bartels SJ. Feasibility of behavioral weight loss treatment enhanced with peer support and mobile health technology for individuals with serious mental illness. Psychiatr Q. 2016;87(3):401-15. PMID: 26462674

28. Naslund JA, **Aschbrenner KA,** and Marsch L, Bartels SJ. The future of mental health care: Peer-to-peer support and social media. Epidemiol and Psychiatr Sci. 2016 April;25(2):113-22. PMID: 26744309

29. **Aschbrenner KA,** Naslund JA, Gill LE, Bartels SJ, and Ben-Zeev D. A qualitative study of client-clinician text exchanges in a mobile health intervention for individuals with psychotic disorders and substance use. J Dual Diagn. 2016;12(1):63-71. PMID: 26829356

30. Jimenez DE, Burrows K, **Aschbrenner KA**, Pratt SI, Alegria M, and Bartels SJ. Health behavior change benefits: Perspectives of Latinos with serious mental illness. Transcult Psychiatry. 2016 June;53(3):313-29. PMID: 26873582

31. Naslund JA, **Aschbrenner KA,** and Bartels SJ. Wearable devices and smartphones for activity tracking among people with serious mental illness. Ment Health and Phys Act. 2016 Mar;10:10-17. PMID: 27134654

32. **Aschbrenner KA**, Naslund JA, Shevenell M, Kinney E, and Bartels SJ. A pilot study of a peer-group lifestyle intervention enhanced with mHealth technology and social media for adults with serious mental illness. J Nerv Ment Dis. 2016 June;204(6): 483-6. PMID: 27233056

33. Ben-Zeev D, Brian RM, **Aschbrenner KA**, Jonathan G, Steingard S. Video-based mHealth interventions for schizophrenia: Bringing the "pocket therapist" to life. Psychiatr Rehabil J. 2016 June 13. [Epub ahead of print]. PMID: 27295133

34. **Aschbrenner KA,** Mueser KT, Naslund JA, Gorin A, Kinney A, Daniels L, and Bartels SJ. Feasibility study of increasing social support to enhance a lifestyle intervention for individuals with serious mental illness. J Soc Social Work Res. 2016 Summer;7(2):289-313

35. Naslund JA, **Aschbrenner KA,** and Bartels SJ. Wearable devices and mobile technologies for supporting behavioral weight loss among people with serious mental illness. Psychiatry Res. 2016 Oct 30;244:139-44. PMID: 27479104

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37. Naslund JA, **Aschbrenner KA,** and Bartels SJ. How people living with serious mental illness use smartphones, mobile apps, and social media. Psychiatr Rehab J. 2016 Dec;88(4):364-67. PMID: 27845533

38. Naslund JA, **Aschbrenner KA,** Marsch L, and Bartels SJ. Feasibility and acceptability of Facebook for health promotion among people with serious mental illness. Digital Health. 2016 Nov; 2 Epub Jun 1. PMID: 28367321

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65. Fortuna, KL, Ferron, J, Pratt, SI, Muralidharan, A, Williams, AM, **Aschbrenner, KA**, Deegan, PE, & Salzer, S. Unmet needs of people with serious mental illness: Perspectives from certified peer specialists. *Psychiatric Quarterly*. Forthcoming.

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Reviews:

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2. Naslund JA, Kim SJ, **Aschbrenner KA**, McCulloch LJ, Brunette MF, Dallery J, Bartels SJ, and Marsch LA. Systematic review of social media interventions for smoking cessation. Addictive Behaviors. 2017 Oct;73:81-93. PMID: 28499259

Book chapters:

1. Gehlert S, **Kovac K**, and Song I. Rural women's mental health. In Rural women's health: Linking mental, behavioral, and physical health. Editors: R. T. Coward, L. Davis, C. H. Gold, C. H. Smiciklas-Wright, L. E. Thorndyke, & F. W. Vondracek. Publisher: New York: Springer Publishing.

2. Angell B, Cooke A, and **Kovac K**. First person accounts of stigma. In On the stigma of mental illness: Practical strategies for research and social change. Editor: Patrick W. Corrigan. Publisher: Washington, DC: American Psychological Association.

B. Other scholarly work in print or other media

1. **Aschbrenner KA**, Naslund JA, and Bartels SJ. Technology supported peer-to-peer lifestyle interventions for adults with serious mental illness. Psychiatr Serv. 2016 Aug;67(8):928-9. PMID: 27476896

2. **Aschbrenner KA** and Brunette MF. The Role of Peers in Health Promotion and Illness Management for Serious Mental Illness. Psychiatr Serv. 2018 May;69:5.

Thesis

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Aschbrenner KA. The Long-term Impact of Parenting an Adult Child with Severe Mental Illness. Dissertation. Madison, Wisconsin: The University of Wisconsin; 2007.

C. Abstracts:

Aschbrenner, KA, Greenberg, JS, and Seltzer, MM. "Parenting an adult child with bipolar disorder in later life", paper presentation, Annual Conference of the Society for Social Work and Research, Washington D.C., 2008.

Aschbrenner KA, Greenberg JS, and Seltzer MM. "Identifying resilience and vulnerability in a community-based sample of aging parents of adults with serious mental illness", poster presentation, AHRQ National Research Service Award Trainee Conference, Washington D.C., 2008.

Aschbrenner KA, Pratt SI, and Bartels SJ. "In SHAPE: 12-month outcomes of a randomized controlled trail of a fitness intervention for people with serious mental illness", paper presentation, Annual Conference of the Society for Social Work and Research, Tampa, FL, 2011.

Aschbrenner KA, Mueser KT, Bartels SJ, and Pratt SI. "Family contact and health and mental health status among older adults with serious mental illness", paper presentation, Annual Conference of the Society for Social Work and Research, Tampa, FL, 2011.

Aschbrenner KA, Grabowski DC, Cai S, Bartels S, and Mor, V. "Medical comorbidity and functional status in elderly vs. non-elderly persons with major mental illness newly admitted to nursing homes", poster presentation, American Association for Geriatric Psychiatry Annual Meeting, San Antonio, TX, 2011.

Aschbrenner, KA, Bartels SA, Pratt SI, Williams G, Jeudy M, and Jue K. "In SHAPE: CBPR and a Health Promotion Intervention to Reduce Early Mortality in a Health Disparity Population with Serious Mental Illness", poster presentation, Centers for Disease Control Prevention Research Centers Annual Meeting, Atlanta, GA, 2011.

Aschbrenner KA, Mueser KT, Gorin A, Pratt SI, Kinney A, and Bartels SJ. "Feasibility of social support strategies to enhance health promotion in a health disparity population with serious mental illness", poster presentation, Society of Behavioral Medicine Annual Meeting, San Antonio, TX, 2013.

Aschbrenner KA, Bartels SJ, and Mueser KT. "Social support for health behavior change among adults with SMI enrolled in a healthy lifestyle intervention," paper presentation, Annual Conference of the Society for Social Work and Research, San Diego, CA, 2013.

Aschbrenner KA, Mueser KT, and Bartels SJ. "The other 23 hours: Fitness provider perspectives on engaging support for health behavior change for persons with serious mental illness", in K. A. Aschbrenner (Chair) "Achieving better health: Developing interventions to promote health behavior change in persons with serious mental illness", symposium presentation, Annual Conference of the Society for Social Work and Research, San Antonio, TX, 2014.

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Aschbrenner KA, Naslund JA, and Bartels SJ. "Feasibility study of a peer and technology enhanced health promotion intervention for overweight and obese individuals with serious mental illness", In S. J. Bartels (Chair) "Changing Organizational Culture, Physician Prescribing, and Consumer Engagement in a System-Wide Health Promotion Intervention To Reduce Early Mortality in Adults With Serious Mental Illness, Obesity, and Tobacco Dependence", paper presentation, NIMH Conference on Mental Health Services Research, Bethesda, MD, 2014.

Aschbrenner KA. "A feasibility study of a family-based social support intervention to enhance health promotion in a health disparity population", paper presentation, Annual International Mixed Methods International Research Association, Boston, MA, 2014.

Aschbrenner, KA. "Peer and mobile technology enhanced health promotion for adults with serious mental illness", in S. J. Bartels (Chair) "Implementation of a system-wide health promotion intervention to reduce early mortality in high-risk adults with serious mental illness", paper presentation, Annual Science of Dissemination and Implementation. Bethesda, MD, 2014.

Aschbrenner KA. "Implementing evidence-based health promotion in mental health settings", paper presentation, National Council for Behavioral Health Annual Meeting, Orlando, FL, 2015.

Aschbrenner KA, Naslund JN, Carpenter-Song E, Ferron J, Brunette MF, and Nilson W. "Using mHealth to address health behaviors in high risk populations: Challenges and opportunities to advance a research agenda", panel discussion, Society of Behavioral Medicine Annual Meeting, Washington, DC, 2016.

Aschbrenner KA, Mueser KT, Naslund J.A Gorin A, Pratt S, and Bartels S. "Facilitating partner support to enhance health promotion in a health disparity population with serious mental illness", poster presentation, Society of Behavioral Medicine Annual Meeting, Washington, D.C., 2016.

Aschbrenner KA, Schneider E, Naslund JA, Brunette MF, and O'Malley AJ. "Smoking in the social networks of adults with serious mental illness enrolled in cessation treatment at mental health centers", poster presentation, Society of Behavioral Medicine Annual Meeting, San Diego, CA, 2017.

Aschbrenner KA, Naslund JA, Bienvenida JCM, Bartels SJ, and Brunette MF. "A Survey of Online and Mobile Technology Use at Peer Support Agencies", poster presentation, McLean Hospital Technology in Psychiatry Summit, Harvard Medical School, Boston, MA, 2017.

Aschbrenner KA, Bond G, Pratt S, Williams G, Jue K, and Bartels SJ. "Adaptations to Health Promotion Programs in Mental Health Settings", poster presentation, Annual Conference on the Science of Dissemination and Implementation in Health, Washington, D.C., 2017.

Aschbrenner, KA, Tomlinson, EF, Shea, K., Kinney, A., Nikitas, Z., Gorin, A., & Bartels, SJ. "An mHealth Coach Facilitated Peer Intervention to Promote Physical Activity Among Adolescents in Community Mental Health: Pilot Design and Implementation", UConn Center for mHealth and Social Media, Storrs CT. May 2018.

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Aschbrenner KA. "Using Peer Support and Mobile Health Technology to Address Cardiometabolic Risk in Young Adults with SMI," in S. Azrin (Chair) "Practical Strategies to Reduce Premature Mortality and Improve Health in People with Schizophrenia: Outcomes in Real World Settings," symposium presentation, 2019 Congress of the Schizophrenia International Research Society, Orlando, FL. April 2019.

XXIII. Personal Statement:

I lead an innovative program of locally, regionally and nationally funded research that has had a significant impact on the field of mental health by generating new strategies for addressing cardiovascular health risk behaviors that have been intractable in vulnerable populations to date. My intervention work focuses on developing and evaluating interventions that leverage peer support and digital health technology to address health disparities in adolescents and young adults with the most severe mental illnesses, including schizophrenia and psychotic disorders, bipolar disorder, and major depression. In addition to intervention research, I lead novel projects in implementation science that examine the impact of contextual factors on the implementation of health interventions in complex health care settings and intervention fidelity and adaptation by providers in real world practice settings. My work blends intervention research, community-engagement, digital health technologies, mixed quantitative and qualitative methods, and implementation science. The combined areas of my expertise and scientific contributions are highly novel at Dartmouth and nationally. I have played a vital role as principal investigator and co-investigator in obtaining, sustaining and implementing numerous federally funded research grants related to these areas.

I am leading the only team in the nation focused on an intervention that leverages peer social networks and technology to motivate health behavior change in young adults with serious mental illness (SMI). I am the PI of an R01-funded nationally by a special NIH funding announcement to support population-based approaches to interventions targeting cardiometabolic risk in young adults with SMI. The main cause of early death among persons with SMI is cardiovascular disease associated with risk factors that can be changed, such as obesity and smoking. Virtually all of the research to date on this problem has focused on middle aged and older adults. I have developed an intervention with a team of collaborators from Geisel, Boston University, Harvard Medical School and the University of Connecticut that uses social media and wearable activity trackers to enhance group lifestyle and exercise sessions that are engaging and highly relevant to young adults. The results of this study will have a significant impact on the field nationally and internationally by informing early intervention strategies to address cardiovascular risk among young people with SMI and will lay the groundwork for the first generation of evidence-based practices for this high-risk, highly challenging population.

My work on the development and rigorous testing of health interventions for complex patient populations in real world practice settings has spawned my new line of research on intervention fidelity and adaptation in implementation science. I lead an NIMH-funded supplement to a national R01 study of implementation strategies for delivering health promotion in mental health. The supplement project involves a study of adaptations to an evidence-based intervention in routine mental health care settings. Adapting evidence-based interventions to fit provider

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characteristics, organizational contexts, and service settings may improve intervention delivery, patient engagement, and intervention effectiveness. However, modifying evidence-based interventions in the absence of guidance from theory and research may have a negative impact on implementation and patient-level outcomes. This study will specify and evaluate adaptations to an evidence-based health coaching intervention (InSHAPE) targeting obesity in persons with SMI implemented in 55 mental health agencies across the US. This research will yield insights into the dynamic process of adaptation in routine health care settings and their impact on implementation and participant outcomes. My expertise in adaptation research recently led to a new collaboration as a co-investigator on the Methods Core for the NCI-funded Implementation Science Center for Cancer Control Equity led by Dr. Karen Emmons at Harvard School of Public Health. I am co-leading a pilot study where we are developing and evaluating a guided adaptation process for a cancer screening protocol with stakeholders to ensure the successful implementation and sustainment of the protocol. This research will generate new methods to promote health equity for cancer control and prevention through stakeholder engagement.

Since joining the faculty at Geisel I have built a distinct and unique program of research using my expertise in behavioral interventions, peer and family social support, serious mental illness, community-engaged research, mixed methods, and implementation science. As evidence of the national recognition and impact of my work, I have been invited to participate as an ad hoc reviewer for six scientific review committees since 2016 at the National Institutes of Health. For the past two years I have served as a standing member on the only NIMH standing review committee, SERV (Mental Health Services Research Committee).

At Geisel, I have served on the Community Engagement Advisory Board for Dartmouth SYNERGY Clinical Translational Sciences Institute, a role that enabled me to have a direct impact on establishing standards and practices for partnered research at Dartmouth. In addition, my involvement in teaching and training at Geisel provides opportunities for students and fellows to receive guidance and mentoring on research development. I am a national mentor in the NIH sponsored Mixed Methods Research Training Program for the Health Sciences at Johns Hopkins Bloomberg School of Public Health.

My work involves a unique blend of intervention research, community-engagement, emerging technologies, mixed methods, and implementation science. I am leading several projects at the forefront of behavioral interventions and implementation science to promote health in vulnerable populations. My program of research has the potential for high impact on approaches to addressing health disparities and implementing and sustaining evidence-based health promotion programs in partnership with practice setting stakeholders.

Updated by: March 1, 2021

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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

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- 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

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Jeffrey C. Fetter, MD
New Hampshire Hospital
[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, 2020	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-Dec 2030	Board Certified in Psychiatry, Diplomate #60814
April 2010-present	Certified in Transcranial Magnetic Stimulation (Neurostar, Inc.)
Nov 2016-present	DEA Buprenorphine X-Waiver

Academic Appointment
July 2006-Jan 2010
Assistant Professor of Psychiatry
Geisel School of Medicine at Dartmouth

Hospital Appointments and Clinical Responsibilities

June 2020-Present
Chief Medical Officer
New Hampshire Hospital
Concord, NH

- Clinical oversight of state contract with Dartmouth-Hitchcock Health
- Supervision of 26 Providers

Aug 2018 – June 2020
Chief Medical Officer

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Riverbend Community Mental Health Center
Concord, NH

- Supervision of 18 providers: CSP, Inpatient, Child, Integration, MAT
- Assertive Community Treatment Team Psychiatrist
- 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 for 2400 inmates
- 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 (Until June 2020)
    - 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

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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-Dec 2018
Fellowship Committee, American College of Correctional Physicians

May 2016-May 2018
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

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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

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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
April 2020-present	Weekly COVID-19 Briefing for NH Community Mental Health Centers
Dec 23, 2020	"COVID-19 and the Mental Health System" NH CMHC Statewide Zoom
Dec 29, 2020	"COVID-19 Vaccination" Riverbend Community Mental Health, Inc.
Jan 7, 2021	"COVID-19 Vaccines for Mentally Ill Patients" NH Office of Public Guardian
Jan 21, 2021	"COVID-19 Vaccine Messaging and Disinformation" National Association of State Mental Health Program Directors
Feb 4, 2021	"COVID-19 Vaccine Messaging and Disinformation" NH Hospital Grand Rounds
Mar 10, 2021	"Involuntary Emergency Admissions" NH Hospital Association

Original Articles:

Fetter, JC. COVID-19 Vaccination Strategies in Public Psychiatry. Psychiatric Services 2021; 72(2). 10.1176/appi.ps.72203

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Fetter, JC. Framework for Psychiatrists' Role in the COVID-19 Response. Community Mental Health Journal 2021. Epub ahead of print.

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

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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

Other Activities:
October 2018-present: Den leader and Assistant Cubmaster, Cub Scout Pack 86, Concord NH
August 2020-present: Pandemic Policy Committee, Unitarian Universalist Church of Concord
2019-2020: Board of Directors, Unitarian Universalist Church of Concord
2015-present: Fiddle and 3-string Guitar, Wholly Rollers bluegrass/old time gospel band

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Debra A. Fournier, MHCDS, MSN, RN, APRN, ANP-BC, PMHNP-BC

[redacted]

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

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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

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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.

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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

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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.

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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

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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

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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

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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*

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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.

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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

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- 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

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Cathy Schen, MD
PGY4 psychotherapy supervisor
cathy-schen@hms.harvard.edu, 978.287.0104

Letters will be provided upon request.

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CURRICULUM VITAE

NAME: Robert M. Roth, Ph.D., ABPP-CN

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Department of Psychiatry
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Lebanon, NH 03753
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Phone (603) 650-5824
Fax (603) 630-0404

Date Prepared: March 1, 2021

I. EDUCATION

DATES	INSTITUTION	DEGREE
1994-2000	Concordia University, Montreal	Ph.D., Clinical Psychology
1991-1994	Concordia University, Montreal	M.A., Experimental Psychology
1987-1991	McGill University, Montreal	B.A., Psychology, with Honors

II. POSTDOCTORAL TRAINING

DATES	INSTITUTION	SPECIALTY
2000-2001	Neuropsychology & Neuroimaging Program, Department of Psychiatry, Dartmouth Medical School	Postdoctoral Fellowship in Neuropsychology and Neuroimaging
1999-2000	Neuropsychology Program, Department of Psychiatry, Dartmouth Medical School	Clinical Neuropsychology Internship
1998-1999	Department of Psychiatry, Yale University School of Medicine, New Haven, CT	Clinical Internship, Specialization in Clinical Neuropsychology

III. ACADEMIC APPOINTMENTS

DATES	INSTITUTION	TITLE
4/2011-Present	Geisel School of Medicine at Dartmouth, Hanover, NH	Associate Professor of Psychiatry
9/2004-4/2011	Geisel School of Medicine at Dartmouth, Hanover, NH	Assistant Professor of Psychiatry
2002-2012	Centre de Recherche Fernand Seguin, Montreal, Canada	Chercheur Associé
11/2001-9/2004	Dartmouth Medical School, Hanover, NH	Clinical Associate & Instructor in Psychiatry

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IV. INSTITUTIONAL LEADERSHIP ROLES:

DATES	INSTITUTION	TITLE
3/2019-10/2019, 8/2020-Present	New Hampshire Hospital, Concord, NH	Interim Director, Neuropsychology
3/2019-Present	Department of Psychiatry, DHMC/Geisel School of Medicine	Director of Clinical Neuropsychology Training
10/2018-2/2019	Department of Psychiatry, DHMC/Geisel School of Medicine	Associate Director of Clinical Neuropsychology Training
10/2010-Present	Department of Psychiatry, DHMC/Geisel School of Medicine	Director, Adult Neuropsychology
1/2009-6/2019	Hanover Psychiatry, Hanover NH	Director, Neuropsychology
01/07-09/2010	Department of Psychiatry, DHMC/Geisel School of Medicine	Coordinator, Clinical Neuropsychology Service
11/01-12/2006	Department of Psychiatry, DHMC/Geisel School of Medicine	Co-Coordinator, Clinical Neuropsychology Service

V. LICENSURE AND CERTIFICATION:

DATES	LICENSURE/CERTIFICATION
2017-Present	Board Certified in Clinical Neuropsychology (ABPP-CN; #8350)
2011-2019	Licensed Psychologist, Quebec (#11794-11)
9/2001-Present	Licensed Psychologist, State of New Hampshire (#974)

VI. HOSPITAL OR HEALTH SYSTEM APPOINTMENTS:

DATES	INSTITUTION	POSITION/TITLE
11/01-Present	Department of Psychiatry, DHMC/Geisel School of Medicine	Clinical Neuropsychologist
11/01-Present	New Hampshire Hospital, Concord, NH	Staff Neuropsychologist

VII. OTHER PROFESSIONAL POSITIONS:

DATES	INSTITUTION	POSITION/TITLE
2009-2012	Centre D'Etudes sur les Troubles Obsessionnels-Compulsifs et les Tics, Montreal	External member
06/96-08/96	Department of Psychology, University of New Mexico, Albuquerque, NM	Teaching Assistant, Child Psychopathology Laboratory
06/96-08/96	Department of Psychology, University of New Mexico, Albuquerque, NM	Research Assistant, Clinical Neuroscience Laboratory
1994-1998	Centre de Recherche Fernand Seguin, Hopital Louis H. Lafontaine, Montreal	Research Assistant, Neuropsychology Section
1991-1994	Department of Psychology, Concordia, Montreal	Teaching Assistant, Behavioral Disorders
1990-1991	Department of Psychology, McGill University, Montreal	Research Assistant, Alcohol Research Laboratory
1990-1991	Douglas Hospital / WHO, Collaborative Group on Mental Health, McGill University, Montreal	Research Assistant

VIII. PROFESSIONAL DEVELOPMENT ACTIVITIES (from 2016)

Not applicable

IX. TEACHING ACTIVITIES:

A. UNDERGRADUATE (COLLEGE) EDUCATION

Dates	Institution	Course Title	Role	Hours/ Year
1998	Concordia University	Fundamentals of Abnormal Psychology, Department of Psychology,	Lecturer	28 hrs

B. GRADUATE EDUCATION

Not applicable

C. UNDERGRADUATE MEDICAL EDUCATION:

Not applicable

i. CLASSROOM TEACHING:

Not applicable

ii. CLERKSHIP OR OTHER CLINICAL UME TEACHING (e.g., ON-DOCTORING)

Not applicable

D. GRADUATE MEDICAL EDUCATION

Dates	Institution	Course Title	Role	Hours/ Year
3/21/2019	DHMC	Psychology Intern Seminar	Presenter	1 hr
3/12/2018	DHMC	Memory and Other Cognitive Concerns in Older Adults. DHMC Associate Provider Meeting	Presenter	1 hr
11/7/2011	Geisel	Anxiety disorders. Scientific Basis of Medicine course	Presented	2 hrs
5/11/2010	WRJ VA	Neuropsychology of Selected Psychiatric Disorders. White River Junction Veteran's Hospital Intern Assessment Seminar	Presenter	1.5 hrs
2009-2012	DHMC	Intern Research Seminar, Dartmouth Medical School and White River Junction Veteran's Hospital	Organizer	20 hrs/yr
2/23/2009	DHMC	Apathy: From Stigma to neuroscientific understanding. Pathophysiology of Brain Disease course; Neuroscience Center at Dartmouth	Presenter	1 hr
2008-Present	DHMC	Professional Development Seminar for interns and post-doctoral fellows in Neuropsychology and Psychology	Organizer	12 hrs/yr
2006-2015	DHMC	Surviving your first year on the job. Professional Development Seminar for	Presenter	1 hr/yr

2006-2020	DHMC	interns and post-doctoral fellows in Neuropsychology and Psychology Lecture for PEMM students seminar; "Brain reward circuitry in co-occurring schizophrenia and substance use disorder"	Presenter	1.5 hrs/yr
2006	Dartmouth College	OCD; undergraduate Abnormal Psychology course, Department of Psychological & Brain Sciences	Presenter	1 hr
2003-Present	DHMC	Neuropsychology Seminar for interns and post-doctoral fellows in Neuropsychology	Organizer	50 hrs/yr
2003-2012	DHMC	Topics such as Critical issues in neuropsychological assessment; Neuropsychological assessment and reports; or Neuropsychology of psychiatric disorders. Psychology Intern Assessment Seminar	Presenter	1.5 hr/yr
2003-Present	DHMC	Topics such as Neuroimaging in Psychiatric Disorders, Neuropsychology: The basics, and Neuropsychology of Psychiatric Disorders. PGY I/II/IV Resident lecture series	Presenter	1-2 hrs/yr
2001-Present	DHMC	Supervision of clinical neuropsychology evaluations	Supervisor	600 hr/yr

E. OTHER CLINICAL EDUCATION (e.g., PA programs)

Clinical Training of Predoctoral Interns (Neuropsychology track) and Practicum Students in Neuropsychology:

DATES	STUDENT'S NAME	PROGRAM NAME	DEGREE
2001-2002	Laura Rabin	Fordham University (internship)	PhD
2001-2002	Anna Hutton	Pepperdine University (practicum)	PsyD
2002-2003	Marlana Borgos	University of Rhode Island (internship)	PhD
2003-2004	Howard Cleavinger	Brigham Young Universitt (internship)	PhD
2003-2004	Catherine Hynes	Dartmouth College (practicum)	PhD
2005-2006	Ellen Crouse	University of Montana (internship)	PhD
2005-2006	Matt Garlinghouse	Univ. of North Dakota (internship)	PhD
2007-2008	Jessica Englert	University of Buffalo (internship)	PhD
2008-2009	Lindsay Hines	Nova University (internship)	PhD
2009-2010	Vidya Kamath	University of Central Florida (internship)	PhD
2010-2011	Daniel Seichepine	Suffolk University (internship)	PhD
2011-2012	Shivani Patel	St. John's University (internship)	PhD
2011-2012	Rebecca Richards	Antioch University New England (internship)	PsyD
2012-2013	Fadi Tayim	Pacific Graduate School of Psychology (internship)	PhD
2012-2013	Crystal Lantrip	University of Texas-Austin (internship)	PhD
2013-2014	Rachel Baek	Ferkauf Graduate School of Psychology (internship)	PhD
2013-2014	Megan Baldassarre	Chicago School of Professional Psychology (internship)	PsyD
2014-2015	Joanna Peters	Ferkauf Graduate School of Psychology (internship)	PsyD

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2014-2015	Vanessa D'Orio	Ferkauf Graduate School of Psychology (internship)	PsyD
2015-2016	Katie Eichstaedt	Florida School of Professional Psychology (internship)	PsyD
2015-2016	Jami Halpern	La Salle University (internship)	PhD
2016-2017	Catherine Williams	Idaho State University (internship)	PhD
2016-2017	Andrea Jackson	University of Windsor (internship)	PhD
2017-2018	Zachary Merz	St. Louis University (internship)	PhD
2017-2018	Sloane Sheldon	Ferkauf Graduate School of Psychology (internship)	PhD
2018-2019	Bryant Duda	University of Georgia (internship)	PhD
2018-2019	Katelyn Gettens	University of Connecticut (internship)	PhD
2019-2020	Mirjana Ivanisevic	University of Kansas (internship)	PhD
2019-2020	Margaret Cadden	Penn State University (internship)	PhD
2020-2021	Tiffany Andersen	Eastern Michigan University (internship)	PhD
2020-2021	Jennifer Lee	Ferkauf Graduate School of Psychology (internship)	PhD

Clinical Training of Postdoctoral Fellows in Neuropsychology:

DATES	STUDENT'S NAME	SPECIALTY
2000-2002	Brenna McDonald, PsyD, ABPP	Clinical Neuropsychology
2001-2003	Juliana Ward, PhD, ABPP	Clinical Neuropsychology
2001-2003	John Randolph, PhD, ABPP	Clinical Neuropsychology
2002-2004	Franklin Brown, PhD, ABPP	Clinical Neuropsychology
2002-2005	Laura Rabin, PhD	Clinical Neuropsychology
2003-2005	Marlana Borgos, PhD	Clinical Neuropsychology
2004-2006	Howard Cleavinger, PhD	Clinical Neuropsychology
2004-2006	Nancy Koven, PhD	Clinical Neuropsychology
2004-2006	Nadia Pare, PhD	Clinical Neuropsychology
2005-2007	Ellen Crouse, PhD	Clinical Neuropsychology
2005-2007	Jo Cara Pendergrass, PhD	Clinical Neuropsychology
2006-2008	Angeles Cheung, PhD, ABPP	Clinical Neuropsychology
2006-2009	Matthew Garlinghouse, PhD	Clinical Neuropsychology
2007-2009	Laura Hoskins, PsyD	Clinical Neuropsychology
2007-2009	Sheba Kumbhani, PhD	Clinical Neuropsychology
2007-2009	Alanna Kessler, PsyD	Pediatric Neuropsychology
2008-2010	Tracy Kreiling (Carothers), PsyD	Clinical Neuropsychology
2008-2010	Jessica Englert, PhD	Clinical Neuropsychology
2009-2011	Eben Schwartz, PhD, ABPP	Clinical Neuropsychology
2009-2011	Wanda Reiman, PhD	Pediatric Neuropsychology
2009-2012	Evelyn Reilly, PsyD	Clinical Neuropsychology
2010-2012	Reid Kehoe, PsyD	Clinical Neuropsychology
2010-2012	Rayna Ericson (Hirst), PhD	Clinical Neuropsychology
2012-2014	Laszlo Erdodi, PhD	Clinical Neuropsychology
2012-2014	Brad Tyson, PsyD	Clinical Neuropsychology
2012-2014	Erin Almklov, PhD	Clinical Neuropsychology
2012-2014	Matthew Holcomb, Ph.D	Pediatric Neuropsychology
2013-2014	Jonathan Lichtenstein, PsyD	Pediatric Neuropsychology
2013-2015	Crystal Lantrip, PhD	Clinical Neuropsychology
2013-2015	Fadi Tayim, Ph.D	Clinical Neuropsychology
2014-2016	Megan Baldassarre, Psy.D, ABPP	Clinical Neuropsychology
2014-2016	Stephanie Towns, PhD, ABPP	Clinical Neuropsychology

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2014-2016	Maurissa Abecassis, Ph.D	Clinical Neuropsychology
2015-2017	Jeremy Carmasin, Ph.D	Clinical Neuropsychology
2015-2017	Nichole Miller, PsyD	Clinical Neuropsychology
2016-2018	Jami Halpern, PsyD	Clinical Neuropsychology
2016-2018	George Lin, PhD	Clinical Neuropsychology
2016-2018	Irving Arevalo, PhD	Clinical Neuropsychology
2017-2019	Catherine Williams, PhD	Clinical Neuropsychology
2017-2019	Andrea Jackson, PhD	Clinical Neuropsychology
2018-2020	Reema Jayakar, PhD	Clinical Neuropsychology
2018-2020	Amy Werry-McFarlin, PsyD	Clinical Neuropsychology
2018-2020	Cierra Keith, PHD	Clinical Neuropsychology
2018-2020	Jennifer Amato, PsyD	Pediatric Neuropsychology
2019-2021	Erica Pollock, PhD	Pediatric Neuropsychology
2019-2021	Grant Moncrief, PhD	Clinical Neuropsychology
2019-2021	Janelle Eloi, PsyD	Clinical Neuropsychology
2020-2022	Stephen Aita, PhD	Clinical Neuropsychology
2020-2022	Bryce Jacobson, PsyD	Clinical Neuropsychology
2020-2022	Christi Trask, PhD	Clinical Neuropsychology
2020-2022	Kelsey Grodner, PsyD	Pediatric Neuropsychology

X. PRIMARY RESEARCH ADVISING

A. UNDERGRADUATE STUDENTS

DATES	STUDENT'S NAME	PROGRAM (e.g., WISP, Presidential Scholar)
2006	Fiona Lundie	Women in Science Program (WISP) at Dartmouth
2006	Wei Diao	Women in Science Program (WISP) at Dartmouth

B. GRADUATE STUDENTS

DATES	STUDENT'S NAME	PROGRAM NAME	DEGREE
2010-2013	Adina Fischer	PEMM (MD/PhD)	MD-PhD

C. NON-DEGREE PROGRAM STUDENTS (e.g., certificate programs, post-baccalaureate programs)

Not applicable

D. MEDICAL STUDENTS

Not applicable

E. RESIDENTS/FELLOWS

DATES	MENTEE'S NAME	SPECIALTY
2001-2003	Juliana Ward, PhD	Clinical Neuropsychology
2002-2004	Franklin Brown, PhD	Clinical Neuropsychology
2004-2006	Howard Cleavinger, PhD	Clinical Neuropsychology
2004-2006	Nancy Koven, PhD	Clinical Neuropsychology
2005-2007	Jo Cara Pendergrass, PhD	Clinical Neuropsychology
2006-2009	Matthew Garlinghouse, PhD	Clinical Neuropsychology
2007-2009	Sheba Kumbhani, PhD	Clinical Neuropsychology

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2009-2011	Eben Schwartz, PhD	Clinical Neuropsychology
2010-2012	Reid Kehoe, PsyD	Clinical Neuropsychology
2012-2014	Laszlo Erdodi, PhD	Clinical Neuropsychology
2012-2014	Brad Tyson, PsyD	Clinical Neuropsychology
2012-2014	Erin Almklov, PhD	Clinical Neuropsychology
2013-2015	Crystal Lantrip, PhD	Clinical Neuropsychology
2013-2015	Fadi Tayim, PhD	Clinical Neuropsychology
2015-2017	Jeremy Carmasin, PhD	Clinical Neuropsychology
2016-2018	George Lin, PhD	Clinical Neuropsychology
2017-2019	Catherine Williams, PhD	Clinical Neuropsychology
2017-2019	Andrea Jackson, PhD	Clinical Neuropsychology
2018-2020	Reema Jayakar, PhD	Clinical Neuropsychology
2018-2020	Cierra Keith, PhD	Clinical Neuropsychology
2019-2021	Grant Moncrief, PhD	Clinical Neuropsychology
2019-2021	Janelle Eloi, PsyD	Clinical Neuropsychology
2020-2022	Stephen Aita, PhD	Clinical Neuropsychology
2020-2022	Christi Trask, PhD	Clinical Neuropsychology

F. FACULTY

DATES	MENTEE'S NAME	SPECIALTY
Not applicable		

G. ADDITIONAL INFORMATION

Not applicable

XI. ADVISING/MENTORING (OTHER) RESEARCH TEACHING/MENTORING

A. UNDERGRADUATE STUDENTS

DATES	STUDENT'S NAME	PROGRAM (e.g., WISP, Presidential Scholar)
2004-2005	Jennifer Kosty	Presidential Scholar Research Program, Dartmouth College, Department of Psychological & Brain Sciences
2005	Jeanna Farleigh	Presidential Scholar Research Program, Dartmouth College, Department of Psychological & Brain Sciences
2005-2006	Tara Muratore	Independent Research course, Dartmouth College, Department of Psychological & Brain Sciences
2005-2006	Laura Buzzuto	Work Study, Dartmouth College
2006	Timothy Laumann	Co-mentor of senior thesis, Department of Psychological & Brain Sciences Dartmouth College
2005-2007	Laura DeSouza	Presidential Scholar Research Program, Dartmouth College, Department of Psychological & Brain Sciences
2006-2007	Carlton P. Frost	Work Study, Dartmouth College
2006-2007	Shannon K. Hextrum	Work Study, Howard Hughes Medical Institute Research Fellow, Dartmouth College
2007	Ryan Griffin	External Examiner, Undergraduate senior thesis committee, Department of Psychology, Bates College,

		Lewiston, MA
2008	Jonathan Wolfe	Co-mentor of senior thesis, Department of Psychological & Brain Sciences Dartmouth College
2008-2009	Lynn Symonds	Presidential Scholar Research Program, Dartmouth College, Department of Psychological & Brain Sciences
2008-2009	Kathryn B. Holroyd	Howard Hughes Medical Institute Research Fellow; winner of a Goldwater Scholarship
2008-2009	Kelsey E. Sheehan	Co-mentor of senior thesis, Department of Psychological & Brain Sciences Dartmouth College; winner of a Neuroscience Center at Dartmouth Honors Thesis Prize
2009	Jacqueline Parker	Summer research fellow, Middlebury College, VT
2009-2010	Michelle R. VanTieghem	Research practicum, Twelve College Exchange at Dartmouth, Mount Holyoke College, MA
2010	Emily A. Mason	Research practicum, Beloit College, WI
2010	Kathleen F. O'Brian	Research practicum, Neuroscience Major at Dartmouth College
2011	Rosalind Isquith	Research practicum, Thetford High School
2012	Emma B. Steele	Research practicum, English major & Neuroscience Minor at Dartmouth College
2012	Emily A. Mason	Research practicum, Boston College
2012-2014	Hanna Kim	Junior Research Scholar, Dartmouth College
2015	Ramya Ghantasala	External Examiner, Undergraduate senior thesis committee, Department of Psychology, Bates College, Lewiston, MA
2019	Laina Fitzgerald	Research internship at NHH, University of New Hampshire
2019	Jacob Harper	Research practicum, Keene State College
2019	Michael Cheney	Research practicum, Keene State College

B. GRADUATE STUDENTS

DATES	STUDENT'S NAME	PROGRAM NAME	DEGREE
2006	Katherine Nutter-Upham	External Examiner, Master's Thesis Committee, Department of Psychology, Brooklyn College, Brooklyn, NY	MA
2007	Christopher S. Keene	External Examiner, Doctoral Dissertation Committee, Department of Psychological & Brain Sciences, Dartmouth College	PhD
2009	Geneviève Thibault	External Examiner, Doctoral Dissertation Committee, Department of Psychology, University of Montreal	PhD
2009	Shannon Coleman	External Examiner, Doctoral Dissertation Committee, Department of Psychology, SUNY - Binghamton, Binghamton, NY	PhD
2015	Anna Polotskaia	External Examiner, Doctoral Dissertation Committee, Department of Educational & Counselling Psychology, McGill University, Montreal, Canada	PhD
2021	Skylee Campbell	Dissertation Reader, Clinical Psychology program,	PsyD

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Chicago School of Professional Psychology,
Chicago, IL

C. MEDICAL STUDENTS
Not applicable

D. RESIDENTS/FELLOWS/RESEARCH ASSOCIATES
Not applicable

E. FACULTY

DATES	MENTEE'S NAME	SPECIALTY

Not applicable

XII. Engagement, Community Service/Education
Not applicable

XIII. RESEARCH ACTIVITIES (reverse chronological order)

RESEARCH FUNDING:

A. Sponsored Activity (grants and contracts)

MS190134 (Wishart) 7/1/2020 – 6/30/2022
Department of Defense, MS Research Program $149,997 .24 calendar
A self-administered, motor-free, cognitive screening battery for MS: Development and initial validation.
This projects seeks to evaluate the utility of a tablet based, self-administered, voice-recognition based neuropsychological test battery in patients with MS.
Role: Co-investigator

R15 (Rabin) 2/01/2020 – 12/31/2022
NIA 1R15AG066039-01 $349,904
Novel Multimodal assessment of practical judgment across the Alzheimer's continuum: Toward a better understanding of how to predict risk in the elderly.
This study examines practical judgement ability and its corresponding biological underpinnings in distinct preclinical and clinical neurodegenerative conditions including MCI, AD, FTD, and vascular dementia. Neuroimaging will be used to assess structural and functional correlates of impaired practical judgment.
Role: Consultant

1R01DA034699-01A1 (Green) 9/15/2013-5/31/2020
NIDA $510.523 .60 calendar
Cannabis, Schizophrenia and Reward: Self-Medication and Agonist Treatment?
The goal of this study is to use fMRI to confirm whether a brain reward circuit dysfunction in patients with schizophrenia and co-occurring cannabis use disorder, or with cannabis use disorder only, will be normalized when patients smoke cannabis or are administered dronabinol.
Role" Co-investigator

Reeves (Robbins) 7/1/2019-6/30/2021

Reeves Foundation $50,000 0.24 calendar
Does noradrenergic dysfunction explain the association between orthostatic hypotension and neuropsychiatric symptoms in Parkinson's disease?
In this study, we are evaluating whether noradrenergic (NA) dysfunction underlies the comorbidity between orthostatic hypotension and non-motor symptoms (cognitive and neuropsychiatric) of PD. A series of physiologic tests will be used to elucidate the contributions of central and peripheral NA dysfunction in OH in PD, including administration of yohimbine as a pharmacologic tool to study the NA system in the illness.
Role: Co-investigator

RO1 DC009972 Supplement (Buckey) 7/01/2019 - 6/30/2020
NIDCD $100,621 1.2 calendar
Auditory brain function as a marker for Alzheimer's disease
The goal of this project is to determine if central auditory tests could serve as a marker for mild cognitive impairment (MCI; amnestic and amnestic multi-domain subtypes), and could assist with risk prediction for cognitive decline and the development of Alzheimer's disease. The study will relate central auditory network findings in individuals with MCI to central auditory test findings and neuropsychological test performances.
Role: Co-investigator

Hitchcock Foundation Pilot Grant (Boone) 7/1/2019 – 6/30/2020
DHMC $40,000 0.6 calendar
The role of brain wave monitoring in reducing the incidence of postoperative cognitive dysfunction
In this project, we will monitor brain wave activity (EEG) during surgery to adjust the amount of general anesthesia delivered in order to reduce the risk of receiving too much anesthesia. The study will determine whether such monitoring is a promising way to reduce the risk of developing postoperative cognitive dysfunction (POCD) in older adults.
Role: Co-investigator

1R01AG067416-01 (Liang) 9/30/2019 - 5/31/2023
NIH (DHHS) $300,000 1.8 calendar
SCH: INT: Collaborative Research: Exploiting voice assistant systems for early detection of cognitive decline
This project aims to develop a low-cost, passive, and practical cognitive assessment method using Voice Assistant Systems (VAS) for early detection of cognitive decline. If successful, the proposed system may be widely disseminated for the early diagnosis of cognitive impairment to complement existing diagnostic modalities that could ultimately enable long-term patient and caregiver planning to maintain individual's independence at home.
Role: Co-investigator

A13-090 (Clavier) 1/2015 - 3/2019
Department of Defense $251,784 1.2 calendar
Self-Administered Neuropsychological Assessment Battery
Role: Co-Investigator

U48DP005018-S1 (Jobst) 9/2014-9/2019
Centers for Disease Control and Prevention $350,000 .24 calendar
Reducing disparities in health for vulnerable populations in NH & VT (category 2). Home based self-management and cognitive training changes lives (HOBSCOTCH);
Role: Co-Investigator

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01DA032533 (green) 7/2012-3/2017
National Institute on Drug Abuse) $733,292 0.3 calendar
Clozapine for cannabis use disorder in schizophrenia.
Role: Co-Investigator

(McAllister) 1/2009-12/2009
Philips $60,000
Rapid volumetric and shape analysis (surface deformation/adaptation) of targeted brain regions in neuropsychiatric disorders.
Role: Co-investigator

No Number 7/2008-6/2009
Dartmouth Department of Psychiatry Gary Tucker Junior Investigator Research Award $15,000
ERP and fMRI investigation of the effects of threat on performance monitoring.
Role: PI

No Number (Garlinghouse) 7/2007-6/2009
NARSAD Young Investigator Award $60,000
National Alliance for Research on Schizophrenia and Depression
Reward circuitry in schizotypal personality disorder.
Role: Co-mentor

No Number 2005-2006
Neuroscience Center at Dartmouth $19,000
fMRI of response inhibition in children with obsessive-compulsive disorder.
Role: PI

(Kikinis) 2004-2006;
NIH - National Alliance for Medical Image Computing $167,985
Structural and functional connectivity in schizophrenia
Role: Co-investigator

No Number 2004-2007
Hitchcock Foundation, Joshua Burnett Clinical Research Fellowship $290,980
Neuroimaging of reward circuitry in comorbid schizophrenia and substance use disorder.
Role: PI

R21 A019215-01 (Green) 2004-2006
National Institute on Drug Abuse $275,000
Cannabis and schizophrenia: fMRI of reward circuitry biomarker.
Role: Co-investigator

(Gioia) 2003-2007
Centers for Disease Control $1,455,273
Outcome measurement of mild traumatic brain injury in children and adolescence.
Role: Co-investigator

No Number 2002-2003
Anxiety Disorders Association of America Junior Faculty Research Grant $30,000
fMRI study of neural changes following treatment in PTSD.

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Role: PI

No Number 2002-2004
NARSAD Young Investigator Award $60,000
Structural MRI and fMRI study of inhibition in bipolar disorder.
Role: PI

No Number 2000-2001
Obsessive Compulsive Foundation of America $25,000
Functional MRI of inhibition in obsessive-compulsive disorder
Role: PI

No Number 1994-1996
Fonds Pour La Formation de Chercheurs et L'Aide a la Recherche Bourse D'Excellence $39,000 (CDN)
A multimodal evaluation of executive functions in obsessive compulsive disorder.
Role : PI

B. PENDING SUBMISSIONS

NIDCD R21 (Buckey) $513,607 .24 calendar
Detecting Central Nervous System Dysfunction using Central Auditory Tests in patients with persistent COVID-19 symptoms
This collaborative study with the University of Connecticut seeks to determine whether tests of central auditory processing can be used to identity neural changes in patients with persistent mental fatigue due to COVID-19.
Role: Co-Investigator

NIH R01 (Buckey)
Predicting HIV Cognitive Outcomes Using Central Auditory Tests
The project, a longitudinal extension of prior work, involves a unique cohort of HIV+ and HIV- individuals in Tanzania having tests of both tests of central auditory processing (CAP) and neurocognition collected over several years. The project seeks to determine whether integrity of CAP can predict neurocognitive outcomes in those who are HIV+.
Role: Co-Investigator

COBRE NIH P20 (Jobst)
The Dartmouth-Hitchcock Center of Neurocircuitry and Neuromodulation (DH-CNN)
We propose to develop a multidisciplinary center to study the neurocircuitry underlying neuropsychiatric disorders with the goal of understanding the biologic characteristics of such disorders on an individual basis, thus allowing for personalization of therapeutic interventions such as neurostimulation, pharmacology, or psychotherapy.
Role: Co-investigator [Director of Clinical Assessment and Biostatistics Core]

XIV. PROGRAM DEVELOPMENT

Clinical
Adult Neuropsychology Service at DHMC: As Director of the service, expanded workforce and clinical services, as well as enhanced efficiency of clinical care. Some examples include increasing access to services to internal and external providers, improved coordination with

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Neurology and Radiology to facilitate provision of Wada test presurgical patients, developed and implemented pre-DBS neuropsychological evaluations for patients with movement disorders, and developed and implemented computerized procedures to heighten accuracy and efficiency of clinical report completion.

Neuropsychology Service at Hanover Psychiatry: Founded this service, including related Adult ADHD Clinic, at Hanover Psychiatry in 2009 and served as director until July 2019. Grew the service to include a postdoctoral fellow, expanded clinical services to include multidisciplinary evaluations (neuropsychology, psychiatry, clinical psychology), including providing neuropsychological and psychoeducational evaluations for older adolescents and college students at Dartmouth and elsewhere.

Healthy Aging Brain Clinic (HABC) & Cognition in Older Adults (COA) Clinic at DHMC: In collaboration with faculty in DHMC Psychiatry and Neurology, developed the HABC Clinic (2014-2018) and with Neurology the newer version of the clinic, the COA Clinic (2019 – ongoing). This clinic provides multidisciplinary evaluations for older adults with cognitive concerns to inform differential diagnosis and treatment planning. Developed a Multidisciplinary PET/CT Case Conference in collaboration with faculty in Neurology and Radiology to review cases of older adults where there is concern for MCI or dementia.

Huntington's Disease (HD) Clinic at DHMC: In collaboration with faculty in DHMC Neurology, developed and implemented neuropsychological evaluations (2019 – ongoing) as part of this multidisciplinary clinic.

Educational

Clincial Neuropsychology Training Program at Dartmouth: Assumed director role in March, 2019. Developed clinical training opportunities for interns and postdoctoral fellows in clinical neuropsychological evaluation and multidisciplinary collaboration at DHMC as part of the HABC/COA and HD Clinics, as well as the Multidisciplinary PET/CT Case Conference. Offer training on conducing Wada tests to interns and postdoctoral fellows in neuropsychology (since 2001). Provide opportunities for residents in psychiatry and neurology at DH to shadow and learn about neuropsychological evaluations services.

Currently collaborating with neuropsychologists/licensed psychologists in New Hampshire, Vermont, and Maine to develop the *Northern New England Neuropsychological Association* (NNENA). There are few opportunities for neuropsychologists, and trainees with an interest in neuropsychology, in northern New England to interact and discuss important issues in the field in general, as well as issues especially relevant to practicing in this region (e.g., assessment of rural populations). This association, intended to be a non-profit, seeks to remedy the dearth of opportunities.

Research

Brain Research Network at Dartmouth: Co-founded the multidisciplinary Brain Research Network at Dartmouth in 2018. This group of researchers seeks to enhance collaborative research and funding at Dartmouth.

XV. ENTREPRENEURIAL ACTIVITIES

Not applicable

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XVI. MAJOR COMMITTEE ASSIGNMENTS, INCLUSIVE OF PROFESSIONAL SOCIETIES

A. National/international

DATES	COMMITTEE	ROLE	INSTITUTION
2018-2023	Clinical Research Grants Committee	Chair	National Academy of Neuropsychology

B. Regional

DATES	COMMITTEE	ROLE	INSTITUTION
Not applicable			

C. Institutional

DATES	COMMITTEE	ROLE	INSTITUTION
Not applicable			

XVII. INSTITUTIONAL CENTER OR PROGRAM AFFILIATIONS

Not applicable

XVIII. EDITORIAL BOARDS:

DATES	SOCIETY/JOURNAL	ROLE
2017-Present	Frontiers in Psychiatry (Addictive Disorders)	Review editor
2007-Present	Brain Imaging and Behavior	Member

XIX. JOURNAL REFEREE ACTIVITY:

JOURNAL NAME	NUMBER OF REVIEWS
Aging and Mental Health	1
Aggressive Behavior	1
American Journal of Addictions	1
American Journal of Geriatric Psychiatry	1
American Journal of Psychiatry	2
Applied Cognitive Psychology	1
Applied Neuropsychology	5
Archives of Clinical Neuropsychology	8
Archives of General Psychiatry	2
Biological Psychiatry	6
Biological Psychology	5
BMC Psychiatry	1
Brain and Cognition	1
Brain Imaging and Behavior	34
Child Neuropsychology	1
Criminal Justice and Behavior	1
Depression and Anxiety	1
Drug and Alcohol Dependence	1

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European Archives of Psychiatry and Clinical Neuroscience	1
European Psychiatry	2
Frontiers in Psychiatry	4
International Journal of Geriatric Psychiatry	1
International Psychogeriatrics	1
JAMA	1
Journal of Anxiety Disorders	1
Journal of Clinical and Experimental Neuropsychology	1
Journal of Clinical Psychopharmacology	3
Journal of Cognitive Neuroscience	1
Journal of Dual Diagnosis	1
Journal of the International Neuropsychological Society	17
Journal of Mental Health	1
Journal of Nervous and Mental Disease	1
Journal of Neuropsychiatry & Clinical Neurosciences	4
Journal of Neuroscience Methods	1
Journal of Personality and Social Psychology	1
Journal of Psychiatric Neuroscience	1
Journal of Psychiatric Research	1
Journal of Psychiatry and Neuroscience	1
Journal of Psychopharmacology	1
Journal of Substance Abuse Treatment	6
Mental Illness	1
Neuroscience Letters	1
NeuroImage	1
Neuropsychology	10
Neuropsychology Review	1
Neuropsychologia	1
Neuropsychopharmacology	2
Pediatrics	1
PLOS One	1
Progress in Neuropsychopharmacology & Biological Psychiatry	1
Psychiatrics	1
Psychiatry Research	1
Psychiatry Research: Neuroimaging	1
Psychological Injury and Law	2
Psychological Medicine	1
Psychological Reports	1
Revue Santé Mentale au Québec	1
Schizophrenia Research	10
Social, Cognitive and Affective Neuroscience	1
Social Psychiatry and Psychiatric Epidemiology	1
Substance Use and Misuse	3
The Clinical Neuropsychologist	3

XX. AWARDS AND HONORS:

DATE	AWARD
1995-1996	American Psychological Foundation Graduate Research Scholarship in Psychology
1994-1996	Concordia University External Grant Holder's Doctoral Scholarship for

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Superior Academic Achievement

XVII. MEMBERSHIPS, OFFICE AND COMMITTEE ASSIGNMENTS IN PROFESSIONAL SOCIETIES:

Memberships:

DATES	SOCIETY	ROLE
2017-Present	American Academy of Clinical Neuropsychology	Member
2010-Present	National Academy of Neuropsychology	Member
2005-2012	Scientific advisory board for annual Human Brain Mapping conference	Member
2002-2012	Organization for Human Brain Mapping	Member
2000-Present	International Neuropsychological Society	Member
2000-2010	Obsessive-Compulsive Foundation	Professional Member

National/international committees:

DATES	COMMITTEE	ROLE	INSTITUTION
2018-2021	Annual Conference Program committee	Reviewer	American Academy of Clinical Neuropsychology
2018	Program Committee, mid-year meeting	Member	International Neuropsychological Society
2015-2017	Clinical Research Grants Committee	Member	National Academy of Neuropsychology
2012, 2014	Review Committee; Clinical Training Research Fellowship: Neuroscience & Mental Health Board	Reviewer	Medical Research Council (U.K.)
2011-2014	Advisory Committee	Consultant	Exploration of Neurocognition and Executive Function in MDD Advisory Board (Shire Pharmaceuticals)
2011-2013	Program Committee	Member	International Neuropsychological Society
2010	Review Committee	Reviewer	The Netherlands Organization for Scientific Research Innovational Research Incentives Scheme Vici 2010 MaGW
2009	Review Committee	Reviewer	City University of New York Collaborative Incentive Research Grant (CIRG) Program
2008-2009	Clinical Pilot Research Fund	Reviewer	University of Kansas Medical Center Research Institute; at request of the American

2006	Review Committee	Reviewer	Association for the Advancement of Science (AAAS) Research Competitiveness Program National Institute on Drug Abuse Imaging-Science Track Award for Research Transition (I/START) Program

Regional committees:

DATES	COMMITTEE	ROLE	INSTITUTION
2009	Review Committee	Reviewer	Neurogenetics Seed Grant Program, Maine Institute of Human Genetics and Health (MIHGH)

Institutional committees:

DATES	COMMITTEE	ROLE	INSTITUTION
2020	Adult neuropsychologist search committee	Member	DHMC / Geisel School of Medicine
2020	Child neuropsychologist search committee	Member	DHMC / Geisel School of Medicine
2020-Present	Education Policy Committee	Member	Department of Psychiatry, DHMC
2019-present	Grand Rounds Committee	Member	Department of Psychiatry, DHMC
2019-Present	Research Innovation Group (RIG)	Member	New Hampshire Hospital
2019	Adult neuropsychologist search committee	Member	DHMC / Geisel School of Medicine
2018-Present	Brain Research Network at Dartmouth	Founding Member	DHMC / Geisel School of Medicine
2014	Grant review committee	Reviewer	Hitchcock Foundation, DHMC
2008	Poster Review Committee	Member	Student Poster Prizes, Neuroscience Day at Dartmouth, Hanover, NH
2007-2008	Subcommittee, Departmental Data Safety Monitoring Board Scientific Review Committee	Member	Department of Psychiatry, Dartmouth Medical School
2007	Review Committee	Reviewer	Blake Fellowship, Hitchcock Foundation, Lebanon, NH
2006-2007	Systems administrator / programmer search committee	Co-Chair	Brain Imaging Laboratory, Department of Psychiatry, Dartmouth Medical School
2006	Subcommittee on junior faculty research grants, Scientific Review Committee	Member	Department of Psychiatry, Dartmouth Medical School
2006-2012	Scientific Review Committee	Member	Department of Psychiatry, Dartmouth Medical School
2004-Present	Recruitment, Residency Training Program	Interviewer	Department of Psychiatry, Dartmouth Medical School

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XXI. INVITED PRESENTATIONS:

- * presentations to which you, individually, were extended an invitation to present
- # presentations that were meetings where you presented a poster/talk, but not following a personalized invitation.
- ^ talk/presentation was applicable as a CME activity.

A. International:

DATE	TOPIC/TITLE	ORGANIZATION	LOCATION
10/4/2019	But it's Subjective! Evidence supporting the validity and utility of executive function rating scales*^	Regional Assessment and Resource Centre, Queen's University	Kingston, ON
10/4/2019	Cannabis use in schizophrenia: From epidemiology to neurobiology*^	Regional Assessment and Resource Centre, Queen's University	Kingston, ON
4/1/2016	From here to modernity: Enhancing everyday evaluations (with Isquith)*	Lester B. Pearson School Board	Montreal, QC
2012	Video, Web, and Computer Technology in Assessment*	Moderator	Paper session at the International Neuropsychological Society annual meeting, Montreal
3/15/2012	Executive functions: From assessment to neuroscience (with Isquith)*^	Lester B. Pearson school board	Montreal, QC
8/26/2011	Executive Functions: From concepts and assessment to neuroscience*	Hôpital Louis-H. Lafontaine	Montreal, QC
2/07/2010	Orbitofrontal morphology correlates with cognitive flexibility and memory in bipolar disorder (with Kamath, Garlinghouse, Flashman, Saykin)#	38th Annual Meeting of the International Neuropsychological Society,	Acapulco, Mexico
11/08/2008	An update on neuroscience research on OCD*	6th Annual Meeting of the Quebec Obsessive Compulsive Foundation	Montreal, QC
12/02/2005	Neuroimaging of frontal-subcortical circuitry in obsessive-	Centre de Recherche Fernand Seguin	Montreal, QC.

	compulsive disorder*		
11/12/2005	OCD and the brain: Imaging symptoms and cognition.*	3rd Annual Meeting of the Quebec Obsessive Compulsive Foundation	Montreal, QC
12/2001	Contribution of executive functions to memory deficits in adults with ADHD (with Wishart, Flashman, Saykin, Riordon, Huey)#	29th Annual Meeting of the International Neuropsychological Society	Chicago, IL

B. National:

DATE	TOPIC	ORGANIZATION	LOCATION
2/7/2020	Transforming our understanding of children: Profiles in everyday executive functioning#^	National Association of School Psychologists	Baltimore, MD
10/25/2017	Writing a successful NAN clinical research grant*	37th Annual Conference of the National Academy of Neuropsychology	Boston, MA
8/30/2012	Executive functions: Concepts, assessments and clinical presentations (with Isquith)*	Neurodevelopmental Science Center	Akron, OH
2/03/2010	Introduction to the TEC: A novel measure of executive function (with Isquith, Gioia)#^	Annual Conference of the National Academy of School Psychologists	Chicago, IL
11/13/2009	The Tasks of Executive Control (with Isquith, Gioia)#^	29th Annual Conference of the National Academy of Neuropsychology	New Orleans, LA
9/14/2009	Neuroimaging in co-occurring schizophrenia and substance use disorder*	NIAAA Neuroscience Work Group: Toward Optimal Treatment for Schizophrenia and Co-Occurring Alcohol Use Disorder	Fairlee, VT
11/15/2008	Executive functions in health and illness*^	Gallaudet Neuropsychology Conference, Gallaudet University	Washington, DC
5/11/2006	Neuroimaging and the neurobiology of OCD*	Colloquium Sponsored by the Department of Psychology, Brooklyn College	New York, NY

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10/2005	The Behavioral Rating Inventory of Executive Function - Adult version (with Isquith, Gioia)#^	25th Annual Conference of the National Academy of Neuropsychology	Tampa, FL
4/1996	Consciousness and the Capgras syndrome: A neuropsychological perspective (with Baribeau, Debruille)#	Tuscon III: Towards a Science of Consciousness	Tucson, AZ

C. Regional/Local:

DATE	TOPIC	ORGANIZATION	LOCATION
11/29/2016	An overview of research on cognitive concerns in older adults*^	Department of Psychiatry Grand Rounds, DHMC	Lebanon, NH
10/28/2016	Cognitive concerns in older adults*^	Neurology for the Non-Neurologist Conference	Essex, VT
4/18/2015	Cognition in adults with epilepsy*^	Epilepsy Foundation of New England	Lebanon, NH
10/24/2014	Is it Adult ADHD? The Value of Neuropsychology*^	Neurology for the Non-Neurologist Conference	Essex, VT
10/18/2014	Adult ADHD: Diagnosis Du Jour? *^	New England Psychological Association Meeting	Lewiston, Maine
4/25/2014	Neuropsychological assessment in adult ADHD: Why bother?*^	Department of Neurology Grand Rounds, Dartmouth	Lebanon, NH
4/10/2014	Neuropsychological assessment in adult ADHD: Why bother?*	Riverview Psychiatric Center	Augusta, ME
11/3/2012	Neuroscience of executive functions: Implications for assessment and treatment*^	Main Psychological Association	Lewiston, ME
12/20/2011	Executive functions: What are they and why you should care*^	Department of Psychiatry Grand Rounds, Dartmouth Medical School	Lebanon, NH
10/21/2011	Losing your mind*	Pathways: Lost and Found (undergraduate course); Colby-Sawyer College	New London, NH
5/20/2011	The Neuroscience of OCD*^	Department of Neurology Grand Rounds,	Lebanon, NH

		Dartmouth Medical School	
10/23/2010	Neuroscience of OCD and its implications for treatment*^	New Hampshire Psychological Association Fall Conference	Jackson, NH
1/18/2010	Neuroimaging of addiction: Reward, executive dysfunction and beyond*	Dartmouth Center on Addiction Recovery and Education	Hanover, NH
10/17/2009	Executive functions: From assessment to intervention (with Isquith)#^	New Hampshire Psychological Association Conference	Jackson, NH
9/14/2008	Toward the prevention of severe mental illness and substance abuse: Brain reward circuits (with Green)*	Healthy Minds Across America: NARSAD Sponsored Public Forums on the Progress, Challenges and Promise of Mental Health Research	Lebanon, NH
3/23/2008	Apathy in neuropsychiatric disorders*^	Department of Psychiatry, Dartmouth Medical School Grand Rounds	Lebanon, NH
4/27/2007	The many faces of schizophrenia: Symptoms, cognition, and neuroimaging*	Department of Psychology, Bates College	Lewiston, Maine
11/17/2006	Neuropsychological assessment: The basics*^	Neurology Mega Rounds, Dartmouth Hitchcock Medical Center	Lebanon, NH
11/03/2006	Executive functions across the lifespan: Conceptualization and assessment (with Isquith)#^	Massachusetts Psychological Association	Boston, MA
10/26/2006	Inhibitory control in obsessive-compulsive disorder: From Freud to fMRI*	Symposium on Brain Imaging Research at Dartmouth College	Hanover, NH
10/06/2006	Schizophrenia and Substance Abuse: Is it all about reward? (with Green)*	New Frontiers in Psychiatry; Sponsored by Dartmouth-Hitchcock Medical Center	Stowe, VT
9/29/2006	Executive functions across the lifespan: Conceptualization and Assessment (with Isquith)#^	New Hampshire Psychological Association	Concord, NH

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8/23/2006	Clinical neuroscience of the child and adolescent brain*	Heath Care and Rehabilitation Services of Southeastern Vermont	Bellows Falls, VT
1/31/2006	Thinking again about the brain in obsessive-compulsive disorder*^	Department of Psychiatry, Dartmouth Medical School Grand Rounds	Lebanon, NH
12/06/2005	Advances in the neuroimaging of obsessive-compulsive disorder*	Dartmouth College Health Services	Hanover, NH
10/14/2005	Feeling good about reward*	New Hampshire Hospital Psychology Service Annual Retreat	Lebanon, NH
9/16/2005	Schizophrenia, co-occurring substance use disorder, and the brain reward system (with Green)*	Psychiatric Research Center at Dartmouth	Lebanon, NH
4/21/2005	Obsessive-compulsive disorder: From Freud to fMRI*	New Hampshire Hospital Professional Grand Rounds	Concord, NH
9/22/2002	Neuroimaging in OCD*	Symposium, 10 Years of Clinical Neuroscience & Neuroimaging at Dartmouth	DHMC, Lebanon, NH

XXII. BIBLIOGRAPHY:

A. Peer-reviewed publications in print or other media

1. Most significant publications (3-5):

a. Provide a list (3-5) of those publications* in print or other media that *you consider* having the highest impact/significance. (Candidates should address in personal statement or here why so designated).

- **Roth, R.M.**, Flashman, L.A., Saykin, A.J., McAllister, T.W., & Vidaver, R. (2004). Apathy in schizophrenia: Reduced frontal volume and neuropsychological deficits. American Journal of Psychiatry, 161: 157-159.

- **Roth, R.M.**, Isquith, P.K., & Gioia, G.A. (2005). BRIEF-A: Behavior Rating Inventory of Executive Function - Adult Version. Lutz, FL: Psychological Assessment Resources.

- **Roth, R.M.**, Saykin, A.J., Flashman, L.A., Pixley, H.S., & West, J.D. (2007). Event-related fMRI of response inhibition in obsessive-compulsive disorder. Biological Psychiatry, 62: 901-909.

- Caller, T.A., Ferguson, R.J., **Roth, R.M.**, Secore, K.L., Alexandre, F.P., Zhao, W., Tosteson, T.D., Henegan, P.L, Birney, K., & Jobst, B.C. (2016). A cognitive behavioral intervention (HOBSCOTCH) improves quality of life and attention in epilepsy. Epilepsy and Behavior, 57(Pt A), 111-117. doi: 10.1016/j.yebeh.2016.01.024.

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2. All other publications (excluding any listed in part 1)

b. Original peer-reviewed articles:

1. **Roth, R.M.**, & Baribeau, J. (1996). Performance of subclinical compulsive checkers on putative tests of frontal and temporal lobe memory functions. The Journal of Nervous and Mental Disease, 184: 411-416.

2. Baribeau, J., Berman, B., Atkin, A., & **Roth, R.M.** (1996). Musical experience and auditory P300 in a divided attention task. Brain and Cognition, 30: 378-380.

3. Baribeau, J., **Roth, R.M.**, & Velikonja, K. (1996). Auditory brain potentials in musicians: Effects of attention, task difficulty and ear of stimulation. Brain and Cognition, 32(2): 296-299.

4. Milovan, D., Baribeau, J., **Roth, R.M.**, & Achim, A. (1996). Processing of semantic ambiguity as reflected by event-related negativities. Brain and Cognition, 32: 131-135.

5. **Roth, R.M.**, & Baribeau, J. (1997). Gender and schizotypal personality features. Personality and Individual Differences, 22 (3): 411-416.

6. **Roth, R.M.**, Milovan, D.L., Baribeau, J., & Stip, E. (1999). Visual P300 in treatment-refractory schizophrenic patients. Brain and Cognition, 40 (1): 247-251.

7. **Roth, R.M.**, & Baribeau, J. (2000). The relationship between schizotypal and obsessive-compulsive features in university students. Personality and Individual Differences, 29 (6): 1083-1093.

8. Wishart, H.A., Roberts, D.W., **Roth, R.M.**, McDonald, B.C., Coffey, D.C., Mamourian, A.C., Hartley, C., Flashman, L.A., Fadul, C.E., & Saykin, A.J. (2003). Chronic deep brain stimulation for the treatment of tremor in multiple sclerosis: Review and case reports. Journal of Neurology, Neurosurgery, and Psychiatry, 74: 1392-1397.

9. **Roth, R.M.**, Wishart, H.A., Flashman, L.A., Saykin, A.J., Riordon, H., & Huey, L. (2004). Contribution of organizational strategy to verbal learning and memory in adult ADHD. Neuropsychology, 18(1): 78-84.

10. Milovan, D., Baribeau, J., **Roth, R.M.**, & Stip, E. (2004). ERP study of pre-attentive auditory processing in treatment-refractory schizophrenia. Brain and Cognition, 55: 355-357.

11. **Roth, R.M.**, Milovan, D.L., Baribeau, J., O'Connor, K., & Todorov, C. (2004). Organizational strategy use in obsessive-compulsive disorder. Psychiatry Research, 128: 267-272.

12. **Roth, R.M.**, Baribeau, J., Milovan, D., O'Connor, K., & Todorov, C. (2004). Procedural and declarative memory in obsessive-compulsive disorder. Journal of the International Neuropsychological Society, 10(5): 647-654.

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Kumbhani, S.R., **Roth, R.M.**, Kruck, C.L., Flashman, L.A., & McAllister, T.W. (2008). Obsessive compulsive symptom subtypes and executive functioning in schizophrenia. Poster presented at the *28th Annual Meeting of the National Academy of Neuropsychology*, New York. Archives of Clinical Neuropsychology, 23, p. 726.

Pixley, H.S., Kruck, C.L., **Roth, R.M.**, Garlinghouse, M.A., Flashman, L.A., & McAllister, T.W. (2008). The utility of the Cognitive Estimation Test in schizophrenia and bipolar disorder. Poster

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presented at the *28th Annual Meeting of the National Academy of Neuropsychology*, New York. Archives of Clinical Neuropsychology, 23, p. 727.

Kruck, C.L., **Roth, R.M.**, Garlinghouse, M.A., Flashman, L.A., & McAllister, T.W. (2008). Inferential reasoning impairment in schizophrenia-spectrum disorders. Poster presented at the *28th Annual Meeting of the National Academy of Neuropsychology*, New York. Archives of Clinical Neuropsychology, 23, p. 727.

Cheung, A.M., Hoskins, L.L., **Roth, R.M.**, McAllister, T.W., Flashman, L.A., McDonald, B.C., & Saykin, A.J. (2008). Self- and informant reports of executive function on the BRIEF-A in mild traumatic brain injury (mTBI). *Proceedings of the American Academy of Clinical Neuropsychology*

Roth, R.M., Jobst, B.C., Thadani, V.M., Gilbert, K.L., & Roberts, D.W. (2008). New onset obsessive compulsive disorder following resection of right hippocampus and occipital pole: A case study. Poster presented at the *Annual Meeting of the American Epilepsy Society.*

Vaughan, C.G., Vincent, D.T., Leaffer, E., Schneider, J.C., **Roth, R.M.**, Isquith, P.K., & Gioia, G.A. (2008). Psychometric properties of a working memory and inhibitory control battery for use in pediatric concussion evaluation. Presented at the 3rd International meeting of the Concussion in Sport Group, Zurich, Switzerland.

Vaughan, C.G., Vincent, D.T., Leaffer, E., Schneider, J.C., **Roth, R.M.**, Isquith, P.K., & Gioia, G.A. (2008). Clinical utility of a working memory and inhibitory control battery for use in pediatric concussion evaluation. Presented at the 3rd International meeting of the Concussion in Sport Group, Zurich, Switzerland.

Paré, N., Rabin, L.A., **Roth, R.M.**, Wishart, H.A., Santulli, R.B., & Saykin, A.J. (2008). Objective and subjective reports of working memory difficulties in amnestic MCI. Proceedings of the 36th Annual Meeting *of the International Neuropsychological Society.*

Wishart, H.A., **Roth, R.M.**, Koven, N.S., Flashman, L.A., Saykin, A.J., McAllister, T.W., Rhodes, C.H., & Tsongalis, G.J. (2008). COMT polymorphism is associated with cognitive flexibility. Proceedings of the 36th Annual Meeting *of the International Neuropsychological Society.*

Garlinghouse, M.A., Flashman, L.A., **Roth, R.M.**, Pendergrass, J., Koven, N.S., Kruck, C.L., * Saykin, A.J., & McAllister, T.W. (2008). Evidence for neural involvement consistent with anosognosia in unawareness of illness in individuals with schizophrenia. Proceedings of the 36th Annual Meeting *of the International Neuropsychological Society.*

Flashman, L.A., **Roth, R.M.**, Garlinghouse, M.A., Pendergrass, J.C., Kruck, C.L., & McAllister, T.W. (2008). Relationship between unawareness of illness and IQ measures and estimates in individuals with schizophrenia. Proceedings of the 36th Annual Meeting *of the International Neuropsychological Society.*

McAllister, T.W., Cheung, A.M., Garlinghouse, M.A., **Roth, R.M.**, Wishart, H.A., Flashman, L.A., & Saykin, A.J. (2008). Gray matter density correlates with a measure of attention one month after mild traumatic brain injury. *Journal of Neuropsychiatry and Clinical Neurosciences,*

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Koven, N.S., **Roth, R.M.**, Rubin, M., Flashman, L.A., & Saykin, A.J. (2008). Obitofrontal cortical volume mediates cognitive flexibility in obsessive-compulsive disorder. *Journal of Neuropsychiatry and Clinical Neurosciences.*

Fogarty, J., **Roth, R.M.**, & Borrie, M. (2009). Validation of the Behavior Rating Inventory of Executive Function (BRIEF-A) in dementia. Poster presented at the *5th Canadian Conference on Dementia*, Toronto, October.

Vaughan, C.G., Vincent, D.T., Leaffer, E., Schneider, J.C., **Roth, R.M.**, Isquith, P.K., & Gioia GA (2009). Clinical Utility of a Computer Administered Working Memory and Inhibitory Control Battery for Children with Concussion. *British Journal of Sports Medicine.*

Vaughan, C.G., Vincent, D.T., Leaffer, E., Schneider, J.C., **Roth, R.M.**, Isquith, P.K., & Gioia G.A. (2009). Clinical Utility of a Computer Administered Working Memory and Inhibitory Control Battery for Children with Concussion. Proceedings of the 38th Annual Meeting *of the International Neuropsychological Society, p.* 190.

Vaughan, C.G., Vincent, D.T., Leaffer, E., Schneider, J.C., **Roth, R.M.**, Isquith, P.K., & Gioia GA (2009). Psychometric properties of a computer administered working memory and inhibitory control battery for children. Proceedings of the 38th Annual Meeting *of the International Neuropsychological Society, p.* 163-164.

Taylor, S., Flashman, L.A., Rhodes, H.C., Garlinghouse, M.A., **Roth, R.M.**, Hoskins, L., Moore, J., Tsongalis, G., Saykin, A.J., McDonald, B.C., McAllister, T.W. (2009). Effect of COMT Val108/158Met genotype on cognition and cerebral activation after mild traumatic brain injury. *Journal of Neuropsychiatry and Clinical Neurosciences.*

West, J.D., Saykin, A.J., **Roth, R.M.**, Flashman, L.A., Koven, N.S., Garlinghouse, M.A., Pendergrass, J.C., & Dzemidzic, M. (2009). Selective association of positive and negative symptoms in schizophrenia with brain activation and connectivity during working memory. Poster to be presented at the *15th Annual Meeting of the Organization for Human Brain Mapping*, San Francisco, CA.

Wan, J., Shen, L., Sheehan, K.E., Kim, S., **Roth, R.M.**, Ford, J., Fang, S., Saykin, A.J., & Wishart, H.A., (2009). Shape analysis of thalamic atrophy in multiple sclerosis. *Proceedings of the 12th International Conference on Medical Image Computing and Computer Assisted Intervention*, London, UK, September.

Sheehan, K., Wishart, H., **Roth, R.M.**, Shen, L., Wan, J., MacDonald, J., Ford, J., Seville, J., Oliver, B., & Kasper, L. (2009). The relationship of thalamic volume and shape to pain in relapsing-remitting MS. Poster presented at the *2009 European Conference on Treatment and Research in MS.*

Brown, F.C., Katz, L., & **Roth, R.M.** (2010). Adults with ADHD demonstrate an isolated impairment in rotated memory for location on the Brown Location Test. Poster presented at the *30h Annual Meeting of the National Academy of Neuropsychology*, New York. Archives of Clinical Neuropsychology, 25(6), p. 495.

Lazow, S.P., Roberts, D.W., Thadani, V.M., Gilbert, K.L., Morse, R.P., Bujarski, K.A., **Roth, R.M.**, Kulandaivel, K., Scott, R. Jobst, B. C. (2010). Long-term follow-up after frontal lobe

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epilepsy surgery. Poster presented at the *Annual American Epilepsy Society Meeting*, San Antonia, TX. December.

Keefe, R.S., Madhoo, M., **Roth, R.M.**, Sambunaris, A., Wu, J., Trivedi, M., Anderson, C., & Lasser, R. (2011). Efficacy and safety of lisdexamfetamine dimesylate in adults with executive function impairment and partial or full remission of major depressive disorder. Poster presented at the *50th Annual Meeting of the American College of Neuropsychopharmacology*, Hawaii, December.

Isquith, P.K., **Roth, R.M.**, & Gioia, G.A. (2011). Sensitivity to working memory load in children with ADHD-I, ADHD-C or mild TBI on the Tasks of Executive Control. Proceedings of the 39th Annual Meeting *of the International Neuropsychological Society,* p. 47-48

Kehoe, R.A., **Roth, R.M.**, Flashman, L.A., & McAllister, T.W. (2012). Subjective report of executive function in everyday life in mild traumatic brain injury (mTBI). Poster presented at the 40th Annual Meeting of the *International Neuropsychological Society, Montreal.*

Abecassis, M., **Roth, R.M.**, & Giancola, P.R. (2012). Retrospective report of childhood trauma predicts executive functioning in current everyday life. Poster presented at the 40th Annual Meeting of the *International Neuropsychological Society, Montreal.*

Abecassis, M., **Roth, R.M.**, Isquith, P.I. & Gioia, G.A. (2012). Relationship between family functioning and executive control in a mixed pediatric clinical sample. Poster presented at the 40th Annual Meeting of the *International Neuropsychological Society, Montreal.*

Roth, R.M., Isquith, P.K., Gioia, G.A., & Vaughan, C.G. (2012). Evidence of validity for Pediatric ImPACT based on convergence with the Tasks of Executive Control. Poster presented at the 40th Annual Meeting of the *International Neuropsychological Society, Montreal.*

Kehoe, R.A., **Roth, R.M.**, Flashman, L.A., & McAllister, T.W. (2012). Subjective report of executive function approximately one-month and one-year post mild traumatic brain injury (mTBI). Poster presentation at the *International Brain Injury Association's Ninth World Congress on Brain Injury*, Edinburgh, Scotland, March.

Madhoo, M., Keefe, R.S.E., **Roth, R.M.**, Sambunaris, A., Wu, J., Trevedi, M., Anderson, C., & Lasser, R. (2012). Clinical trial design assessing augmentation for cognitive function in major depressive disorder. Poster presented at the *International Society for CNS Clinical Trials and Methodology Meeting*, Washington, February.

Madhoo, M., Keefe, R.S.E., **Roth, R.M.**, Sambunaris, A., Wu, J., Trevedi, M., Anderson, C., & Lasser, R. (2012). Efficacy and safety of lisdexamfetamine dimesylate in adults with executive dysfunction and partial or full remission of major depressive disorder. Poster presented at the *28th CINP World Congress of Neuropsychopharmacology*, Stockholm.

Madhoo, M., **Roth, R.M.**, Keefe, R.S.E., Sambunaris, A., Scheckner, B., Nielsen, J., Adeyi, B., Wu, J., & Lasser, R. (2012). Lisdexamfetamine dimesylate augmentation effects on executive function in major depressive disorder based on depressive symptom levels. Poster presented at the *25th Annual meeting of the European College of Neuropsychopharmacology* (ECNP), Vienna.

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Fischer, A.S., Whitfield-Gabrieli, S., **Roth, R.M.**, Brunette, M.F., O'Keefe, C., & Green, A.I. (2012). Resting state connectivity of the brain reward circuitry in patients with schizophrenia and cannabis use disorder: Effects of cannabis and dronabinol. Poster presented at the *Annual meeting of the Society for Neuroscience*, October, New Orleans.

Roth, R.M., Keefe, R.S., Sambunaris, A., Madhoo, M., Wu, J., Trivedi, M., Anderson, C.S., & Lasser, R. (2012). Efficacy of lisdexamfetamine dimesylate augmentation for executive dysfunction in adults with fully or partially remitted major depressive disorder. Poster presented at the *165th Annual Meeting of the American Psychiatric Association*, Philadelphia, May.

Harvey, P.D., **Roth, R.M.**, Bilder, R.M., Richards, C., Lasser, R., Geibel, B., Geo, J., Scheckner, B., & Trivedi, M. (2012). Assessment of executive dysfunction in adults with major depressive disorder receiving lisdexamfetamine dimesylate augmentation of escitalopram. Poster presented at the *165th Annual Meeting of the American Psychiatric Association*, Philadelphia, May.

Keefe, R.S., Boyd, A., Madhoo, M., **Roth, R.M.**, Sambunaris, A., Wu, J., Trivedi, M., Anderson, C.S., & Lasser, R. (2012). Lisdexamfetamine dimesylate in the treatment of cognitive dysfunction in patients with partially or fully remitted major depressive disorder. Poster presented at the *165th Annual Meeting of the American Psychiatric Association*, Philadelphia.

Madhoo, M., Keefe, R.S., **Roth, R.M.**, Sambunaris, A., Wu, J., Trivedi, M., Anderson, C.S., & Lasser, R. (2012). Efficacy and safety of lisdexamfetamine dimesylate in adults with executive dysfunction and partial or full remission of major depressive disorder. Poster presented at the *Annual Meeting of the College of Psychiatric & Neurologic Pharmacists*.

Madhoo, M., Keefe, R.S.E., **Roth, R.M.**, Sambunaris, A., Wu, J., Trevedi, M., Anderson, C., & Lasser, R. (2012). Item analysis of lisdexamfetamine dimesylate augmentation effects on depressive symptoms in adults with major depressive disorder. Poster presented at the *Annual Meeting of the New Clinical Drug Evaluation Unit (NCDEU),* Phoenix, AZ.

Fischer, A.S., Whitfield-Gabrieli, S., **Roth, R.M.**, Brunette, M.F., Noordsy, D., O'Keefe, C., & Green, A.I. (2013). Effects of cannabis and dronabinol on connectivity of the brain reward circuitry in patients with schizophrenia and cannabis use disorder. Poster presented at the *Annual meeting of the American Neuropsychiatric Association*, February, Boston.

Tayim, F.M., Flashman, L.A., **Roth, R.M.**, & McAllister, T.W. (2013). Use of the CVLT-II item-specific deficit approach (ISDA) to understand episodic memory performance one month after mild traumatic brain injury. Poster presented at the *Annual Meeting of the American Neuropsychiatric Association*, Boston. *Journal of Neuropsychiatry & Clinical Neurosciences, 25*(2), 17 (abstract)

Tayim, F.M., Flashman, L.A., **Roth, R.M.**, & McAllister, T.W. (2013). Trajectory of recovery of learning and episodic memory after mild traumatic brain injury (mTBI). Poster presented at the *Annual Meeting of the American Neuropsychiatric Association*, Boston. *Journal of Neuropsychiatry & Clinical Neurosciences, 25*(2), 16-17 (abstract)

Kuiper, C., Godlaski, A., Giancola, P. & **Roth, R.** (2013). Negative urgency mediates the relation between components of executive functioning and alcohol-related aggression. Poster presented at the *Annual Meeting of the Association for Psychological Science,* Washington, DC.

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Cutler, A., Richards, C., Geibel, B., Scheckner, B., James, S., Adeyi, B., Sambunaris, A., Patkar, A.A., **Roth, R.M.**, & Trevedi, M. (2013). Response to lisdexamfetamine dimesylate augmentation in major depression in people with or without baseline executive function impairment. Poster presented at the *166th Annual Meeting of the American Psychiatric Association*, San Francisco.

Keefe, R.S.E., Madhoo, M., **Roth, R.M.**, Iverson, G.L., Sambunaris, A., Scheckner, B., Adeyi, B., James, S., Hartshaw, E., & Trevedi, M.H. (2013). Lisdexamfetamine dimesylate augmentation effects on executive function in major depressive disorder: Impact of baseline SSRI monotherapy. Poster to be presented at the *Annual Meeting of the New Clinical Drug Evaluation Unit (NCDEU),* Hollywood, Fl.

Trevedi, M.H., Richards, C., Harvey, P.D., Bilder, R.M., Patkar, A.A., Sambunaris, A., Geibel., B., Scheckner, B., James, S., Adeyi, B., & **Roth, R.M.** (2013). Lisdexamfetamine dimesylate augmentation effects on executive function in major depressive disorder based on level of executive function impairment. Poster to be presented at the *Annual Meeting of the Society of Biological Psychiatry*, Philadelphia, PA.

Fischer, A.S.,* Whitfield-Gabrieli, S., **Roth, R.M.**, Brunette, M.F., & Green, A.I. (2013). Functional connectivity of reward circuitry in schizophrenia and co-occurring cannabis use disorder: Effects of smoked cannabis and oral delta-9-tetrahydrocannabinal. Poster presented at *the 14th International Congress on Schizophrenia Research*, April, Grande Lakes, Florida.

Roth, R.M., Holcomb, M.J., Fischer, A.S., Kenealy, L. & Isquith, P.K. (2013). Two vs. three factor model scores on the BRIEF in children and adults with ADHD. Poster presented at the Annual Mid-year Meeting of the International Neuropsychological Society, Amsterdam.

Abecassis, M., **Roth, R.M.**, & Giancola, P.R. (2013). Parenting style in childhood and executive functions in the everyday life of young adults. Poster presented at the Annual Mid-year Meeting of the International Neuropsychological Society, Amsterdam.

Welsh, K., **Roth, R.M.**, & Isquith, P.K. (2013). Self-reported executive function in adolescents and perceived risk-taking in others. Poster presented at the *Annual Mid-year Meeting of the International Neuropsychological Society*, Amsterdam.

Caller, T.A., Secore, K., Ferguson, R., **Roth, R.M.**, Kleen, J., Alexandre, F., & Jobst, B.C. (2014). A pilot study of a self-management intervention for cognitive impairment in epilepsy Platform presentation at the *American Academy of Neurology 66th Annual Meeting*, Philadelphia, PA. *Clinical Neurophysiology, 125*(11), e50 (abstract)

Whitfield-Gabrieli, S., Fischer, A.S., **Roth, R.M.**, & Green, A.I. (2014). Cannabinoid agonist improves intrinsic functional brain organization of the default mode network in patients with schizophrenia and co-occurring cannabis use disorder. Poster presented at the *69th Annual Meeting of the Society of Biological Psychiatry*, New York.

Erdodi, L.A., Pelletier, C., Tyson, B.T., Lichtenstein, J., Holcomb, M.J., Condiracci, C., & **Roth, R.M.** (2014). Embedded validity indicators in Conners' continuous performance test, second edition (CPT-II) discriminate valid from invalid profiles more accurately during the repeat administration in a psychiatric sample. Poster presented at the *34th Annual Conference of the National Academy of Neuropsychology*, November, Fajardo, Puerto Rico.

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Fischer, A.S., Whitfield-Gabrieli, S., **Roth, R.M.**, & Green, A.I. (2014).Cannabinoid agonists, functional connectivity of the default mode network, and working memory performance in patients with schizophrenia and cannabis use disorder. Poster presented at *53rd Annual Meeting of the American College of Neuropsychopharmacology,* Phoenix.

Almklov, E.L., Kim, H., **Roth, R.M.**, Ford, J.C., Wishart, H.A., Randolph, J.S., Flashman, L.A., & McAllister, T.W. (2014). Structural and functional MRI in relation to glutamate receptor gene (GRIN2B) polymorphism. Poster presented at the *42nd Annual Meeting of the International Neuropsychological Society,* Seattle.

Baldassarre, M., Baek, R., Erdodi, L., Tyson, B., Jobst, B., Bujarski, K., & **Roth, R.M.** (2014). Neuropsychological profiles associated with epilepsy, non-epileptic seizures and psychiatric disorders. Poster presented at the *42nd Annual Meeting of the International Neuropsychological Society,* Seattle.

Baek, R., Baldassarre, M., Erdodi, L., Tyson, B., Jobst, B., Bujarski, K., & **Roth, R.M.** (2014). Performance validity testing in patients with epilepsy, non-epileptic seizures and psychiatric disorders. Poster presented at the *42nd Annual Meeting of the International Neuropsychological Society,* Seattle.

Lantrip, C., Isquith, P.K., Koven, N., Welsh, K.R., & **Roth, R.M.** (2014). Relationship between emotion regulation strategies and executive functions adolescents' daily lives. Poster presented at the 42nd Annual Meeting of the *International Neuropsychological Society,* Seattle.

Lantrip, C., Towns, S., **Roth, R.M.**, & Giancola, P. (2015). Psychopathic personality traits and executive functions in daily life. Poster presented at the *35th Annual Meeting of the National Academy of Neuropsychology*, Austin, TX, November.

Rabin, L.A., Meltzer, E.P., Fogel, J., Kapoor, A., Elbulok-Charcape, M.M., **Roth, R.M.**, Katz, M., & Lipton, R. (2015). Association of mood, functional activities, and scores on objective executive function tasks with self-reported executive function symptoms in non-demented older adults. Poster presented at the *35th Annual Meeting of the National Academy of Neuropsychology*, Austin, TX, November.

Isquith, P.K., Kenealy, K., **Roth, R.M.**, & Gioia, G. (2015). Diagnostic accuracy of a revised Behavior Rating Inventory of Executive Function (BRIEF) for children with ADHD. Poster presented at the 43rd Annual Meeting of the *International Neuropsychological Society,* Denver.

Fischer, A.S., Whitfield-Gabrieli, S., **Roth, R.M.**, Brunette, M.F., & Green, A.I. (2015). Improvement in anti-correlation between regions of the 'task positive' and default mode and networks induced by cannabis and THC in patients with schizophrenia: Implications for working memory? Poster presented at the *15th International Congress on Schizophrenia Research*, Colorado Springs, CO.

Erdodi, L., & **Roth, R.M.** (2016). Aggregating embedded validity indicators (EVIs) within Conners' CPT-II provides a better estimate of performance validity than individual cutoffs in patients with traumatic brain injury. Poster presented at the *Annual Meeting of the Midwestern Psychological Association*, Chicago.

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Mohile, P., Baker, J., Erdodi, L., & **Roth, R.M.** (2016). Developing and validating a five-item screener to sample relevant psychiatric variables in a clinical sample. Poster presented at the *Behavior Analysis Association of Michigan Convention*, Ypsilanti MI, February.

Shahein, A., Pelletier, C. Baker, J., Zuccato, B., Seke, K., Kucharski, B., Beaudoin, A., Mohile, P., Berberi, A., Truong, J., Charron, C., Schwartz, E., **Roth, R.M.**, & Erdodi, L., (2016). Low scores on the Grooved Pegboard Test are associated with invalid responding and anxiety, not fine motor impairment in a mixed clinical sample of adults referred for neuropsychological testing. Poster presented at the *28th American Psychological Society Annual Convention*, May, Chicago, IL.

Baker, J.N., Park, W., & **Roth, R.M.** (2016). Revitalizing activism by incorporating evidence based arguments into the social justice rhetoric: An example of interdisciplinary collaboration with allied health professionals. Poster presented at the *CASWE-ACFTS Conference*, May-June, Calgary.

Erdodi, L. A., Mazur-Mosiewicz, A., Schwartz, E.S., Pelletier, C.L., Rai, J.K., Baker, J.N., & **Roth, R.M.** (2016). How high can we go? An exploration of TOMM trial 1 cutoffs in a mixed clinical sample. Poster presented at the *Annual Conference of the American Academy of Clinical Neuropsychology (AACN)*, Chicago, June.

Roth, R.M., Abecassis, M., Pelletier, C.L., Caller, T.A., Alexandre, F.P., & Jobst, B.C. (2016). Self-rated executive dysfunction in adults with focal epilepsy. Poster presented at the *44th Annual Meeting of the International Neuropsychological Society*, Boston, February.

Roth, R.M., Pelletier, C.L., Abecassis, M., Erdodi, L., Caller, T.A., Alexandre, F.P., & Jobst, B.C. (2016). RBANS embedded effort measures in adults with focal epilepsy. Poster presented at the *44th Annual Meeting of the International Neuropsychological Society*, Boston, February.

Rai, J., Pelletier, C., Zuccato, B., Kucharski, B., Schwartz, E., **Roth, R.M.**, Erdodi, L. (2016). Aggregating embedded validity indicators (EVIs) within Conners' CPT-II provides a better estimate of performance validity than cutoffs on individual scales in patients with traumatic brain injury. Poster presented at the Annual *Mid-Year Meeting of the International Neuropsychological Society*, London, July.

Streltzov, N.A., Schmidt, S.S., Zhao, W., **Roth, R.M.**, Secore, K.L., Schommer, L.M., Birney, K., Chu, F., Henninger, H.L., Nagle, K.J., Jarvis, P.R., & Jobst, B. (2017). Improving quality of life in epilepsy: Replication and generalizability of an epilepsy self-management and cognitive training program (HOBSCOTCH). Poster to be presented at the *American Academy of Neurology 69th Annual Meeting*, April, Boston.

Richardson, R.J., Abeare, C.A., Tyson, B.T., Hurtubise, J., **Roth, R.M.**, & Erdodi, L. (2017). Lateral dominance influences the likelihood of failing the Word Choice and Recognition Memory tests. Poster to be presented at the *78th Annual Meeting of the Canadian Psychological Association*, Toronto.

Henricks, A.M., Fischer, A.S., **Roth, R.M.**, Brunette, M.F., & Green, A.I. (2017). Cannabis use disorder and cognition in schizophrenia. *Gordon Research Conference: Cannabinoids in the CNS*. Waterville Valley, NH, USA

Carmasin, R., **Roth, R.M.**, Rabin, L.A., Englert, J., Flashman, L.A., Saykin, A.J., & (2017)

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Stability of self-rated executive dysfunction in MCI and older adults with subjective cognitive dysfunction. Poster presented at the *45th Annual Meeting of the International Neuropsychological Society*, New Orleans, February.

Seke, K., Sagar, S., Charron, C., Zougari, A., Baker, J. N., **Roth, R. M.**, & Erdodi, L. A. (2017). The Stroop test as a measure of performance validity in adults clinically referred for neuropsychological assessment. Poster presented at the *45th Annual Meeting of the International Neuropsychological Society*, New Orleans, February.

Sagar, S., Hurtubise, J., Charron, C., Zougari, A., Seke, K., **Roth, R.M.**, & Erdodi, L. A. (2017). Gender and lateral dominance influences likelihood of failure on performance validity tests. Poster presented at the *45th Annual Meeting of the International Neuropsychological Society*, New Orleans, February.

Roth, R.M., Fried, R., & Isquith, P.K. (2018). Executive functioning in everyday life in emerging adults with ADHD. Poster presented at the *APSARD Annual Meeting*, Washington, D.C.

Henricks, A.H., Fischer, A.F., **Roth, R.M.**, & Green, A.I. (2018). Comorbid cannabis use disorder is not associated with improved cognition in patients with schizophrenia. Poster presented at the *46th Annual Meeting of the International Neuropsychological Society*, Washington, February.

Jackson, A., Pineault, L., Buchanan, L., Flashman, L., & **Roth, R.M.** (2018). Semantic processing on verbal fluency tasks in schizophrenia spectrum disorder. Poster presented at the *46th Annual Meeting of the International Neuropsychological Society*, Washington, February.

Schmidt, S.S., Zhao, W., **Roth, R.M.**, Schommer, L., Yang, H., Mazanec, M.T., Henninger, H., Chu, F. (2019). Successful expansion of self-management practices: A replication trial of HOBSCOTCH for memory problems in epilepsy. Presented at the *71st Annual Meeting of the American Academy of Neurology,* May, Philadelphia, PA.

Lawn, C.L., Allen, L.V., McEnaney, K.E., Clavier, O.H., & **Roth, R.M.** (2019). Usability of the Self-Administered Neuropsychological Assessment Battery. Poster presented at the *47th Annual Meeting of the International Neuropsychological Society*, New York, February.

Isquith, P.K., Abecassis, M., Welsh, K.R., & **Roth, R.M.** (2019). Adolescents with poorer self-regulation perceive peers as taking greater risks. Poster presented at the *47th Annual Meeting of the International Neuropsychological Society*, New York, February.

Mistler, L., Zisman-Ilani Y., Williams, C., & **Roth, R.M.** (2019). Cognitive and motivational factors and engagement in SDM in people with severe mental illness. Poster presented at the *47th Annual Meeting of the International Neuropsychological Society*, New York, February.

Streltzov, N. Schmidt, S., Zhao, W., **Roth, R.**, Schommer, L., Kiriakopoulos, E., Mazanec, M., Chu, F., Henninger, H., & Jobst, B. (2020). The longitudinal effects of HOBSCOTCH—a self-management program for people with epilepsy. Presented at the *72nd Annual Meeting of the American Academy of Neurology*, May.

Schmidt, S., Streltzov, N. Zhao, W., **Roth, R.**, Schommer, L., Kiriakopoulos, E., Mazanec, M., Chu, F., Henninger, H., & Jobst, B. (2020). Advantages of face-to-face contact versus video conferencing in the delivery of a self-management program for people with epilepsy. Presented at the *72nd Annual Meeting of the American Academy of Neurology*, May.

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Batsis, J., Haudenschild, C., **Roth, R.M.**, Roderka, M., Masterson, T., Brand, J., Gooding, T., Lohman, M.C., & Mackenzie, T.A. (2020). Incident cognitive decline in sarcopenic obesity: Data from the National Health and Aging Trends Survey. Poster presented at the *International Conference on Frailty & Sarcopenia Research* (ICFSR 2020), March, Toulouse, France.

Crow, R.S., Haudenschild, C., **Roth, R.M.**, Roderka, M., Masterson, T., Brand, J., Gooding, T., Lohman, M.C., Mackenzie, T.A., Elinsky, C., & Batsis, J.A. (2020). STEADI Fall Risk score predicts incident cognitive impairment: Data from the National Health and Aging Trends Survey. Poster presented at the *International Conference on Frailty & Sarcopenia Research* (ICFSR 2020), March, Toulouse, France.

Roth, R.M., Abecassis, M., Isquith, P.K., & Fielding, W.J. (2020). Corporal punishment in childhood is associated with self-rated executive functions in Bahamian college students. Poster presented at the *48th Annual Meeting of the International Neuropsychological Society*, Denver, February.

Keith, C.M., **Roth, R.M.**, Rabin, L.A., Ford, J.C., Flashman, L.A., & Saykin, A.J. (2020). Subjective working memory is associated with reduced cortical thickness in amnestic mild cognitive impairment. Poster presented at the *48th Annual Meeting of the International Neuropsychological Society*, Denver, February.

Kaewpoowat, Q., Rerkasem,A., Rerkasem, K., Robertson, K., **Roth, R.M.**, Choovuthayakorn, J., Ausayakhun, S., Supparatpinyo, K., & Robbins, N.M. (2020). Arterial wall stiffness measured by the cardio-ankle vascular index (CAVI) is associated with neurocognitive impairment in people living with well-controlled HIV in Thailand. Poster presented at the annual meeting of the *European Academy of Neurology*.

Roth, R.M., Isquith, P.K., Gioia, G.A., Greene, J.A., Trujillo, S.D., Iwanicki, S., & Morera, C.C. (2020). Enhanced interpretation of the Behavior Rating Inventory of Executive Function – Adult version (BRIEF-A). Poster presented at the *40th Annual Conference of the National Academy of Neuropsychology* (online).

Moncrief, G., Aita, S.L., Abecassis, M., **Roth, R.M.**, Caller, T.A., Schmidt, S.S., & Jobst, B.C. (2021). Self-rated executive dysfunction in adults with epilepsy and effects of a cognitive-behavioral intervention (HOBSCOTCH). Poster presented at the *49th Annual Meeting of the International Neuropsychological Society*, Online, February.

Trask, C.L., Mistler, L., Koven, N., & **Roth, R.M.** (2021). Delay discounting in schizotypal personality. Poster presented at the *49th Annual Meeting of the International Neuropsychological Society*, Online, February.

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XXIII. Personal Statement:

Since arriving at Dartmouth in 1999 for a postdoctoral fellowship in clinical neuropsychology and neuroimaging, I have been dedicated to clinical care, clinical and research training and mentorship, as well as clinical research. I joined the Department of Psychiatry at Dartmouth as an *Instructor* in 2001, was promoted to *Assistant Professor* in 2004, and then to *Associate Professor* in 2011 on the *Clinician-Educator track*. In addition to directing the Adult Clinical Neuropsychology Services at DHMC, Hanover Psychiatry, and New Hampshire Hospital, I have practiced as a clinical neuropsychologist, supervised/mentored numerous trainees at various levels of experience, and pursued my own program of research, as well as conducting collaborative research with colleagues at Dartmouth and other institutions.

Clinical Service

As faculty at DHMC/Dartmouth, I have worked as a clinical neuropsychologist in several settings, providing clinical care to wide variety of adult and geriatric patient populations. At DHMC, I served as coordinator (2001-2010) then director (2010-current) of Adult Neuropsychology. I founded the Neuropsychology Service at Hanover Psychiatry (a private practice of the Department of Psychiatry at DHMC) in 2009 and continued as director until summer 2019. I have also served as staff neuropsychologist at New Hampshire Hospital (NHH; the State of NH inpatient psychiatric facility), and on two recent occasions (3/2019-10/2019 and 8/2020-current) served as interim director of Neuropsychology there, a role I fulfilled in addition to my other clinical, supervisory, and administrative demands. In addition to these clinical leadership roles, my expertise in clinical neuropsychology was recognized in 2017 when I obtained board certification in clinical neuropsychology from the American Board of Professional Psychology.

I have been committed to introducing evidence-based assessments and working with other faculty at DHMC to improve care and maximize positive outcomes for patients. I have long been part of the multidisciplinary epilepsy surgery planning team, including conducting "Wada tests" for patients with epilepsy being considered for neurosurgery; and for the past 13 years I have been the only neuropsychologist in Northern New England conducting the Wada test. In collaboration with faculty in Psychiatry and Neurology, we developed the Healthy Aging and Brain Clinic (HABC; 2014-2018), and its more recent iteration the Cognition in Older Adults (COA) Clinic (2019-current). In 2019, in collaboration with Neurology faculty, I began providing brief neuropsychological evaluations as part of the Huntington's Disease (HD) Clinic. These clinics provide multidisciplinary evaluations to inform differential diagnosis and treatment planning. I will be working with my colleagues to expand these clinics to include other specialties to provide more comprehensive and integrated care. Related to the COA Clinic, with Neurology and Radiology faculty, we developed a PET/CT Case Conference to enhance collaborative care of older adults with concerns for dementia. Finally, at Hanover Psychiatry, in collaboration with clinical psychology and psychiatry faculty, we developed multidisciplinary clinical evaluations to provide a more comprehensive understanding of a patient's functioning and treatment needs, including for those with complex psychiatric, substance use, and social histories.

Teaching and Mentorship

A vital part of my career as a scientist-practitioner has been providing clinical and research training and mentorship. I have always been closely involved in our neuropsychology training program, and as of March 2019, took over as Director of the Clinical Neuropsychology Training Program. Thus far, I have supervised/mentored 31 pre-doctoral interns/practicum students and 52 post-doctoral fellows in clinical neuropsychology. My trainees have gone on to successful careers in clinical practice, teaching/research, and clinical/research positions (including some as directors) at prestigious institutions such as the Harvard, Yale, and Johns Hopkins University schools of medicine. I have provided research mentorship to 23 students

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from Dartmouth and other institutions though programs such as Work Study, the Presidential Scholar Research program, and the Howard Hughes Medical Research Institute Fellowship. I have also served as a committee member for several undergraduate theses and doctoral dissertations (e.g., Dartmouth, McGill University, Chicago School of Professional Psychology, Bates College), sought out for my expertise in neuropsychological research.

As part of my commitment to clinical training at Dartmouth, I developed and have organized/led a weekly Neuropsychology Seminar since 2003, and a Professional Development Seminar since 2008 for interns and postdoctoral fellows in clinical psychology and neuropsychology. In March 2019 I organized and held the first annual *Women in Clinical Psychology* meeting, which brought together female clinical psychology faculty with interns and fellows in clinical psychology/neuropsychology at Dartmouth, to discuss issues related to challenges pertaining to being a woman in our field. I have provided numerous lectures on topics in neuropsychology to audiences such as associate providers at DHMC, residents, and psychology interns. In addition, I developed clinical training opportunities for interns and postdoctoral fellows in clinical neuropsychological evaluation and multidisciplinary collaboration at DHMC including within HABC/COA and HD Clinics, and the PET/CT Case Conference.

Professional Activities

I have engaged in numerous professional activities over the years, both within and outside of my department and institution. For example, I played a central role in the development of criteria and materials for the Department of Psychiatry's junior faculty research award, have served on my Department's Scientific Review Committee, review internal grant proposals, and serve on my department's Education Policy and Grand Rounds committees, as well as being a member of search committees to hire new neuropsychology faculty. I am also a founding member of three multi-disciplinary research groups at Dartmouth: the Dartmouth Brain Imaging Group, Dartmouth Neurogenetics Group, and Brain Research Network.

I have contributed to the scientific community by regularly reviewing (via invitation) manuscripts in my areas of expertise for a wide variety of psychiatric and neuroscience journals. I am an editorial board member for the journal *Brain Imaging and Behavior* (2007-current) and a review editor for *Frontiers in Psychiatry* (2017-current). I typically review about 4-6 manuscripts per year, some done with trainees in order to afford them the opportunity to gain supervised experience in reviewing manuscripts for scientific journals. I also collaborated on a multi-site study to help better understand physician preferences in how neuropsychological evaluation results are communicated (Schoenberg et al., 2016).

I was a member of the Clinical Research Grants committee for the National Academy of Neuropsychology (2015-2017), became chair of that committee in January 2018, and was recently reappointed for a second three-year term. I have also served on program committees for two of the premier neuropsychological organization conferences (INS, AACN). In 2019, I was asked to join the Research Innovation Group at NHH, to help facilitate the development of research there, including providing mentorship and consultation. My expertise in neuropsychology, and especially on executive functions, has led to invitations to present on this topic at local, national, and international venues. My expertise has also been tapped to serve on advisory and scientific review committees (e.g., U.K. Medical Research Council), as well as serving as a scientific consultant to a pharmaceutical company (Shire Pharmaceuticals) and an engineering company (Creare LLC).

Most recently, I have been collaborating with neuropsychologists in New Hampshire, Vermont, and Maine to develop the *Northern New England Neuropsychological Association* (NNENA). This non-profit will have as its primary mission to remedy the dearth of opportunities for neuropsychologists, and trainees with interest in neuropsychology, located in northern New England to interact and discuss important issues in the field in general, as well as issues especially relevant to practicing in this region (e.g., assessment of rural populations).

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Research

Despite being primarily funded through clinical practice (.8 FTE or more since 2007), I have always pursued research endeavors; and have had some salary support as a PI or co-investigator since being a postdoc at Dartmouth. My research has three primary emphases: (1) executive functions; (2) apathy/motivational systems; and (3) providing expertise in neuropsychology within collaborative research. To date, I have over 120 peer-reviewed publications [33 as first author and 30 as senior author], including 84 empirical papers, 19 review papers, and 19 book chapters], in addition to developing and publishing two psychological measures [BRIEF-A; Tasks of Executive Control].

Executive functions are cognitive processes fundamental for goal-directed behavior and for independent, adaptive functioning in society. Since graduate school, my primary research focus has been on executive functions, their presentation and correlates in various clinical and non-clinical populations, their neural substrates, and how such knowledge informs treatment. To that end, I have used multiple research tools such as structural and functional neuroimaging and neuropsychological tests. My work on executive functions has resulted in numerous publications in peer-reviewed journals, including the first study using fMRI to identify abnormalities during response inhibition in OCD (Roth et al., 2007) and one of the first papers examining response inhibition using fMRI in bipolar disorder (Roth et al., 2006). I developed and published as lead author the first standardized rating scale of executive functions for adults, the *Behavior Rating Inventory of Executive Function - Adult version* (BRIEF-A; Roth et al., 2015), which has contributed to my international reputation as an expert on executive functions. This measure has been translated into over 40 languages/dialects around the world, and is employed in numerous clinical settings and research programs nationally and internationally, including large multi-center and multi-national clinical trials. I am regularly contacted by students, researchers, and clinicians from around the world (e.g., Australia, Ecuador, Germany, China) about the BRIEF-A and its use in dissertations, research programs, and clinical practice.

My research on apathy/motivational systems has focused on schizophrenia, seeking to gain a better understanding of its cognitive and neural substrates. Among other work, I was lead author on the first paper showing an association between apathy and frontal lobe volume using MRI in patients with schizophrenia (Roth et al., 2004), and the first linking apathy to volume reduction in the ventral striatum in schizophrenia (Roth et al., 2016), a brain region intimately involved in the processing of cues for reward. These findings emphasize the need to eliminate the stigma of apathy in persons with the illness, as it is not simply due to oppositionality or willful lack of effort. I have also had a longstanding involvement as co-investigator in a second line of research on motivational systems (with Dr. Alan Green and others in the Department of Psychiatry at Dartmouth). This has shown that abnormal functional connectivity of the ventral striatum improves following an acute cannabis challenge in patients with co-occurring schizophrenia and cannabis use disorder (CUD); which used a novel hookah-like device my colleagues and I designed to permit smoking a joint in the MR scanner. We are continuing this line of research, including in patients with CUD-only, which will also allow me to examine whether executive dysfunction and apathy differ in severity/nature, as well as neural correlates, in dual diagnosis and CUD-only groups.

Finally, I have greatly valued the opportunity to share my expertise on executive functions specifically, and neuropsychology more generally, to address important questions related to cognition in other's programs of research. I have been sought out for collaboration by faculty from several DHMC/Dartmouth departments (Psychiatry, Neurology, Neurosurgery, Medicine, Radiology, Cardiology, Philosophy, and Anesthesiology), as well as by researchers nationally (e.g., USF, U Mass), and internationally (e.g., Ontario, Alberta, and Quebec in Canada; Australia; Bahamas; Iran; Thailand). This has yielded numerous publications addressing issues such as outcomes of neurosurgery and cognitive strategy training for epilepsy [the latter of which involved

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providing expertise in neuropsychology to help inform the development and testing of a now widely adopted program to aid memory in persons with epilepsy; Caller et al., 2016]; the pattern of executive dysfunction in depression, chronic pain, and fetal alcohol syndrome; as well as studies on subjective and objective cognitive functioning in older adults (e.g., MCI, mild AD, and in relation to obesity).

I have been fortunate to pursue my career at Dartmouth/DHMC over the past 20 years, making substantial contributions to the clinical, education/training, and research missions of DHMC and the Geisel School of Medicine at Dartmouth. I look forward to continuing to serve that mission.

Updated by: Robert M. Roth
Date: March 1, 2021

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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.

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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

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Dartmouth-Hitchcock

Mary Hitchcock Memorial Hospital

Key Personnel for New Hampshire Hospital

Relative to Amendment #4 – Service Area #1

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Jeffrey Fetter, MD	Chief Medical Officer	$349,673	100%	$349,673
Patrick Hattan, MD Samantha Swetter, MD	Associate Medical Directors	$316,891	100%	$316,891
Elizabeth Sanders, MD	General Medical Director	$309,000	100%	$309,000
Robert Roth, PhD	Director of Neuropsychology Lab	$74,675	100%	$74,675
Barbara Dieckman, RN, MS, MBA	Director of Health System Data & Info Services	$146,583	100%	$146,583
Kelly Aschbrenner, PhD	Research Director	$190,000	100%	$190,000
Debra Fournier, MHCDS, MSN, RN	Director of Quality Systems & APRN Services	$153,182	100%	$153,182

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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
603-271-9200 1-800-852-3345 Ext. 9200
Fax: 603-271-4912 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

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

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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	$13,388,111
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

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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

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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

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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

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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

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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: Christine 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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New Hampshire Department of Health and Human Services
Physician Clinical and Administrative Services

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-C. 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 [illegible] 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.

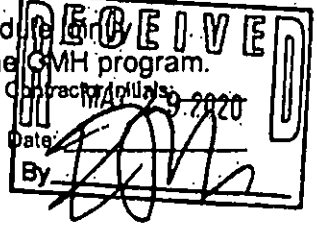
b. The Contractor shall develop, in collaboration with the DHHS designee, a specific schedule designating specific time periods for each CMH program, ACT and EBSE fidelity or QIP review. The schedule shall be subject to the advanced approval of the DHHS designee.

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 jointly 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**

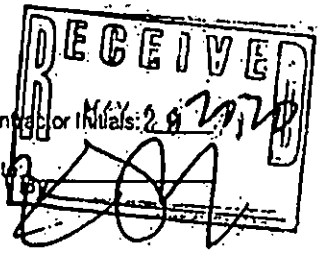
2.7.5.1. The Contractor shall be responsible for performing regular time studies in accordance with CMS and DHHS Medicaid Cost Allocation procedures in order to document activities, relating directly to the administration of the Medicaid program, to draw down federal matching revenues, which will be 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 addiction

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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

3.3.1.5.1 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

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.

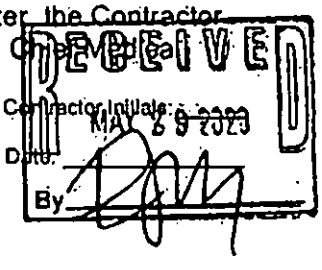
(ii) Performance measured by random monthly audits which are provided to the Chief Medical Officer and Chief Executive Officer of NHH.

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



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.

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

Jeffrey A. Meyers
Commissioner

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-9389 1-800-852-3345 Ext. 9389
Fax: 603-271-4332 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

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

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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

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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

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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

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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

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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**

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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

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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.

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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

New Hampshire Department of Health and Human Services
Physician Clinical and Administrative Services

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. Eglisl
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

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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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

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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

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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.

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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Exhibit A Amendment #2

#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

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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

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

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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.

4.6.2. **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

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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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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION FOR BEHAVIORAL HEALTH
NEW HAMPSHIRE HOSPITAL

Jeffrey A. Meyers
Commissioner

Lori A. Shibinette
Chief Executive Officer

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.

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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

The Department of Health and Human Services' Mission is to join communities and families in providing opportunities for citizens to achieve health and independence.

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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.

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New Hampshire Department of Health and Human Services
Physician Clinical and Administrative Services

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

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New Hampshire Department of Health and Human Services
Physician Clinical and Administrative Services

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:
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:

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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

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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

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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:

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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

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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,

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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;

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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;

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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

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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

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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.

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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

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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.

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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;

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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

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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.

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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

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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;

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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.

3.3.1.6. 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

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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;

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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

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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

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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

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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

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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

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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

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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

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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.

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

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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

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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

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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 or 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

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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

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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.

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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 formal 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

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New Hampshire Department of Health and Human Services
DHHS Security Requirements
Exhibit K

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

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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

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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.

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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

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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

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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

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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

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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

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6A

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

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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

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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

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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

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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.

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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.

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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

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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 Tourin, DHHS, Department Controller
6.
7.
8.
9.

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FORM NUMBER P-37 (version 5/8/15)

Subject: Physician Clinical and Administrative Services/RFP-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 Dtary	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 $36,556,042
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:

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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

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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.

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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.

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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.

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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;

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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

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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.

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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

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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.

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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.

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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.

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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.

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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 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.

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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

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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.

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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.

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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.

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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;

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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

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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.

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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

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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;

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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:

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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.

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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.

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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;

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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.

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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.

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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;

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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

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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.

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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.

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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:

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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.

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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

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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

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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.

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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

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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:

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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.

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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

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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

3.5.1. 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;

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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.

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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

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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

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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.

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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.

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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:

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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.

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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 collected 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;

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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.

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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.

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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.

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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.

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4.6.9. Service Areas #2, 3, 6, 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.

4.6.10. 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.

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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

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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, 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	$219,576	$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

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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

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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.

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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.

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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;

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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.

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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

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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

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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.

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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.

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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.

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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

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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.

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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

Name: Robert A Greene, MD
Title: EVP
chief Population Health Management officer

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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

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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:

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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.

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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:

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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

Name:
Title: MD

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HEALTH INSURANCE PORTABILITY 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.

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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

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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

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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

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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.

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e. Severability. 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

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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

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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: _____