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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 18, 2022

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 enter into a **Sole Source** contract with Mary Hitchcock Memorial Hospital (VC#177160), Lebanon, New Hampshire, in the amount of $9,109,658 to provide clinical and administrative services to meet the specialized health and related clinical and administrative needs of New Hampshire residents, with the option to renew for up to four (4) additional years, effective upon Governor and Council approval, through June 30, 2025. 28% Federal Funds. 72% General Funds.

This request represents one (1) of three (3) corresponding requests with Mary Hitchcock Memorial Hospital for the following services: 1) Clinical and Administrative Services; 2) Psychiatric and Medical Services; and 3) Neuropsychology Services. This request is contingent upon Governor and Council approval of all three (3) requests.

Funds are available in the following accounts for State Fiscal Years 2022 and 2023, and are anticipated to be available in State Fiscal Years 2024 and 2025, 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 Fiscal Detail Sheet Attached

EXPLANATION

The Department currently has an agreement with the Mary Hitchcock Memorial Hospital, which was competitively bid in 2016, to provide physician, clinical, and administrative services in seven (7) service areas: New Hampshire Hospital; Glencliff Home; Medicaid; Children, Youth, and Families; Behavioral Health; Elderly and Adult Services; and Developmental Services. The existing agreement includes an option to renew services through June 30, 2025. However, House Bill 2, of the 2021 Regular Legislative Session, appropriated $30 million to the Department for the purpose of constructing a 24-bed forensic psychiatric hospital. Consequently, the Department needed to reassess the existing contracted services to incorporate the new clinical needs arising from the planned New Hampshire Forensic Hospital and released competitive bids for 1) Psychiatric and Medical Services and 2) Neuropsychology Services.

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The following table outlines the Department's reprocurement strategy, which includes three (3) distinct actions. The Department will terminate the current agreement upon approval of the contracts specified in the table. As noted below, the neuropsychology, psychiatric, and medical services components of the existing contract have been bid out to incorporate the new forensic psychiatric hospital needs rather than incorporating them into an existing agreement. The purpose of this **Sole Source** request is to enter into a new contract to continue the other five (5) service areas that are not being reprocured and would have been continued under the existing agreement. The Contractor is uniquely experienced and qualified to provide the complex array of clinical and administrative services to the Department in these five (5) service areas. These services enable the Department to meet a wide range of specialized health and clinical needs of New Hampshire residents.

Reprocurement Strategy		
Description of Service Area	**Procurement**	**DHHS Areas Served**
Clinical and Administrative Services	New Sole Source	Medicaid Children, Youth, and Families Behavioral Health Elderly and Adult Services Developmental Services
Psychiatric and Medical Services	RFP issued July 2021	NHH Glencliff Forensic Hospital*
Neuropsychology	RFP issued November 2021	NHH Forensic Hospital*
* The Department anticipates the Forensic Hospital will open in State Fiscal Year 2024.		

Approval of this request will allow the Contractor to continue to work with the Department to apply principles of managed care for clinical treatment, educational and training programs. The Contractor will continue to provide the Department with a Chief Medical Officer, who plays an integral role in providing medical oversight of the State's publicly funded health insurance programs, informing key policy decisions, and shaping administrative planning strategies to enhance the operating efficiency of Medicaid and Children's Health Insurance Program (CHIP) and related healthcare initiatives across the state. In addition, the Contractor will identify and address medical research issues relative to the Department mission under RSA 135-C.

The Contractor will develop strategic clinical relationships with physicians as well as 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 will provide 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

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collaboration between Juvenile Justice Services, area mental health agencies and New Hampshire Hospital to enhance mental health services of adjudicated youth. The Contractor will also provide the personnel needed to help the Department achieve positive outcomes for individuals serviced by the behavioral health program; coordinate long-term care support services and to direct resources where they are needed most; and provide psychiatric and services and expert guidance and training to the Department's developmental services staff.

The Department will monitor contracted services by requiring the Contractor to:

- Identify performance metrics and monitoring processes, in collaboration with the Department;
- Develop a Quality Assurance and Monitoring Plan and report on progress toward goals;
- Review staff performance annually; and
- Adhere to certification guidelines.

As referenced in Exhibit A of the attached agreement, the parties have the option to extend the agreement for up four (4) additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties and Governor and Council approval.

Should the Governor and Council 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 many of the State's most vulnerable residents at risk.

Area served: Statewide

Source of Federal Funds: Catalog of Federal Assistance (CFDA) #93.778, CFDA #93.994, CFDA #93.004, CFDA #93.958 and CFDA #93.959.

Respectfully submitted,

Lori A. Shibinette
Commissioner

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Fiscal Detail Sheet
SS-2022-OCOM-02-CLINI-01
Clinical and Administrative Services

05-95-95-950010-50000000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS, COMMISSIONER'S OFFICE, OFFICE OF THE COMMISSIONER, COMMISSIONER'S OFFICE

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2022	102-500731	Contracts for Prog Svc	95063303	$148,811
2023	102-500731	Contracts for Prog Svc	95063303	$459,358
2024				$ 0
2025				$ 0
			Subtotal	*$608,169*

05-95-47-470010-79370000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS, DIVISION OF MEDICAID SERVICES, OFC OF MEDICAID SERVICES, MEDICAID ADMINISTRATION

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2022				$ 0
2023				$ 0
2024	102-500731	Contracts for Prog Svc	47000021	$ 472,670
2025	102-500731	Contracts for Prog Svc	47000021	$ 486,381
			Subtotal	*$959,051*

05-95-42-421510-66430000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS, HHS: HUMAN SERVICES, SUNUNU YOUTH SERVICE CENTER, SYSC HB2 91:327

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2022	101-506224	Medical Payments to Providers	42151501	$279,985
2023	101-506224	Medical Payments to Providers	42151501	$864,807
2024	101-506224	Medical Payments to Providers	42151501	$890,406
2025	101-506224	Medical Payments to Providers	42151501	$916,773
			Subtotal	*$2,951,971*

Fiscal Detail Sheet
SS-2022-OCOM-02-CLINI-01
Clinical and Administrative Services

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

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2022	102-500731	Contracts for Prog Svc	92204117	$199,947
2023	102-500731	Contracts for Prog Svc	92204117	$616,422
2024	102-500731	Contracts for Prog Svc	92204117	$634,191
2025	102-500731	Contracts for Prog Svc	92204117	$652,492
			Subtotal	*$2,103,052*

05-95-92-922010-41200000 HEALTH AND SOCIAL SERVICES HEALTH AND HUMAN SVCS, HHS: BEHAVIORAL HEALTH DIV, BUREAU OF MENTAL HEALTH SERVIC, MENTAL HEALTH BLOCK GRANT

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2022	102-500731	Contracts for Prog Svc	92254120	$97,114
2023	102-500731	Contracts for Prog Svc	92254120	$286,437
2024	102-500731	Contracts for Prog Svc	92254120	$207,564
2025	102-500731	Contracts for Prog Svc	92254120	$84,041
			Subtotal	*$675,156*

05-95-48-481010-78720000 HEALTH AND SOCIAL SERVICES HEALTH AND HUMAN SVCS, HHS: DLTSS-ELDERLY&ADULT SVCS, GRANTS FOR SOCIAL SVC PROG, ADM ON AGING

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2022	540-500382	Social Svc Contracts	48130305	$13,420
2023	540-500382	Social Svc Contracts	48130305	$41,461
2024	540-500382	Social Svc Contracts	48130305	$42,696
2025	540-500382	Social Svc Contracts	48130305	$43,968
			Subtotal	*$141,545*

Fiscal Detail Sheet
SS-2022-OCOM-02-CLINI-01
Clinical and Administrative Services

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

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2022	561-500911	Specialty Clinics	93001000	$30,000
2023	561-500911	Specialty Clinics	93001000	$30,000
2024	561-500911	Specialty Clinics	93001000	$30,000
2025	561-500911	Specialty Clinics	93001000	$30,000
			Subtotal	*$120,000*

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

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2022	102-500731	Contracts for Prog Svc	93005947	$74,788
2023	102-500731	Contracts for Prog Svc	93005947	$293,514
2024	102-500731	Contracts for Prog Svc	93005947	$302,938
2025	102-500731	Contracts for Prog Svc	93005947	$312,645
			Subtotal	*$983,885*

05-95-92-920510-19810000 HEALTH AND SOCIAL SERVICES HEALTH AND HUMAN SVCS, HHS: BEHAVIORAL HEALTH DIV, BUREAU OF DRUG & ALCOHOL SVCS, SABG ADDITIONAL

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2022	102-500731	Contracts for Prog Svc	92059502	$77,876
2023	102-500731	Contracts for Prog Svc	92059502	$231,038
2024	102-500731	Contracts for Prog Svc	92059502	$173,875
2025	102-500731	Contracts for Prog Svc	92059502	$84,040
			Subtotal	*$566,829*
			TOTAL	**$9,109,658**

Subject: Clinical and Administrative Services (SS-2022-OCOM-02-CLINI-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 New Hampshire Department of Health and Human Services		1.2 State Agency Address 129 Pleasant Street Concord, NH 03301-3857	
1.3 Contractor Name Mary Hitchcock Memorial Hospital		1.4 Contractor Address One Medical Center Drive Lebanon, New Hampshire 03756	
1.5 Contractor Phone Number (603) 650-5000	1.6 Account Number 05-95-92-922010-4117 05-95-92-922010-4120 05-95-92-920510-1981 05-95-42-421510-6643 05-95-95-950010-5000 05-95-93-930010-5191 05-95-93-930010-5947 05-95-48-481010-7872 05-95-47-470010-7937	1.7 Completion Date June 30, 2025	1.8 Price Limitation $9,109,658
1.9 Contracting Officer for State Agency Nathan D. White, Director		1.10 State Agency Telephone Number (603) 271-9631	
1.11 Contractor Signature DocuSigned by: Edward J. Merrens 8ACA3CECA0CC438... Date: 3/2/2022		1.12 Name and Title of Contractor Signatory Edward J. Merrens Chief Clinical Officer	
1.13 State Agency Signature DocuSigned by: Lori A. Weaver 4C4A92994125473... Date: 3/2/2022		1.14 Name and Title of State Agency Signatory Lori A. Weaver Deputy Commissioner	
1.15 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)* By:		Director, On:	
1.16 Approval by the Attorney General (Form, Substance and Execution) *(if applicable)*			

Contractor Initials DS EJM

Date 3/2/2022

By: DocuSigned by: Takhmina Rakhmatova EDF521C625C34AC... On: 3/2/2022

1.17 Approval by the Governor and Executive Council *(if applicable)*

G&C Item number: G&C Meeting Date:

Contractor Initials DS EJM

Date 3/2/2022

2. 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 B 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 1.17, 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 1.13 ("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 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 for Services provided in EXHIBIT B, in whole or in part. 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 reduce or terminate the Services under this Agreement immediately upon giving the Contractor notice of such reduction or termination. The State shall not be required to transfer funds from any other account or source 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 C 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 applicable 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 employment opportunity laws. In addition, if this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all federal executive orders, rules, regulations and statutes, and with any rules, regulations and guidelines as the State or the United States issue to implement these regulations. The Contractor shall also comply with all applicable intellectual property 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. The Contractor 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 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.

Contractor Initials DS EJM

Date 3/2/2022

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 cured, 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 give the Contractor a written notice specifying the Event of Default and 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 give the Contractor a written notice specifying the Event of Default, treat the Agreement as breached, terminate the Agreement and pursue any of its remedies at law or in equity, or both.

8.3. 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.

9. TERMINATION.

9.1 Notwithstanding paragraph 8, the State may, at its sole discretion, terminate the Agreement for any reason, in whole or in part, by thirty (30) days written notice to the Contractor that the State is exercising its option to terminate the Agreement.

9.2 In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall, at the State's discretion, 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 B. In addition, at the State's discretion, 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.

10. DATA/ACCESS/CONFIDENTIALITY/ PRESERVATION.

10.1 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.

10.2 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.

10.3 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.

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.

12.1 The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written notice, which shall be provided to the State at least fifteen (15) days prior to the assignment, and a written consent of the State. For purposes of this paragraph, a Change of Control shall constitute assignment. "Change of Control" means (a) merger, consolidation, or a transaction or series of related transactions in which a third party, together with its affiliates, becomes the direct or indirect owner of fifty percent (50%) or more of the voting shares or similar equity interests, or combined voting power of the Contractor, or (b) the sale of all or substantially all of the assets of the Contractor.

12.2 None of the Services shall be subcontracted by the Contractor without prior written notice and consent of the State. The State is entitled to copies of all subcontracts and assignment agreements and shall not be bound by any provisions contained in a subcontract or an assignment agreement to which it is not a party.

13. INDEMNIFICATION. Unless otherwise exempted by law, the Contractor shall indemnify and hold harmless the State, its officers and employees, from and against any and all claims, liabilities and costs for any personal injury or property damages, patent or copyright infringement, or other claims asserted against the State, its officers or employees, which arise out of (or which may be claimed to arise out of) the acts or omission of the

Contractor Initials EJM (DS)

Date 3/2/2022

Contractor, or subcontractors, including but not limited to the negligence, reckless or intentional conduct. The State shall not be liable for any costs incurred by the Contractor arising under this paragraph 13. 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 continuously maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:

14.1.1 commercial general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $1,000,000 per occurrence and $2,000,000 aggregate or excess; and

14.1.2 special cause of loss coverage form covering all property subject to subparagraph 10.2 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.

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 ten (10) days prior to the expiration date of each insurance policy. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference.

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. The 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. 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.

17. 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.

18. CHOICE OF LAW AND FORUM. This Agreement shall be governed, interpreted and 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. Any actions arising out of this Agreement shall be brought and maintained in New Hampshire Superior Court which shall have exclusive jurisdiction thereof.

19. CONFLICTING TERMS. In the event of a conflict between the terms of this P-37 form (as modified in EXHIBIT A) and/or attachments and amendment thereof, the terms of the P-37 (as modified in EXHIBIT A) shall control.

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 or modifying provisions set forth in the attached EXHIBIT A 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 with respect to the subject matter hereof.

Contractor Initials DS EJM

Date 3/2/2022

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

EXHIBIT A

Revisions to Standard Agreement Provisions

1. Revisions to Form P-37, General Provisions

1.1. Paragraph 3, Effective Date/Completion of Services, is amended by adding subparagraph 3.3 as follows:

3.3. The parties may extend the Agreement for up to four (4) additional years from the Completion Date, contingent upon satisfactory delivery of services, available funding, agreement of the parties, and approval of the Governor and Executive Council.

1.2. Paragraph 7, Personnel, is amended by modifying subparagraphs 7.1 and 7.2 to read:

7.1. The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor certifies 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's personnel involved in this project, 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 Agreement. This provision shall survive termination of this Agreement.

1.3. Paragraph 9, Termination, is amended by modifying subparagraph 9.2 to read:

9.2 In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall, at the State's discretion, deliver to the Contracting Officer, not later than thirty (30) 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 B. In addition, at the State's discretion, the Contractor shall, within thirty (30) days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement.

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

EXHIBIT A

1.4. Paragraph 12, Assignment/Delegation/Subcontracts, is amended by adding subparagraph 12.3 as follows:

12.3. Subcontractors are subject to the same contractual conditions as the Contractor and the Contractor is responsible to ensure subcontractor compliance with those conditions. The Contractor shall have written agreements with all subcontractors, specifying the work to be performed and how corrective action shall be managed if the subcontractor's performance is inadequate. The Contractor shall manage the subcontractor's performance on an ongoing basis and take corrective action as necessary. The Contractor shall annually provide the State with a list of all subcontractors provided for under this Agreement and notify the State of any inadequate subcontractor performance.

1.5. Paragraph 14, Insurance, is amended by modifying subsection 14.1.2 to delete the text in its entirety and replace it to read:

14.1.2. Professional liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 per annual aggregate.

1.6. Paragraph 14, Insurance, is amended by modifying subparagraph 14.2 to read:

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 or registered to conduct business in the State of New Hampshire.

1.7. Paragraph 17, Amendment, is amended by adding subparagraph 17.1, to read:

17.1 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 paragraph 17.

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

EXHIBIT B

Scope of Services

1. Statement of Work

1.1. The Contractor shall provide clinical and administrative services to the Department of Health and Human Services (the "Department") and various populations served by the Department in all five (5) Service Areas identified below and as described herein:

1.1.1. Service Area #1 – Medicaid

1.1.2. Service Area #2 – Children, Youth and Families

1.1.3. Service Area #3 – Behavioral Health

1.1.4. Service Area #4 – Elderly and Adult Services

1.1.5. Service Area #5 – Developmental Services

1.2. For the purposes of this agreement, all references to days shall mean business days, unless otherwise specified.

1.3. For the purposes of this Solicitation, one (1) full-time equivalent (FTE) is equal to one (1) full-time employee who works forty (40) hours per week.

1.4. The Contractor shall provide all services described herein for the full term of the contract.

1.5. General Requirements Applicable to All Service Areas

1.5.1. The Contractor shall deliver the services to the Service Areas in Subsection 1.1 as described in this Exhibit B, Scope of Services, by providing qualified personnel, and as otherwise necessary, to fulfill the requirements described herein.

1.5.2. The Contractor shall work with the Department 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.

1.5.3. The Contractor shall work with the Department 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 Department 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.

1.5.4. 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.

1.5.5. 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 five (5) Service Areas.

1.5.6. The Department shall identify one (1) primary designee for each Service Area. The designee will serve as the primary point of contact, oversee the services provided, and provide required approvals as described herein for each Service Area.

1.6. Specific Service Requirements – Service Area #1 – Medicaid

1.6.1. **Chief Medical Officer**

1.6.1.1. The Contractor shall provide one (1) Full-Time Equivalent (FTE) physician to serve as the Department's Chief Medical Officer.

1.6.1.2. The Chief Medical Officer shall plan and direct all aspects of the Department's medical policies and programs to ensure the provision of integrated primary care services to individuals eligible for the Medicaid program, in collaboration with the Department designee.

1.6.1.3. The Chief Medical Officer shall:

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

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

1.6.1.3.3. Possess a graduate degree in public health or health care administration with demonstrated experience in public health or healthcare administration systems development;

1.6.1.3.4. Have a minimum of five (5) 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;

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

1.6.1.3.6. 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;

1.7. Specific Service Requirements – Service Area #2 – Children, Youth and Families

1.7.1. Staff Psychologist

1.7.1.1. The Contractor shall provide one (1) FTE Staff Psychologist who is a faculty member and/or employee of the Contractor, to provide the services described herein to the programs within the Children, Youth and Families service area.

1.7.1.2. The Contractor shall work directly with the Department designee for the Sununu Youth Services Center (SYSC) and ensure the Staff Psychologist:

1.7.1.2.1. Provides treatment planning oversight, clinical consultations, case reviews, and assessments to treatment coordinators and Juvenile Probation and Parole Officers;

1.7.1.2.2. Documents the number of treatment team meetings and clinical consultations attended annually with multi-disciplinary team members at SYSC;

1.7.1.2.3. Provides program development at SYSC, using a resiliency-building framework, and implements Evidence-Based Practices (EBP) to include interpersonal problem-solving skills, trauma-focused cognitive behavioral therapy, and dialectical behavioral therapy;

1.7.1.2.4. Documents specific types and numbers of evidence-based treatment interventions implemented annually at SYSC;

1.7.1.2.5. Oversees implementation of research initiatives on the effectiveness and outcomes of services and programs within and for Juvenile Justice Services (JJS);

1.7.1.2.6. Fosters improved interagency collaboration between JJS services, Community Mental Health Centers (CMHCs), and New Hampshire Hospital (NHH) and/or Hampstead Hospital to enhance mental health services for adjudicated youths, and to improve transitional processes between residential and community-based programs for court-involved youths; and

1.7.1.2.7. Documents the number of youths consulted on annually by Juvenile Probation and Parole Officers and interagency collaborative teams.

1.7.1.3. The Contractor shall ensure the Staff Psychologist meets the following qualifications:

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

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

1.7.1.3.3. Certification by NH Board of Psychologists.

1.7.1.3.4. Maintains an unrestricted license to practice Psychology

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

1.7.1.4. The Staff Psychologist will maintain a professional calendar electronically, in a format subject to Department approval, and make the calendar available to the Department designee as necessary. The Contractor shall ensure the calendar is kept up to date and includes appropriate information, including, but not limited to, approved leave time, conferences, and trainings.

1.7.1.5. The Contractor shall ensure 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. The Staff Psychologist shall provide prior, timely notification to the designated Department representative of any leave time taken. Absences due to vacation and/or continuing education shall be planned in advanced in consideration of the business needs of the Department. The Contractor shall ensure appropriate coverage for any clinical and/or operational responsibilities or tasks that need oversight while the Staff Psychologist is on leave.

1.7.1.6. The Contractor shall ensure that any out-of-state travel for conferences and/or trainings for the Staff Psychologist is subject to the prior approval of the Department designee.

1.7.1.7. The Staff Psychologist's primary workspace shall be located in Manchester, New Hampshire, in a Department-designated facility. The Department shall provide office space, furniture, a computer with access to Department shared network drives, as necessary, the usual and customary office supplies, a mobile phone for business use and administrative and clerical support.

The Contractor shall ensure the Staff Psychologist utilizes Department-provided information and technology resources consistent with applicable State policies.

1.7.2. **Staff Psychiatrist**

1.7.2.1. The Contractor shall provide one (1) part-time (.25 FTE) Staff Psychiatrist who is a faculty member and/or employee of the Contractor to provide psychiatric services to programs within the Children, Youth and Families service area for a minimum of ten (10) hours per week.

1.7.2.2. The Staff Psychiatrist's responsibilities shall include, but are not limited to:

1.7.2.2.1. Providing medical and psychiatric services at SYSC.

1.7.2.2.2. 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.

1.7.2.2.3. Providing clinical supervision and teaching child psychiatry residents and fellows at SYSC.

1.7.2.2.4. Providing supervision and teaching interns, residents, and fellows at SYSC.

1.7.2.3. The Contractor shall ensure the Staff Psychiatrist meets the following qualifications:

1.7.2.3.1. Possesses a medical degree (MD or DO);

1.7.2.3.2. Specializes in child psychiatry with an interest in criminal justice;

1.7.2.3.3. Completed both an ACGME approved residency program in psychiatry and a two (2) year ACGME approved fellowship in child/adolescent psychiatry;

1.7.2.3.4. Board certified by the American Board of Psychiatry and Neurology in Psychiatry;

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

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

1.7.3. **Psychiatric Consultant**

1.7.3.1. The Contractor shall provide one (1) part-time (.25 FTE) Psychiatric Consultant to provide psychiatric consultation services to programs within the Children, Youth and Families service area for a minimum of ten (10) hours per week.

1.7.3.2. The Psychiatric Consultant shall provide consultation to the Department on psychotropic medication prescriptions for youth who are in out-of-home care at a location other than SYSC. Consultation typically includes 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.

1.7.3.3. The Contractor shall ensure the Psychiatric Consultant meets the following qualifications:

1.7.3.3.1. Has clinical experience in addiction treatment and criminal justice.

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

1.7.4. **Sununu Youth Services Center (SYSC) – Medical Doctor**

1.7.4.1. The Contractor shall provide one (1) Medical Doctor to perform medical rounds to address and follow up on resident medical concerns or ailment for one (1) hour per day on Monday, Wednesday, and Friday each week, not to exceed three (3) hours per week. The Contractor shall maintain an on-call rotation to address and manage emergent situations and provide aid to Registered Nursing (RN) staff, as requested by the Department.

1.7.4.2. The Contractor shall ensure that admissions and readmission physical assessments are completed within three (3) business days of resident arrival.

1.7.4.3. The Medical Doctor shall prescribe medication and/or perform other medical procedures for residents as needed, including but not limited to:

1.7.4.3.1. X-rays.

1.7.4.3.2. Laboratory work.

1.7.4.4. The Medical Doctor shall make service referrals for residents as needed to other providers, including but not limited to:

1.7.4.4.1. SYSC Staff Dentist.

1.7.4.4.2. SYSC Psychiatrist.

1.7.4.4.3. External medical providers.

1.7.4.5. The Medical Doctor shall ensure all medications for residents are ordered and received prior to any upcoming furlough or discharge of residents from SYSC.

1.7.5. **Sununu Youth Services Center – Clinicians**

1.7.5.1. The Contractor shall provide two (2) licensed Clinicians to provide clinical support and services to SYSC residents in accordance with SYSC policies and protocols. Services shall include, but are not limited to:

1.7.5.1.1. Individual, group and family therapy;

1.7.5.1.2. Watch assessments;

1.7.5.1.3. Crisis intervention and/or support and processing; and

1.7.5.1.4. Development of youth treatment plans.

1.7.5.2. The Contractor shall ensure Clinicians are available to provide on-call services Monday through Friday from 5:00 p.m. to 7:00 a.m. and weekends.

1.7.5.3. The Clinicians shall complete the On-Call Coverage Report and submit a copy to the SYSC supervisor by the following business day.

1.7.5.4. The Clinicians shall conduct clinical assessments and screenings, including but not limited to:

1.7.5.4.1. Initial watch assessment, including PREA interviews and suicide screenings.

1.7.5.4.2. Full psychosocial assessment, including a clinical interview and information gathering about the youth, their history, and family history.

1.7.5.4.3. Mental health screening.

1.7.5.4.4. Substance use screening.

1.7.5.4.5. Trauma screening.

1.7.5.5. The Clinicians shall conduct Child and Adolescent Needs and Strengths Assessment and prepare parole and court reports and participate in hearings as necessary.

1.7.5.6. The Contractor shall ensure Clinicians complete all necessary documentation.

1.7.5.7. The Clinicians shall attend all required meetings to support the clinical work of the facility, including but not limited to:

1.7.5.7.1. Monthly Treatment Plan Meetings.

1.7.5.7.2. Twice weekly case reviews.

1.7.5.7.3. Bi-weekly clinical team meetings.

1.7.5.7.4. Monthly youth clinical ranking meetings.

1.7.5.7.5. Monthly staff meetings.

1.7.5.7.6. Weekly individual supervision.

1.7.5.7.7. Various consultation meetings.

1.7.5.8. The Clinicians shall schedule and facilitate youth trust meetings, as requested by the Department.

1.8. Specific Service Requirements – Service Area #3 – Behavioral Health

1.8.1. **Medical Director**

1.8.1.1. The Contractor shall provide one part-time (.50 FTE) Medical Director to provide the services descried herein to the Behavioral Health service area.

1.8.1.2. The Contractor shall ensure the Medical Director is present on-site at a Department-designated location for twenty (20) hours per week. The Medical Director shall be available via telephone, email, and in person by appointment.

1.8.1.3. The Medical Director shall, in collaboration with the Department, be responsible for the following:

1.8.1.3.1. Meeting weekly with the Department designee;

1.8.1.3.2. Addressing Behavioral Health clinical issues;

1.8.1.3.3. Reviewing and informing Behavioral Health policy issues;

1.8.1.3.4. Enhancing housing support capacity planning;

1.8.1.3.5. Reviewing and informing Medicaid and state rule issues;

1.8.1.3.6. Assisting in developing telemedicine capacity;

1.8.1.3.7. Utilizing electronic medical records, as needed;

1.8.1.3.8. Coordinating care between NHH and CMHCs;

1.8.1.3.9. Overseeing and consulting on implementation of Evidence Based Practices;

1.8.1.3.10. Developing funding and reimbursement strategies;

1.8.1.3.11. Reviewing and informing the sustainability of behavior change programs; and

1.8.1.3.12. Assessing the needs of patients in NHH and Transitional Housing Services who might be served in the community.

1.8.1.4. The Medical Director shall attend meetings with the Department's Behavioral staff and various community stakeholder groups, including, but not limited to the Community Behavioral Health Association and the Disabilities Rights Center, to communicate, develop support for, and gather input on Behavioral Health initiatives; and

1.8.1.5. The Medical Director shall serve as the Lead Manager for the ProHealth integration grant, working in collaboration with the Department and identified programs, to implement grant deliverables.

1.8.1.6. The Medical Director shall oversee quality assurance and quality improvement functions including, but not limited to:

1.8.1.6.1. Monitoring the effectiveness of the Department's Behavioral Health contracted services to enhance cost effectiveness and promote positive health outcomes for service recipients; and

1.8.1.6.2. Developing research-based outcome measures and quality oversight models for community mental health services in collaboration with the Department.

1.8.1.7. The Medical Director shall be responsible for the following:

1.8.1.7.1. Participating on departmental and legislative committees, as required by the Department, which may include, but are not limited to, the Mental Health Commission, the Mental Health Council, the Drug Utilization and Review Board, and the Department Institutional Review Board;

1.8.1.7.2. Providing expert review and consultation to inform and support legislation that will affect individuals and families affected by severe and persistent mental illness to ensure the implications and outcomes are in the best interest of this population;

1.8.1.7.3. Serving as secretary for the Mental Health Council and ensuring that the work of the council supports the goals of the Department;

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

1.8.1.7.5. Attending monthly Institutional Review Board meetings, review research protocols as needed each month to ensure safety of Department research participants;

1.8.1.7.6. Participating on several Behavioral Health System Transformation Workgroups, including the Evidence Based Practices Steering Committee, Programmatic Workgroup, and Quality Assurance Group;

1.8.1.7.7. Coordinating and meeting with Department leadership as required by the Department;

1.8.1.7.8. Conducting meetings monthly, or at a frequency as otherwise requested by the Department, to coordinate efforts between the Department and CMHCs to address Behavioral Health issues and initiatives that include, but are not limited to:

1.8.1.7.8.1. 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, but not limited to, preferred drug list issues.

1.8.1.7.8.2. Providing Consultation and Technical Assistance.

1.8.1.7.8.3. Coordination with NHH admissions and treatment.

1.8.1.7.8.4. Medicaid interruption during institutionalization.

1.8.1.7.8.5. Enhancement of community housing supports.

1.8.1.7.8.6. Use of information technology.

1.8.1.7.8.7. Administrative issues.

1.8.1.7.8.8. Use and implementation of evidence, implementation of Evidence Based Practices.

1.8.1.7.8.9. Integration of mental and physical health care.

1.8.1.7.8.10. Smoking cessation.

1.8.1.7.9. 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.

1.8.1.7.10. Monitoring the effectiveness of the preferred drug list in enhancing cost effective and safe psychotropic medication prescribing in New Hampshire, including, but not limited to, 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;

1.8.1.7.11. Communicating regularly with and providing clinical consultation, including but, not limited to, potential site visits, conference calls, and written reports, to Behavioral Health management staff regarding current and challenging clinical issues, including, but not limited to, conditional discharges, Medicaid consumer cases, and suicide monitoring;

1.8.1.7.12. Collaborating with other Department staff, including, but not limited to, Medical Directors, on a regular basis to monitor medical care and related patient care issues throughout New Hampshire, including, but not limited to, 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;

1.8.1.7.13. Providing oversight of and implementing evidence-based practices, including, but not limited to, the Medicaid Program for Community Mental Health

Services practices and practices specifically required in accordance with the Community Mental Health Agreement.

1.8.1.7.14. Supporting the expansion and development of new programs informed by evidenced-based and emerging best practices to fill gaps in the mental health continuum of care.

1.8.1.8. The Contractor shall ensure the Medical Director meets the following qualifications:

1.8.1.8.1. Possesses a medical degree (MD or DO);

1.8.1.8.2. Board Certified by the American Board of Psychiatry and Neurology in Psychiatry;

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

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

1.8.2. **Evidence-Based Practices (EBP) Training and Consultation**

1.8.2.1. The Contractor shall provide part-time Trainers and/or Consultants, equal to (2) FTEs in total, to provide EBP Training and Consultation Services as described herein to sustain and continuously improve the quality of EBP in the Community Mental Health system as follows:

1.8.2.1.1. **Illness Management and Recovery (IMR):** The Contractor shall develop, in collaboration with the Department, and conduct training for CMH staff on IMR and/or **Enhanced IMR (E-IMR)** in specific topic areas, subject to Department approval. The Contractor shall conduct IMR/E-IMR training sessions as follows:

1.8.2.1.1.1. Two (2) trainings of no less than fifteen (15) hours each training, presented in two (2) full-day or four (4) half-day training sessions, for new IMR/E-IMR practitioners, to fulfill the specifications described in He-M 426 to provide IMR/E-IMR services. The capacity for each training event shall be no fewer than ten (10) participants and no more than forty (40) participants, depending on the availability of the training space;

1.8.2.1.1.2. No fewer than eight (8) hours of training, presented in one (1) or two (2) training sessions, for supervisors of and/or experienced IMR/E-IMR staff that shall fulfill the specifications in He-M 426 for ongoing providers of IMR/E-IMR services. The content shall include information on supporting the learning of IMR skills for colleagues and improving the quality and outcomes of IMR/E-IMR services through practice-specific supervision. The capacity for this training event shall be no fewer than ten (10) participants and no more than twenty (20) participants.

1.8.2.1.2. **Individual Placement and Support Supported Employment (IPS-SE):** The Contractor shall develop, in collaboration with the Department, and conduct training for CMH staff on IPS-SE services in specific topic areas, subject to Department approval. The Contractor shall conduct IPS-SE training sessions as follows:

1.8.2.1.2.1. Two (2) trainings of no less than fifteen (15) hours each training, presented in two (2) full-day or four (4) half-day training sessions, for new IPS-SE practitioners to fulfill the specifications described in He-M 426 to provide evidence based SE services. The capacity for each training shall be no fewer than ten (10) participants and no more than forty (40) participants.

1.8.2.1.2.2. No fewer than eight (8) hours of training, presented in one (1) or two (2) training sessions for experienced IPS-SE practitioners. The combination of attending these two events shall fulfill the specifications described in He-M 426 for ongoing providers of IPS-SE services. This training will focus on job development strategies used with community partners and employers. The capacity for each of these training events shall be no fewer than ten (10) participants and no more than thirty (30) participants.

1.8.2.1.2.3. No fewer than eight (8) hours of training, presented in one (1) or two (2) training sessions for experienced IPS-SE practitioners and IPS-SE supervisors and/or experienced IPS-SE staff. The combination of attending these two events shall fulfill the specifications described in He-M 426 for ongoing providers of evidence based SE 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 IPS-SE services. The capacity for each of these training events shall be no fewer than ten (10) participants and no more than twenty (20) participants.

1.8.2.1.3. **Assertive Community Treatment Teams (ACT):** The Contractor shall develop, in collaboration with the Department, ACT services training for CMH staff on specific topic areas, subject to Department approval. The Contractor shall conduct ACT trainings as follows:

1.8.2.1.3.1. Two (2) trainings of no less than fifteen (15) hours each training, presented in two (2) full-day or four (4) half-day training sessions, for new ACT practitioners to fulfill the specifications described in He-M 426 to provide IPS-SE services. The capacity for each training shall be no fewer than ten (10) participants and no more than forty (40) participants.

1.8.2.1.3.2. No fewer than eight (8) hours of training, presented in one (1) or two (2) training sessions for experienced ACT practitioners. The combination of attending the two (2) events shall fulfill the specifications described in He-M 426 for ongoing providers of ACT services. This training will focus on working with individuals with co-occurring substance use disorders. The capacity for each training shall be no fewer than ten (10) participants and no more than forty (40) participants.

1.8.2.1.3.3. No fewer than eight (8) hours of training, presented in one (1) or two (2) training sessions for experienced ACT practitioners and ACT supervisors. The combination of attending the two (2) events shall fulfill the specifications described in He-M 426 for ongoing providers of ACT services. The capacity for each training shall be no fewer than ten (10) participants and no more than twenty (20) participants.

1.8.2.1.4. **Consultation to CMH Program Leadership and Workforce Development:** The Contractor shall provide agency-based consultations to all CMH programs as designated by the Department designee to assist agencies in sustaining and providing continuous quality improvement for IMR/E-IMR, ACT and IPS-SE 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 in Subparagraph 1.9.2.7, and at the Department's request. 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 IPS-SE services.

1.8.2.1.4.1. In cases where CMH programs would benefit from specific agency-based workforce development interventions from the Contractor's staff, the Contractor shall provide such further interventions upon mutual agreement of the Department designee, the Contractor, and CMH program leadership.

1.8.2.1.4.2. Such interventions shall be targeted and focused and customized to improving designated fidelity areas that are identified as a result of agency-based post fidelity consultations.

1.8.2.1.5. **NH Behavioral Health Service Area Consultations and Collaboration:** The Contractor shall assist with sustaining and improving the quality of IMR/E-IMR,

ACT and IPS-SE services in the NH Community Mental Health system by providing consultation services to the Department and CMHCs, as identified by the Department, including but not limited to, consulting on, in collaboration with the Department designee, emerging best practices, evidence-based practices, and practice innovations to support overall system implementation and to inform the design and/or transformation of services.

1.8.2.2. The Contractor shall provide staff or other qualified professionals, subject to the approval by the Department, necessary to provide additional education, training, technical assistance, and consultation to Department and CMH providers, including but not limited to, training the CMH workforce to improve the quality of IMR/E-IMR, IPS-SE, and ACT services. The Contractor shall:

1.8.2.2.1. Provide education and training to CMH staff identified by the Department. The Contractor shall provide a total of eighteen (18) days of training, but schedules and requirements for each EBP as outlined below may be adjusted upon mutual agreement between the Department and Contractor in order to meet the needs of the CHM staff.

1.8.2.2.2. 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/E-IMR, IPS-SE, 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.

1.8.2.2.3. Ensure each training event includes, at a minimum:

1.8.2.2.3.1. Invitations provided to CMHC staff before the training event;

1.8.2.2.3.2. A description of who should attend the training;

1.8.2.2.3.3. Outcomes for participants attending the training;

1.8.2.2.3.4. Sufficient time to provide instruction and practice for skills;

1.8.2.2.3.5. Content designed to improve the fidelity of the practice at CMHCs;

1.8.2.2.3.6. Documentation of all participants attending the training; and

1.8.2.2.3.7. Certificates of attendance for all participants completing the training.

1.8.2.3. The Contractor shall prepare research information, specific ideas, interventions, feedback, data and strategies, as collaboratively agreed upon by the Department designee and the Contractor.

1.8.2.4. The Contractor's attendance at other events as collaboratively agreed upon by the Department designee and the Contractor for the purposes of sustaining and improving the quality of IMR/E-IMR, ACT, and IPS-SE.

1.8.2.5. **Evidence Based Practices Fidelity Assessments:** The Contractor shall conduct fidelity assessments to determine organizational faithfulness to the principles of ACT and evidence based SE practices for all CMH programs, as requested by the Department. The Contractor shall:

1.8.2.5.1. Conduct fidelity assessments for the purpose of monitoring the implementation of ACT and IPS-SE and for providing information about the capacity, strengths and areas in need of improvement in providing the practice at the designated CMH programs.

1.8.2.5.2. Develop, in collaboration with the Department designee, a specific schedule designating specific time periods for each CMH program, ACT and IPS-SE fidelity assessment and/or related consultations(s). The schedule shall be subject to the advanced approval of the Department designee.

1.8.2.5.3. Ensure that each fidelity assessment includes, at a minimum:

1.8.2.5.3.1. Written instructions to the CMH program regarding preparation for fidelity assessments that includes necessary observations, interviews, data access/documents and other activities for the assessment.

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

1.8.2.5.3.3. Sufficient time to assess and evaluate the CMH program's delivery of ACT or IPS-SE.

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

1.8.2.5.3.5. A written fidelity assessment report to include findings, rationale/observations, scoring, identified strengths, identified areas of improvement with recommendations provided to CMH leadership and the Department no later than four weeks following the assessment visit.

1.8.2.6. The Contractor shall provide one (1) full-time position (1.0 FTE) to provide training, consultation and technical assistance to community mental health and substance use disorder treatment contracting organizations on:

1.8.2.6.1. Organizational change and workflows to support treatment of co-occurring disorders for organization leaders and team leaders, including hiring, treatment program structures, supervision practices, EMR changes, and other organizational structures and practices;

1.8.2.6.2. Identification and diagnosis of substance use disorders in people with mental health disorders from both clinical and systems perspectives;

1.8.2.6.3. Identification and diagnosis of mental health disorders in people with substance use disorders (SUD) from both clinical and systems perspectives;

1.8.2.6.4. Evidence-based practice treatment for co-occurring disorders including:

1.8.2.6.4.1. Motivational interviewing for behavior change;

1.8.2.6.4.2. Cognitive and behavioral treatment for SUD;

1.8.2.6.4.3. Incorporating SUD treatment into Assertive Community Treatment;

1.8.2.6.4.4. Cognitive and behavioral treatment for PTSD and depressive disorders in people with SUD;

1.8.2.6.4.5. Medication assisted treatment for SUD including alcohol, opioid, and tobacco use disorders;

1.8.2.6.4.6. Medication treatment for PTSD and depressive disorder in people with SUD;

1.8.2.6.4.7. Six (6) months of weekly group consultation/case supervision to support treatment skills following evidence-based practice treatment for co-occurring disorders training; and

1.8.2.6.4.8. Use of digital interventions in conjunction with EBPs to extend and enhance treatment

1.8.2.6.5. The position will work with the Department to engage contracting organizations in order to tailor training content, schedule training, engage trainees and assess outcomes of training, consultation and technical assistance;

1.8.2.6.6. The position will develop training materials and provide the to the Department to post and distribute;

1.8.2.6.7. The position will conduct satisfaction surveys with trainees and continuously improve training, consultation, and technical assistance;

1.8.2.6.8. The position will work with current EBP Trainers and Consultants and Department staff to collaborate and coordinate activities.

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

1.8.3.1. The Contractor shall provide a part-time (.10 FTE) Behavioral Health Policy Institute Consultant. Under the direction of the Department designee and the Behavioral Health Medical Director, the Behavioral Health Policy Institute Consultant shall:

1.8.3.1.1. Conduct analyses of Medicaid claims, as requested by the Department, to address policy issues and questions under consideration from the Behavioral Health program.

1.8.3.1.2. Participate in regular meetings with the Department designee and/or the Behavioral Health Medical Director to review analyses and associated policy implications.

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

1.8.4.1. The Contractor shall provide one (1) part-time (.15 FTE) Support Staff/Co-Chair and one (1) part-time (.50 FTE) Research Assistant to support the Committee for the Protection of Human Services.

1.8.4.2. Responsibilities of the Contractor staff shall include, but are not limited to:

1.8.4.2.1. Attending and fully participating in CPHS full committee meetings (once per month);

1.8.4.2.2. Conducting expedited reviews as requested by the CPHS Administrator;

1.8.4.2.3. Providing consultation, support, and guidance to the CPHS Administrator, Chairperson, and Committee members regarding the interpretation of federal regulations and human subject protections, including, but not limited to, pre-reviewing materials, reviewing requirements for exempt and expedited determinations, and reviewing significant adverse event reports;

1.8.4.2.4. Serving on the Consent Form Template and Forms sub- committees, or other sub-committees, as requested by the CPHS Chairperson; and

1.8.4.2.5. Serving as the Co-Vice Chair to the CPHS.

1.8.4.2.6. Revision of the aforementioned deliverables may be done by mutual agreement of the Contractor and the Department designee. The availability of additional federal funds to support the implementation of additional EBP 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.

1.8.4.3. The Contractor shall provide research, scientific and human subject expertise to the CPHS for the purpose of sustaining and supporting oversight of research funded by federal agencies and other non-state sources and conducted in New Hampshire Department-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.

1.8.5. **Crisis System Transformation Evaluation**

1.8.5.1. The Contractor shall provide consultation and technical assistance to review, advise on, and support successful implementation of NH's behavioral health crisis system (Rapid Response).

1.8.5.2. The Contractor shall provide consultation and technical assistance to evaluate NH's behavioral health crisis system (Rapid Response) transformation and impact.

1.8.5.3. The Contractor shall work with the Department in months 0-3 to evaluate and inform the initial transformation of NH's crisis system by:

1.8.5.3.1. Developing a process to review the initial crisis transformation data, which is intended to determine if, and to what extent, the target CMHCs have converted services from hospital-based emergency services to community-based mobile crisis services.

1.8.5.3.2. Identifying available data sources for evaluation of the system transformation, including emergency department waitlists, Designated Receiving Facility (DRF) census data, and Rapid Response system data.

1.8.5.3.3. Identifying key leaders and stakeholders involved in crisis system transformation and conducting semi-structured interviews to identify important contextual variables across the different CMHCs, as well as potential barriers and facilitators to crisis system transformation.

1.8.5.3.4. Developing a comprehensive evaluation plan that outlines measures and methods for collecting process and outcome data, with particular focus on collecting process / implementation data in the first six months to guide roll-out of the Rapid Response system at the second cohort of clinics.

1.8.5.4. The Contractor shall work with the Department in months 0-6 to evaluate and inform the initial transformation of NH's crisis system by:

1.8.5.4.1. Analyzing quantitative and qualitative data to make quality improvement recommendations for the Rapid Response system. Activities shall include:

1.8.5.4.1.1. Reviewing comprehensive data regarding initial Rapid Response implementation;

1.8.5.4.1.2. Gathering community provider, stakeholder, and user input about their experience and opportunities for process and/or system improvements; and

1.8.5.4.1.3. Issuing an initial report of findings and recommendations to the Department.

1.8.5.4.2. Developing a process or system, such as a data dashboard, to compile and review crisis system data over time, including but not limited to the emergency department waitlist, Designated Receiving Facility (DRF) census data, and initial Rapid Response system data to determine if, and to what extent, the Rapid Response system has changed utilization trends for inpatient hospitalization and/or crisis apartment utilization.

1.8.5.4.3. Providing consultation and technical assistance regarding findings and recommendations that may include:

1.8.5.4.3.1. Consultation to improve implementation per fidelity to the current Rapid Response model;

1.8.5.4.3.2. Adaptation of the Rapid Response crisis system for NH's environments, specifically rural regions; and

1.8.5.4.3.3. Consultation to expand the stabilization component of the Rapid Response model that will be sustainable and accessible statewide. Models such as crisis apartments, in-home stabilization services, and additional stationary crisis centers all need to be explored as potential solutions.

1.8.5.4.4. Developing a plan for any needed adaptations of the NH Rapid response crisis model based on national research, data review, stakeholder, and provider input.

1.8.5.5. The Contractor shall work with the Department in months 6-12 to evaluate and guide the transformation of NH's crisis system by:

1.8.5.5.1. Providing technical assistance to the CMHCs to adapt services based on recommendations outlined in the above plan;

1.8.5.5.2. Refining the longitudinal evaluation plan to track and analyze data to assess crisis system changes, reach, and effectiveness over time, including the baseline year before and after the changes;

1.8.5.5.3. Developing a crisis system quality review tool for ongoing quality monitoring of the community-based Rapid Response crisis teams;

1.8.5.5.4. Consulting on a set of standardized data dashboards the Department can use on a quarterly and annual basis to monitor the quality, reach, and effectiveness of NH's Rapid Response crisis system; and

1.8.5.5.5. Consulting on a set of data reports, including extracts from the internal dashboards, that the Department should develop for public reporting in order to communicate effectiveness of the system, overall system trends, and specific data points for tracking the implementation of the crisis system transformation.

1.8.5.6. The Contractor shall work with the Department in months 12-24 to support, refine, and guide sustainability of the transformation of NH's crisis system by:

1.8.5.6.1. Collecting and comparing clinic-level qualitative and quantitative data to explore what is working well, where (i.e., CMHCs) and for whom (e.g., types of crises, patient backgrounds), to inform implementation adjustments to scale successes and strengthen sustainability across all centers;

1.8.5.6.2. Providing data-informed technical assistance to centers to support successful implementation and ensure fidelity to the model;

1.8.5.6.3. Providing technical assistance to the Department to refine dashboards and reporting tools based on feedback from key stakeholders and the public;

1.8.5.6.4. Providing technical assistance to the Department regarding utilization of the crisis system quality review tool; and

1.8.5.6.5. Consulting with the Department on ongoing quality improvement, needed adaptations to the selected crisis model, and data reporting.

1.8.5.7. In collaboration with the Department, the Contractor shall prepare a public report regarding efficacy and outcomes of the crisis system transformation. The final report shall include, but is not limited to:

1.8.5.7.1. Findings from both quantitative and qualitative data collected at various time points;

1.8.5.7.2. Summary of needed adaptations, if applicable, with rationale and recommendations;

1.8.5.7.3. Summary of any identified crisis system gaps that became evident throughout the analysis; and

1.8.5.8. Evaluation findings regarding the "fit" of the crisis system model to rural settings, staffing capacity, and funding and other resources necessary to meet current and anticipated future needs.

1.8.6. **Time Studies** – The Contractor shall perform regular time studies in accordance with the Centers for Medicare and Medicaid Services (CMS) and Department Medicaid Cost Allocation procedures to document activities relating directly to the administration of the Medicaid program and to draw down federal matching revenues. The Contractor shall provide any such time studies in a format approved by the Department.

1.9. Specific Service Requirements – Service Area #4 – Elderly and Adult Services

1.9.1. **Medical Director**

1.9.1.1. The Contractor shall provide one (1) part-time (.125 FTE) Medical Director to provide consultation services to the Elderly and Adult Services service area. The Medical Director shall:

1.9.1.1.1. Provide consultation and direction for the Elderly and Adult Services clinical components to policies and procedures, forms and administrative rules;

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

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

1.9.1.1.4. 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;

1.9.1.1.5. As requested by the Department, participate in the quality initiative, Sentinel Event Reviews and other case consultation and case reviews, as requested by the Department; and

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

1.9.1.2. The Contractor shall ensure the Medical Director meets the following qualifications:

1.9.1.2.1. Possesses a medical degree (MD or DO);

1.9.1.2.2. Maintains board certification in Gerontology or Preventive Medicine/Community Health;

1.9.1.2.3. Possesses expertise in clinical, policy or outcomes research; and

1.9.1.2.4. Possesses expertise 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.

1.10. Specific Service Requirements – Service Area #5 – Developmental Services

1.10.1. **Medical Director**

1.10.1.1. The Contractor shall provide one (1) part-time (.40 FTE) Medical Director to provide psychiatric consultation services to the Developmental Services service area sixteen (16) hours per week. The Medical Director shall:

1.10.1.1.1. Provide services in response to referrals from the ten (10) Area Agencies and the Department's Bureau for Family Centered Services (BFCS). Referrals shall be prioritized over all other duties and may include performing evaluations, consultations and medication reviews. Reports and recommendations must be shared with the referring entity.

1.10.1.1.2. Based on He-M 1201, serve as chairperson for and facilitate meetings for the Developmental Services Medication Committee, and provide expert opinion and leadership to ensure the Committee functions effectively.

1.10.1.1.3. Assist the Department's Developmental Services staff in addressing medical issues related to quality assurance activities or Sentinel Event Reviews.

1.10.1.1.4. Provide educational training to the Department's Developmental Services staff, Area Agencies, subcontracted agencies and other stakeholders as identified and directed by the Department.

1.10.1.1.5. Provide additional expertise and support to improve New Hampshire's developmental services system, as directed by the Department.

1.10.1.1.6. Submit encounter documentation and data as requested by the Department.

1.10.1.2. The Contractor shall ensure the Medical Director meets the following qualifications:

1.10.1.2.1. Possesses a medical degree (MD or DO);

1.10.1.2.2. Maintains board certification in Child and Adult Psychiatry; and

1.10.1.2.3. Possesses expertise and experience in developmental disability, including Autism Spectrum Disorders.

1.10.2. **Developmental Services Interdisciplinary Clinic Team**

1.10.2.1. The Contractor shall provide the following part-time positions for the children and adults Developmental Services Interdisciplinary Clinic Team:

1.10.2.1.1. Child Psychiatrist - 0.1 FTE

1.10.2.1.2. Psychiatrist - 0.1 FTE

1.10.2.1.3. Neuropsychologist - 0.1 FTE

1.10.2.1.4. Neuropsychology Fellow - 0.15 FTE

1.10.2.1.5. Neurologist - 0.05 FTE

1.10.2.1.6. Primary Care Physician - 0.05 FTE

1.10.2.1.7. Occupational Therapist - 0.05 FTE

1.10.2.1.8. Administrative Support - 0.05 FTE

1.10.2.2. The Interdisciplinary Clinic Team members' responsibilities are as follows:

1.10.2.2.1. **Psychiatrist (Child Psychiatrist):** The Psychiatrist shall serve as the Clinic Director, coordinating the team and/or providers involved in the Clinic. The Psychiatrist shall conduct a comprehensive psychiatric examination, including reviewing clients' 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.

1.10.2.2.2. **Neuropsychologist**: The Neuropsychologist will review all clients' psychiatric medical records, neuropsychological testing and behavioral incidents. The Neuropsychologist shall document recommendations as part of the comprehensive report. The Neuropsychologist shall supervise the Neuropsychology Fellow and oversee the documentation of historical information regarding the client.

1.10.2.2.3. **Neuropsychology Fellow**: The Neuropsychology Fellow shall review clients' medical and psychiatric records, neuropsychological testing, behavioral incidents and document pertinent historical information regarding each person as part of the comprehensive report.

1.10.2.2.4. **Neurologist**: The Neurologist shall review clients' medical records, conduct a physical examinations, and document findings and recommendations as part of the comprehensive report.

1.10.2.2.5. **Primary Care Physician**: The Primary Care Physician shall review past medical records, conduct a physical examination, and document findings and recommendations as part of the comprehensive report.

1.10.2.2.6. **Occupational Therapist**: The Occupational Therapist shall review past medical records, conduct an occupational therapy evaluation, document findings and recommendations as part of the comprehensive report; and

1.10.2.2.7. **Administrative Support Staff**: The Administrative Support Staff shall schedule appointments, review

received documents and checklists of requested documents, copy records for providers and fax completed reports. In addition, Administrative Support Staff will support the Developmental Services Medical Director.

1.10.2.3. The Contractor shall:

1.10.2.3.1. Ensure the Interdisciplinary Clinic Team accepts children and adults referred from the Area Agencies;

1.10.2.3.2. Prioritize clients based on the most immediate need and critical situation;

1.10.2.3.3. Provide high quality interdisciplinary evaluations to children and adults with developmental disabilities and acquired brain injuries:

1.10.2.3.4. Develop one (1) comprehensive report for each client that includes, but is not limited to:

1.10.2.3.4.1. A comprehensive understanding of each client with a focus on a biological, psychological, social and/or environmental approach and the interaction of these factors as they relate to the clients' strengths, skills, and interests.

1.10.2.3.4.2. 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.

1.10.2.3.5. Serve as the 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.

1.10.2.3.6. Convene the Interdisciplinary Clinic Team one (1) time per month and conduct a face-to-face or remote appointment with two (2) clients per month, for a total of twenty-four (24) clients per year.

1.10.2.3.6.1. Interdisciplinary clinic team meetings and client appointments shall take place by telehealth or in person at DHMC in Lebanon, as determined clinically appropriate and

necessary by the Interdisciplinary Clinic Team.

1.10.2.3.6.2. The Contractor's Interdisciplinary Clinic Team shall review all previous records of each client prior to each client appointment. The Interdisciplinary Clinic Team shall meet with the client and the client's team of caregivers as part of the evaluation to obtain history and/or concerns and to examine the client.

1.10.2.3.6.3. After meeting and examining the client, the Interdisciplinary Clinic Team will meet to discuss recommendations.

1.10.2.3.6.4. The Interdisciplinary Clinic Team shall draft a comprehensive report regarding the visit and recommendations. The report shall be made available within fifteen (15) business days from the date of the last meeting of the Interdisciplinary Clinic Team.

1.10.2.3.7. 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.

1.10.2.3.8. Submit encounter documentation as directed by the Department.

1.11. General Staffing Requirements applicable to all Service Areas and personnel provided under the Agreement

1.11.1. The Contractor shall recruit and retain qualified individuals for the staffing needs as specified, and as otherwise necessary, to fulfill the requirements as described in this Exhibit B, Scope of Services, Section 1. Statement of Work.

1.11.2. All personnel provided under this Contract shall be subject to Department approval prior to the Contractor notifying candidates of assignment and/or hire to fulfill a specified staffing role. The Department shall inform the Contractor of its applicable designee for this purpose per position or service area. The Department designee, at their discretion, shall be entitled to interview any such candidate. The Contractor shall facilitate coordinating such interviews upon the Department designee's request.

1.11.3. The Department 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:

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

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

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

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

1.11.3.5. Any other reason that includes, but is not limited to misconduct, violation of Department policy, or violation of state or federal laws and regulations pertaining to the applicable Department 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.

1.11.4. In the event of such rescission:

1.11.4.1. The Department shall provide the Contractor with reasonable advance notice to the extent possible and the applicable reason. No additional payments will be paid by the State for any staff removed from duty by the Department for any reason;

1.11.4.2. The Contractor's applicable staff member shall be prohibited from providing services under the Agreement for the period of time that the Department exercises this right;

1.11.4.3. The Contractor shall provide replacement personnel who shall meet all of the applicable requirements under this contract including, but not limited to, being subject to the Department approval specified in 1.11.2;

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

1.11.4.5. The Department will inform the Contractor of the anticipated duration for which approval will remain rescinded. If the duration of a temporarily rescinded approval is greater than five (5) 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.

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

1.11.5. The Contractor shall ensure, prior to providing the applicable services to the applicable Department service area or facility, all required licenses, certifications, privileges or other specified minimum qualifications are met for all Contractor staff, and where applicable, are maintained throughout the provision of services for the full term of the contract. The Contractor shall provide the applicable Department designee with a copy of all such documents. The Contractor acknowledges and agrees that the Department 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.

1.11.6. Work schedules for Contractor staff provided under this Agreement may be modified as needed to meet the requirements described herein, subject to the approval of the appropriate Department designee.

1.11.7. The Contractor shall ensure all staff provided under this Agreement are subject to the Contractor's normal and customary employee benefits and policies, including leave provisions. In addition to any required approvals by the Contractor for its employees, Contractor staff providing services under this Agreement shall provide timely, prior notification to the applicable Department designee for any anticipated leave time, including, but not limited to, vacation and continuing education leave time.

1.11.8. The Contractor shall ensure all staffing positions provided under this Agreement are continuously filled or in active recruitment.

1.11.9. The Contractor will automatically reduce invoices for payment by the appropriate amount immediately upon a position becoming vacant.

1.11.10. 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 last

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 in the table below:

Service Area		Required Background, Registry, Screening, and Medical Examinations
1	Medicaid Program	Criminal Background, BEAS State Registry, DCYF Central Registry
2	Children, Youth & Families	Criminal Background, DCYF Central Registry, TB Testing
3	Behavioral Health	Criminal Background, BEAS State Registry, DCYF Central Registry
4	Elderly and Adult Services	Criminal Background, BEAS State Registry
5	Developmental Services	Criminal Background, BEAS State Registry, DCYF Central Registry

1.11.11. The Contractor shall ensure the criminal background, registry, screening and medical examinations above are kept current as required and in accordance with the Department's confidentiality policy; the Department receives copies of all required documentation prior to the commencement of services; and the Department will not be responsible for any costs incurred in obtaining the documentation.

1.11.12. The Contractor shall not utilize any personnel including Subcontractors, to fulfill any obligations of this contract, who have been convicted of any crime of dishonesty, including but not limited to criminal fraud, or otherwise convicted of any felony or misdemeanor offense for which incarceration for up to one (1) year is an authorized penalty. The Contractor will initiate a criminal background check re-investigation of all personnel provided under this contract every five (5) years. The five (5) year period will be based on the date of the last criminal background check conducted by the Contractor or its agents.

1.11.13. State Owned Devices, Systems and Network Usage

1.11.13.1. Personnel provided by the Contractor under this Agreement shall use a state-issued device, including, not limited to computers,

tablets or mobile telephones, in fulfilling the requirements of this contract. The Contractor shall ensure all personnel provided under this Agreement:

1.11.13.1.1. Use the information that they have permission to access solely for conducting official state business. All other use or access is strictly forbidden including, but not limited, to personal or other private and non-State use, and that at no time shall Contractor workforce or agents access or attempt to access information without having the express authority of the Department to do so;

1.11.13.1.2. Not access or attempt to access information in a manner inconsistent with the approved policies, procedures, and/or agreement relating to system entry/access;

1.11.13.1.3. Not copy, share, distribute, sub-license, modify, reverse engineer, rent, or sell software licensed, developed, or being evaluated by the state. At all times the Contractor must use utmost care to protect and keep such software strictly confidential in accordance with the license or any other agreement executed by the State. Only equipment or software owned, licensed, or being evaluated by the State can be used by the Contractor. Non-standard software shall not be installed on any equipment unless authorized by the Department's Information Security Office;

1.11.13.1.4. Agree that email and other electronic communication messages created, sent, and received on a state-issued email system are the property of the State of New Hampshire and to be used for business purposes only. Email is defined as "internal email systems" or "state-funded email systems." The Contractor understands and agrees that use of email shall follow Department and State standard policies; and

1.11.13.1.5. The Internet and/or Intranet is to be used for access to and distribution of information in direct support of the business of the State of New Hampshire according to policy. At no time should the Internet be used for personal use.

2. Exhibits Incorporated

2.1. The Contractor shall use and disclose Protected Health Information in compliance with the Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) (45 CFR Parts 160 and 164) under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and in accordance with the attached Exhibit I, Business Associate Agreement, which has been executed by the parties.

2.2. The Contractor shall manage all confidential data related to this Agreement in accordance with the terms of Exhibit K, DHHS Information Security Requirements.

2.3. The Contractor shall comply with all Exhibits D through K, which are attached hereto and incorporated by reference herein.

3. Reporting Requirements for All Service Areas

3.1. The Contractor shall provide the Department with detailed personnel listings for all staff performing services in each Service Area under the Agreement on an annual basis for each State Fiscal Year, or more frequently as required by the Department, to ensure the accuracy of information contained therein and proper cost allocation. The listings will include information for each Service Area that includes, but is not limited to staff names, titles and personnel costs (including salary costs, fringe benefit costs, and indirect rates). The listings will be in a format as determined and approved by the Department.

4. Performance Measures and Monitoring

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

4.1.1. Within forty-five (45) days of the contract effective date of the Chief Medical Officer, and annually thereafter, the Contractor and the Department 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 Department designee prior to being effective. Performance measures and monitoring tools may include, but are not limited to:

4.1.1.1. Attendance records of Medicaid Management Team meetings; and

4.1.1.2. A checklist of core duties and expectations, as described in Subsection 1.6, with feedback solicited the Department.

4.1.2. The Department designee and Chief Medical Officer shall meet quarterly, or on a frequency as otherwise determined by the Department, to review these performance metrics and associated data. These meetings shall be documented with written progress notes by the Department designee.

4.1.3. The Contractor shall ensure the services provided by the Chief Medical Officer are satisfactory to the Department. The Contractor shall, no less than annually and more frequently as requested by the Department, provide an evaluation tool that is based on the mutually agreed upon performance metrics for the previous year to solicit input from the Department regarding the Chief Medical Officer's performance in providing of services under the Agreement.

4.1.4. In the event that the Chief Medical Officer's performance requires improvement, as determined by the Contractor and/or the Department, the Contractor shall develop and submit a proposed corrective action plan to the Department for review and approval.

4.1.5. The Department designee, the Contractor, and the Chief Medical Officer shall establish goals annually for the upcoming year will be established at the time of the Contractor's evaluation of the Chief Medical Officer. In the event that the Chief Medical Officer position is vacated and refilled, the evaluation tool shall be completed at six (6) months and at one (1) year of employment, and annually thereafter on the contract anniversary date.

4.2. Service Area #2 – Staff Psychologist – Children, Youth and Families

4.2.1. Within forty-five (45) days of the assignment of the Staff Psychologist, and annually thereafter, the Contractor and the Department designee, in consultation with the Staff Psychologist, shall develop a list of performance metrics based upon the deliverables, functions and responsibilities of the Staff Psychologist, including, but not limited to, clinical documentation monitoring. The performance metrics shall be approved by the Department designee prior to being effective. The Department designee and Staff Psychologist shall meet quarterly, or on a frequency as otherwise determined by the Department, to review these performance metrics. These meetings shall be documented with written progress notes by the Department designee.

4.2.2. The Contractor shall ensure the services provided by the Staff Psychologist are satisfactory to the Department. The Contractor shall, no less than annually and more frequently as requested by the Department, provide an evaluation tool that is based on the mutually agreed upon performance metrics for the previous year to solicit input from the Department regarding the Staff Psychologist's performance in providing of services under the Agreement.

4.2.3. In the event that the Staff Psychologist's performance requires improvement, as determined by the Contractor and/or the Department, the Contractor shall develop and submit a proposed corrective action plan to the Department for review and approval.

4.2.4. The Department designee, the Contractor, and the Staff Psychologist shall establish goals annually for the upcoming year will be established at the time of the Contractor's evaluation of the Staff Psychologist. In the event that the Staff Psychologist position is vacated and refilled, the evaluation tool shall be completed at six (6) months and at one (1) year of employment, and annually thereafter on the contract anniversary date.

4.3. Service Area #2 – Staff Psychiatrist – Children, Youth and Families

4.3.1. Within forty-five (45) days of the assignment of the Staff Psychiatrist, and annually thereafter, the Contractor and the Department 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. Performance metrics and monitoring may include, but are not limited to:

4.3.1.1. Regular checks of the Staff Psychiatrist's electronic calendar to ensure proposed leave time, conferences, and trainings are recorded appropriately;

4.3.1.2. Clinical documentation monitoring to ensure timeliness and completeness standards are being met as established by Children, Youth, and Families;

4.3.1.3. Counts of activities, including, but not limited to, the number of treatment team meetings and clinical consultations provided, types and numbers of EBP provided, number of teaching and supervision contacts with interns, residents, and fellows at SYSC; and

4.3.1.4. Feedback collected in a checklist to assess effectiveness in establishing interagency collaboration between JJS, CMHCs, and NHH.

4.3.2. Performance metrics shall be approved by the Department designee prior to being effective. The Department designee and Staff Psychiatrist shall meet quarterly, or on a frequency as otherwise determined by the Department, to review these performance metrics. These meetings shall be documented with written progress notes by the Department designee.

4.3.3. The Contractor shall ensure the services provided by the Staff Psychiatrist are satisfactory to the Department. The Contractor shall, no less than annually and more frequently as requested by the Department, provide an evaluation tool that is based on the mutually agreed upon performance metrics for the previous year to solicit input from the Department regarding the Staff Psychiatrist's performance in providing of services under the Agreement.

4.3.4. In the event that the Staff Psychiatrist's performance requires improvement, as determined by the Contractor and/or the Department, the Contractor shall develop and submit a proposed corrective action plan to the Department for review and approval.

4.3.5. The Department designee, the Contractor, and the Staff Psychiatrist shall establish goals annually for the upcoming year will be established at the time of the Contractor's evaluation of the Staff Psychiatrist. In the event that the Staff Psychiatrist position is vacated and refilled, the evaluation tool shall be completed at six (6) months and at one (1) year of employment, and annually thereafter on the contract anniversary date.

4.4. Service Areas #3 Behavioral Health, #4 Elderly and Adult Services and #5 Developmental Services

4.4.1. Upon Department request, the Contractor shall identify performance metrics, develop performance goals, establish monitoring processes and engage in collaborative performance evaluation processes for Service Areas 3, 4 and 5.

4.5. Performance Evaluations

4.5.1. The Contractor shall conduct performance reviews annually for all staff provided under the Agreement, unless otherwise specified in the Agreement, in a format as approved by the Department.

4.5.2. The Contractor shall conduct such reviews by first obtaining feedback from the applicable Department 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 the Department over the course of the contract period.

4.6. Quality Assurance Plan and Monitoring

4.6.1. The Contractor shall develop and submit a Quality Assurance Plan, subject to approval and/or modification as requested by the Department. The Quality Assurance Plan shall include, at a minimum:

4.6.1.1. Services and activities that will be monitored;

4.6.1.2. How monitoring will be conducted;

4.6.1.3. Individuals who will conduct the monitoring, specifying the roles and responsibilities of staff and any other third party, if applicable;

4.6.1.4. Department resources, if any, that will be requested for the monitoring process, and how the Department resources will be involved; and

4.6.1.5. Process for documenting monitoring efforts and results.

4.6.2. The Contractor shall monitor progress toward the stated goals in the Quality Assurance and Monitoring Plan and provide progress reports to the Department, as requested by the Department.

4.6.3. In consultation with the Department, the Contractor shall review and revise the Quality Assurance and Monitoring Plan at minimum on an annual basis, or as otherwise requested by the Department.

4.7. The Contractor shall actively and regularly collaborate with the Department to enhance contract management, improve results, and adjust program delivery and policy based on successful outcomes.

4.8. The Contractor may be required to provide other key data and metrics to the Department, including client-level demographic, performance, and service data.

4.9. Where applicable, the Contractor shall collect and share data with the Department in a format specified by the Department.

5. Additional Terms

5.1. Impacts Resulting from Court Orders or Legislative Changes

5.1.1. The Contractor agrees that, to the extent future state or federal legislation or 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. In the event that any future state or federal legislation or court order impacts the Services described herein, the Department shall provide the Contractor with reasonable advanced notice of any necessary modification to Service priorities and expenditure requirements. The parties agree to cooperate in the implementation and planning of any such modification and the Department shall consider Contractor's reasonable requests with respect to such modifications. Notwithstanding the foregoing, the Department shall retain the final right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance with any future state or federal legislation or court orders that have an impact on the Services described herein.

5.2. Credits and Copyright Ownership

5.2.1. All documents, notices, press releases, research reports and other materials prepared during or resulting from the performance of the services of the Agreement shall include the following statement, "The preparation of this (report, document etc.) was financed under an 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."

5.2.2. All materials produced or purchased under the Agreement shall have prior approval from the Department before printing, production, distribution or use.

5.2.3. The Department shall retain copyright ownership for any and all original materials produced, including, but not limited to:

5.2.3.1. Brochures.

5.2.3.2. Resource directories.

5.2.3.3. Protocols or guidelines.

5.2.3.4. Posters.

5.2.3.5. Reports.

5.2.4. The Contractor shall not reproduce any materials produced under the Agreement without prior written approval from the Department.

5.3. Eligibility Determinations

5.3.1. 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.

5.3.2. 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.

5.3.3. 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.

5.3.4. 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.

6. Records

6.1. The Contractor shall keep records that include, but are not limited to:

6.1.1. Books, records, documents and other electronic or physical data evidencing and reflecting all costs and other expenses incurred by the Contractor in the performance of the Agreement, and all income received or collected by the Contractor.

6.1.2. All records must 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.

6.2. During the term of this Agreement 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 Agreement for purposes of audit, examination, excerpts and transcripts. Upon the purchase by the Department of the maximum number of units provided for in the Agreement and upon payment of the price limitation hereunder, the Agreement and all the obligations of the parties hereunder (except such obligations as, by the terms of the Agreement are to be performed after the end of the term of this Agreement and/or survive the termination of the Agreement) 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.

7. Continuity of Services and Liquidated Damages

7.1. Liquidated damages are specified in, and may be assessed in accordance with, Exhibit C, Payment Terms, Section 17.

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

EXHIBIT C

Payment Terms

1. This Agreement is funded by:
   1.1. 28% Federal Funds from:
      1.1.1. The Centers for Medicare & Medicaid Services (CMS), Catalog of Federal Assistance (CFDA) #93.778;
      1.1.2. Health Resources and Services Administration (HRSA), Maternal and Child Health Block Grant, CFDA #93.994;
      1.1.3. Administration on Aging, Title III-B Social Services, CFDA #93.004;
      1.1.4. Substance Abuse & Mental Health Services Administration (SAMHSA), Community Mental Health Block Grant, CFDA #93.958; and
      1.1.5. SAMHSA, Substance Abuse Block Grant ARPA, CFDA #93.959.
   1.2. 72% General funds.
2. For the purposes of this Agreement:
   2.1. The Department has identified the Contractor as a Contractor, in accordance with 2 CFR 200.331.
   2.2. The Department has identified this Agreement as NON-R&D, in accordance with 2 CFR §200.332.
3. Payment shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this Agreement, and shall be in accordance with the approved line items, as specified in Exhibit C-1, Budget through Exhibit C-7, Budget.
   3.1. Services provided in the event of a healthcare system emergency as specified in Paragraph 1.5.5 of Exhibit B, Scope of Services, are budgeted to serve any or all of the five (5) service areas. 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	Effective Date to 6/30/2022	7/1/2022 to 6/30/2023	7/1/2023 to 6/30/2024	7/1/2024 to 6/30/2025
Healthcare Emergency	$921,941	$2,823,038	$2,754,340	$2,610,338

4. The Contractor shall submit five (5) monthly invoices to the Department in a form satisfactory to the State by the twentieth (20th) working day of the following month, with the exception of June invoices, which shall be submitted by the tenth (10th) working day of the following month, including one distinct and separate invoice for each of the five (5) Service Areas requesting reimbursement for authorized expenses incurred for services provided in the prior month. The five (5) Service Areas include:
   4.1. Service Area #1 – Medicaid
   4.2. Service Area #2 – Children, Youth and Families
   4.3. Service Area #3 – Behavioral Health
   4.4. Service Area #4 – Elderly and Adult Services
   4.5. Service Area #5 – Developmental Services
5. The Contractor shall reduce invoices by the appropriate amount immediately upon a position becoming vacant and not being backfilled with a locum.
6. In the event that the Contractor provides healthcare system emergency services specified in Subsection 3.1 above, the Contractor shall submit a separate invoice that distinctly identifies and differentiates the expenses as charged according to each of the five (5) Service Areas for which services are provided. The invoice shall include the dates worked, the name of the employee and their title, the hourly rate, and the number of hours worked per day.
7. The Contractor shall ensure the invoices are completed, dated and returned to the Department in order to initiate payment.
8. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to Mary.E.Calise@dhhs.nh.gov, or invoices may be mailed to:

   Financial Manager
   Department of Health and Human Services
   129 Pleasant Street
   Concord, NH 03301

9. 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.
   9.1. 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.

10. The Department shall make payment to the Contractor within thirty (30) days of receipt of each invoice, subsequent to approval of the submitted invoice and if sufficient funds are available, subject to Paragraph 4 of the General Provisions Form Number P-37 of this Agreement.

11. The final invoices shall be due to the Department no later than forty (40) days after the contract completion date specified in Form P-37, General Provisions Block 1.7 Completion Date.

12. The Contractor must provide the services in Exhibit B, Scope of Services, in compliance with funding requirements.

13. The Contractor agrees that funding under this Agreement may be withheld, in whole or in part in the event of non-compliance with the terms and conditions of Exhibit B, Scope of Services.

14. Notwithstanding anything to the contrary herein, the Contractor agrees that funding under this agreement may be withheld, in whole or in part, in the event of non-compliance with any Federal or State law, rule or regulation applicable to the services provided, or if the said services or products have not been satisfactorily completed in accordance with the terms and conditions of this agreement.

15. Notwithstanding Paragraph 17 of the General Provisions Form P-37, changes limited to adjusting amounts within the price limitation and adjusting encumbrances between State Fiscal Years and budget class lines through the Budget Office may be made by written agreement of both parties, without obtaining approval of the Governor and Executive Council, if needed and justified.

16. Audits

16.1. The Contractor must email an annual audit to melissa.s.morin@dhhs.nh.gov if **any** of the following conditions exist:

16.1.1. Condition A - The Contractor expended $750,000 or more in federal funds received as a subrecipient pursuant to 2 CFR Part 200, during the most recently completed fiscal year.

16.1.2. Condition B - The Contractor is subject to audit pursuant to the requirements of NH RSA 7:28, III-b, pertaining to charitable organizations receiving support of $1,000,000 or more.

16.1.3. Condition C - The Contractor is a public company and required by Security and Exchange Commission (SEC) regulations to submit an annual financial audit.

16.2. If Condition A exists, the Contractor shall submit an annual single audit performed by an independent Certified Public Accountant (CPA) to the Department within 30 days after the completion of the single audit or upon submission of the Contractor's single audit to the Federal Audit Clearinghouse conducted in accordance with the requirements of 2 CFR Part 200, Subpart F of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal awards.

16.3. If Condition B or Condition C exists, the Contractor shall submit an annual financial audit performed by an independent CPA within 120 days after the close of the Contractor's fiscal year.

16.4. 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.

17. Liquidated Damages

17.1. **Continuity of Services**:

17.1.1. The Contractor and Department agree that the Contractor's failure to provide required staffing, required services, or meet the performance standards and reporting requirements as described in Exhibit B, Scope of Services, shall result in liquidated damages.

17.1.2. The Contractor and the Department agree that:

17.1.2.1. 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 B, Scope of Services;

17.1.2.2. Any such 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; and

17.1.2.3. The liquidated damages as specified in this Exhibit C, Payment Terms, are reasonable and fair and not intended as a penalty.

17.2. **Notification**:

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

17.2.1.1. A citation of the contract provision violated;

17.2.1.2. The remedies to be applied, and the date the remedies shall be imposed (cure period) for the Contractor to remedy such failure. A reasonable cure period will be determined by the Department based on service type, and to the extent possible, the notice will not be less than 30 days;

17.2.1.3. The basis for the Department's determination that the remedies shall be imposed;

17.2.1.4. A request for a written Corrective Action Plan from the Contractor below; and

17.2.1.5. The timeframe and procedure for the Contractor to dispute the Department's determination.

17.2.2. The Contractor shall submit the written Corrective Action Plan referenced in Subparagraph 17.2.1.4 above to the Department for review within five (5) business days of receiving notification as specified in Subsection 17.2. Notification.

17.2.3. The Contractor agrees that the Corrective Action Plan is subject to the Department's approval prior to its implementation.

17.2.4. No liquidated damages will be assessed against Contractor if the parties have agreed to a Corrective Action Plan and the Contractor is in compliance with the terms of the Corrective Action Plan.

17.2.5. If the failure to perform by the Contractor is not resolved within the cure period as specified in the Corrective Action Plan, as approved by the Department, 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.

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

17.3. **Liquidated Damages:**

17.3.1. 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 B, Scope of Services.

17.3.2. 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 B, Scope of Services.

17.3.3. 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 B, Scope of Services.

17.3.4. 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 B, Scope of Services.

17.3.5. Liquidated damages, if assessed, shall apply until the Contractor cures the failure cited in the notification described in Subsection 17.2, or until the resulting dispute is resolved in the Contractor's favor.

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

17.3.7. During the term of this Agreement 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 Agreement for purposes of audit, examination, excerpts and transcripts. Upon the purchase by the Department of the maximum number of units provided for in the Agreement and upon payment of the price limitation hereunder, the Agreement and all the obligations of the parties hereunder (except such obligations as, by the terms of the Agreement are to be performed after the end of the term of this Agreement and/or survive the termination of the Agreement) 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.

17.4. **Assessment**:

17.4.1. The Department shall be entitled to assess and recover liquidated damages cumulatively under each section applicable to any given incident.

17.4.2. Assessment and recovery of liquidated damages by the Department shall be in addition to, and not exclusive of, any other remedies, including actual damages, as may be available to the Department for breach of contract, both at law and in equity, and shall not preclude the Department 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 the Department to terminate the Contract for default as provided in Paragraph 8 of the General Provisions (P-37).

17.5. **Damages Related to Failure to Document Medical Necessity**:

17.5.1. The Contractor shall be liable to the Department for any losses incurred by the Department which arise out of the failure of Contractor staff to provide the required documentation to support medical necessity as identified in Exhibit B, Scope of Services.

Exhibit C-1 Budget - Medicaid

New Hampshire Department of Health and Human Services

Contractor Name: *Mary Hitchcock Memorial Hospital*
Budget Request for: *Clinical and Administrative Services - Service Area #1 Medicaid*
Budget Period *SFY22 through SFY25*

Line Item	Total Program Cost *Enter all costs that will be incurred through this contract/agreement*	SFY22 7/1/21 to 6/30/22	SFY23 7/1/22 to 6/30/23	SFY24 7/1/23 to 6/30/24	SFY25 7/1/24 to 6/30/25
1. Salary/Wages	$ 1,119,343	106,090	327,818	337,653	347,782
2. Employee Benefits	$ 198,124	18,778	58,024	59,765	61,557
3. Consultants	$ -				
4.(a) Equipment - Rental	$ -				
4.(b) Equipment - Repairs & Maintenance	$ -				
4.(c) Equipment - Purchase	$ -				
5.(a) Supplies - Educational	$ -				
5.(b) Supplies - Lab	$ -				
5.(c) Supplies - Pharmacy	$ -				
5.(d) Supplies - Medical	$ -				
5.(e) Supplies Office	$ -				
6. Travel	$ 12,000	1,200	3,600	3,600	3,600
7. Occupancy	$ -				
9. Software	$ -				
10. Marketing/Communications	$ -				
11. Staff Education and Training	$ 33,333	3,333	10,000	10,000	10,000
12. Subcontracts/Agreements	$ -				
13. Other (Provide specific details)	$ -				
Total Direct Costs	$ 1,362,800	$ 129,401	$ 399,442	$ 411,017	$ 422,940
Indirect Cost Rate %	15%				
Total Indirect Costs	$ 204,420	19,410	59,916	61,653	63,441
TOTAL	**1,567,220**	**148,811**	**459,358**	**472,670**	**486,381**

Contractor Initials DS EJM

Date 3/2/2022

Exhibit C-2 Budget - Children, Youth and Families

New Hampshire Department of Health and Human Services

Contractor Name: *Mary Hitchcock Memorial Hospital*
Budget Request for: *Clinical and Administrative Services - Service Area #2 Children, Youth and Families*
Budget Period *SFY22 through SFY25*

Line Item	Total Program Cost *Enter all costs that will be incurred through this contract/agreement*	FY22 7/1/21 to 6/30/22	FY23 7/1/22 to 6/30/23	FY24 7/1/23 to 6/30/24	FY25 7/1/24 to 6/30/25
1. Salary/Wages	$ 1,989,165	188,531	582,560	600,037	618,038
2. Employee Benefits	$ 544,433	51,601	159,446	164,230	169,157
3. Consultants	$ -				
4.(a) Equipment - Rental	$ -				
4.(b) Equipment - Repairs & Maintenance	$ -				
4.(c) Equipment - Purchase	$ -				
5.(a) Supplies - Educational	$ -				
5.(b) Supplies - Lab	$ -				
5.(c) Supplies - Pharmacy	$ -				
5.(d) Supplies - Medical	$ -				
5.(e) Supplies Office	$ -				
6. Travel	$ 3,333	333	1,000	1,000	1,000
7. Occupancy	$ -				
9. Software	$ -				
10. Marketing/Communications	$ -				
11. Staff Education and Training	$ 30,000	3,000	9,000	9,000	9,000
12. Subcontracts/Agreements	$ -				
13. Other (Provide specific details)	$ -				
Total Direct Costs	$ 2,566,932	$ 243,465	$ 752,006	$ 774,266	$ 797,194
Indirect Cost Rate %	15%				
Total Indirect Costs	$ 385,040	36,520	112,801	116,140	119,579
TOTAL	**2,951,971**	**279,985**	**864,807**	**890,406**	**916,773**

Contractor Initials DS EJM

Date 3/2/2022

Exhibit C-3 Budget - Behavioral Health

New Hampshire Department of Health and Human Services

Contractor Name: *Mary Hitchcock Memorial Hospital*
Budget Request for: *Clinical and Administrative Services - Service Area #3 Behavioral Health*
Budget Period *SFY22 through SFY25*

Line Item	Total Program Cost *Enter all costs that will be incurred through this contract/agreement*	SFY22 7/1/21 to 6/30/22	SFY23 7/1/22 to 6/30/23	SFY24 7/1/23 to 6/30/24	SFY25 7/1/24 to 6/30/25
1. Salary/Wages	$ 1,315,316	124,664	385,212	396,768	408,671
2. Employee Benefits	$ 374,941	35,536	109,808	113,102	116,495
3. Consultants	$ -				
4.(a) Equipment - Rental	$ -				
4.(b) Equipment - Repairs & Maintenance	$ -				
4.(c) Equipment - Purchase	$ -				
5.(a) Supplies - Educational	$ 68,485	6,667	20,000	20,600	21,218
5.(b) Supplies - Lab	$ -				
5.(c) Supplies - Pharmacy	$ -				
5.(d) Supplies - Medical	$ -				
5.(e) Supplies Office	$ -				
6. Travel	$ 50,000	5,000	15,000	15,000	15,000
7. Occupancy	$ -				
9. Software	$ -				
10. Marketing/Communications	$ -				
11. Staff Education and Training	$ 20,000	2,000	6,000	6,000	6,000
12. Subcontracts/Agreements	$ -				
13. Other (Provide specific details)	$ -				
Total Direct Costs	$ 1,828,741	$ 173,867	$ 536,020	$ 551,470	$ 567,384
Indirect Cost Rate %	15%				
Total Indirect Costs	$ 274,311	26,080	80,403	82,721	85,108
TOTAL	**2,103,052**	**199,947**	**616,422**	**634,191**	**652,492**

Contractor Initials DS EJM

Date 3/2/2022

Exhibit C-4 Budget - Behavioral Health (Co-Occurring Trainer)

New Hampshire Department of Health and Human Services

Contractor Name: *Mary Hitchcock Memorial Hospital*
Budget Request for: *Clinical and Administrative Services - Service Area #3 Behavioral Health (Co-occurring Trainer)*
Budget Period *SFY22 through SFY25*

Line Item	Total Program Cost *Enter all costs that will be incurred through this contract/agreement*	SFY22 7/1/21 to 6/30/22	SFY23 7/1/22 to 6/30/23	SFY24 7/1/23 to 6/30/24	SFY25 7/1/24 to 6/30/25
1. Salary/Wages	$ 304,974	28,905	89,317	91,996	94,756
2. Employee Benefits	$ 104,911	9,943	30,725	31,647	32,596
3. Consultants	$ -				
4.(a) Equipment - Rental	$ -				
4.(b) Equipment - Repairs & Maintenance	$ -				
4.(c) Equipment - Purchase	$ -				
5.(a) Supplies - Educational	$ 17,121	1,667	5,000	5,150	5,305
5.(b) Supplies - Lab	$ -				
5.(c) Supplies - Pharmacy	$ -				
5.(d) Supplies - Medical	$ -				
5.(e) Supplies Office	$ -				
6. Travel	$ 25,000	2,500	7,500	7,500	7,500
7. Occupancy	$ -				
9. Software	$ -				
10. Marketing/Communications	$ -				
11. Staff Education and Training	$ 19,000	1,000	6,000	6,000	6,000
12. Subcontracts/Agreements	$ -				
13. Other (Provide specific details)	$ -				
Total Direct Costs	$ 471,006	$ 44,015	$ 138,542	$ 142,293	$ 146,157
Indirect Cost Rate %	15%				
Total Indirect Costs	$ 70,651	6,602	20,781	21,344	21,923
TOTAL	**541,657**	**50,617**	**159,323**	**163,637**	**168,080**

Contractor Initials DS EJM

Date 3/2/2022

Exhibit C-5 Budget - Behavioral Health (Crisis System Evaluator)

New Hampshire Department of Health and Human Services

Contractor Name: *Mary Hitchcock Memorial Hospital*
Budget Request for: *Clinical and Administrative Services - Service Area #3 Behavioral Health (Crisis System Evaluator)*
Budget Period *SFY22 through SFY25*

Line Item	Total Program Cost *Enter all costs that will be incurred through this contract/agreement*	SFY22 7/1/21 to 6/30/22	SFY23 7/1/22 to 6/30/23	SFY24 7/1/23 to 6/30/24	SFY25 7/1/24 to 6/30/25
1. Salary/Wages	$ 70,159	11,294	34,900	23,965	
2. Employee Benefits	$ 24,135	3,885	12,006	8,244	
3. Consultants	$ -				
4.(a) Equipment - Rental	$ -				
4.(b) Equipment - Repairs & Maintenance	$ -				
4.(c) Equipment - Purchase	$ -				
5.(a) Supplies - Educational	$ -				
5.(b) Supplies - Lab	$ -				
5.(c) Supplies - Pharmacy	$ -				
5.(d) Supplies - Medical	$ -				
5.(e) Supplies Office	$ -				
6. Travel	$ -				
7. Occupancy	$ -				
9. Software	$ -				
10. Marketing/Communications	$ -				
11. Staff Education and Training	$ -				
12. Subcontracts/Agreements	$ 514,687	92,970	264,532	157,185	
13. Other (Provide specific details)	$ -				
Total Direct Costs	$ 608,980	$ 108,149	$ 311,437	$ 189,394	$ -
Indirect Cost Rate %	15%				
Total Indirect Costs	$ 91,347	16,222	46,716	28,409	0
TOTAL	**700,327**	**124,372**	**358,153**	**217,803**	**0**

Contractor Initials DS EJM
3/2/2022

Exhibit C-6 Budget - Elderly and Adult Services

New Hampshire Department of Health and Human Services

Contractor Name: *Mary Hitchcock Memorial Hospital*
Budget Request for: *Clinical and Administrative Services - Service Area #4 Elderly and Adult Services*
Budget Period *SFY22 through SFY25*

Line Item	Total Program Cost *Enter all costs that will be incurred through this contract/agreement*	SFY22 7/1/21 to 6/30/22	SFY23 7/1/22 to 6/30/23	SFY24 7/1/23 to 6/30/24	SFY25 7/1/24 to 6/30/25
1. Salary/Wages	$ 103,865	9,844	30,419	31,331	32,271
2. Employee Benefits	$ 18,384	1,742	5,384	5,546	5,712
3. Consultants	$ -				
4.(a) Equipment - Rental	$ -				
4.(b) Equipment - Repairs & Maintenance	$ -				
4.(c) Equipment - Purchase	$ -				
5.(a) Supplies - Educational	$ -				
5.(b) Supplies - Lab	$ -				
5.(c) Supplies - Pharmacy	$ -				
5.(d) Supplies - Medical	$ -				
5.(e) Supplies Office	$ -				
6. Travel	$ 833	83	250	250	250
7. Occupancy	$ -				
9. Software	$ -				
10. Marketing/Communications	$ -				
11. Staff Education and Training	$ -				
12. Subcontracts/Agreements	$ -				
13. Other (Provide specific details)	$ -				
Total Direct Costs	$ 123,083	$ 11,670	$ 36,053	$ 37,127	$ 38,233
Indirect Cost Rate %	15%				
Total Indirect Costs	$ 18,462	1,750	5,408	5,569	5,735
TOTAL	**141,545**	**13,420**	**41,461**	**42,696**	**43,968**

Contractor Initials DS EJM

Date 3/2/2022

Exhibit C-7 Budget - Developmental Services

New Hampshire Department of Health and Human Services

Contractor Name: *Mary Hitchcock Memorial Hospital*
Budget Request for: *Clinical and Administrative Services - Service Area #5 Developmental Services*
Budget Period *SFY22 through SFY25*

Line Item	Total Program Cost *Enter all costs that will be incurred through this contract/agreement*	SFY22 7/1/21 to 6/30/22	SFY23 7/1/22 to 6/30/23	SFY24 7/1/23 to 6/30/24	SFY25 7/1/24 to 6/30/25
1. Salary/Wages	$ 777,658	73,705	227,750	234,582	241,620
2. Employee Benefits	$ 155,076	14,698	45,416	46,779	48,182
3. Consultants	$ -				
4.(a) Equipment - Rental	$ -				
4.(b) Equipment - Repairs & Maintenance	$ -				
4.(c) Equipment - Purchase	$ -				
5.(a) Supplies - Educational	$ -				
5.(b) Supplies - Lab	$ -				
5.(c) Supplies - Pharmacy	$ -				
5.(d) Supplies - Medical	$ -				
5.(e) Supplies Office	$ -				
6. Travel	$ 16,667	1,667	5,000	5,000	5,000
7. Occupancy	$ -				
9. Software	$ -				
10. Marketing/Communications	$ -				
11. Staff Education and Training	$ 10,500	1,050	3,150	3,150	3,150
12. Subcontracts/Agreements	$ -				
13. Other (Provide specific details)	$ -				
Total Direct Costs	$ 959,900	$ 91,120	$ 281,316	$ 289,511	$ 297,952
Indirect Cost Rate %	15%				
Total Indirect Costs	$ 143,985	13,668	42,197	43,427	44,693
TOTAL	**1,103,885**	**104,788**	**323,514**	**332,938**	**342,645**

Contractor Initials DS EJM

Date 3/2/2022

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Program Support Center
Financial Management Portfolio
Cost Allocation Services

26 Federal Plaza, Room 3412
New York, NY 10278
PHONE: (212) 264-2069
EMAIL: CAS-NY@psc.hhs.gov

April 26, 2019

Ms. Tina Naimie
Vice President, Corporate Finance
Dartmouth-Hitchcock
One Medical Center Drive
Lebanon, NH 03756

Dear Ms. Naimie:

A copy of an indirect cost rate agreement is being sent to you for signature. This agreement reflects an understanding reached between your organization and a member of my staff concerning the rate(s) that may be used to support your claim for indirect costs on grants and contracts with the Federal Government.

Please have the agreement signed by an authorized representative of your organization and returned to me by email, retaining the copy for your files. Our email address is CAS-NY@psc.hhs.gov. We will reproduce and distribute the agreement to the appropriate awarding organizations of the Federal Government for their use.

An indirect cost rate proposal, together with the supporting information, is required to substantiate your claim for indirect costs under grants and contracts awarded by the Federal Government. Thus, your next proposal based on actual costs for the fiscal year ending 06/30/2020 is due in our office by 12/31/2020.

Sincerely,

Darryl W. Mayes
Deputy Director
Cost Allocation Services

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3/2/2022

DocuSign Envelope ID: 2CB8C0DD-6E2A-46B0-A7C3-920722D8F6FC

HOSPITALS RATE AGREEMENT

EIN: 1020222140A1

ORGANIZATION:
Dartmouth-Hitchcock
Mary Hitchcock Memorial Hospital
One Medical Center Drive
Lebanon, NH 03756-

DATE:04/26/2019

FILING REF.: The preceding agreement was dated 11/28/2017

The rates approved in this agreement are for use on grants, contracts and other agreements with the Federal Government, subject to the conditions in Section III.

SECTION I: INDIRECT COST RATES

RATE TYPES: FIXED FINAL PROV. (PROVISIONAL) PRED. (PREDETERMINED)

	EFFECTIVE PERIOD				
TYPE	**FROM**	**TO**	**RATE(%)**	**LOCATION**	**APPLICABLE TO**
PRED.	07/01/2018	06/30/2021	31.00	On-Site	Other Sponsored Programs
PROV.	07/01/2021	06/30/2024	31.00	On-Site	Other Sponsored Programs

*BASE

Total direct costs excluding capital expenditures (buildings, individual items of equipment; alterations and renovations), that portion of each subaward in excess of $25,000; hospitalization and other fees associated with patient care whether the services are obtained from an owned, related or third party hospital or other medical facility; rental/maintenance of off-site activities; student tuition remission and student support costs (e,g., student aid, stipends, dependency allowances, scholarships, fellowships).

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DS EJM

3/2/2022

DocuSign Envelope ID: 2CB8C0DD-6E2A-46B0-A7C3-920722D8F6FC

ORGANIZATION: Dartmouth-Hitchcock

AGREEMENT DATE: 4/26/2019

SECTION II: SPECIAL REMARKS

TREATMENT OF FRINGE BENEFITS:

Fringe Benefits applicable to direct salaries and wages are treated as direct costs.

TREATMENT OF PAID ABSENCES

Vacation, holiday, sick leave pay and other paid absences are included in salaries and wages and are claimed on grants, contracts and other agreements as part of the normal cost for salaries and wages. Separate claims are not made for the cost of these paid absences.

Equipment means tangible personal property (including information technology systems) having a useful life of more than one year and a per-unit acquisition cost which equals or exceeds the lesser of the capitalization level established by the non-Federal entity for financial statement purposes, or $5,000.

Your next proposal based upon fiscal year ending 06/30/20 is due by 12/31/20.

DS EJM

3/2/2022

DocuSign Envelope ID: 2CB8C0DD-6E2A-46B0-A7C3-920722D8F6FC

ORGANIZATION: Dartmouth-Hitchcock

AGREEMENT DATE: 4/26/2019

SECTION III: GENERAL

A. LIMITATIONS:

The rates in this Agreement are subject to any statutory or administrative limitations and apply to a given grant, contract or other agreement only to the extent that funds are available. Acceptance of the rates is subject to the following conditions: (1) Only costs incurred by the organization were included in its indirect cost pool as finally accepted: such costs are legal obligations of the organization and are allowable under the governing cost principles; (2) The same costs that have been treated as indirect costs are not claimed as direct costs; (3) Similar types of costs have been accorded consistent accounting treatment; and (4) The information provided by the organization which was used to establish the rates is not later found to be materially incomplete or inaccurate by the Federal Government. In such situations the rate(s) would be subject to renegotiation at the discretion of the Federal Government.

B. ACCOUNTING CHANGES:

This Agreement is based on the accounting system purported by the organization to be in effect during the Agreement period. Changes to the method of accounting for costs which affect the amount of reimbursement resulting from the use of this Agreement require prior approval of the authorized representative of the cognizant agency. Such changes include, but are not limited to, changes in the charging of a particular type of cost from indirect to direct. Failure to obtain approval may result in cost disallowances.

C. FIXED RATES:

If a fixed rate is in this Agreement, it is based on an estimate of the costs for the period covered by the rate. When the actual costs for this period are determined, an adjustment will be made to a rate of a future year(s) to compensate for the difference between the costs used to establish the fixed rate and actual costs.

D. USE BY OTHER FEDERAL AGENCIES:

The rates in this Agreement were approved in accordance with the cost principles promulgated by the Department of Health and Human Services, and should be applied to the grants, contracts and other agreements covered by these regulations subject to any limitations in A above. The hospital may provide copies of the Agreement to other Federal Agencies to give them early notification of the Agreement.

E. OTHER:

If any Federal contract, grant or other agreement is reimbursing indirect costs by a means other than the approved rate(s) in this Agreement, the organization should (1) credit such costs to the affected programs, and (2) apply the approved rate(s) to the appropriate base to identify the proper amount of indirect costs allocable to these programs.

BY THE INSTITUTION:

Dartmouth-Hitchcock

(INSTITUTION)

(SIGNATURE)

Tina E. Naimie

(NAME)

VP Corporate Finance

(TITLE)

May 14, 2019

(DATE)

ON BEHALF OF THE FEDERAL GOVERNMENT:

DEPARTMENT OF HEALTH AND HUMAN SERVICES

(AGENCY)

Darryl W. Mayes -S Digitally signed by Darryl W. Mayes -S DN: c=U.S, o=U.S. Government, ou=HHS, ou=PSC, ou=People, 0.9.2342.19200300.100.1.1=20001316 69, cn=Darryl W. Mayes -S Date: 2019.05.08 06:20:58 -04'00'

(SIGNATURE)

Darryl W. Mayes

(NAME)

Deputy Director, Cost Allocation Services

(TITLE)

4/26/2019

(DATE) 2642

HHS REPRESENTATIVE: Ryan McCarthy

Telephone: (212) 264-2069

DS EJM

3/2/2022

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The Vendor 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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Vendor Initials _____

3/2/2022
Date _____

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.

Vendor Name:

3/2/2022
Date

DocuSigned by:
Edward J. Merrens
8ACA3CF8A3CC430...
Name: Edward J. Merrens
Title: Chief Clinical Officer

New Hampshire Department of Health and Human Services
Exhibit E

CERTIFICATION REGARDING LOBBYING

The Vendor 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.

Vendor Name:

3/2/2022
Date

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

CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Executive Office of the President, Executive Order 12549 and 45 CFR Part 76 regarding Debarment, Suspension, and Other Responsibility Matters, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

INSTRUCTIONS FOR CERTIFICATION

1. By signing and submitting this proposal (contract), the prospective primary participant is providing the certification set out below.

2. The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. If necessary, the prospective participant shall submit an explanation of why it cannot provide the certification. The certification or explanation will be considered in connection with the NH Department of Health and Human Services' (DHHS) determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.

3. The certification in this clause is a material representation of fact upon which reliance was placed when DHHS determined to enter into this transaction. If it is later determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, DHHS may terminate this transaction for cause or default.

4. The prospective primary participant shall provide immediate written notice to the DHHS agency to whom this proposal (contract) is submitted if at any time the prospective primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

5. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549: 45 CFR Part 76. See the attached definitions.

6. The prospective primary participant agrees by submitting this proposal (contract) that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by DHHS.

7. The prospective primary participant further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions," provided by DHHS, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

8. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or involuntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List (of excluded parties).

9. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and

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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 (I)(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:

DocuSigned by:
Edward J. Merrens
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3/2/2022
Date

Name: Edward J. Merrens
Title: Chief Clinical Officer

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Contractor Initials

3/2/2022
Date

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.

DS
EJM

New Hampshire Department of Health and Human Services
Exhibit G

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:

DocuSigned by:
Edward J. Merrens
8AC43CFCA0CC438...

3/2/2022
Date

Name: Edward J. Merrens
Title: Chief Clinical Officer

DS
EJM
Contractor Initials

3/2/2022
Date

New Hampshire Department of Health and Human Services
Exhibit H

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:

DocuSigned by:
Edward J. Merrens
8ACA3CF5A0CC498...

3/2/2022
Date

Name: Edward J. Merrens
Title: Chief Clinical Officer

BUSINESS ASSOCIATE AGREEMENT

The Contractor identified in Section 1.3 of the General Provisions of the Agreement (Form P-37) ("Agreement") agrees, as a Business Associate, to comply with the Health Insurance Portability and Accountability Act, Public Law 104-191, the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160, 162, and 164 (HIPAA), provisions of the HITECH Act, Title XIII, Subtitle D, Parts 1&2 of the American Recovery and Reinvestment Act of 2009, 42 USC 17934, et sec., applicable to business associates, and as applicable, to be bound by the provisions of the Confidentiality of Substance Use Disorder Patient Records, 42 USC s. 290 dd-2, 42 CFR Part 2, (Part 2), as any may be amended from time to time.

(1) Definitions.

a. "Business Associate" shall mean the Contractor and its agents who receive, use, or have access to protected health information (PHI) as defined in this Business Associate Agreement ("BAA") and the Agreement, and "Covered Entity" shall mean the State of New Hampshire, Department of Health and Human Services.

b. The following terms have the same meaning as defined in HIPAA, the HITECH Act, and Part 2, as they may be amended from time to time:

> "Breach," "Covered Entity," "Designated Record Set," "Data Aggregation," Designated Record Set," Health Care Operations," HITECH Act," "Individual," "Privacy Rule," "Required by law," "Security Rule," and "Secretary."

c. "Protected Health Information" ("PHI") as used in this Agreement means protected health information defined in HIPAA 45 CFR 160.103, limited to the information created, received, or used by Business Associate from or on behalf of Covered Entity, and includes any Part 2 records relating to substance use disorder, if applicable, as defined below.

d. "Part 2 record" means any patient "Record," relating to a "Patient," and "Patient Identifying Information," as defined in 42 CFR Part 2.11.

e. "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.

(2) Business Associate Use and Disclosure of Protected Health Information.

a. Business Associate shall not use, disclose, maintain, store, or transmit Protected Health Information (PHI) except as reasonably necessary to provide the services outlined under Exhibit B, Scope of Services, of the Agreement. Further, Business Associate, including

Contractor Initials DS EJM

Date 3/2/2022

but not limited to all its directors, officers, employees, and agents, shall protect any PHI as required by HIPPA and 42 CFR Part 2, and not use, disclose, maintain, store, or transmit PHI in any manner that would constitute a violation of HIPAA or 42 CFR Part 2.

b. Business Associate may use or disclose PHI, as applicable:

I. For the proper management and administration of the Business Associate;

II. As required by law, pursuant to the terms set forth in paragraph c. and d. below;

III. According to the HIPAA minimum necessary standard; and

IV. For data aggregation purposes for the health care operations of the Covered Entity.

c. To the extent Business Associate is permitted under the BAA or the Agreement to disclose PHI to any third party or subcontractor, prior to making any disclosure, the Business Associate must obtain, a business associate agreement with the third party or subcontractor, that complies with HIPAA and ensures that all requirements and restrictions placed on the Business Associate as part of this BAA with the Covered Entity, are included in those business associate agreements with the third party or subcontractor.

d. The Business Associate shall not, disclose any PHI in response to a request or demand for disclosure, such as by a subpoena or court order, on the basis that it is required by law, without first notifying Covered Entity so that Covered Entity can determine how to best protect the PHI. If Covered Entity objects to the disclosure, the Business Associate agrees to refrain from disclosing the PHI and shall cooperate with the Covered Entity in any effort the Covered Entity undertakes to contest the request for disclosure, subpoena, or other legal process. If applicable relating to Part 2 records, the Business Associate shall resist any efforts to access part 2 records in any judicial proceeding.

(3) Obligations and Activities of Business Associate.

a. Business Associate shall implement appropriate safeguards to prevent unauthorized use or disclosure of all PHI in accordance with HIPAA Privacy Rule and Security Rule with regard to electronic PHI, and Part 2, as applicable.

b. The Business Associate shall immediately notify the Covered Entity's Privacy Officer at the following email address, DHHSPrivacyOfficer@dhhs.nh.gov after the Business Associate has determined that any use or disclosure not provided for by its contract, including any known or suspected privacy or security incident or breach has occurred potentially exposing or compromising the PHI. This includes inadvertent or accidental uses or disclosures or breaches of unsecured protected health information.

c. In the event of a breach, the Business Associate shall comply with the terms of this Business Associate Agreement, all applicable state and federal laws and regulations and any additional requirements of the Agreement.

d. The Business Associate shall perform a risk assessment, based on the information available at the time it becomes aware of any known or suspected privacy or security breach as described above and communicate the risk assessment to the Covered Entity. The risk assessment shall include, but not be limited to:

I. The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
II. The unauthorized person who accessed, used, disclosed, or received the protected health information;
III. Whether the protected health information was actually acquired or viewed; and
IV. How the risk of loss of confidentiality to the protected health information has been mitigated.

e. The Business Associate shall complete a risk assessment report at the conclusion of its incident or breach investigation and provide the findings in a written report to the Covered Entity as soon as practicable after the conclusion of the Business Associate's investigation.

f. 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 US Secretary of Health and Human Services for purposes of determining the Business Associate's and the Covered Entity's compliance with HIPAA and the Privacy and Security Rule, and Part 2, if applicable.

g. Business Associate shall require all of its business associates that receive, use or have access to PHI under the BAA or 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)n, and an agreement that the Covered Entity shall be considered a direct third party beneficiary of the Business Associate's business associate agreements with Business Associate's intended business associates, who will be receiving PHI pursuant to this BAA, with rights of enforcement and indemnification from such business associates who shall be governed by standard provision #13 of this Agreement for the purpose of use and disclosure of protected health information.

h. Within ten (10) 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 BAA and the Agreement.

i. 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.

j. 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.

k. Business Associate shall document any disclosures of PHI and information related to any 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.

l. 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.

m. In the event any individual requests access to, amendment of, or accounting of PHI directly from the Business Associate, the Business Associate shall within five (5) 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.

n. Within thirty (30) 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-ups of such PHI in any form or platform.

    i. 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 as long as the Business Associate maintains such PHI. If Covered Entity, in its sole discretion, requires that the Business Associate destroy any or all PHI, the Business Associate shall certify to Covered Entity that the PHI has been destroyed.

(4) Obligations of Covered Entity

a. Covered Entity shall notify Business Associate of any changes or limitation(s) in its Notice of Privacy Practices provided to individuals in accordance with 45 CFR Section 164.520, to the extent that such change or limitation may affect Business Associate's use or disclosure of PHI. A current version of Covered Entity's Notice of Privacy

Practices and any changes thereto will be posted on the Covered Entity's website: https://www.dhhs.nh.gov/oos/hipaa/publications.htm .

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 BAA, 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 of Agreement for Cause

In addition to Paragraph 9 of the General Provisions (P-37) of the Agreement, the Covered Entity may immediately terminate the Agreement upon Covered Entity's knowledge of a material breach by Business Associate of the Business Associate Agreement. 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.

(6) Miscellaneous

a. Definitions, Laws, and Regulatory References. All laws and regulations used, herein, shall refer to those laws and regulations as amended from time to time. A reference in the Agreement, as amended to include this Exhibit I, to a Section in HIPAA or 42 Part 2, 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 BAA, from time to time as is necessary for Covered Entity and/or Business Associate to comply with the changes in the requirements of HIPAA, 42 CFR Part 2 other 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 BAA and the Agreement shall be resolved to permit Covered Entity and the Business Associate to comply with HIPAA and 42 CFR Part 2.

e. Segregation. If any term or condition of this BAA 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 BAA regarding the use and disclosure of PHI, return or destruction of PHI, extensions of the protections of the BAA in section (3) I, the defense and indemnification provisions of section (3) e and Paragraph 13 of the General Provisions (P-37) of the Agreement, shall survive the termination of the BAA.

IN WITNESS WHEREOF, the parties hereto have duly executed this Exhibit I.

Department of Health and Human Services	Dartmouth-Hitchcock Health
The State	Name of the Contractor
DocuSigned by: Lori A. Weaver 464A0208A125F7...	DocuSigned by: Edward J. Merrens 8AGA3CECA0CC438...
Signature of Authorized Representative	Signature of Authorized Representative
Lori A. Weaver	Edward J. Merrens
Name of Authorized Representative	Name of Authorized Representative
Deputy Commissioner	Chief Clinical Officer
Title of Authorized Representative	Title of Authorized Representative
3/2/2022	3/2/2022
Date	Date

New Hampshire Department of Health and Human Services
Exhibit J

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:

DocuSigned by:
Edward J. Merrens
8ACA3EEEA6CC483...

3/2/2022
Date

Name: Edward J. Merrens
Title: Chief Clinical Officer

New Hampshire Department of Health and Human Services
Exhibit J

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: QYLXERHDAQL4

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: _____

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

storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent. Incidents include the loss of data through theft or device misplacement, loss or misplacement of hardcopy documents, and misrouting of physical or electronic documents or mail.

7. "Open Wireless Network" means any network or segment of a network that is not designated by the State of New Hampshire's Department of Information Technology or delegate as a protected network (designed, tested, and approved, by means of the State, to transmit) will be considered an open network and not adequately secure for the transmission of unencrypted PI, PFI, PHI or confidential DHHS data.

8. "Personal Information" (or "PI") means information which can be used to distinguish or trace an individual's identity, such as their name, social security number, personal information as defined in New Hampshire RSA 359-C:19, biometric records, etc., alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc.

9. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

10. "Protected Health Information" (or "PHI") has the same meaning as provided in the definition of "Protected Health Information" in the HIPAA Privacy Rule at 45 C.F.R. § 160.103.

11. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. Part 164, Subpart C, and amendments thereto.

12. "Unsecured Protected Health Information" means Protected Health Information that is not secured by a technology standard that renders Protected Health Information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

I. RESPONSIBILITIES OF DHHS AND THE CONTRACTOR

A. Business Use and Disclosure of Confidential Information.

1. The Contractor must not use, disclose, maintain or transmit Confidential Information

except as required or permitted under this Contract or required by law. Further, Contractor, including but not limited to all its directors, officers, employees and agents, must not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

2. The Contractor must not disclose any Confidential Information in response to a request for disclosure on the basis that it is required by law, in response to a subpoena, etc., without first notifying DHHS so that DHHS has an opportunity to consent or object to the disclosure.
3. The Contractor agrees that DHHS Data or derivative there from disclosed to an End User must only be used pursuant to the terms of this Contract.

II. METHODS OF SECURE TRANSMISSION OF DATA

1. Application Encryption. If Contractor is transmitting DHHS Data containing Confidential Data between applications, the Contractor attests the applications have been evaluated by an expert knowledgeable in cyber security and that said application's encryption capabilities ensure secure transmission via the internet.
2. Computer Disks and Portable Storage Devices. Contractor may not use computer disks or portable storage devices, such as a thumb drive, as a method of transmitting DHHS Data.
3. Encrypted Email. Contractor may only employ email to transmit Confidential Data if email is encrypted and being sent to and being received by email addresses of persons authorized to receive such information.
4. Encrypted Web Site. If Contractor is employing the Web to transmit Confidential Data, the secure socket layers (SSL) must be used and the web site must be secure. SSL encrypts data transmitted via a Web site.
5. File Hosting Services, also known as File Sharing Sites. Contractor may not use file hosting services, such as Dropbox or Google Cloud Storage, to transmit Confidential Data.
6. Ground Mail Service. Contractor may only transmit Confidential Data via *certified* ground mail within the continental U.S. and when sent to a named individual.
7. Laptops and PDA. If Contractor is employing portable devices to transmit Confidential Data said devices must be encrypted and password-protected.
8. Open Wireless Networks. Contractor may not transmit Confidential Data via an open wireless network. End User must employ a virtual private network (VPN) when remotely transmitting via an open wireless network.
9. Remote User Communication. If Contractor is employing remote communication to

access or transmit Confidential Data, a secure method of transmission or remote access, which complies with the terms and conditions of Exhibit K, must be used.

10. SSH File Transfer Protocol (SFTP), also known as Secure File Transfer Protocol. If Contractor is employing an SFTP to transmit Confidential Data, End User will structure the Folder and access privileges to prevent inappropriate disclosure of information. SFTP folders and sub-folders used for transmitting Confidential Data will be coded for 24-hour auto-deletion cycle (i.e. Confidential Data will be deleted every 24 hours).
11. Wireless Devices. If Contractor is transmitting Confidential Data via wireless devices, all data must be encrypted to prevent inappropriate disclosure of information.

III. RETENTION AND DISPOSITION OF IDENTIFIABLE RECORDS

The Contractor will only retain DHHS Data and any derivative of the data for the duration of this Contract. After such time, the Contractor will have thirty (30) days to destroy the data and any derivative in whatever form it may exist, unless, otherwise required by law or, if it is infeasible to return or destroy DHHS Data, protections are extended to such information, in accordance with the termination provisions in this Section. To this end, the parties must:

A. Retention

1. The Contractor agrees it will not store, transfer or process data collected in connection with the services rendered under this Contract outside of the United States. This physical location requirement shall also apply in the implementation of cloud computing, cloud service or cloud storage capabilities, and includes backup data and Disaster Recovery locations.
2. The Contractor agrees to ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems accessed or utilized for purposes of carrying out this contract.
3. The Contractor agrees to provide security awareness and education for its End Users in support of protecting DHHS Confidential information.
4. The Contractor agrees to retain all electronic and hard copies of Confidential Data in a secure location and identified in section IV. A.2
5. The Contractor agrees Confidential Data stored in a Cloud must be in a FedRAMP/HITECH compliant solution and comply with all applicable statutes and regulations regarding the privacy and security. All servers and devices must have currently-supported and hardened operating systems, current, updated, and

maintained anti-malware (e.g. anti-viral, anti-hacker, anti-spam, anti-spyware) utilities. The environment, as a whole, must have aggressive intrusion-detection and firewall protection.

6. The Contractor agrees to and ensures its complete cooperation with the State's Chief Information Officer in the detection of any security vulnerability of the hosting infrastructure.

B. Disposition

If the Contractor maintains any Confidential Information on its systems (or its sub-contractor systems) and it has not done so previously, the Contractor will implement policies and procedures to ensure that any storage media on which such data maybe recorded will be rendered unreadable and that the data will be un-recoverable when the storage media is disposed of. Upon request, the Contractor will provide the Department with copies of these policies and with written documentation demonstrating compliance with the policies. The written documentation will include all details necessary to demonstrate data contained in the storage media has been rendered unreadable and un-recoverable. Where applicable, regulatory and professional standards for retention requirements may be jointly evaluated by the State and Contractor prior to destruction.

1. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to destroy all hard copies of Confidential Data using a secure method such as shredding.
2. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to completely destroy all electronic Confidential Data by means of data erasure, also known as secure data wiping.

IV. PROCEDURES FOR SECURITY

A. Contractor agrees to safeguard the DHHS Data received under this Contract, and any derivative data or files, as follows:

1. The Contractor will maintain proper security controls to protect Department confidential information collected, processed, managed, and/or stored in the delivery of contracted services.
2. The Contractor will maintain policies and procedures to protect Department confidential information throughout the information lifecycle, where applicable, (from creation, transformation, use, storage and secure destruction) regardless of the media

used to store the data (i.e., tape, disk, paper, etc.).

3. The Contractor will maintain appropriate authentication and access controls to contractor systems that collect, transmit, or store Department confidential information where applicable.

4. If the Contractor will be sub-contracting any core functions of the engagement supporting the services for State of New Hampshire, the Contractor will ensure End-User will maintain an internal process or processes that defines specific security expectations, and monitoring compliance to security requirements that at a minimum match those for the Contractor, including breach notification requirements.

5. The Contractor will work with the Department to sign and comply with all applicable State of New Hampshire and Department system access and authorization policies and procedures, systems access forms, and computer use agreements as part of obtaining and maintaining access to any Department system(s). Agreements will be completed and signed by the Contractor and any applicable sub-contractors prior to system access being authorized.

6. If the Department determines the Contractor is a Business Associate pursuant to 45 CFR 160.103, the Contractor will execute a HIPAA Business Associate Agreement (BAA) with the Department and is responsible for maintaining compliance with the agreement.

7. The Contractor will not store any State of New Hampshire or Department data offshore or outside the boundaries of the United States unless prior express written consent is obtained from the Information Security Office leadership member within the Department.

8. Data Security Breach Liability. In the event of any computer security incident, incident, or breach Contractor shall make efforts to investigate the causes of the breach, promptly take measures to prevent future breach and minimize any damage or loss resulting from the breach. The State shall recover from the Contractor all costs of response and recovery from the breach, including but not limited to: credit monitoring services, mailing costs and costs associated with website and telephone call center services necessary due to the breach.

9. Contractor must, comply with all applicable statutes and regulations regarding the privacy and security of Confidential Information, and must in all other respects maintain the privacy and security of PI and PHI at a level and scope that is not less than the level and scope of, HIPAA Privacy and Security Rules (45 C.F.R. Parts 160 and 164) and 42 C.F.R. Part 2 that govern protections for individually identifiable

health information and as applicable under State law.

10. Contractor agrees to establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality of the Confidential Data and to prevent unauthorized use or access to it. The safeguards must provide a level and scope of security that is not less than the level and scope of security requirements established by the State of New Hampshire, Department of Information Technology. Refer to Vendor Resources/Procurement at https://www.nh.gov/doit/vendor/index.htm for the Department of Information Technology policies, guidelines, standards, and procurement information relating to vendors.

11. Contractor agrees to maintain a documented breach notification and incident response process. The Contractor must notify the DHHS Security Office and the Program Contact via the email addresses provided in Section VI of this Exhibit, immediately upon the Contractor determining that a breach or security incident has occurred and that DHHS confidential Information/data may have been exposed or compromised. 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 immediately notify the State's Privacy Officer, Information Security Office and Program Manager of any Security Incidents and Breaches as specified in Section IV, paragraph 11 above.

The Contractor must further handle and report Incidents and Breaches involving PHI in accordance with DHHS's documented Incident Handling and Breach Notification procedures and in accordance with– the HIPAA, Privacy and Security Rules. In addition

to, and notwithstanding, Contractor's compliance with all applicable obligations and procedures, Contractor's procedures must also address how the Contractor will:

1. Identify Incidents;
2. Determine if personally identifiable information is involved in Incidents;
3. Report suspected or confirmed Incidents as required in this Exhibit or P-37;
4. Identify and convene a core response group to determine the risk level of Incidents and determine risk-based responses to Incidents; and
5. Determine whether Breach notification is required, and, if so, identify appropriate Breach notification methods, timing, source, and contents from among different options, and bear costs associated with the Breach notice as well as any mitigation measures.

Incidents and/or Breaches that implicate PI must be addressed and reported, as applicable, in accordance with NH RSA 359-C:20.

VI. PERSONS TO CONTACT

A. DHHS contact for Data Management or Data Exchange issues:
DHHSInformationSecurityOffice@dhhs.nh.gov

B. DHHS contacts for Privacy issues:
DHHSPrivacyOfficer@dhhs.nh.gov

C. DHHS contact for Information Security issues:
DHHSInformationSecurityOffice@dhhs.nh.gov

D. DHHS contact for Breach notifications:
DHHSInformationSecurityOffice@dhhs.nh.gov
DHHSPrivacyOfficer@dhhs.nh.gov

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

Business ID: **68517**

Certificate Number: **0005357410**



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 26th day of April A.D. 2021.

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, Roberta L. Hines, MD, 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 June 23rd, 2017 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 in furtherance of its charitable purposes."
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.
5. The foregoing authority shall remain in full force and effect, and the State of New Hampshire shall be entitled to rely upon same, until written notice of the modification, rescission or revocation of same, in whole or in part, has been received by the State of New Hampshire. This Certificate shall be effective with respect to any agreement executed or action taken in reliance upon this Certificate before such written notice is received by the State of New Hampshire.

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 10th day of February, 2022.

Roberta L. Hines, MD, Board Chair

STATE OF NH

COUNTY OF GRAFTON

The foregoing instrument was acknowledged before me this 10th day of Feb, 2022 by Roberta L. Hines, MD.

Faith Johnston
Notary Public
My Commission Expires: Aug 4, 2026

FAITH E. JOHNSTON
MY COMMISSION EXPIRES AUG. 4, 2026
NOTARY PUBLIC
NEW HAMPSHIRE

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CERTIFICATE OF INSURANCE

DATE: February 1, 2022

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

INSURED
Mary Hitchcock Memorial Hospital
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		0002021-A	7/1/2021	7/1/2022	EACH OCCURRENCE	$2,000,000
					DAMAGE TO RENTED PREMISES	$1,000,000
X	CLAIMS MADE				MEDICAL EXPENSES	N/A
					PERSONAL & ADV INJURY	$1,000,000
	OCCURRENCE				GENERAL AGGREGATE	$2,000,000
OTHER					PRODUCTS-COMP/OP AGG	$1,000,000
PROFESSIONAL LIABILITY		0002021-A	7/1/2021	7/1/2022	EACH CLAIM	$1,000,000
X	CLAIMS MADE				ANNUAL AGGREGATE	$3,000,000
	OCCURENCE					
OTHER						

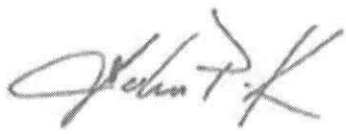
DESCRIPTION OF OPERATIONS/ LOCATIONS/ VEHICLES/ SPECIAL ITEMS (LIMITS MAY BE SUBJECT TO RETENTIONS)
Certificate is issued as evidence of insurance.

CERTIFICATE HOLDER

NH Department 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) 6/30/2021

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: Angela Columbus PHONE (A/C, No, Ext): (774) 233-6204 FAX (A/C, No): E-MAIL ADDRESS: Angela.Columbus@hubinternational.com	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : Safety National Casualty Corporation	15105
INSURED Dartmouth-Hitchcock Health 1 Medical Center Dr. Lebanon, NH 03756	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 Y / N			AGC4065185	7/1/2021	7/1/2022	X PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory In NH)	N / A					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)

Evidence of Workers Compensation coverage for

Cheshire Medical Center
Dartmouth-Hitchcock Health
Mary Hitchcock Memorial Hospital
Alice Peck Day Memorial Hospital
New London Hospital Association
Mt. Ascutney Hospital and Health Center

CERTIFICATE HOLDER

NH DHHS
129 Pleasant Street
Concord, NH 03301

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

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Dartmouth-Hitchcock

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)

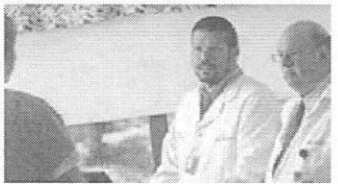
DHMC is the state's only academic medical center, and the only Level I Adult and Pediatric Trauma Center in New Hampshire. The Dartmouth-Hitchcock Advanced Response Team (DHART), based in Lebanon and Manchester, provides ground and air medical transportation to communities throughout northern New England. 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

Consolidated Financial Statements
June 30, 2020 and 2019

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Dartmouth-Hitchcock Health and Subsidiaries
Index
June 30, 2020 and 2019

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Report of Independent Auditors

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

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, 2020 and 2019, and the related consolidated statements of operations and changes in net assets and of cash flows for the years then ended.

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. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

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

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Dartmouth-Hitchcock Health and its subsidiaries as of June 30, 2020 and 2019, 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.

PricewaterhouseCoopers LLP, 101 Seaport Boulevard, Suite 500, Boston, MA 02210
T: (617) 530 5000, F: (617) 530 5001, www.pwc.com/us

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Emphasis of Matter

As discussed in Note 2 to the consolidated financial statements, the Health System changed the manner in which it accounts for leases and the presentation of net periodic pension costs in 2020. Our opinion is not modified with respect to these matters.

Other Matter

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 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.

PricewaterhouseCoopers LLP

Boston, Massachusetts
November 17, 2020

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Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Balance Sheets
June 30, 2020 and 2019

(in thousands of dollars)	2020	2019
Assets		
Current assets		
Cash and cash equivalents	$ 453,223	$ 143,587
Patient accounts receivable (Note 4)	183,819	221,125
Prepaid expenses and other current assets	161,906	95,495
Total current assets	798,948	460,207
Assets limited as to use (Notes 5 and 7)	1,134,526	876,249
Other investments for restricted activities (Notes 5 and 7)	140,580	134,119
Property, plant, and equipment, net (Note 6)	643,586	621,256
Right of use assets, net (Note 16)	57,585	-
Other assets	137,338	124,471
Total assets	$ 2,912,563	$ 2,216,302
Liabilities and Net Assets		
Current liabilities		
Current portion of long-term debt (Note 10)	$ 9,467	$ 10,914
Current portion of right of use obligations (Note 16)	11,775	-
Current portion of liability for pension and other postretirement plan benefits (Note 11 and 14)	3,468	3,468
Accounts payable and accrued expenses	129,016	113,817
Accrued compensation and related benefits	142,991	128,408
Estimated third-party settlements (Note 4 and 17)	302,525	41,570
Total current liabilities	599,242	298,177
Long-term debt, excluding current portion (Note 10)	1,138,530	752,180
Long-term right of use obligations, excluding current portion (Note 16)	46,456	-
Insurance deposits and related liabilities (Note 12)	77,146	58,407
Liability for pension and other postretirement plan benefits, excluding current portion (Note 11 and 14)	324,257	281,009
Other liabilities	143,678	124,136
Total liabilities	2,329,309	1,513,909
Commitments and contingencies (Notes 4, 6, 7, 10, 13, 16 and 17)		
Net assets		
Net assets without donor restrictions (Note 9)	431,026	559,933
Net assets with donor restrictions (Notes 8 and 9)	152,228	142,460
Total net assets	583,254	702,393
Total liabilities and net assets	$ 2,912,563	$ 2,216,302

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, 2020 and 2019

(in thousands of dollars)	2020	2019
Operating revenue and other support		
Patient service revenue (Note 4)	$ 1,880,025	$ 1,999,323
Contracted revenue	74,028	75,017
Other operating revenue (Note 5)	374,622	210,698
Net assets released from restrictions	16,260	14,105
Total operating revenue and other support	2,344,935	2,299,143
Operating expenses		
Salaries	1,144,823	1,062,551
Employee benefits	272,872	262,812
Medications and medical supplies	455,381	407,875
Purchased services and other	360,496	323,435
Medicaid enhancement tax (Note 4)	76,010	70,061
Depreciation and amortization	92,164	88,414
Interest (Note 10)	27,322	25,514
Total operating expenses	2,429,068	2,240,662
Operating (loss) income	(84,133)	58,481
Non-operating gains (losses)		
Investment income, net (Note 5)	27,047	40,052
Other components of net periodic pension and post retirement benefit income (Note 11)	10,810	11,221
Other losses, net (Note 10)	(2,707)	(3,562)
Loss on early extinguishment of debt	-	(87)
Total non-operating gains, net	35,150	47,624
(Deficiency) excess of revenue over expenses	$ (48,983)	$ 106,105

Consolidated Statements of Operations and Changes in Net Assets – Continues on Next Page

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 - Continued
Years Ended June 30, 2020 and 2019

(in thousands of dollars)	2020	2019
Net assets without donor restrictions		
(Deficiency) excess of revenue over expenses	$ (48,983)	$ 106,105
Net assets released from restrictions for capital	1,414	1,769
Change in funded status of pension and other postretirement benefits (Note 11)	(79,022)	(72,043)
Other changes in net assets	(2,316)	-
(Decrease) increase in net assets without donor restrictions	(128,907)	35,831
Net assets with donor restrictions		
Gifts, bequests, sponsored activities	26,312	17,436
Investment income, net	1,130	2,682
Net assets released from restrictions	(17,674)	(15,874)
Contribution of assets with donor restrictions from acquisition	-	383
Increase in net assets with donor restrictions	9,768	4,627
Change in net assets	(119,139)	40,458
Net assets		
Beginning of year	702,393	661,935
End of year	$ 583,254	$ 702,393

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, 2020 and 2019

(in thousands of dollars)	2020	2019
Cash flows from operating activities		
Change in net assets	$ (119,139)	$ 40,458
Adjustments to reconcile change in net assets to net cash provided by operating and non-operating activities		
Depreciation and amortization	93,857	88,770
Amortization of right of use asset	8,218	-
Payments on right of use lease obligations - operating	(7,941)	-
Change in funded status of pension and other postretirement benefits	79,022	72,043
Gain on disposal of fixed assets	(39)	(1,101)
Net realized gains and change in net unrealized gains on investments	(14,060)	(31,397)
Restricted contributions and investment earnings	(3,605)	(2,292)
Proceeds from sales of securities	-	1,167
Changes in assets and liabilities		
Patient accounts receivable	37,306	(1,803)
Prepaid expenses and other current assets	(78,907)	2,149
Other assets, net	(13,385)	(9,052)
Accounts payable and accrued expenses	9,772	17,898
Accrued compensation and related benefits	14,583	2,335
Estimated third-party settlements	260,955	429
Insurance deposits and related liabilities	18,739	2,378
Liability for pension and other postretirement benefits	(35,774)	(33,104)
Other liabilities	19,542	12,267
Net cash provided by operating and non-operating activities	269,144	161,145
Cash flows from investing activities		
Purchase of property, plant, and equipment	(128,019)	(82,279)
Proceeds from sale of property, plant, and equipment	2,987	2,188
Purchases of investments	(321,152)	(361,407)
Proceeds from maturities and sales of investments	82,986	219,996
Cash received through acquisition	-	4,863
Net cash used in investing activities	(363,198)	(216,639)
Cash flows from financing activities		
Proceeds from line of credit	35,000	30,000
Payments on line of credit	(35,000)	(30,000)
Repayment of long-term debt	(10,665)	(29,490)
Proceeds from issuance of debt	415,336	26,338
Repayment of finance lease	(2,429)	-
Payment of debt issuance costs	(2,157)	(228)
Restricted contributions and investment earnings	3,605	2,292
Net cash provided by (used in) financing activities	403,690	(1,088)
Increase (decrease) in cash and cash equivalents	309,636	(56,582)
Cash and cash equivalents		
Beginning of year	143,587	200,169
End of year	$ 453,223	$ 143,587
Supplemental cash flow information		
Interest paid	$ 22,562	$ 23,977
Net assets acquired as part of acquisition, net of cash aquired	-	(4,863)
Construction in progress included in accounts payable and accrued expenses	17,177	1,546
Donated securities	-	1,167

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 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 for VT and NH are VT not-for-profit corporations exempt from federal income taxes under Section 501(c)(3) of the IRC.

On September 30, 2019, D-HH and GraniteOne Health ("GOH") entered into an agreement ("The Combination Agreement") to combine their respective healthcare systems. The GOH system is comprised of Catholic Medical Center ("CMC"), an acute care community hospital in Manchester, New Hampshire, Huggins Hospital ("HH") located in Wolfeboro, NH and Monadnock Community Hospital, ("MCH") located in Petersborough, NH. Both HH and MCH are designated as Critical Access Hospitals. The three member hospitals of GOH have a combined licensed bed count of 380 beds. GOH is a non-profit, community based health care system. The overarching rationale for the proposed combination is to improve access to high quality primary and specialty care in the most convenient, cost-effective sites of service for patients and the communities served by D-HH and GOH. Other stated benefits of the combination include reinforcing the rural health network, investing in needed capacity to accommodate unmet and anticipated demand, and drawing on our combined strengths to attract the necessary health care workforce. The parties have submitted regulatory filings with the Federal Trade Commission and the New Hampshire Attorney General's office seeking approval of the proposed transaction.

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

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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 2019 was approximately $143,013,000. The 2020 Community Benefits Reports are expected to be filed in February 2021.

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, 2019:

(in thousands of dollars)

Government-sponsored healthcare services	$	291,013
Health professional education		40,621
Charity care		15,281
Subsidized health services		15,165
Community health services		6,895
Research		5,238
Community building activities		3,777
Financial contributions		1,597
Community benefit operations		1,219
Total community benefit value	$	380,806

In fiscal years 2020 and 2019, funds received to offset or subsidize charity care costs provided were $1,224,000 and $487,000, respectively.

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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.

(Deficiency) Excess of Revenue over Expenses

The consolidated statements of operations and changes in net assets include the (deficiency) 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, realized gains/losses on sales of investment securities and changes in unrealized gains/losses on investments are reported as non-operating gains (losses).

Changes in net assets without donor restrictions which are excluded from the (deficiency) 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, and change in funded status of pension and other postretirement benefit plans.

Charity Care

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

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

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

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

Other Revenue
The Health System recognizes other revenue which is not related to patient medical care but is central to the day-to-day operations of the Health System. Other revenue primarily consists of revenue from retail pharmacy, which the Health System records as customer revenues in the amounts that reflect the consideration to which it expects to be entitled in exchange for the prescription. Other revenue also includes the Department of Health and Human Services ("HHS") Coronavirus Aid, Relief, and Economic Securities Act ("CARES Act" Provider Relief Funds ("Provider Relief Funds") operating agreements, grant revenue, cafeteria sales and other support service revenue.

Cash Equivalents
Cash and cash equivalents include amounts on deposit with financial institutions; short-term investments with maturities of three months or less at the time of purchase and other highly liquid investments, primarily cash management funds. Short-term highly liquid investments held within the endowment and similar investment pools are classified as investments rather than cash equivalents and restricted cash is defined as that which is legally restricted to withdrawal and usage.

Investments and Investment Income
Investments in equity securities with readily determinable fair values, mutual funds, governmental securities, debt securities, and pooled/commingled funds are reported at fair value with changes in fair value included in the (deficiency) 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 (deficiency) excess of revenues over expenses. All investments, whether

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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 non-distressed 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 (deficiency) excess of revenue over expenses and classified as non-operating 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 amounts of patient accounts receivable, prepaid and other current assets, accounts payable and accrued expenses approximate 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

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leasehold improvements. Certain software development costs are amortized using the straight-line method over a period of up to 10 years. Net interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

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

Gifts of capital assets such as land, buildings, or equipment are reported as support, and excluded from the (deficiency) 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 $10,007,000 and $10,524,000 as intangible assets associated with its affiliations as of June 30, 2020 and 2019, respectively.

Gifts
Gifts without donor restrictions are recorded net of related expenses as non-operating 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 January 2016, the FASB issued ASU 2016-01- *Recognition and Measurement of Financial Assets and Financial Liabilities*, which addresses 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. The standard has been adopted during the current fiscal year and no material impact was noted.

In February 2016, the FASB issued *ASU 2016-02 – Leases (Topic 842)*. Under the new guidance, lessees are required to recognize the following for all leases (with the exception of leases with a term of twelve months or less) at the commencement date: (a) a lease liability, which is a lessee's obligation to make lease payments arising from a lease, measured on a discounted basis; and (b) a right-of-use asset, which is an asset that represents the lessee's right to use, or control the use of, a specified asset for the lease term. Leases are classified as either operating or finance. Operating leases result in straight-line expense in the statement of operations (similar to previous operating leases), while finance leases result in more expense being recognized in the earlier years of the lease term (similar to previous capital leases). The Health System adopted the new standard on July 1, 2019 using the modified retrospective approach. The Health System elected the transition method that allows for the application of the standard at the adoption date rather than at the beginning of the earliest comparative period presented in the consolidated financial statements. The Health System also elected available practical expedients (Note 16).

In March 2017, the FASB issued ASU 2017-07, *Compensation – Retirement Benefits* (Topic 715): *Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost*. Under the new standard, the service cost component of the net benefit cost will be included within income from operations as a component of benefits expenses and the other components of net benefit cost as defined by ASC 715 will be reported in non-operating activities within the consolidated statements of operations and changes in net assets. The standard also prohibits reporting of the other components of net benefit cost in the same line as other pension related changes on the statements of operations and changes in net assets. ASU 2017-07 is effective for the fiscal year ended June 30, 2020 and is applied on a retrospective basis.

Reclassifications

As a result of adopting the provisions of ASU 2017-07, the Health System reclassified $11,221,000 from benefits expense to non-operating activities within the consolidated statements of operations and changes in net assets for the fiscal year ended June 30, 2019. The amount included in non-operating activities for the fiscal year ending June 30, 2020 was $10,810,000.

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3. Acquisition

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.

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.

Vermont imposes a provider tax on home health agencies in the amount of 4.25% of annual net patient revenue. In fiscal years 2020 and 2019, home health provider taxes paid were $624,000 and $628,000, respectively.

Medicaid Enhancement Tax & Disproportionate Share Hospital

On May 22, 2018, the State of New Hampshire and all New Hampshire hospitals (Hospitals) agreed to resolve disputed issues and enter into a seven-year agreement to stabilize Disproportionate Share Hospital (DSH) payments, with provisions for alternative payments in the event of legislative changes to the DSH program. Under the agreement, the State committed to make DSH payments to the Hospitals in an amount no less than 86% of the Medicaid Enhancement Tax (MET) proceeds collected in each fiscal year, in addition to providing for directed payments or increased rates for Hospitals in an amount equal to 5% of MET proceeds collected from state fiscal year (SFY) 2020 through SFY 2024. The agreement prioritizes DSH payments to critical access hospitals in an amount equal to 75% of allowable uncompensated care (UCC), with the remainder distributed to Hospitals without critical access designation in proportion to their allowable UCC amounts.

During the years ended June 30, 2020 and 2019, the Health System received DSH payments of approximately, $71,133,000 and $69,179,000 respectively. DSH payments are subject to audit and therefore, for the years ended June 30, 2020 and 2019, the Health System recognized as revenue DSH receipts of approximately $67,500,000 and approximately $64,864,000, respectively.

During the years ended June 30, 2020 and 2019, the Health System recorded State of NH MET and State of VT Provider taxes of $76,010,000 and $70,061,000, respectively. The taxes are calculated at 5.4% for NH and 6% for VT of certain patient service revenues. 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

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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 services 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, 2020 and 2019, the Health System had reserves of $302,525,000 and $41,570,000, respectively, recorded in Estimated third-party settlements. Included in the 2020 Estimated third party settlements is $239,500,000 of Medicare accelerated and advanced payments, received as working capital support during the novel coronavirus ("COVID-19") outbreak at June 30, 2020. In addition, $10,900,000 has been recorded in Other liabilities as of June 30, 2020 and 2019, respectively.

For the years ended June 30, 2020 and 2019, additional increases in revenue of $2,314,000 and $1,800,000, respectively, were recognized due to changes in estimates of implicit price concessions for performance obligations satisfied in prior years.

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, 2020 and 2019.

(in thousands of dollars)	2020 PPS	2020 CAH	2020 Total
Hospital			
Medicare	$ 461,990	$ 64,087	$ 526,077
Medicaid	130,901	10,636	141,537
Commercial	718,576	60,715	779,291
Self Pay	2,962	2,501	5,463
Subtotal	1,314,429	137,939	1,452,368
Professional			
Professional	383,503	22,848	406,351
VNA	-	-	21,306
Other Revenue	-	-	376,185
Provider Relief Fund	-	-	88,725
Total operating revenue and other support	$ 1,697,932	$ 160,787	$ 2,344,935

(in thousands of dollars)	2019 PPS	2019 CAH	2019 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
Subtotal	1,346,382	152,281	1,498,663
Professional			
Professional	454,425	23,707	478,132
VNA	-	-	22,528
Other Revenue	-	-	299,820
Total operating revenue and other support	$ 1,800,807	$ 175,988	$ 2,299,143

Accounts Receivable
The following table categorizes payors into four groups based on their respective percentages of patient accounts receivable as of June 30, 2020 and 2019:

	2020	2019
Medicare	36%	34%
Medicaid	13%	12%
Commercial	39%	41%
Self Pay	12%	13%
Patient accounts receivable	100%	100%

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5. Investments

The composition of investments at June 30, 2020 and 2019 is set forth in the following table:

(in thousands of dollars)	2020	2019
Assets limited as to use		
Internally designated by board		
Cash and short-term investments	$ 9,646	$ 21,890
U.S. government securities	103,977	91,492
Domestic corporate debt securities	199,462	196,132
Global debt securities	70,145	83,580
Domestic equities	203,010	167,384
International equities	123,205	128,909
Emerging markets equities	22,879	23,086
Real Estate Investment Trust	313	213
Private equity funds	74,131	64,563
Hedge funds	36,964	32,287
	843,732	809,536
Investments held by captive insurance companies (Note 12)		
U.S. government securities	15,402	23,241
Domestic corporate debt securities	8,651	11,378
Global debt securities	8,166	10,080
Domestic equities	15,150	14,617
International equities	7,227	6,766
	54,596	66,082
Held by trustee under indenture agreement (Note 10)		
Cash and short-term investments	236,198	631
Total assets limited as to use	1,134,526	876,249
Other investments for restricted activities		
Cash and short-term investments	7,186	6,113
U.S. government securities	28,055	32,479
Domestic corporate debt securities	35,440	29,089
Global debt securities	11,476	11,263
Domestic equities	26,723	20,981
International equities	15,402	15,531
Emerging markets equities	2,766	2,578
Private equity funds	9,483	7,638
Hedge funds	4,013	8,414
Other	36	33
Total other investments for restricted activities	140,580	134,119
Total investments	$ 1,275,106	$ 1,010,368

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 non-distressed basis.

The following tables summarize the investments by the accounting method utilized, as of June 30, 2020 and 2019. Accounting standards require disclosure of additional information for those securities accounted for using the fair value method, as shown in Note 7.

	2020		
(in thousands of dollars)	**Fair Value**	**Equity**	**Total**
Cash and short-term investments	$ 253,030	$ -	$ 253,030
U.S. government securities	147,434	-	147,434
Domestic corporate debt securities	198,411	45,142	243,553
Global debt securities	44,255	45,532	89,787
Domestic equities	195,014	49,869	244,883
International equities	77,481	68,353	145,834
Emerging markets equities	1,257	24,388	25,645
Real Estate Investment Trust	313	-	313
Private equity funds	-	83,614	83,614
Hedge funds	-	40,977	40,977
Other	36	-	36
	$ 917,231	$ 357,875	$ 1,275,106

	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

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For the years ended June 30, 2020 and 2019 investment income is reflected in the accompanying consolidated statements of operations and changes in net assets as other operating revenue of approximately $936,000 and $983,000 and as non-operating gains of approximately $27,047,000 and $40,052,000, 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, 2020 and 2019, the Health System has committed to contribute approximately $172,819,000 and $164,319,000 to such funds, of which the Health System has contributed approximately $119,142,000 and $109,584,000 and has outstanding commitments of $53,677,000 and $54,735,000, respectively.

6. Property, Plant, and Equipment

Property, plant, and equipment are summarized as follows at June 30, 2020 and 2019:

(in thousands of dollars)	2020	2019
Land	$ 40,749	$ 38,232
Land improvements	39,820	42,607
Buildings and improvements	893,081	898,050
Equipment	927,233	888,138
Equipment under capital leases	-	15,809
	1,900,883	1,882,836
Less: Accumulated depreciation and amortization	1,356,521	1,276,746
Total depreciable assets, net	544,362	606,090
Construction in progress	99,224	15,166
	$ 643,586	$ 621,256

As of June 30, 2020, construction in progress primarily consists of two projects. The first project, started in fiscal 2019, consists of the addition of the ambulatory surgical center (ASC) located in Manchester, NH. The estimated cost to complete the project is $42 million. The anticipated completion date is the second quarter of fiscal 2021. The second project, involves the addition of the in-patient tower located in Lebanon, NH. The estimated cost to complete the tower project is $140 million over the next three fiscal years.

The construction in progress as of June 30, 2019, included both the ASC, as well as renovations taking place at the various pharmacy locations to bring their facilities compliant with Regulation USP800. The pharmacy upgrade was completed during the first quarter of fiscal year 2021. Capitalized interest of $2,297,000 and $0 is included in Construction in progress as of June 30, 2020 and 2019, respectively.

Depreciation and amortization expense included in operating and non-operating activities was approximately $92,217,000 and $88,496,000 for 2020 and 2019, respectively.

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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, 2020 and 2019:

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Notes to Financial Statements
June 30, 2020 and 2019

	2020					
(in thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Assets						
Investments						
Cash and short term investments	$ 253,030	$ -	$ -	$ 253,030	Daily	1
U.S. government securities	147,434	-	-	147,434	Daily	1
Domestic corporate debt securities	17,577	180,834	-	198,411	Daily–Monthly	1–15
Global debt securities	22,797	21,458	-	44,255	Daily–Monthly	1–15
Domestic equities	187,354	7,660	-	195,014	Daily–Monthly	1–10
International equities	77,481	-	-	77,481	Daily–Monthly	1–11
Emerging market equities	1,257	-	-	1,257	Daily–Monthly	1–7
Real estate investment trust	313	-	-	313	Daily–Monthly	1–7
Other	2	34	-	36	Not applicable	Not applicable
Total investments	707,245	209,986	-	917,231		
Deferred compensation plan assets						
Cash and short-term investments	5,754	-	-	5,754		
U.S. government securities	51	-	-	51		
Domestic corporate debt securities	7,194	-	-	7,194		
Global debt securities	1,270	-	-	1,270		
Domestic equities	24,043	-	-	24,043		
International equities	3,571	-	-	3,571		
Emerging market equities	27	-	-	27		
Real estate	11	-	-	11		
Multi strategy fund	51,904	-	-	51,904		
Guaranteed contract	-	-	92	92		
Total deferred compensation plan assets	93,825	-	92	93,917	Not applicable	Not applicable
Beneficial interest in trusts	-	-	9,202	9,202	Not applicable	Not applicable
Total assets	$ 801,070	$ 209,986	$ 9,294	$ 1,020,350		

	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		

The following table is a rollforward of financial instruments classified by the Health System within Level 3 of the fair value hierarchy defined above.

	2020		
(in thousands of dollars)	Beneficial Interest in Perpetual Trust	Guaranteed Contract	Total
Balances at beginning of year	$ 9,301	$ 89	$ 9,390
Net unrealized (losses) gains	(99)	3	(96)
Balances at end of year	$ 9,202	$ 92	$ 9,294

	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 (losses) gains	(73)	3	(70)
Balances at end of year	$ 9,301	$ 89	$ 9,390

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, 2020 and 2019.

8. Net Assets with Donor Restrictions

Net assets with donor restrictions are available for the following purposes at June 30, 2020 and 2019:

(in thousands of dollars)	2020	2019
Investments held in perpetuity	$ 59,352	$ 56,383
Healthcare services	33,976	20,140
Research	22,116	26,496
Health education	16,849	19,833
Charity care	12,366	12,494
Other	4,488	3,841
Purchase of equipment	3,081	3,273
	$ 152,228	$ 142,460

Income earned on donor restricted net assets held in perpetuity is available for these purposes.

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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, 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, 2020 and 2019.

Endowment net asset composition by type of fund consists of the following at June 30, 2020 and 2019:

	2020		
(in thousands of dollars)	Without Donor Restrictions	With Donor Restrictions	Total
Donor-restricted endowment funds	$ -	$ 80,039	$ 80,039
Board-designated endowment funds	33,714	-	33,714
Total endowed net assets	$ 33,714	$ 80,039	$ 113,753

	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

Changes in endowment net assets for the years ended June 30, 2020 and 2019 are as follows:

	2020		
(in thousands of dollars)	Without Donor Restrictions	With Donor Restrictions	Total
Balances at beginning of year	$ 31,421	$ 78,268	$ 109,689
Net investment return	713	1,460	2,173
Contributions	890	2,990	3,880
Transfers	14	267	281
Release of appropriated funds	676	(2,946)	(2,270)
Balances at end of year	$ 33,714	$ 80,039	$ 113,753

Balances at end of year	80,039
Beneficial interest in perpetual trusts	6,782
Net assets with donor restrictions	$ 86,821

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	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

Balances at end of year	78,268
Beneficial interest in perpetual trusts	8,422
Net assets with donor restrictions	$ 86,690

10. Long-Term Debt

A summary of long-term debt at June 30, 2020 and 2019 is as follows:

(in thousands of dollars)	2020	2019
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 2020A, principal maturing in varying annual amounts, through August 2059 (2)	125,000	-
Series 2017A, principal maturing in varying annual amounts, through August 2040 (3)	122,435	122,435
Series 2017B, principal maturing in varying annual amounts, through August 2031 (3)	109,800	109,800
Series 2019A, principal maturing in varying annual amounts, through August 2043 (4)	99,165	-
Series 2018C, principal maturing in varying annual amounts, through August 2030 (5)	25,160	25,865
Series 2012, principal maturing in varying annual amounts, through July 2039 (6)	24,315	25,145
Series 2014A, principal maturing in varying annual amounts, through August 2022 (7)	19,765	26,960
Series 2014B, principal maturing in varying annual amounts, through August 2033 (7)	14,530	14,530
Series 2016B, principal maturing in varying annual amounts, through August 2045 (8)	10,970	10,970
Note payable		
Note payable to a financial institution due in monthly interest only payments through May 2023 (9)	125,000	-
Total obligated group debt	$ 1,062,597	$ 722,162

A summary of long-term debt at June 30, 2020 and 2019 is as follows (continued):

(in thousands of dollars)	2020	2019
Other		
Note payable to a financial institution payable in interest free monthly installments through July 2015; collateralized by associated equipment	$ 287	$ 445
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	273	323
Mortgage note payable to the US Dept of Agriculture; monthly payments of $10,892 include interest of 2.375% through November 2046	2,560	2,629
Obligations under capital leases	-	17,526
Total nonobligated group debt	3,120	20,923
Total obligated group debt	1,062,597	722,162
Total long-term debt	1,065,717	743,085
Add: Original issue premium and discounts, net	89,542	25,542
Less: Current portion	9,467	10,914
Debt issuance costs, net	7,262	5,533
	$ 1,138,530	$ 752,180

Aggregate annual principal payments for the next five years ending June 30 and thereafter are as follows:

(in thousands of dollars)	2020
2021	$ 9,467
2022	9,419
2023	131,626
2024	1,871
2025	1,954
Thereafter	911,380
	$ 1,065,717

Dartmouth-Hitchcock Obligated Group (DHOG) Debt

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, 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 non-operating 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 2020A Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds Series 2020A in February, 2020. The proceeds from the Series 2020A Revenue Bonds are being used primarily to fund the construction of a 212,000 square foot inpatient pavilion in Lebanon, NH as well as various equipment. The interest on the Series 2020A Revenue Bonds is fixed with an interest rate of 5.00% and matures in variable amounts through 2059.

(3) 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.

(4) Series 2019A Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds Series 2019A in October, 2019. The proceeds from the Series 2019A Revenue Bonds are being used primarily to fund the construction of a 91,000 square foot expansion of facilities in Manchester, NH to include an Ambulatory Surgical Center as well as various equipment. The interest on the Series 2019A Revenue Bonds is fixed with an interest rate of 4.00% and matures in variable amounts through 2043.

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(5) 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.

(6) 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.

(7) 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.

(8) 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.

(9) Note payable to financial institution

The DHOG issued a note payable to TD Bank in May 2020. Issued in response to the COVID-19 pandemic, the proceeds from the note will be used to fund working capital as needs require. The interest on the note payable is fixed with an interest rate of 2.02% and matures in 2023.

Outstanding joint and several indebtedness of the DHOG at June 30, 2020 and 2019 approximates $1,062,597,000 and $722,162,000, respectively.

The Health System Indenture agreements require establishment and maintenance of debt service reserves and other trustee held funds. Trustee held funds of approximately $236,198,000 and $631,000 at June 30, 2020 and 2019, respectively, are classified as assets limited as to use in the accompanying consolidated balance sheets (Note 5). In addition, debt service reserves of approximately $9,286,000 and $1,331,000 at June 30, 2020 and 2019, respectively, are classified as other current assets in the accompanying consolidated balance sheets. The debt service reserves are mainly comprised of escrowed construction funds at June 30, 2020 and escrowed funds held for future principal and interest payments at June 30, 2019.

For the years ended June 30, 2020 and 2019 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 $27,322,000 and $25,514,000 and other non-operating losses of $3,784,000 and $3,784,000, respectively.

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, 2020 and 2019:

(in thousands of dollars)	2020	2019
Service cost for benefits earned during the year	$ 170	$ 150
Interest cost on projected benefit obligation	43,433	47,814
Expected return on plan assets	(62,436)	(65,270)
Net loss amortization	12,032	10,357
Total net periodic pension expense	$ (6,801)	$ (6,949)

The following assumptions were used to determine net periodic pension expense as of June 30, 2020 and 2019:

	2020	2019
Discount rate	3.00% - 3.10%	3.90 % – 4.60%
Rate of increase in compensation	N/A	N/A
Expected long-term rate of return on plan assets	7.50%	7.50%

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, 2020 and 2019:

(in thousands of dollars)	2020	2019
Change in benefit obligation		
Benefit obligation at beginning of year	$ 1,135,523	$ 1,087,940
Service cost	170	150
Interest cost	43,433	47,814
Benefits paid	(70,778)	(51,263)
Expenses paid	(168)	(170)
Actuarial loss	139,469	93,358
Settlements	(38,549)	(42,306)
Benefit obligation at end of year	1,209,100	1,135,523
Change in plan assets		
Fair value of plan assets at beginning of year	897,717	884,983
Actual return on plan assets	121,245	85,842
Benefits paid	(70,778)	(51,263)
Expenses paid	(168)	(170)
Employer contributions	19,986	20,631
Settlements	(38,549)	(42,306)
Fair value of plan assets at end of year	929,453	897,717
Funded status of the plans	(279,647)	(237,806)
Less: Current portion of liability for pension	(46)	(46)
Long term portion of liability for pension	(279,601)	(237,760)
Liability for pension	$ (279,647)	$ (237,806)

As of June 30, 2020 and 2019, 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 $546,818,000 and $478,394,000 of net actuarial loss as of June 30, 2020 and 2019, respectively.

The estimated amounts to be amortized from net assets without donor restrictions into net periodic pension expense in fiscal year 2021 for net actuarial losses is $12,752,000.

The accumulated benefit obligation for the defined benefit pension plans was approximately $1,209,282 and $1,135,770,000 at June 30, 2020 and 2019, respectively.

The following table sets forth the assumptions used to determine the benefit obligation at June 30, 2020 and 2019:

	2020	2019
Discount rate	3.00% - 3.10%	4.20 % – 4.50 %
Rate of increase in compensation	N/A	N/A

The primary investment objective for the Plan's assets is to support the Pension liabilities of the Pension Plans for Employees of the Health System, by providing long-term capital appreciation and by also using a Liability Driven Investing ("LDI") strategy to partially hedge the impact fluctuating interest rates have on the value of the Plan's liabilities. As of both June 30, 2020 and 2019, 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	40
Global debt securities	6–26	7
Domestic equities	5–35	18
International equities	5–15	11
Emerging market equities	3–13	5
Real estate investment trust funds	0–5	1
Private equity funds	0–5	0
Hedge funds	5–18	10

To the extent an asset class falls outside of its target range on a quarterly basis, the Health System shall determine appropriate steps, as it deems necessary, to rebalance the asset class.

The Boards of Trustees of the Health System, as Plan Sponsors, oversee the design, structure, and prudent professional management of the Health System's Plans' assets, in accordance with Board approved investment policies, roles, responsibilities and authorities and more specifically the following:

- Establishing and modifying asset class targets with Board approved policy ranges,
- Approving the asset class rebalancing procedures,
- Hiring and terminating investment managers, and
- Monitoring performance of the investment managers, custodians and investment consultants.

The hierarchy and inputs to valuation techniques to measure fair value of the Plans' assets are the same as outlined in Note 7. In addition, the estimation of fair value of investments in private equity and hedge funds for which the underlying securities do not have a readily determinable value is made using the NAV per share or its equivalent as a practical expedient. The Health System's Plans own interests in these funds rather than in securities underlying each fund and, therefore, are generally required to consider such investments as Level 2 or 3, even though the underlying securities may not be difficult to value or may be readily marketable.

The following table sets forth the Health System's Plans' investments and deferred compensation plan assets that were accounted for at fair value as of June 30, 2020 and 2019:

	2020					
(in thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Investments						
Cash and short-term investments	$ -	$ 7,154	$ -	$ 7,154	Daily	1
U.S. government securities	49,843		-	49,843	Daily–Monthly	1–15
Domestic debt securities	133,794	318,259	-	452,053	Daily–Monthly	1–15
Global debt securities	-	69,076	-	69,076	Daily–Monthly	1–15
Domestic equities	152,688	24,947	-	177,635	Daily–Monthly	1–10
International equities	13,555	70,337	-	83,892	Daily–Monthly	1–11
Emerging market equities	-	39,984	-	39,984	Daily–Monthly	1–17
REIT funds	-	2,448	-	2,448	Daily–Monthly	1–17
Private equity funds	-	-	17	17	See Note 7	See Note 7
Hedge funds	-	-	47,351	47,351	Quarterly–Annual	60–96
Total investments	$ 349,880	$ 532,205	$ 47,368	$ 929,453		

	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		

The following tables present additional information about the changes in Level 3 assets measured at fair value for the years ended June 30, 2020 and 2019:

	2020		
(in thousands of dollars)	Hedge Funds	Private Equity Funds	Total
Balances at beginning of year	$ 44,126	$ 21	$ 44,147
Net unrealized gains (losses)	3,225	(4)	3,221
Balances at end of year	$ 47,351	$ 17	$ 47,368

	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

The total aggregate net unrealized gains (losses) included in the fair value of the Level 3 investments as of June 30, 2020 and 2019 were approximately $18,261,000 and $14,617,000, respectively. There were no transfers into and out of Level 3 measurements during the years ended June 30, 2020 and 2019.

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, 2020 and 2019.

The weighted average asset allocation for the Health System's Plans at June 30, 2020 and 2019 by asset category is as follows:

	2020	2019
Cash and short-term investments	1 %	2 %
U.S. government securities	5	5
Domestic debt securities	49	44
Global debt securities	8	9
Domestic equities	19	20
International equities	9	11
Emerging market equities	4	4
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 $25,755,000 to the Plans in 2021 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)

2021	$ 51,007
2022	53,365
2023	55,466
2024	57,470
2025	59,436
2026 – 2028	321,419

Effective May 1, 2020, the Health System terminated a defined benefit plan and settled the accumulated benefit obligation of $18,795,000 by purchasing nonparticipating annuity contracts. The plan assets at fair value were $11,836,000.

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 $51,222,000 and $40,537,000 in 2020 and 2019, 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 2020 and 2019 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, 2020 and 2019:

(in thousands of dollars)	2020	2019
Service cost	$ 609	$ 384
Interest cost	1,666	1,842
Net prior service income	(5,974)	(5,974)
Net loss amortization	469	10
	$ (3,230)	$ (3,738)

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, 2020 and 2019:

(in thousands of dollars)	2020	2019
Change in benefit obligation		
Benefit obligation at beginning of year	$ 46,671	$ 42,581
Service cost	609	384
Interest cost	1,666	1,842
Benefits paid	(3,422)	(3,149)
Actuarial loss	2,554	5,013
Benefit obligation at end of year	48,078	46,671
Funded status of the plans	$ (48,078)	$ (46,671)
Current portion of liability for postretirement medical and life benefits	$ (3,422)	$ (3,422)
Long term portion of liability for postretirement medical and life benefits	(44,656)	(43,249)
Liability for postretirement medical and life benefits	$ (48,078)	$ (46,671)

As of June 30, 2020 and 2019, 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)	2020	2019
Net prior service income	$ (3,582)	$ (9,556)
Net actuarial loss	10,335	8,386
	$ 6,753	$ (1,170)

The estimated amounts that will be amortized from net assets without donor restrictions into net periodic postretirement income in fiscal year 2021 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, 2021 and thereafter:

(in thousands of dollars)

2021	$	3,422
2022		3,436
2023		3,622
2024		3,642
2025		3,522
2026-2028		16,268

In determining the accumulated postretirement medical and life benefit obligation, the Health System used a discount rate of 2.90% in 2020 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, 2020 and 2019 by $1,772,000 and $1,601,000 and the net periodic postretirement medical benefit cost for the years then ended by $122,000 and $77,000, 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, 2020 and 2019 by $1,603,000 and $1,452,000 and the net periodic postretirement medical benefit cost for the years then ended by $108,000 and $71,000, 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, 2020 and 2019, are summarized as follows:

	2020		
	HAC	RRG	Total
(in thousands of dollars)			
Assets	$ 93,686	$ 1,785	$ 95,471
Shareholders' equity	13,620	50	13,670

	2019		
	HAC	RRG	Total
(in thousands of dollars)			
Assets	$ 75,867	$ 2,201	$ 78,068
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.

Lines of Credit
The Health System has entered into Loan Agreements with financial institutions establishing access to revolving loans ranging from $10,000,000 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 31, 2021. There was no outstanding balance under the lines of credit as of June 30, 2020 and 2019. Interest expense was approximately $20,000 and $95,000, 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, 2020:

	2020			
(in thousands of dollars)	Program Services	Management and General	Fundraising	Total
Operating expenses				
Salaries	$ 981,320	$ 161,704	$ 1,799	$ 1,144,823
Employee benefits	231,361	41,116	395	272,872
Medical supplies and medications	454,143	1,238	-	455,381
Purchased services and other	236,103	120,563	3,830	360,496
Medicaid enhancement tax	76,010	-	-	76,010
Depreciation and amortization	26,110	65,949	105	92,164
Interest	5,918	21,392	12	27,322
Total operating expenses	$ 2,010,965	$ 411,962	$ 6,141	$ 2,429,068

	Program Services	Management and General	Fundraising	Total
Non-operating income				
Employee benefits	$ 9,239	$ 1,549	$ 22	$ 10,810
Total non-operating income	$ 9,239	$ 1,549	$ 22	$ 10,810

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	188,634	73,845	333	262,812
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	$ 1,841,476	$ 394,764	$ 4,422	$ 2,240,662

	Program Services	Management and General	Fundraising	Total
Non-operating income				
Employee benefits	$ 9,651	$ 1,556	$ 14	$ 11,221
Total non-operating income	$ 9,651	$ 1,556	$ 14	$ 11,221

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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, 2020 and 2019 to meet cash needs for general expenditures within one year of June 30, 2020 and 2019, are as follows:

(in thousands of dollars)	2020	2019
Cash and cash equivalents	$ 453,223	$ 143,587
Patient accounts receivable	183,819	221,125
Assets limited as to use	1,134,526	876,249
Other investments for restricted activities	140,580	134,119
Total financial assets	$ 1,912,148	$ 1,375,080
Less: Those unavailable for general expenditure within one year:		
Investments held by captive insurance companies	54,596	66,082
Investments for restricted activities	140,580	134,119
Bond proceeds held for capital projects	245,484	-
Other investments with liquidity horizons greater than one year	111,408	97,063
Total financial assets available within one year	$ 1,360,080	$ 1,077,816

For the years ended June 30, 2020 and June 30, 2019, the Health System generated positive cash flow from operations of approximately $269,144,000 and $161,145,000, 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. Lease Commitments

In February 2016, the FASB issued ASU 2016-02 (Topic 842) "Leases." Topic 842 supersedes the lease requirements in Accounting Standards Codification Topic 840, "Leases." Under Topic 842, lessees are required to recognize assets and liabilities on the balance sheet for most leases and provide enhanced disclosures. Leases will be classified as either finance or operating. D-HH adopted Topic 842 effective July 1, 2019.

D-HH applied Topic 842 to all leases as of July 1, 2019 with comparative periods continuing to be reported under Topic 840. We have elected the practical expedient package to not reassess at adoption (i) expired or existing contracts for whether they are or contain a lease, (ii) the lease classification of any existing leases or (iii) initial direct costs for existing leases. We have also elected the policy exemption that allows lessees to choose to not separate lease and non-lease components by class of underlying asset and are applying this expedient to all relevant asset classes.

D-HH determines if an arrangement is or contains a lease at inception of the contract. Right-of-use assets represent our right to use the underlying assets for the lease term and our lease liabilities represent our obligation to make lease payments arising from the leases. Right-of-use assets and lease liabilities are recognized at commencement date based on the present value of lease payments over the lease term. We use the implicit rate noted within the contract. If not readily available, we use our estimated incremental borrowing rate, which is derived using a collateralized borrowing rate for the same currency and term as the associated lease. A right-of-use asset and lease liability is not recognized for leases with an initial term of 12 months or less and we recognize lease expense for these leases on a straight-line basis over the lease term within lease and rental expense.

Our operating leases are primarily for real estate, including certain acute care facilities, off-campus outpatient facilities, medical office buildings, and corporate and other administrative offices. Our real estate lease agreements typically have initial terms of 5 to 10 years. These real estate leases may include one or more options to renew, with renewals that can extend the lease term from 2 to 5 years. The exercise of lease renewal options is at our sole discretion. When determining the lease term, we included options to extend or terminate the lease when it is reasonably certain that we will exercise that option.

On adoption, the Health System recognized lease liabilities and right-of-use assets of $60,269,884, respectively.

The components of lease expense for the year ended June 30, 2020 are as follows:

(in thousands of dollars)	**12 months ended June 30, 2020**
Operating lease cost	8,992
Variable and short term lease cost (a)	1,497
Total lease and rental expense	10,489
Finance lease cost:	
Depreciation of property under finance lease	2,454
Interest on debt of property under finance lease	524
Total finance lease cost	2,978

(a) Includes equipment, month-to-month and leases with a maturity of less than 12 months.

Supplemental cash flow information related to leases for the year ended June 30, 2020 are as follows:

(in thousands of dollars)	**12 months ended June 30, 2020**
Cash paid for amounts included in the measurement of lease liabilities:	
Operating cash flows from operating leases	8,755
Operating cash flows from finance leases	542
Financing cash flows from finance leases	2,429
	$ 11,726

Supplemental balance sheet information related to leases as of June 30, 2020 are as follows:

(in thousands of dollars)	**12 months ended June 30, 2020**
Operating Leases	
Right of use assets - operating leases	42,621
Accumulated amortization	(8,425)
Right of use assets - operating leases, net	**34,196**
Current portion of right of use obligations	9,194
Long-term right of use obligations, excluding current portion	25,308
Total operating lease liabilities	**34,502**
Finance Leases	
Right of use assets - finance leases	26,076
Accumulated depreciation	(2,687)
Right of use assets - finance leases, net	**23,389**
Current portion of right of use obligations	2,581
Long-term right of use obligations, excluding current portion	21,148
Total finance lease liabilities	**23,729**
Weighted Average remaining lease term, years	
Operating leases	4.64
Finance leases	19.39
Weighted Average discount rate	
Operating leases	2.24%
Finance leases	2.22%

Included in the $42.6 million of right-of-use assets obtained in exchange for operating lease obligations is $5.6 million of new and modified operating leases entered into during the year ended June 30, 2020. Included in the $26.1 million of right-of-use assets obtained in exchange for finance lease obligations is $2.3 million of new and modified operating leases entered into during the year ended June 30, 2020.

Future maturities of lease liabilities as of June 30, 2020 are as follows:

(in thousands of dollars)	Operating Leases	Finance Leases
Year ending June 30:		
2021	9,852	3,314
2022	8,274	3,003
2023	6,836	2,718
2024	5,650	1,892
2025	3,023	1,109
Thereafter	2,794	17,339
Total lease payments	36,429	29,374
Less: Imputed interest	1,927	5,645
Total lease payments	$ 34,502	$ 23,729

Future minimum rental payments under lease commitments with a term of more than one year as of June 30, 2019, prior to our adoption of ASC 842 are as follows:

(in thousands of dollars)	Capital Leases	Operating Leases
Year ending June 30:		
2020	1,706	11,342
2021	1,467	10,469
2022	1,471	7,488
2023	1,494	6,303
2024	1,230	4,127
Thereafter	10,158	5,752
Total lease payments	$ 17,526	$ 45,481

The Health System's rental expense totaled approximately $12,707,000 for the year ended June 30, 2019.

17. COVID - 19

In March 2020, the World Health Organization declared the COVID-19 outbreak a pandemic and the United States federal government declared COVID-19 a national emergency. The Health System quickly developed and implemented an emergency response to the situation to ensure the safety of its patients and staff across the System. A key decision was made to postpone elective and non-urgent care in mid-March. Several factors drove that decision, including efforts to reduce the spread of COVID-19; conservation of personal protective equipment ("PPE"), which was and remains in critically short supply worldwide; and at the urging of the CDC and U.S. Surgeon General who in March urged all hospitals to reduce the number of elective procedures and visits.

On March 27, 2020, the President of the United States signed into law the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act") to provide economic assistance to a wide array of industries to ease the financial impact of COVID-19. As part of the CARES Act, the Centers for Medicare and Medicaid Services ("CMS") expanded its Accelerated and Advance Payment Program which allows participants to receive expedited payments during periods of national emergencies.

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As of June 30, 2020, the Health System has received approximately $88,877,000 in governmental assistance including funding under the CARES Act. This includes recognition of approximately $88,725,000 of stimulus revenue recorded as a component of other operating revenue in the consolidated statements of operations and changes in net assets as a result of satisfying the conditions of general and targeted grant funding under the Provider Relief Fund established by the CARES Act. The Health System recognized revenue related to the CARES Act provider relief funding based on information contained in laws and regulations, as well as interpretations issued by the HHS, governing the funding that was publicly available as of June 30, 2020. The Health System recorded approximately $239,500,000 attributable to the Medicare Accelerated and Advance Payment Program representing working capital financing to be repaid through the provision of future services. These funds are recorded as a contract liability as a payment received before performing services. This amount is reported as a component of estimated third party settlements in the consolidated balance sheet as of June 30, 2020. Subsequent to June 30, 2020, the Health System received additional stimulus funding attributable to a targeted distribution of approximately $19,700,000 for Safety Net Hospitals and $2,500,000 for a general distribution.

Additionally, the CARES Act provides for payroll tax relief, including employee retention tax credits and the deferral of all employer Social Security tax payments to help employers in the face of economic hardship related to the COVID-19 pandemic. As of June 30, 2020, the Health System deferred approximately $13,727,000 attributable to the employer portion of Social Security taxes and $2,600,000 of employee retention tax credits. D-HH Leadership has also taken advantage of additional Federal and State programs including the Payroll Tax Deferral, Employee Retention Credit, First Responder Support, Front-Line Employees Hazard Pay Grant Program and FEMA funding to help offset some of the incremental costs being incurred to provide comprehensive and safe care during the pandemic.

18. Subsequent Events

The Health System has assessed the impact of subsequent events through November 17, 2020, 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.

HHS Reporting Requirements for the CARES Act

In September 2020 and October 2020, HHS issued new reporting requirements for the CARES Act provider relief funding. The new requirements first require Hospitals to identify healthcare-related expenses attributable to the COVID-19 pandemic that remain unreimbursed by another source. If those expenses do not exceed the provider relief funding received, Hospitals will need to demonstrate that the remaining provider relief funds were used to compensate for a negative variance in year over year patient service revenue. HHS is entitled to recoup Provider Relief Funding in excess of the sum of expenses attributable to the COVID-19 pandemic that remain unreimbursed by another source and the decline in calendar year over year patient care revenue. Due to these new reporting requirements there is at least a reasonable possibility that amounts recorded under the CARES Act provider relief fund by the Health System may change in future periods.

Medicare and Medicaid Services ("CMS") expanded Accelerated and Advance Payment Program

In October 2020, new regulations were issued to revise the recoupment start date from August 2020 to April 2021.

Note Payable Amendment

In October 2020, the note payable issued to TD Bank in May 2020 was amended. Under the amended terms, the interest on the note payable is fixed at a rate of 2.56%, and matures in 2035. Repayment terms are semi-annual, interest only through July 2024, with annual principal payments to begin August 2024. The obligation can be satisfied at any time beforehand, without penalty.

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Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2020

(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	$ 108,856	$ 217,352	$ 43,940	$ 26,079	$ 22,874	$ 14,377	$ -	$ 433,478	$ 19,745	$ -	$ 453,223
Patient accounts receivable, net	-	146,886	11,413	8,634	10,200	4,367	-	181,500	2,319	-	183,819
Prepaid expenses and other current assets	25,243	179,432	37,538	3,808	6,105	1,715	(82,822)	171,019	(8,870)	(243)	161,906
Total current assets	134,099	543,670	92,891	38,521	39,179	20,459	(82,822)	785,997	13,194	(243)	798,948
Assets limited as to use	344,737	927,207	19,376	13,044	12,768	12,090	(235,568)	1,093,654	40,872	-	1,134,526
Notes receivable, related party	848,250	593	-	1,211	-	-	(848,843)	1,211	(1,211)	-	-
Other investments for restricted activities	-	98,490	6,970	97	3,077	6,266	-	114,900	25,680	-	140,580
Property, plant, and equipment, net	8	466,938	64,803	20,805	43,612	16,823	-	612,989	30,597	-	643,586
Right of use assets	1,542	32,714	1,822	17,574	621	3,221	-	57,494	91	-	57,585
Other assets	2,242	122,481	1,299	14,748	5,482	4,603	(10,971)	139,884	(2,546)	-	137,338
Total assets	$ 1,330,878	$ 2,192,093	$ 187,161	$ 106,000	$ 104,739	$ 63,462	$ (1,178,204)	$ 2,806,129	$ 106,677	$ (243)	$ 2,912,563
Liabilities and Net Assets											
Current liabilities											
Current portion of long-term debt	$ -	$ 7,380	$ 865	$ 747	$ 147	$ 232	$ -	$ 9,371	$ 96	$ -	$ 9,467
Current portion of right of use obligations	338	8,752	420	1,316	259	631	-	11,716	59	-	11,775
Current portion of liability for pension and other postretirement plan benefits	-	3,468	-	-	-	-	-	3,468	-	-	3,468
Accounts payable and accrued expenses	272,764	126,283	39,845	3,087	4,250	3,406	(318,391)	131,244	(1,985)	(243)	129,016
Accrued compensation and related benefits	-	122,392	7,732	3,570	3,875	3,582	-	141,151	1,840	-	142,991
Estimated third-party settlements	-	210,144	34,664	25,421	24,667	6,430	-	301,326	1,199	-	302,525
Total current liabilities	273,102	478,419	83,526	34,141	33,198	14,281	(318,391)	598,276	1,209	(243)	599,242
Notes payable, related party	-	814,525	-	-	27,718	6,600	(848,843)	-	-	-	-
Long-term debt, excluding current portion	1,050,694	37,373	23,617	24,312	147	10,595	(10,970)	1,135,768	2,762	-	1,138,530
Right of use obligations, excluding current portion	1,203	24,290	1,432	16,429	368	2,698	-	46,420	36	-	46,456
Insurance deposits and related liabilities	-	75,697	475	325	388	220	-	77,105	41	-	77,146
Liability for pension and other postretirement plan benefits, excluding current portion	-	301,907	21,840	-	-	511	-	324,258	(1)	-	324,257
Other liabilities	-	117,631	1,506	384	2,026	-	-	121,547	22,131	-	143,678
Total liabilities	1,324,999	1,849,842	132,396	75,591	63,845	34,905	(1,178,204)	2,303,374	26,178	(243)	2,329,309
Commitments and contingencies											
Net assets											
Net assets without donor restrictions	5,524	242,824	47,729	29,464	36,158	21,247	-	382,946	48,040	40	431,026
Net assets with donor restrictions	355	99,427	7,036	945	4,736	7,310	-	119,809	32,459	(40)	152,228
Total net assets	5,879	342,251	54,765	30,409	40,894	28,557	-	502,755	80,499	-	583,254
Total liabilities and net assets	$ 1,330,878	$ 2,192,093	$ 187,161	$ 106,000	$ 104,739	$ 63,462	$ (1,178,204)	$ 2,806,129	$ 106,677	$ (243)	$ 2,912,563

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Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2020

(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	$ 108,856	$ 218,295	$ 47,642	$ 22,874	$ 14,568	$ 34,072	$ 6,916	$ -	$ 453,223
Patient accounts receivable, net	-	146,887	11,413	10,200	4,439	8,634	2,246	-	183,819
Prepaid expenses and other current assets	25,243	180,137	27,607	6,105	1,737	2,986	1,156	(83,065)	161,906
Total current assets	134,099	545,319	86,662	39,179	20,744	45,692	10,318	(83,065)	798,948
Assets limited as to use	344,737	946,938	18,001	12,768	13,240	13,044	21,366	(235,568)	1,134,526
Notes receivable, related party	848,250	593	-	-	-	-	-	(848,843)	-
Other investments for restricted activities	-	105,869	25,272	3,077	6,265	97	-	-	140,580
Property, plant, and equipment, net	8	469,613	68,374	43,612	18,432	40,126	3,421	-	643,586
Right of use assets	1,542	32,714	1,822	621	3,220	17,574	92	-	57,585
Other assets	2,242	122,647	7,429	5,482	2,152	8,199	158	(10,971)	137,338
Total assets	$ 1,330,878	$ 2,223,693	$ 207,560	$ 104,739	$ 64,053	$ 124,732	$ 35,355	$ (1,178,447)	$ 2,912,563
Liabilities and Net Assets									
Current liabilities									
Current portion of long-term debt	$ -	$ 7,380	$ 865	$ 147	$ 257	$ 747	$ 71	$ -	$ 9,467
Current portion of right of use obligations	338	8,752	420	259	631	1,316	59	-	11,775
Current portion of liability for pension and other postretirement plan benefits	-	3,468	-	-	-	-	-	-	3,468
Accounts payable and accrued expenses	272,762	126,684	35,117	4,251	3,517	3,528	1,791	(318,634)	129,016
Accrued compensation and related benefits	-	122,392	7,732	3,875	3,626	3,883	1,483	-	142,991
Estimated third-party settlements	-	210,143	34,664	24,667	6,430	25,421	1,200	-	302,525
Total current liabilities	273,100	478,819	78,798	33,199	14,461	34,895	4,604	(318,634)	599,242
Notes payable, related party	-	814,525	-	27,718	6,600	-	-	(848,843)	-
Long-term debt, excluding current portion	1,050,694	37,373	23,618	147	10,867	24,312	2,489	(10,970)	1,138,530
Right of use obligations, excluding current portion	1,203	24,290	1,433	368	2,700	16,429	33	-	46,456
Insurance deposits and related liabilities	-	75,697	475	388	222	325	39	-	77,146
Liability for pension and other postretirement plan benefits, excluding current portion	-	301,907	21,840	-	510	-	-	-	324,257
Other liabilities	-	117,631	1,506	2,026	-	22,515	-	-	143,678
Total liabilities	1,324,997	1,850,242	127,670	63,846	35,360	98,476	7,165	(1,178,447)	2,329,309
Commitments and contingencies									
Net assets									
Net assets without donor restrictions	5,526	266,327	48,549	36,158	21,385	24,881	28,160	40	431,026
Net assets with donor restrictions	355	107,124	31,341	4,735	7,308	1,375	30	(40)	152,228
Total net assets	5,881	373,451	79,890	40,893	28,693	26,256	28,190	-	583,254
Total liabilities and net assets	$ 1,330,878	$ 2,223,693	$ 207,560	$ 104,739	$ 64,053	$ 124,732	$ 35,355	$ (1,178,447)	$ 2,912,563

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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
Right of use assets	-	-	-	-	-	-	-	-	-	-	-
Other assets	3,518	108,208	1,279	15,019	6,042	4,388	(10,970)	127,484	(3,013)	-	124,471
Total assets	$ 706,260	$ 1,689,041	$ 128,009	$ 76,831	$ 88,377	$ 54,932	$ (639,289)	$ 2,104,161	$ 115,150	$ (3,009)	$ 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 right of use obligations	-	-	-	-	-	-	-	-	-	-	-
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
Right of use obligations, excluding current portion	-	-	-	-	-	-	-	-	-	-	-
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	7,486	356,880	63,051	27,653	35,518	21,242	-	511,830	48,063	40	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	7,504	447,983	69,296	28,449	40,138	28,678	-	622,048	80,345	-	702,393
Total liabilities and net assets	$ 706,260	$ 1,689,041	$ 128,009	$ 76,831	$ 88,377	$ 54,932	$ (639,289)	$ 2,104,161	$ 115,150	$ (3,009)	$ 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	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
Right of use assets	-	-	-	-	-	-	-	-	-
Other assets	3,518	108,366	7,388	5,476	1,931	8,688	74	(10,970)	124,471
Total assets	$ 706,260	$ 1,720,297	$ 157,894	$ 88,946	$ 55,437	$ 96,472	$ 33,294	$ (642,298)	$ 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 right of use obligations	-	-	-	-	-	-	-	-	-
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
Right of use obligations, excluding current portion	-	-	-	-	-	-	-	-	-
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	7,486	379,498	65,873	36,087	21,300	22,327	27,322	40	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	7,504	478,682	95,434	40,706	28,735	23,980	27,352	-	702,393
Total liabilities and net assets	$ 706,260	$ 1,720,297	$ 157,894	$ 88,946	$ 55,437	$ 96,472	$ 33,294	$ (642,298)	$ 2,216,302

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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, 2020

(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	$ -	$ 1,490,516	$ 207,416	$ 65,496	$ 53,943	$ 41,349	$ -	$ 1,858,720	$ 21,305	$ -	$ 1,880,025
Contracted revenue	5,369	114,906	400	-	10	7,427	(54,543)	73,569	498	(39)	74,028
Other operating revenue	26,349	321,028	16,406	7,179	10,185	7,847	(28,972)	360,022	15,128	(528)	374,622
Net assets released from restrictions	409	13,013	1,315	162	160	84	-	15,143	1,117	-	16,260
Total operating revenue and other support	32,127	1,939,463	225,537	72,837	64,298	56,707	(83,515)	2,307,454	38,048	(567)	2,344,935
Operating expenses											
Salaries	-	947,275	115,777	37,596	33,073	27,600	(34,706)	1,126,615	17,007	1,201	1,144,823
Employee benefits	-	227,138	26,979	6,214	6,741	6,344	(4,864)	268,552	4,009	311	272,872
Medications and medical supplies	-	401,165	36,313	8,390	5,140	2,944	-	453,952	1,429	-	455,381
Purchased services and other	13,615	284,714	31,864	11,639	14,311	13,351	(20,942)	348,552	13,943	(1,999)	360,496
Medicaid enhancement tax	-	59,708	8,476	3,226	2,853	1,747	-	76,010	-	-	76,010
Depreciation and amortization	14	71,108	9,351	3,361	3,601	2,475	-	89,910	2,254	-	92,164
Interest	25,780	23,431	953	906	1,097	252	(25,412)	27,007	315	-	27,322
Total operating expenses	39,409	2,014,539	229,713	71,332	66,816	54,713	(85,924)	2,390,598	38,957	(487)	2,429,068
Operating (loss) margin	(7,282)	(75,076)	(4,176)	1,505	(2,518)	1,994	2,409	(83,144)	(909)	(80)	(84,133)
Non-operating gains (losses)											
Investment income (losses), net	4,877	18,522	714	292	359	433	(198)	24,999	2,048	-	27,047
Other components of net periodic pension and post retirement benefit income	-	8,793	1,883	-	-	134	-	10,810	-	-	10,810
Other (losses) income, net	(3,932)	(1,077)	(569)	(205)	544	4,317	(2,211)	(3,133)	346	80	(2,707)
Total non-operating gains (losses), net	945	26,238	2,028	87	903	4,884	(2,409)	32,676	2,394	80	35,150
(Deficiency) excess of revenue over expenses	(6,337)	(48,838)	(2,148)	1,592	(1,615)	6,878	-	(50,468)	1,485	-	(48,983)
Net assets without donor restrictions											
Net assets released from restrictions for capital	-	564	179	-	344	300	-	1,387	27	-	1,414
Change in funded status of pension and other postretirement benefits	-	(58,513)	(13,321)	-	-	(7,188)	-	(79,022)	-	-	(79,022)
Net assets transferred to (from) affiliates	4,375	(7,269)	(32)	219	1,911	15	-	(781)	781	-	-
Other changes in net assets	-	-	-	-	-	-	-	-	(2,316)	-	(2,316)
Increase in net assets without donor restrictions	$ (1,962)	$ (114,056)	$ (15,322)	$ 1,811	$ 640	$ 5	$ -	$ (128,884)	$ (23)	$ -	$ (128,907)

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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, 2020

(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	$ -	$ 1,490,516	$ 207,416	$ 53,943	$ 41,348	$ 65,496	$ 21,306	$ -	$ 1,880,025
Contracted revenue	5,369	115,403	400	10	7,427	-	-	(54,581)	74,028
Other operating revenue	26,349	323,151	16,472	10,185	9,482	16,726	1,757	(29,500)	374,622
Net assets released from restrictions	409	13,660	1,335	160	83	613	-	-	16,260
Total operating revenue and other support	32,127	1,942,730	225,623	64,298	58,340	82,835	23,063	(84,081)	2,344,935
Operating expenses									
Salaries	-	947,275	115,809	33,073	28,477	41,085	12,608	(33,504)	1,144,823
Employee benefits	-	227,138	26,988	6,741	6,517	7,123	2,918	(4,553)	272,872
Medications and medical supplies	-	401,165	36,313	5,140	2,941	8,401	1,421	-	455,381
Purchased services and other	13,615	287,948	32,099	14,311	13,767	14,589	7,108	(22,941)	360,496
Medicaid enhancement tax	-	59,708	8,476	2,853	1,747	3,226	-	-	76,010
Depreciation and amortization	14	71,109	9,480	3,601	2,596	5,004	360	-	92,164
Interest	25,780	23,431	953	1,097	252	1,159	62	(25,412)	27,322
Total operating expenses	39,409	2,017,774	230,118	66,816	56,297	80,587	24,477	(86,410)	2,429,068
Operating (loss) margin	(7,282)	(75,044)	(4,495)	(2,518)	2,043	2,248	(1,414)	2,329	(84,133)
Non-operating gains (losses)									
Investment income (losses), net	4,877	19,361	1,305	359	463	292	588	(198)	27,047
Other components of net periodic pension and post retirement benefit income	-	8,793	1,883	-	134	-	-	-	10,810
Other (losses) income, net	(3,932)	(1,077)	(569)	(25)	4,318	(205)	914	(2,131)	(2,707)
Total non-operating gains (losses), net	945	27,077	2,619	334	4,915	87	1,502	(2,329)	35,150
(Deficiency) excess of revenue over expenses	(6,337)	(47,967)	(1,876)	(2,184)	6,958	2,335	88	-	(48,983)
Net assets without donor restrictions									
Net assets released from restrictions for capital	-	591	179	344	300	-	-	-	1,414
Change in funded status of pension and other postretirement benefits	-	(58,513)	(13,321)	-	(7,188)	-	-	-	(79,022)
Net assets transferred to (from) affiliates	4,377	(7,282)	10	1,911	15	219	750	-	-
Other changes in net assets	-	-	(2,316)	-	-	-	-	-	(2,316)
Increase in net assets without donor restrictions	$ (1,960)	$ (113,171)	$ (17,324)	$ 71	$ 85	$ 2,554	$ 838	$ -	$ (128,907)

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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	-	217,623	25,983	6,454	5,434	7,152	(3,763)	258,883	3,642	287	262,812
Medications and medical supplies	-	354,201	34,331	8,634	6,298	3,032	-	406,496	1,379	-	407,875
Purchased services and other	11,366	242,106	35,088	15,308	13,528	13,950	(21,176)	310,170	14,887	(1,622)	323,435
Medicaid enhancement tax	-	54,954	8,005	3,062	2,264	1,776	-	70,061	-	-	70,061
Depreciation and amortization	14	69,343	7,977	2,305	3,915	2,360	-	85,914	2,500	-	88,414
Interest	20,677	21,585	1,053	1,169	1,119	228	(20,850)	24,981	533	-	25,514
Total operating expenses	32,057	1,828,123	220,108	74,229	63,107	55,012	(70,471)	2,202,165	38,726	(229)	2,240,662
Operating margin (loss)	(5,549)	59,888	4,641	(2,550)	1,497	(768)	2,295	59,454	(913)	(60)	58,481
Non-operating gains (losses)											
Investment income (losses), net	3,929	32,193	227	469	834	623	(198)	38,077	1,975	-	40,052
Other components of net periodic pension and post retirement benefit income	-	9,277	1,758	-	-	186	-	11,221	-	-	11,221
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)
Total non-operating gains (losses), net	145	43,056	1,798	412	594	1,088	(2,295)	44,798	2,766	60	47,624
(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 for capital	-	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)	-	-
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	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	-	217,623	25,993	5,434	7,319	7,218	2,701	(3,476)	262,812
Medications and medical supplies	-	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	1,832,118	220,610	62,974	56,526	83,653	23,423	(70,700)	2,240,662
Operating (loss) margin	(5,549)	59,688	4,280	1,629	(701)	(2,746)	(355)	2,235	58,481
Non-operating gains (losses)									
Investment income (losses), net	3,929	33,310	129	785	645	469	983	(198)	40,052
Other components of net periodic pension and post retirement benefit income	-	9,277	1,758	-	186	-	-	-	11,221
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)
Total non-operating gains (losses), net	145	44,173	1,716	545	1,119	413	1,748	(2,235)	47,624
(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 for capital	-	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	-	-
Increase (decrease) 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
Note to Supplemental Consolidating Information
June 30, 2020 and 2019

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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DARTMOUTH-HITCHCOCK (D-H)
DARTMOUTH-HITCHCOCK HEALTH (D-HH)

BOARDS OF TRUSTEES AND OFFICERS
(22 D-H Trustees; 13 D-HH Trustees)

Effective: January 1, 2022

Geraldine "Polly" Bednash, PhD, RN, FAAN
(Thomas)
MHMH/DHC/D-HH Trustee
Adjunct Professor, Australian Catholic University

Mark W. Begor, MBA (Kristen)
MHMH/DHC/D-HH Trustee
Chief Executive Officer, Equifax

Duane A. Compton, PhD
MHMH/DHC/D-HH Trustee
Ex-Officio: Dean, Geisel School of Medicine at Dartmouth

Joanne M. Conroy, MD
MHMH/DHC/D-HH Trustee
Ex-Officio: CEO & President, D-H/D-HH
One Medical Center Drive, Lebanon, NH 03756

Paul P. Danos, PhD (Mary Ellen)
MHMH/DHC/D-HH Trustee
Dean Emeritus; Laurence F. Whittemore Professor of Business Administration, Tuck School of Business at Dartmouth

Nancy M. Dunbar, MD (Geoff)
MHMH/DHC Trustee
Medical Director, Blood Bank
Department of Pathology and Laboratory Medicine

Carl "Trey" Dobson, MD (Amy)
MHMH/DHC Trustee
Chief Medical Officer, Southwestern Vermont Medical Center & Medical Director for the D-H Practice, Bennington, Vermont

Elof Eriksson, MD, PhD (Gudrun)
MHMH/DHC Trustee
Professor Emeritus, Harvard Medical School and
Chief Medical Officer, Applied Tissues Technologies, LLC

Elof Eriksson, MD, PhD (Gudrun)
MHMH/DHC Trustee
Professor Emeritus, Harvard Medical School and

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Chief Medical Officer, Applied Tissues Technologies, LLC

Gary L. Freed, MD, PharmD (Meghan Freed, MD)
MHMH/DHC Trustee
Medical Director of the Comprehensive Wound Clinic at D-H & Assistant Professor of Surgery, Geisel School of Medicine at Dartmouth

Thomas P. Glynn, PhD (Marylou Batt)
MHMH/DHC Trustee
Adjust Lecturer, Harvard Kennedy School of Government

Jarvis A. Green (Julien Blanchet)
MHMH/DHC Trustee
Founder & Producing Artistic Director, JAG Productions

Roberta L. Hines, MD (Jerome Liebrand)
MHMH/DHC Boards' Chair | D-HH Trustee
Nicholas M. Greene Professor and Chair, Dept. of Anesthesiology, Yale School of Medicine

David S. Jevsevar, MD, MBA (Kori)
MHMH/DHC Trustee
Chair of the Department of Orthopaedics at the Geisel School of Medicine at Dartmouth and Vice President of the Orthopaedic Service Line for Dartmouth-Hitchcock Health

Aaron J. Mancuso, MD (Allison)
MHMH/DHC (Lebanon Physician) Trustee
Division Director of Thoracic Anesthesia and Assistant Professor of Anesthesiology and Medicine at Geisel

Jennifer L. Moyer, MBA (David Bartlett)
MHMH/DHC/D-HH Trustee
Managing Director & CAO, White Mountains Insurance Group, Ltd

Sherri C. Oberg, MBA (Curt)
MHMH/DHC Trustee
CEO and Co-Founder of Particles for Humanity, PBC

David P. Paul, MBA (Jill)
MHMH/DHC Board Secretary | D-HH Trustee
President & COO, JBG SMITH

Charles G. Plimpton, MBA (Barbara Nyholm)
MHMH/DHC/D-HH Trustee
MHMH/DHC Boards' Treasurer
D-HH Board Treasurer & Secretary
Retired Investment Banker

Thomas Raffio, MBA, FLMI (Ellen)
MHMH/DHC Trustee
President & CEO, Northeast Delta Dental

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Edward Howe Stansfield, III, MA (Amy)
MHMH/DHC Trustee
D-HH Trustee & Board Chair
Senior VP, Resident Director for the Hanover, NH Bank of America/Merrill Lynch Office

Pamela Austin Thompson, MS, RN, CENP, FAAN
(Robert)
MHMH/DHC/D-HH Trustee
Chief executive officer emeritus of the American Organization of Nurse Executives (AONE)

Marc B. Wolpow, JD, MBA (Robin)
MHMH/DHC/D-HH Trustee
Co-Chief Executive Officer of Audax Group

Member of D-HH, not a member of D-H:

Richard J. Powell, MD (Roshini Pinto-Powell, MD)
D-HH Trustee
Section Chief, Vascular Surgery; Professor of Surgery and Radiology

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CURRICULUM VITAE

Jonathan Russell Ballard, M.D., M.P.H., M.Phil., F.A.C.P.M.

[redacted]

BUSINESS ADDRESSES

Associate Professor
Dept. of Psychiatry, Dept. of Community and Family Medicine, and
The Dartmouth Institute for Health Policy and Clinical Practice
Geisel School of Medicine at Dartmouth
Dartmouth-Hitchcock Medical Center
[redacted]

Chief Medical Officer
New Hampshire Department of Health and Human Services
Office of the Commissioner
[redacted]

EDUCATION

1/2009-05/2014 — *The Dartmouth Institute for Health Policy and Clinical Practice*
Geisel School of Medicine at Dartmouth, Hanover, New Hampshire
Master of Public Health

07/2009-12/2013 — *Dartmouth-Hitchcock Leadership Preventive Medicine Residency*
Preventive Medicine Resident
Geisel School of Medicine at Dartmouth, Hanover, New Hampshire
Paul Ambrose Fellow for Healthcare Improvement and Clinical Leadership
Residency Advisory Committee (RAC) Resident Member
Dartmouth-Hitchcock Value Institute Yellowbelt in Performance Improvement

7/2009 –6/2012 — *New Hampshire Dartmouth Family Medicine Residency Program*
Concord, New Hampshire
Family Medicine Resident

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8/05-5/09	*University of Louisville, School of Medicine, Louisville, Kentucky* Doctor of Medicine Introduction to Clinical Medicine Course Representative Rural M3 and M4 Medical Student Experience Clinical Improvement Award for Leadership in Improving Patient Care Department of Family Medicine Award
10/04-07/05	*Cambridge University, Cambridge, England* School of Clinical Medicine, Department of Public Health and Primary Care Master of Philosophy in Epidemiology
8/00-5/04	*University of Louisville, College of Arts and Sciences, Louisville, Kentucky* Bachelor of Arts in Biology, Minor in Political Science *Summa Cum Laude*, *Phi Beta Kappa* of Kentuckiana Scholarship McConnell Scholar and University Honors Scholar

PROFESSIONAL LICENSURE

2012-Present	State of New Hampshire Board of Medicine #15614
2012-Present	Kentucky Board of Medical Licensure #44996

SPECIALTY CERTIFICATION

2015	Board Certification, American Board of Preventive Medicine
2013	Board Certification, American Board of Family Medicine

ACADEMIC APPOINTMENTS

2018-Present	Associate Professor Dept. of Psychiatry, Dept. of Community and Family Medicine, and The Dartmouth Institute for Health Policy and Clinical Practice Geisel School of Medicine at Dartmouth Dartmouth College Hanover, New Hampshire
2018-Present	Chief Medical Officer Department of Health and Human Services State of New Hampshire
2014-2018	Assistant Professor University of Kentucky College of Medicine Department of Family & Community Medicine

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HONORS AND AWARD

2020	Distinguished Service Award for COVID-19 Pandemic Response Activities from the New Hampshire Medical Society
2019	40 Under Forty in Public Health, de Beaumont Foundation
2018	Fellow, American College of Preventive Medicine
2015-2016	National Committee for Quality Assurance (NCQA) Recognized Level 3 Patient Centered Medical Home (PCMH) Practice Leader
2015	University of Kentucky Department of Family and Community Medicine Faculty of the Year Award
2014	Kentucky Regional Extension Center (REC) "Practice Transformation" Award
2013	H. Winter Griffith Scholarship Award for Excellence in Practice Improvement and Patient-centered Care by the Society of Teachers of Family Medicine

ADMINISTRATIVE ACTIVITY AND UNIVERSITY SERVICE

UNIVERSITY OF KENTUCKY COMMITTEE MEMBERSHIP

2016-2018	AEHR User's Group Committee – Member
2016-2018	Anthem EPHC Joint Operating Committee – Member
2016-2017	Data Governance Committee – Member
2014-2017	Primary Care Coordinating Council Committee – Member
2014-2017	PQRS/CQS Clinical Quality Committee – Member
2014-2017	Medical Directors Committee - Member
2015-2017	Primary Care Strategic Planning – Contributor

UNIVERSITY OF KENTUCKY DEPARTMENT OF FAMILY AND COMMUNITY MEDICINE SERVICE

2014-Present	Care Coordination Improvement QI Group – QI Team Faculty Lead
2014-Present	Falls Prevention QI Initiative – Leader
2014-Present	Residency Training Grant Committee – Department of Family & Community Medicine – Member
2014-Present	Residency Applicant Interviewer
2014-2017	Clinic Micro-Team (Green) – Department of Family & Community Medicine – Physician Lead
2017	Department of Family & Community Medicine Retreat Planning Committee - Member
2014-2017	Clinical Competency Committee – Member
2014-2017	Patient Centered Medical Home Committee – Chair
2014-2017	Clinic Management Committee – Department of Family & Community Medicine – Chair
2013-2017	Department of Family & Community Medicine Executive Committee –

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	Member
2016-2017	Substance Abuse Screening Project QI Group (Quality Improvement Project) – QI Team Physician Lead
3/16/2016	Instituted Inaugural University of Kentucky Department of Family and Community Medicine Quality Improvement Symposium
2016	Department of Family & Community Medicine Retreat Planning Committee Chair
2015-2016	Potentially Avoidable Emergency Room Use QI Group (Quality Improvement Project) – Physician Lead
2014	Same-Day Access Improvement (Quality Improvement Project)
2014	Pain Management Improvement (Quality Improvement Project)
2014	PT/OT Coordinating Improvement (Quality Improvement Project)
2014	Home Health Coordination Improvement (Quality Improvement Project)
2013-2014	Retreat Planning Committee – Department of Family & Community Medicine – Member

SERVICE TO PROFESSION

2018- Present	New Hampshire Board of Medicine, Member
2018- Present	Executive Council, New Hampshire Medical Society
2017- 2018	Journal of the Kentucky Academy of Family Physicians – Associate Editor
8/4/17	Kentucky Academy of Family Physicians Conference "A Family Physician's Role in Addressing the Opioid Epidemic" – Opening Remarks
7/27/17	Kentucky Annual Hepatitis Conference – Moderator and Speaker
6/27/17	Kentucky Injury Prevention and Research Center Site Visit by CDC Acting Director Dr. Anne Schuchat – Moderator and Presenter
6/14/17	Rapid Drug Overdose Surveillance Workshop – Presenter
5/1/17	Kentucky Epidemiology Rapid Response Team Member Training Conference - Moderator
5/10/17	Community Outreach – Training and Speaking to Directors of Local Health Departments about Disease Surveillance and Control
4/11/17	Kentucky Zika Summit – Moderator
4/11/17	Lexington News Media Interview Regarding Arbor Viruses and Prevention
4/9/17	Infectious Disease and Epidemiology Interview – PLG 13 News Media Interview regarding Zika and other Arbor Viruses

ADVISING ACTIVITY

2014-Present	Family Medicine Residents, Medical Students; Preventive Medicine Residents Governmental Public Health Practicums; and Master of Public Health Students

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2014-Present

Family Medicine Residents:

Sidra Zaidi MD	2015-2017
Amanda Hemmer MD	2014-2016
Luke Murray MD	2014-2016
Brian Clear MD	2014-2015

Medical Students:

Lolia Abibo	2015-2016
Eric Weber	2015-2016

Preventive Medicine Residents:

Linda Haller MD	2021-Present
Hena Waseem MD	2020-Present
Charles Burney MD	2020-Present
Suthanya Sornprom MD, MPH	2020
Mark Abel MD	2020
Patrick Ho MD, MPH	2020
Ritika Zijoo MD, MPH	2020
Barry Howe MD, MPH	2020
Doug Phelan DO, MPH	2018-2020
Chukwudi Mbagwu MD, MPH	2017-2018
Alisha Thomas MD, MPH	2017-2018
Carolyn Shammas MD, JD, MPH	2015-2017
Charity Kranz MD, MPH	2015-2017

Master of Public Health Students:

Adam Pascoe	2016-2017
Manisha Vasishta	2015-2016

Undergraduate Students:
Benjamin Dewig (Clinical Leadership and Management) 2015-2016

Graduate Students Capstone/Thesis/Dissertation Committees:

Manisha Vasishta	2016 MPH Capstone
Carolyn Shammas MD, JD	2017 MPH Capstone

SCHOLARLY PRESENTATIONS

STATE

Ballard, J. "Experiences with Prevention: Making Every Contact Count to Address the Social Determinants of Health." PH 115 Finance and Strategy in Value-based Public Health and Healthcare Course at The Dartmouth Institute for Health Policy and Clinical Practice Guest Lecture. December 7th, 2018. (PODIUM)

Ballard, J. "Alumni Perspective." Dartmouth-Hitchcock Leadership Preventive Medicine Residency Program Residency Advisory Committee Meeting. October 19th, 2018. (PODIUM)

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Ballard, J. "What is Population Health?" Public Advisory Council Coordinator's Meeting of the New Hampshire Regional Public Health Network. October 18th, 2018. (Podium)
Ballard, J. "Public Health, Hospital, and Private Organization Partnerships in a Changing Health Care Environment: A few experiences after 5 years out of training at DH." Dartmouth-Hitchcock Integrated Delivery Network Meeting. September 10th, 2018. (PODIUM)

Moore, W.; **Ballard, J.**; Fawns, T., Keck, J.; George, C.; Sheriff, R.; Moore, M.; Barron, M.; Elmore, S.; Hatfull, J.; Horner, T.; Miller, R.; Whalen, C.; Byarlay, J. "Resident-Led Initiative to Improve Preventive Care Quality Outcomes Using a Clinical Dashboard." 2017 Kentucky Academy of Family Physicians Annual Meeting, Lexington, KY November, 2017. (Research Poster).

Smith, B.; **Ballard, J.**; Fallin-Bennett, K.; Sass, J.; Keck, J.; Parks, M.; Elder, W.; Byarlay, J.; Moore, W.; Sheriff, R.; George, C.; Duvall, M.; Gay, C.; Gill, M.; Reno. S; Beatty, T. "Implementing substance abuse screening in the primary care setting." 2016 Kentucky Academy of Family Physicians Annual Meeting, Lexington, KY. November, 2016. (Research Poster).

Gonsalves, W.; Voogt, S.; Herman, E.; Cooper, L.; Gibson, **Ballard, J.**; R.; Gottschalk, G.; Meek, M. "Integrating oral health in a primary care practice." 2016 Kentucky Academy of Family Physicians Annual Meeting, Lexington, KY. November, 2016. (Research Poster).

McGaugh, J.; Rankin, W.; Perez, O.; Evans-Rankin, K.; **Ballard, J**.; Meredith, B. "Implementation of standardized controlled substance agreements to improve patient safety and patient/provider satisfaction." 2016 Kentucky Academy of Family Physicians Annual Meeting, Lexington, KY. November, 2016. (Research Poster).

Ballard, J. "Integrated Behavioral Health: Screening, Brief Intervention, and Referral to Treatment" Department of Family and Community Medicine Annual Retreat, Lexington, KY, June, 2016. (PODIUM).

Ballard, J. "Organization influence and communication styles." Department of Family and Community Medicine Residency Conference Lecture Series, Lexington, KY, May, 2016. (LECTURE).

Smith, B.; **Ballard, J.**; Mashindi, R.; Cardarelli, R.; Davidson, E.; Tovar, E.; Perez, O.; Contreras, L.; Byarlay, J.; Greene, K.; Kelly, J.; Horton, F.; Setser, J.; Meredith, B. "Reducing potentially avoidable emergency department visits by improving patient connections with their primary care team in a family medicine residency." University of Kentucky Department of Family and Community Medicine Quality Improvement Project Symposium, Lexington, KY. March, 2016. (POSTER)

Gearlds, A.; Zaidi, S.; Gottschalk, G.; Fleming-Phillips, B; Barron, M.; **Ballard, J.** "Improving diabetes-related national quality forum clinical quality measures through standardized care management developed by a diabetes quality improvement team." University of Kentucky

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Department of Family and Community Medicine Quality Improvement Project Symposium, Lexington, KY. March, 2016. (POSTER)

Ballard, J. "EBM journal follow-up studies on harm." Department of Family and Community Medicine Residency Conference Lecture Series, Lexington, KY, March, 2016. (LECTURE).

Ballard, J. "Studies on harm." Department of Family and Community Medicine Residency Conference Lecture Series, Lexington, KY, February, 2016. (LECTURE).

Ballard, J. "Teach back method and statistical process control." Department of Family and Community Medicine Residency Conference Lecture Series, Lexington, KY, January, 2016. (LECTURE).

Smith, B.; **Ballard, J.**; Mashindi, R.; Cardarelli, R.; Tovar, E.; Perez, O. "Reducing potentially avoidable emergency department visits by improving patient connections with their primary care team in a family medicine residency." 2015 Kentucky Academy of Family Physicians Annual Meeting, Lexington, KY. November, 2015. (Poster) *Won 1st Place.

Ballard, J. "Root cause analysis." Department of Family and Community Medicine Residency Conference Lecture Series, Lexington, KY, November, 2015. (LECTURE).

Ballard, J. "Ishakawa cause and effect fishbone diagrams." Department of Family and Community Medicine Residency Conference Lecture Series, Lexington, KY, October, 2015. (LECTURE).

Ballard, J. "Process mapping." Department of Family and Community Medicine Residency Conference Lecture Series, Lexington, KY, September, 2015. (LECTURE).

Ballard, J. "Plan-Do-Study-Act (PDSA) cycles." Department of Family and Community Medicine Residency Conference Lecture Series, Lexington, KY, August, 2015. (LECTURE).

Ballard, J. "Organization influence and communication styles." Department of Family and Community Medicine Residency Conference Lecture Series, Lexington, KY, July, 2015. (LECTURE).

Ballard, J. "A National Movement for Quality: Patient Centered Medical Home." Department of Family and Community Medicine WIPs Series, Lexington, KY, May, 2015. (LECTURE).

Ballard, J. "Introduction to Social Medicine and Health Disparities." University of Kentucky College of Medicine, Lexington, KY, April, 2015. (LECTURE).

Kern, L.; Sprouse, G.; Rishmawi, H.; Debusk, A.; Clear, B.; King, M.; Barron, M.; **Ballard, J.** "Tobacco Cessation Counseling in a Family Medicine Residency Practice." Kentucky Academy for Family Physicians (KAFP) 63rd Annual Scientific Meeting, Lexington, KY. November, 2014. (POSTER) 2nd Place

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Polly, R.; Mitchell, J.; Perman, S.; Jones, S.; Sprouse, R.; Tovar, E.; Perez, O.; King, M.; **Ballard, J.** "Improving Depression Screening in a Family Medicine Practice: An Application of the Lean 8-Step Problem Solving Method." Kentucky Academy for Family Physicians (KAFP) 63rd Annual Scientific Meeting, Lexington, KY. November, 2014. (POSTER) 3rd Place

Ballard, J. "Journal Club Facilitator." Department of Family and Community Residency Conference Didactics, Lexington, KY, November, 2014. (LECTURE).

Ballard, J. "Research Design and QI Methods." Department of Family and Community Residency Conference Didactics, Lexington, KY, October, 2014. (LECTURE).

Ballard, J. "Quality Improvement Techniques." Kentucky Regional Extension Center PCMH Cohort 3rd In-Person Meeting, Lexington, KY, September, 2014. (PODIUM).

Ballard, J. "FMC Residency Outpatient Orientation." Department of Family and Community Residency Conference Didactics, Lexington, KY, July, 2014. (LECTURE).

Ballard, J. "FMC Empanelment 2014." Department of Family and Community Medicine Combined Team Meeting, Lexington, KY, June, 2014. (LECTURE).

Ballard, J. "Personality Styles at Work." 2013-2014 Department of Family and Community Medicine Retreat, Slade, KY, April, 2014. (PODIUM).

Ballard, J. "Building a Culture for PCMH." 2013-2014 Department of Family and Community Medicine Retreat, Slade, KY, April, 2014. (PODIUM).

Ballard, J. "Elements of a PCMH." 2013-2014 Department of Family and Community Medicine Retreat, Slade, KY, April, 2014. (PODIUM).

Ballard, J. "DFCM PCMH Kickoff." Department of Family and Community Medicine Combined Team Meeting, Lexington, KY, February, 2014. (LECTURE).

Ballard, J. "Team-based, patient-centered care initiatives to improve cardiovascular disease outcomes at the Concord Hospital Family Health Center". Preventive Medicine Capstone Presentation presented to Practicum Review Committee at Concord Hospital, November 2013.

Ballard, J. "Team-based, patient-centered care initiatives to improve cardiovascular disease outcomes at the Concord Hospital Family Health Center". Summative Practicum presented to Practicum Review Committee at Concord Hospital, November 2012.

Ballard, J, Carluzzo, K., and Kotzbauer, G. Your patient: the ultimate diabetes consultant?: A systematic review. Abstract presented at The Dartmouth Institute for Health Policy and Clinical Practice Conference on Inferential Methods, November 2012. (POSTER).

Ballard, J., Sandhu, M., and Godward, S. Trends in colorectal carcinoma incidence in East Anglia, England by gender, age and subsite, 1980-2002. Master's Thesis deposited in University of Cambridge

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School of Clinical Medicine Library. Poster presented at the Kentucky Medical Association 2007 meeting winning 2nd place prize.

Ballard, J. Effect of Delivery System of Photosensitizer in Photodynamic Therapy and Tumor Response Using Liposomal Complexes. University of Louisville Senior Thesis.
Posters presented at the Kentucky Capitol, 2003; Southern Regional Honors Conference, 2002; National Collegiate Honors Council, 2002. (PODIUM).

NATIONAL/INTERNATIONAL

Waseem, H., Ho P., Abel M., Burney M., Zijoo R., Sornprom S., Howe B., Batalden P., and **Ballard J.** Rapid Development of Statewide Crisis Standards of Care During the COVID-19 Pandemic. Preventive Medicine 2021 Annual Conference by the American College of Preventive Medicine. Online Conference May 16-19, 2021. (POSTER).

Ballard, J.; Moore, W.; Keck, J.; Kudrimoti, A.; Barron, M.; Elder, W.; Rankin, W. "Resident-Led Initiative to Improve Preventive Care Quality Outcomes Using a Clinical Dashboard." 2017 Society of Teachers of Family Medicine (STFM) Conference on Practice Improvement, Louisville, KY December, 2017 (POSTER).

Ballard, J. Addressing the Opioid Epidemic in Kentucky: Using Data to Drive Public Health Response. 2017 Harvard Health and Human Services Summit at Harvard University. Cambridge, MA. October, 2017. (PODIUM).

Atherton, J.; Rankin, W.; Kudrimoti, A.; **Ballard, J.** "Leadership in a family medicine residency: Communication and professionalism trends using DiSC behavioral profiles." 2017 Society of Teachers of Family Medicine (STFM) Annual Meeting, San Diego, CA. May, 2017. (POSTER).

Gonsalves, W.; **Ballard, J.**; Wrightson, A.; Herman, E.; Gottschalk, G. "We did it, you can do it, too: Integrating oral health into your residency program." Society of Teachers of Family Medicine (STFM) Conference on Practice Improvement, Newport Beach, CA. December, 2016. (PODIUM).

Ballard, J.; Perez, O.; Elder, W.; Atherton, J.; Hustedde, C.; Bennett, K.; Smith, B. "Improving behavioral health integration in a family medicine residency through implementing the SBIRT (Screening, brief intervention, and referral to treatment) model." Society of Teachers of Family Medicine (STFM) Conference on Practice Improvement, Newport Beach, CA. December, 2016. (POSTER).

Rankin, W.; Perez, O.; Evans-Rankin, K.; McGaugh, JM.; Meredith, B.; Nithyanandam, S.; **Ballard. J.**; Atherton, J. "Implementation of standardized controlled substance abuse agreements to improve patient safety and patient/provider satisfaction." Society of Teachers of Family Medicine (STFM) Conference on Practice Improvement, Newport Beach, CA. December, 2016. (POSTER).

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Ballard, J. "Introduction to SBIRT (Screening, Brief Intervention, and Referral to Treatment)". Integrated Behavioral Health Care in Primary Care Conference sponsored by UK College of Social Work. Lexington, KY, August, 2016. (KEYNOTE).

Atherton, J.; Perez, O.; Tovar, E.; **Ballard, J.** "Developing a 'Residents as Teachers' curriculum track in a family medicine residency program." 2016 Society of Teachers of Family Medicine (STFM) Annual Spring Conference, Minneapolis, MN. April, 2016. (POSTER).

Gearlds, A.; Gottschalk, G.; Atherton, J.; King, M.; Barron, M.; Pearce, K.; Perez, O.; Tovar, E.; **Ballard, J**. "Improving diabetes-related national quality forum clinical quality measures through standardized care management developed by a diabetes quality improvement team." 2015 Society of Teachers of Family Medicine (STFM) Annual Conference on Practice Improvement, Dallas, TX. December, 2015. (POSTER).

Ballard, J.; Cardarelli, R.; Smith, B.; Tovar, E.; Atherton, J.; King, M.; Perez, O. "Reducing potentially avoidable emergency department visits by improving patient connections with their primary care team in a family medicine residency." 2015 Society of Teachers of Family Medicine (STFM) Annual Conference on Practice Improvement, Dallas, TX. December, 2015. (PODIUM).

Tovar, E.; Atherton, J.; **Ballard, J**.; Barron, M.; King, M.; Perez, O. "Beyond PBLI – building a framework for clinic-based quality improvement practice teams." 2015 Society of Teachers of Family Medicine (STFM) Annual Conference on Practice Improvement, Dallas, TX. December, 2015. (PAPER PRESENTATION).

Ballard, J. "Introduction to the Patient Centered Medical Home Model: A framework for Care in Outpatient IBH." Integrated Behavioral Health Care in Primary Care Conference, Lexington, KY. September, 2015. (PODIUM).

Ballard, J. "Preventive Care Results from Expanded Medicaid and Community Partnerships in Kentucky." Keynote Address at Conference on Innovations in Workplace and Community Wellness: Bridging Personal and Population Health. United States Chamber of Commerce, Washington, DC. April, 2015. (PODIUM).

Tovar, E.; **Ballard, J**.; Perez, O.; Barron, M.; King, M. "Beyond PBLI? Building a Framework for Clinical Based Quality Improvement Practice Teams." 2015 Society of Teachers of Family Medicine (STFM) Annual Conference on Practice Improvement, Dallas, TX. December, 2015. (SPECIAL INTEREST DISCUSSION).

Atherton, J.; Tovar, E.; King, M.; Perez, O.; and **Ballard J**. "Use of DiSC Profiles to Identify Family Medicine Specialty Trait Trends and to Facilitate Leadership and Collaboration in a Family Medicine Residency Program." 2015 Society of Teachers of Family Medicine (STFM) Annual Conference on Practice Improvement, Orlando, FL. April, 2015 (SPECIAL INTEREST DISCUSSION).

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Polly, R.; Mitchell, J.; Perman, S.; Jones, S.; Sprouse, R.; Tovar, E.; Perez, O.; King, M.; **Ballard, J.** "Improving Depression Screening in a Family Medicine Practice: An Application of the Lean 8-Step Problem Solving Method." 2014 Society of Teachers of Family Medicine (STFM) Annual Conference on Practice Improvement, Tampa, FL. December, 2014. (POSTER).

Tovar, E.; Atherton, J.; Gomez, M.; King, M.; Perez, O.; **Ballard, J.** "Use of DiSC Profile to Facilitate Teamwork, Communication and Professionalism in a Family Medicine Residency Program." 2014 Society of Teachers of Family Medicine (STFM) Annual Conference on Practice Improvement, Tampa, FL. December, 2014. (SPECIAL INTEREST DISCUSSION).

Ballard, J.; Perez, O. "Improving Nurse Triage and EHR Communication Between Staff and Medical Providers using PCMH Principles at a Family Medicine Residency Practice." 2014 Society of Teachers of Family Medicine (STFM) Annual Conference on Practice Improvement, Tampa, FL. December, 2014. (SPECIAL INTEREST DISCUSSION).

Kern, L.; Sprouse, G.; Rishmawi, H.; Debusk, A.; Clear, B.; King, M.; Barron, M.; **Ballard, J.** "Tobacco Cessation Counseling in a Family Medicine Residency Practice." 2014 Society of Teachers of Family Medicine (STFM) Annual Conference on Practice Improvement, Tampa, FL. December, 2014. (POSTER).

Kern, L.; Sprouse, G.; Rishmawi, H.; Debusk, A.; Clear, B.; King, M.; Barron, M.; **Ballard, J.** "Tobacco Cessation Counseling in a Family Medicine Residency Practice." Kentucky Academy for Family Physicians (KAFP) 63rd Annual Scientific Meeting, Lexington, KY. November, 2014. (POSTER).

PUBLICATIONS

Waseem, H., Ho P., Abel M., Burney M., Zijoo R., Sornprom S., Howe B., Batalden P., and **Ballard J.** Rapid Development of Statewide Crisis Standards of Care during the COVID-19 Pandemic by Resident Physicians. Manuscript submitted to the Journal of Graduate Medical Education on 4/12/21. Acceptance decision pending.

Robinson, A., Ali, N., Costa, O., Rooks-Peek, C., Sorensen-Alawad, A., **Ballard. J.,** Lowerre, K., and Fondario., A. A *Thematic Analysis of Overdose Prevention and Response Efforts in States Experiencing Opioid Mortality Declines*. (2021) Manuscript conditionally accepted for publication in the journal Public Health Reports, the Official Journal of the United States Surgeon General. Publication Date Pending.

Johnson, T. and **Ballard, J.** (2020). *Injury and Violence 2029 Update: The 5-Minute Clinical Consult.* Wolters Kluwer (Book Chapter).

Ballard, J. and Johnson, T. (2019). *Injury and Violence 2019 Update: The 5-Minute Clinical Consult.* Wolters Kluwer (Book Chapter).

Foster, M., Ramachandran, S., Myatt, K., Donovan, D., Bohm, S., Fieldler, J., Barbeau B., Collins J.,

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Thoroughman, D., McDonald E., **Ballard J.,** Eason J., and Jorgensen C. (2018) *Hepatitis A Virus Outbreaks Associated with Drug Use and Homelessness – California, Kentucky, Michigan, and Utah, 2017.* MMWR 2018 Nov 2;67(43):1208-1210.

Ballard, J., Kranz, C., and Johnson, T. (2018). *Injury and Violence 2018 Update: The 5-Minute Clinical Consult.* Wolters Kluwer Health. (Book Chapter).

Ballard, J., Benner, K., Elder, W. *The Role of Family Medicine Physicians in Substance Use Disorder Assessment.* (2018) Journal of the Kentucky Academy of Family Physicians. Winter Edition 2018.

Ballard, J., Rankin, W., Roper K., Weatherford, S., and Cardarelli R. *Effect of Ambulatory Translational Care Management (TCM) on 30-day Readmission Rates.* (2018) American Journal of Medical Quality. Vol 33, Issue 6, 2018.

Ballard, J. and Kranz, C. (2017). *Injury and Violence 2017 Update: The 5-Minute Clinical Consult.* Wolters Kluwer Health. (Book Chapter).

Roper, KL., **Ballard J.,** Rankin W., and Cardarelli, R. *Systematic Review of Ambulatory Transitional Care Management (TCM) Visits on Hospital 30-Day Readmission Rates.* American Journal of Medical Quality Jan/Feb;32(1):19-26 2017.

Ballard, J. (2016). *Injury and Violence 2016 Update: The 5-Minute Clinical Consult.* Wolters Kluwer Health. (Book Chapter).

Ballard, J. *Patient Centered Medical Homes.* Lexington Medical Society Supplement to *The Lexington Herald-Leader*. November 1, 2015 (NEWSPAPER ARTICLE)

Ballard, J. (2015). *Injury and Violence: The 5-Minute Clinical Consult.* Wolters Kluwer Health. Manuscript accepted for publication. (Book Chapter).

Garbo, GM., **Ballard, J**., Harrison, L. Kik, P., Wieman, TJ., and Fingar., V. Modulation of photodynamic activity with Photofrin: effect of dose, time interval, fluence, and delivery system. Proceedings of SPIE--the international society for optical engineering: Optical Methods for Tumor Treatment and Detection: Mechanisms and Techniques in Photodynamic Therapy XIV Vol. 5689 p.78-89, April 2005.

SERVICE TO PROFESSION

Reviewer – *Journal of Implementation Science*

GRANT ACTIVITY

Grants Awarded

2020-Present **Co-Investigator**
National Institute on Drug Abuse

National Institutes of Health
Project Title: Northeast Node of the National Drug Abuse Clinical Trials Network
Marsch, L. (PI)
Study Number: UG1DA040309
Study Dates: 6/1/2020-5/31/2025
Grant Amount: $4,020,602

2017-2018 **Principal Investigator**
Health Resources and Services Administration
Project Title: Ryan White HIV/AIDS Treatment Part B
Grant Number: XO7HA00008
Grant Period: 12/1/2017-12/30/2018 (PI 12/1/17-5/1/18)
Grant Amount: $9,116,375.00

2017-2018 **Principal Investigator**
Council for State and Territorial Epidemiologist
Project Title: Influenza Education among Youth in Agriculture Project
Grant Period: 7/1/2017-6/30/2018 (PI 7/1/17-5/1/18)
Grant Amount: $50,000

2017-2018 **Co-Investigator**
University of Kentucky Office for Value and Innovation in Healthcare Delivery (OVIHD)
Project Title: Value of Innovation to Implement Program (VI^2P): Partnership for Identification and Primary-care based Enrollment to a Prevention Intervention for Diabetes (PIPE to Prevent Diabetes)
Grant Period: 7/17/2017-12/30/2018 (Co-I 7/17/17-5/1/18)
Grant Amount: $110,000

2015- 2018 **Co-Investigator**
Health Resources and Services Administration (HRSA),
Project Title: Collaborative Training in Primary Care Transformation Project
B. Elder (PI)
Grant Period 7/1/16-7/1/2019 (Co-I 7/1/16-5/1/18)
Grant Amount: $2,495,915.55

2015-2018 **Co-Investigator**
Substance Abuse and Mental Health Services Administration (SAMHSA),
Project Title: A Multidisciplinary Program to Train Health Professionals in the SBIRT Model
SAMHSA Grant Number: 1H79TI025976-01
K. Benner. (PI)
Grant Period: 09/01/2015-09/01/2018 (Co-I 9/1/15-5/1/18)
Grant Amount: $942,330

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2014-10/2016 **Co-Investigator**
Health Resources and Services Administration (HRSA),
Project Title: Residency Training Grant in Primary Care
HRSA Grant Number: D58HP23234
O. Perez (PI) 10/2015-9/2016; M. King (PI) 9/2011-9/2015
Grant Period: 09/30/2011-9/26/2016
Grant Amount: $712,458

Submitted Applications Grants Not Awarded:

4/2019 **Multiple Principal Investigator**
National Institute on Drug Abuse
Project Title: Developing and Testing an Integrated Approach to Tackling the Opioid Crisis in New Hampshire
Marsch L. (Co – Multiple Principle Investigator)
Grant Amount: $110,000,000

2/2017 **Co-Investigator**
National Institutes of Health
Project Title: Giving Intervention to Improve Function, Opiod Use, and Life Purpose in Chronic Pain
E. Salt (PI)

9/2016 **Co-Investigator**
PCORI
Project Title: Evaluating the Impact of Transitional Care Management (TCM) for Small to Medium-sized Primary Care Clinics on Patient-Centered Outcomes
R. Cardarelli (PI)

9/2016 **Practice Site- PI** (Co-Investigator)
PCORI, Sub-contract to the University of Vermont
Project Title: Integrating Behavioral Health and Primary Care
B. Littenberg (PI)

3/2016 **Co-Investigator**
National Institutes of Health
Project Title: Enhanced Perinatal Intervention for Cessation (EPIC): Reducing Tobacco use among Opioid Addicted Women
K. Ashford (PI) Application Number 1 R34 DA042318-01
Grant Amount Requested: $677,250

9/2015 **Co-Investigator**
Health Resources and Services Administration (HRSA),
Project Title: Preventive Medicine Residency with Integrative Health Training Program
T. Johnson (PI)
Grant Amount Requested: $1,197,131

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University of Kentucky Institutional Review Board Approved Submissions

IRB # 16-0144-P1H – Effectiveness of transitional care management in an academic medicine center – 2016-2017

IRB# 16-0093-X1B – Outcome Analysis of UK Healthcare's one year participation in the National Million Hearts Campaign - 2016

IRB# 16-0151-X1B – Analysis of quality improvement survey to determine pediatric preferences - 2016

LANGUAGE

1996-2002	Study of Spanish – Novice level

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Samantha L. Morin, Ph.D.

Curriculum Vitae

[redacted] [redacted]

EDUCATION/LICENSES

03/06/20	**Licensed by the NH Board of Registration of Psychologists** NH Psychologist License Number: 1483
08/15/19	**Licensed by the MA Board of Registration of Psychologists** MA Psychologist License Number: 11130
08/11 to 08/17	**Doctor of Philosophy**, Fordham University Major: Clinical Psychology (APA-Accredited Program) Concentration: Forensic Psychology Dissertation: Determining treatment needs and recidivism risk of juveniles with sexual offense adjudications. *Advisor*: Keith Cruise, Ph.D., M.L.S.
08/07 to 05/09	**Master of Arts,** Roger Williams University Major: Forensic Psychology (APA-Accredited Program) Thesis: Understanding perceptions of hypnotically-recovered memories in a civil sexual abuse case. *Advisor*: Judith Platania, Ph.D.
08/03 to 05/07	**Bachelor of Arts,** Saint Anselm College Major: Psychology; Minor/Certificate: Forensics Honors Thesis: Critical incident stress debriefing (CISD): A comparison of law enforcement/arson professionals and college students seeking careers in arson/ law enforcement. *Advisor*: Paul Finn, Ph.D.

CLINCAL EXPERIENCE

03/20 to present — **Licensed Clinical Psychologist/Supervisor of Clinical Services**
Dartmouth-Hitchcock Medical Center, Department of Psychiatry; Contracted position at Sununu Youth Services Center (SYSC), Manchester, NH
Dartmouth Supervisor: William Torrey, MD; *SYSC Director of Operations*: Rhonda Chasse, MPA
Experiences:

- Contracted by Dartmouth Hitchcock Department of Psychiatry as the facility psychologist and supervisor of clinical services at SYSC, the sole juvenile secure treatment facility in the state of NH. Member of the SYSC Leadership team alongside the Director of Operations, Administrator II, and Residential Supervisor VI.
- Provide clinical supervision and treatment planning oversight to the clinical services team, including three to four Masters-level clinicians. This includes: weekly supervision with each clinician, biweekly clinical team meetings,

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assignment of cases to clinicians, review of all clinical documentation (DAP notes, psychosocial assessments, treatment plans, court and parole reports, coaching/safety plans, assessments, etc.), and participation in all treatment plan meetings.

- Provide clinical consultation regarding youth placed at the facility to clinical services team, as well as other facility departments (e.g., medical, school, residential services staff, supervisors), including twice weekly case review meetings open to all staff.
- Responsible for evaluating current treatment programming (groups, milieu, individual and family therapy, assessments, etc.), as well as the development and implementation of facility-wide evidence-based treatment programming.
- Lead a multidisciplinary team of staff in the development of revised, evidence-based behavioral management programming for the facility including the development and implementation of positive behavioral interventions and supports (PBIS).
- Participate in parole hearings and court hearings, as needed/requested.
- Oversee research initiatives within the facility.
- Active participant on several juvenile justice workgroups for the State of NH aimed at improving juvenile justice policies and procedures, as well as promoting positive youth development models in the state.

Population Served:

- Diverse population of justice-involved male and female adolescents, ages 13 to 17, detained or committed by the court. Many of the youth present with significant trauma and/or mental health and substance use difficulties.

09/19 to present

Forensic Evaluator (per diem)
Office of the Forensic Examiner, Concord, NH
Supervisor: Shannon Bader, PhD, ABPP
Experiences:

- Conduct court-ordered evaluations of competence to stand trial.
- Write comprehensive reports for the court addressing competence to stand trial.
- Provide testimony as requested.
- Participate in weekly team meetings/peer consultation.

Population Served:

- Diverse population of male and female adult defendants, aged 18 and older, referred for a court-ordered evaluation in the state of NH.

09/18 to 03/20

Psychologist Ii, Adolescent Continuing Care Unit (ACCU) E2
University of Massachusetts (UMass) Medical School/Worcester Recovery Center and Hospital (WRCH), Worcester, MA
Program Director: Brian Denietolis, PsyD
Experiences:

- Conducted trauma-informed and developmentally appropriate individual and family psychotherapy with adolescents on the unit and their families.
- Managed and conducted initial psychology intake assessments (e.g., psychological diagnostic evaluation, trauma assessment, substance use assessment, specialized

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risk assessment form) with each youth admitted to the unit within first 10 days of admission.
- Managed and conducted risk assessments for youth meeting hospital thresholds (e.g., suicide risk, violence risk, fire-setting risk, elopement risk, problem sexual behavior risk) including record review, youth interview, collateral contact, and composing risk assessment reports.
- Managed, conducted, and supervised psychological testing evaluations for youth indicated by clinical team as in need of evaluation; evaluations typically included self-report and evaluator-administered measures of intelligence, cognition, achievement, and personality. Completed comprehensive evaluation reports including diagnostic information and detailed recommendations were provided to team.
- Provided weekly clinical and testing supervision to psychology graduate student trainees completing practicum at WRCH. Worked collaboratively on cases with trainees. Supervised trainees in conducting and writing initial intake assessments, risk assessments, and psychological evaluation reports.
- Worked collaboratively with other treatment providers including psychiatrists, social workers, psychology trainees and interns, medical students, nurses, occupational and recreational therapists, and mental health counselors for optimal treatment planning.
- Attended and participated in daily unit rounds, weekly unit treatment team meetings, and weekly psychology department meetings.

Population Served:
- Diverse population of male and female adolescents, ages 13 to 18, with significant trauma and/or persistent mental illness. Four beds are allocated to youth admitted from the courts for forensic evaluations.

08/17 to 08/18 **Clinical Psychology Postdoctoral Fellow, Adolescent Risk Assessment/Safety Net**
Cambridge Health Alliance (CHA)/Harvard Medical School (HMS), Cambridge, MA
Training Director: Marla Eby, Ph.D.
Primary Supervisor: James Barrett, Ph.D.
Secondary Supervisors: David Stewart, Ph.D.; Dan Sanford, Psy.D.; William Pollack, Ph.D.
Safety Net Program Experiences:
- Attended Safety Net collaborative meetings twice per month with professionals and representatives from the Cambridge Police Department, Cambridge Public Schools, CHA, and Department of Human Services-Youth Programs.
- Provided outpatient psychological services (e.g., intake evaluation, individual psychotherapy, referrals) to adolescents referred from the Safety Net program to CHA.
- Provided consultation to partners in the Safety Net collaborative on issues related to adolescent mental health and treatment.
- Collaborated with other Safety Net partners on research projects investigating the effectiveness of the diversion program.

Population Served:
- Racially/ethnically diverse population of male and female adolescents participating in pre-complaint police diversion program and presenting with several risk

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indicators (e.g., disruptive family life, mental illness, low school achievement, negative peer relations).

School-Based Assessment Experiences:

- Conducted safety, risk, and psychological assessments for the Cambridge Public Schools.
- Consulted with school personnel regarding recommendations for students referred for assessment.

Population Served:

- Racially/ethnically diverse population of male and female adolescents attending school in the Cambridge Public School system and presenting with risk indicators (e.g., externalizing behaviors, aggression, mental illness, school truancy, low school achievement, negative peer relations) referred to the School-Based Services program.

CHA Child/Adolescent Outpatient Clinic Experiences:

- Conducted intake evaluations with adolescents referred to CHA or the Cambridge-Rindge Latin School (CRLS) Teen Health Center for individual psychotherapy.
- Provided outpatient individual and family psychotherapy with adolescents and their parent(s)/guardian(s) at CHA or CRLS.

Population Served:

- Racially/ethnically diverse population of male and female adolescents referred for psychological services at CHA or CRLS and presenting with a range of mental health difficulties (e.g., depression, substance use, anger, anxiety, PTSD, etc.).

Juvenile Court Clinic Experiences:

- Conducted court-ordered evaluations with adolescents and their parent(s)/guardian(s) including Child Requiring Assistance (CRA) petitions, and shadowed Competency to Stand Trial (CST) evaluations, Criminal Responsibility (CR) evaluations, and Section 35 (substance abuse) evaluations.

Population Served:

- Racially/ethnically diverse population of male and female youthful offenders referred for court-ordered evaluations at the Lowell Juvenile Court Clinic.

08/16 to 08/17 **Clinical Psychology Pre-Doctoral Intern, Forensic Track**
UMass Medical School/WRCH, Worcester, MA
Training Director/Primary Supervisor: Jack Terry, Ph.D.
Secondary Supervisors: Andrea Dinsmore, PsyD.; Ashley Murray, Ph.D.; Phoebe Moore, Ph.D.; Brian Dessureau, Ph.D.; Jeanna Spannring, Ph.D.; Brian Denietolis, Psy.D.
Forensic Service (First Major Rotation, 09/16 to 03/17) Experiences:

- Assisted in conducting forensic evaluations under supervision of a Designated Forensic Psychologist (DFP) including competency to stand trial, criminal responsibility, risk assessment, and need for care and treatment.
- Completed written shadow reports for each forensic evaluation including record review, interview data, testing (when indicated), mental status, clinical opinion of the legal question, and need for care and treatment.
- Conducted testing for court-ordered forensic evaluations including administration and documentation of personality, symptom validity/malingering, and intellectual

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measures (e.g., PAI, Structured Interview of Reported Symptoms, Validity Indicator Profile, Wechsler Abbreviated Scale of Intelligence- 2nd edition).

Population Served:

- Racially/ethnically diverse population of male and female offenders with severe mental illness (e.g., psychotic disorders, bipolar disorder, depression, substance abuse disorders) admitted to the forensic inpatient unit for court-ordered evaluation and psychiatric stabilization.

Pediatric Anxiety Clinic (Minor Rotation, 12 months) Experiences:

- Conducted anxiety and obsessive-compulsive disorder (OCD)-specific intake evaluations utilizing structured interviewing procedures.
- Conducted empirically supported cognitive-behavioral therapy (CBT) for pediatric anxiety and related disorders, using both family and individual approaches.

Population Served:

- Diverse population of children and adolescents with anxiety, OCD, and related disorders (e.g., generalized anxiety disorder, social anxiety, specific phobias) in a subspecialty outpatient clinic.

Outpatient Neuropsychology (Minor Rotation, 12 months) Experiences:

- Conducted outpatient neuropsychological assessments with patients referred from throughout UMass Memorial Center and outside clinics.
- Completed scoring, interpretation, and writing of reports for full neuropsychological test batteries.

Population Served:

- Racially/ethnically diverse population of children, young adults, and adults with a broad spectrum of neurological, medical, and psychiatric disorders.

Primary Care/Behavioral Medicine (Minor Rotation, 12 months) Experiences:

- Conducted consultation, rapid assessment, and behaviorally-oriented brief psychotherapy to patients in a primary care medical setting.
- Facilitated referrals to internal and external providers (e.g., psychiatric evaluations, long-term psychotherapy, group psychotherapy).

Population Served:

- Racially/ethnically diverse population of young adults and adults presenting at the Primary Care clinic with various comorbid medical (e.g., chronic pain, insomnia, hypertension) and mental health concerns (e.g., anxiety disorders, depression, substance abuse, personality disorders).

Adolescent Inpatient (Second Major Rotation, 03/17 to 08/17) Experiences:

- Conducted trauma-informed and developmentally appropriate individual and family psychotherapy with adolescents on the unit and their families.
- Enhanced and utilized skills in assessment and milieu management, including differential diagnosis, risk management, and the child service delivery system.
- Worked collaboratively with other treatment providers including psychiatrists, social workers, nurses, occupational and recreational therapists, and mental health counselors for optimal treatment planning.

Population Served:

- Diverse population of male and female adolescents, ages 13 to 18, with significant trauma and/or persistent mental illness. Four beds are allocated to youth admitted from the courts for forensic evaluations.

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09/15 to 03/16 **Clinical Psychology Extern, Day Treatment Program**
New York City Children's Center- Queens Campus, Bellerose, NY
Supervisors: Diana Miley, Psy.D. (treatment); Amy Daley, Ph.D. (assessment)
Experiences:

- Conducted individual, group, play, and family therapy (e.g., CBT, DBT, behavioral modification) in a fully integrated clinical and educational program.
- Conducted crisis interventions when indicated.
- Completed comprehensive psychological assessments.
- Managed treatment and discharge planning of cases.
- Participated in treatment team activities and attended grand rounds, diagnostic conferences, case conferences, and training lectures.

Population Served:

- Racially/ethnically diverse population of children and adolescents, ages 5 to 14, with severe emotional and behavioral disorders (e.g., ADHD, ODD, Autism Spectrum Disorder, DMDD, Bipolar disorder, Psychosis), and their parents/guardians.

09/14 to 08/15 **Clinical Psychology Extern, Psychological Assessment**
Bronx Lebanon Hospital Center, Bronx, NY
Supervisors: Ali Khadivi, Ph.D. (adult) & Wen Gu, Ph.D. (child/adolescent)
Experiences:

- Conducted individual psychological assessments including record review, clinical interview, and administration of psychological tests, and developed integrated assessment reports for treatment teams.
- Gained experience with various psychological tests including cognitive (e.g., Montreal Cognitive Assessment), intellectual (e.g., WISC-IV, WAIS-IV), personality (e.g., Rorschach, PAI), among others.
- Attended case conferences and grand rounds.

Populations Served:

- Diverse urban population of children, adolescents, and adults with severe mental illness (e.g., depression, schizophrenia, bipolar disorder, disruptive mood dysregulation disorder) admitted to the inpatient psychiatric units.
- Racially/ethnically diverse population of adolescents and adults with severe mental illness (e.g., bipolar disorder, schizophrenia) attending treatment in the outpatient clinic.

08/14 to 06/15 **Forensic Psychology Fellowship**
Fordham University Law Clinic, New York, NY
Supervisor: Barry Rosenfeld, Ph.D., A.B.P.P.
Experiences:

- Conducted psychological assessments (e.g., risk assessment, diagnostic clarification) and prepared reports for the legal team.
- Consulted with Fordham Law School Professors and Students on Criminal and Federal Litigation cases involving a mental health component.
- Assisted in writing legal briefs involving mental health issues presented in a given case.

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- Attended weekly Criminal Defense Clinic and Federal Litigation Clinic seminars, as well as weekly rounds.

Population served:

- Racially/ethnically diverse population of adult criminal defendants and inmates with mental illness (e.g., mood disorders, PTSD, substance abuse disorders).

07/13 to 06/14 **Clinical Psychology Extern, Inpatient Assessment/Treatment**
Bellevue Hospital Center, Forensic Track, New York, NY
Supervisors: Elizabeth Arias, Ph.D.; Melanie Farkas, Ph.D.; Marilyn Chen, Ph.D.
Experiences:

- Conducted intake assessments, and group (e.g., emotion regulation) and individual psychotherapy (e.g., CBT for psychosis, psychodynamic, behavioral modification, mindfulness, DBT skills) on the inpatient forensic unit.
- Conducted comprehensive psychological assessments (e.g., psychodiagnostic, malingering measures, cognitive testing).
- Attended weekly didactic seminars/case conferences and presented one treatment case.

Population Served:

- Diverse urban population of male offenders with severe mental illness (e.g., psychotic disorders, bipolar disorder, depression, substance abuse disorders) admitted to the forensic inpatient unit for psychiatric stabilization.

08/12 to 05/13 **Clinical Psychology Extern, Outpatient Psychotherapy**
Hunter College Counseling Center, New York, NY
Supervisor: Ariella Soffer, Ph.D.
Experiences:

- Conducted brief individual psychodynamic psychotherapy.
- Conducted comprehensive intake assessments and completed intake reports.
- Conducted mental health screenings for students on campus.
- Facilitated referrals and collaborated with community services.
- Participated in weekly didactic seminars/case conferences and presented five treatment cases.

Population Served:

- Racially/ethnically diverse population of college students including adolescents, young adults, and adults presenting at the counseling center with various mental health concerns (e.g., anxiety disorders, depression, substance abuse, personality disorders).

10/11 to 09/12 **Study Therapist**
Project SHARP, New York, NY
Supervisors: Michelle Galietta, Ph.D. & Barry Rosenfeld, Ph.D., A.B.P.P.
Experiences:

- Conducted CBT-based anger management intervention.

Population Served:

- Diverse urban population of male offenders referred for anger management by the NYC courts and Department of Probation.

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CLINICAL SUPERVISION EXPERIENCE

09/18 to 03/20 **Trainee Supervisor**, Adolescent Continuing Care Unit, Worcester Recovery Center and Hospital (WRCH)

- Provided weekly clinical and testing supervision to psychology graduate student trainees completing practicum at WRCH.

11/16 to 05/17 **Trainee Supervisor**: Department of Psychology, WRCH

- Provided weekly clinical supervision to third-year graduate student completing externship at WRCH as part of the UMass Medical School/WRCH Clinical Psychology Predoctoral Internship Program.

08/14 to 05/15 **Peer Supervisor**: Department of Psychology, Fordham University

- Provided weekly clinical supervision to second-year graduate student as part of the Clinical Supervision and Consultation course (PSYC 8222/8223)

OTHER CLINICAL EXPERIENCE

08/08 to 05/09 **Psychology Extern, Outpatient Psychotherapy**
Arbour Counseling Services, Fall River, MA
Supervisors: Janine Gendreau, M.A. & Donald Whitworth, Ph.D.
Experiences:

- Conducted individual psychotherapy (e.g., supportive, CBT, psychodynamic) and co-led group psychotherapy (e.g., DBT).
- Completed initial clinical evaluations.
- Developed and implemented individual treatment plans.

Population Served:

- Racially/ethnically diverse population of adolescents and adults with various mental health concerns (e.g., depression, anxiety disorders, substance abuse, relationship issues, anger management issues, eating disorders, bereavement) attending psychotherapy at an outpatient community clinic.

08/07 to 08/08 **Support Staff**
L.I.F.E. Inc., Bristol, RI
Experiences:

- Provided therapeutic and emotional support and guidance with decision-making.
- Utilized behavioral management techniques.
- Assisted with daily living activities.

Population Served:

- Developmentally and physically disabled adults living in a residential group home.

RESEARCH EXPERIENCE

08/11 to 08/16 **Research Assistant**
Fordham University, Clinical Psychology Ph.D. Program
Project: Adolescent and Parent Perspectives on Teen Risk-Taking Behaviors: Exploring Associations and Ethical Issues (Fordham University Undergraduate Research Grant)
Principal Investigators: Keith Cruise, Ph.D., M.L.S. & Georgia Gaveras, D.O.

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Experiences:

- Conducted comprehensive assessments (e.g., Peer Conflict Scale, Inventory of Callous-Unemotional Traits, BASC-2, FASM, UCLA PTSD Index, SASSI-A2, MAYSI-2) with adolescents participating in an outpatient day treatment program for youth with co-occurring mental health and substance abuse disorders, and their parent/guardian.

Project: Initial Validation of the Short-Term Assessment of Risk and Treatability Present Adolescent Version (START-AV) (Fordham University Faculty Research Grant)
Principal Investigator: Keith Cruise, Ph.D., M.L.S.
Experiences:

- Conducted comprehensive structured interviews and assessments (e.g., START-AV, MAYSI-2, SASSI-A2) with juvenile offenders on probation in Bridgeport, CT for the purposed of validating the START- AV.

05/12 to 08/12 **Research Assistant**
Fordham University, Clinical Psychology Ph.D. Program, Bronx, NY
Project: Differentiating Real versus Feigned Posttraumatic Stress Disorder in a Sample of West African Torture Survivors
Principal Investigators: Rebecca Weiss, M.A. & Barry Rosenfeld, Ph.D., A.B.P.P.
Experiences:

- Conducted comprehensive assessments with adults from West Africa seeking asylum through the Program for Survivors of Torture (PSOT) at Bellevue Hospital. The purpose of the study was to validate measures of malingering (e.g., M-FAST, TOMM, Dot Counting Test, TSI-2) in this population.

06/10 to 09/11 **Research Assistant**
UMASS Medical School, Department of Psychiatry, Worcester, MA
Project: Women's Risk and Treatment for Intimate Partner Violence (Psychiatry Research Fellowship Award)
Principal Investigator: Laura S. Guy, Ph.D.
Experiences:

- Conducted comprehensive assessments (e.g., PAI, URICA) with female perpetrators of intimate partner violence prior to and following the completion of a group therapy intervention.

10/09 to 08/11 **Research Coordinator II**
UMASS Medical School, Department of Psychiatry, Worcester, MA
National Youth Screening and Assessment Project
Supervisors: Thomas Grisso, Ph.D. & Valerie Williams, M.A., M.S.
Experiences:

- Provided technical assistance and training on mental health and risk screening and assessment practices to targeted sites in all four states participating in the MacArthur Foundation's "Models for Change" (MfC) Initiative (Pennsylvania, Washington, Illinois, and Louisiana).

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- Assisted juvenile justice programs with the registration, implementation and ongoing use of the Massachusetts Youth Screening Instrument- Version 2 (MAYSI-2).
- Provided technical support to users of MAYSIWARE, the electronic version of the MAYSI-2.

Project: Youth Risk/Needs Assessment for Recidivism: Implementation and Effectiveness Study (John D. & Catherine T. MacArthur Foundation Grant)
Principal Investigator: Gina Vincent, Ph.D.
Co-Investigator: Laura Guy, Ph.D.
Experiences:

- Conducted phone interviews with juvenile probation officers in two states (Louisiana and Pennsylvania) at time points following the implementation of valid risk/needs assessment tools.
- Coded juvenile probation officer interview transcripts according to an established codebook in order to qualitatively examine the outcomes of implementation.

TEACHING EXPERIENCE

01/14 to 05/16 **Instructor**: Department of Psychology, Fordham University
Undergraduate Courses:
Forensic Psychology (PSYC 3820)
Law and Psychology (PSYC 4340)

Graduate Courses:
Clinical Diagnosis Laboratory (PSYC 7121)

09/11 to 05/12 **Teaching Assistant**: Department of Psychology, Fordham University
Undergraduate Courses:
Foundations of Psychology Lab, Three sections (PSYC 1200)

HONORS AND AWARDS

2017 **Outstanding Student Presentation in Corrections Research**
American Psychology-Law Society 2017 Conference Award

2017 **GSA Professional Development Grant**
Fordham University

2017 **GSAS Research Support Grant**
Fordham University

2012, 2013, 2014 **GSA Travel Award**
Fordham University

2008, 2009 **Provost Fund Grant**
Roger Williams University

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2007 to 2009 **Master of Arts in Forensic Psychology Grant**
Roger Williams University

2003 to 2007 **Psi Chi National Honor Society in Psychology**
Saint Anselm College

2003 to 2007 **Presidential Scholar Academic Scholarship**
Saint Anselm College

2003 to 2007 **Elks Regional Scholar Academic Scholarship**
Elks Club, Worcester, MA

2003 to 2007 **Dean's List 8/8 semesters**
Saint Anselm College

PROFESSIONAL SERVICE

National

2015 to Present **Student Reviewer/Reviewer**
Child and Youth Care Forum

2012 to Present **Student Reviewer/Reviewer**
International Journal of Forensic Mental Health

2010 to 2015 **Student Reviewer**
American Psychology- Law Society Annual Conference
Areas: Risk assessment, developmental/juvenile justice, risk assessment

2010 to 2013 **Student Reviewer**
American Psychological Association Annual Conference
Areas: Jury decision making, expert testimony, division 41 proposals

2010 **Committee Reviewer**
MacArthur Models for Change 5th Annual Working Conference
Reviewed 35 proposals submitted for inclusion

Departmental

2012 to 2014 **Student Interviewer**
Fordham University, Department of Psychology

2012 to 2013 **Class Representative**
Fordham University, Department of Psychology

ADDITIONAL TRAININGS

2016 **Psychopathy and the Psychopathy Checklist-Revised (PCL-R)**
Worcester Recovery Center and Hospital, Forensic Service, Worcester, MA
Instructor: Ashley Murray, Ph.D.

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2015 **Juvenile Competence Workshop**
Summer Training Institute, John Jay College, NY, NY
Instructor: Ivan Kruh, Ph.D.

2014 **HCR-20 Training**
Fordham University, NY, NY
Instructor: Barry Rosenfeld, Ph.D., A.B.P.P.

2013 **MMPI-2-RF Workshop**
Fordham University, NY, NY
Instructor: Yossef Ben-Porath, Ph.D.

2009 **Use of the Psychopathy Checklist-Revised, 2nd Edition (PCL-R) and the Psychopathy Checklist-Revised: Screening Version (PCL: SV)**
UMASS Medical School, Worcester, MA
Instructor: Gina Vincent, Ph.D.

2009 **The Structured Assessment of Violence Risk for Youth (SAVRY)**
UMASS Medical School, Worcester, MA
Instructors: Gina Vincent, Ph.D. & Laura Guy, Ph.D.

PUBLICATIONS

Peer-Reviewed Journal Articles

1. Janopaul-Naylor, E., **Morin, S. L.**, Mullin, B., Lee, E., & Barrett, J. G. (2019). Promising approaches to police–mental health partnerships to improve service utilization for at-risk youth. *Translational Issues in Psychological Science, 5*(2), 206–215. doi:10.1037/tps0000196

2. Holloway, E. D., Cruise, K. R., **Morin, S. L.**, Hinz, H., & Steele, R. (2018). Juvenile probation officers' evaluation of traumatic event exposures and traumatic stress symptoms as responsivity factors in risk assessment and case planning. *Law and Human Behavior, 2*(4): 369-384. doi:10.1037/lhb0000283

3. **Morin, S. L.**, Cruise, K. R., Hinz, H., Holloway, E. D., & Chapman, J. F. (2015). Content, structure, and usefulness of juvenile predisposition psychological evaluations. *Child & Youth Care Forum, 44*(6), 893-917. doi: 10.1007/s10566-015-9312-3

4. Guy, L. S., Vincent, G. M., Nelson, R., & **Fusco-Morin, S.** (2014). What do juvenile probation officers think of using the SAVRY and YLS/CMI for case management, and do they use the tools properly. *International Journal of Forensic Mental Health Services, 13*(3), 227-241.

5. Vincent, G. M., Guy, L. S., **Fusco, S. L.**, & Gershenson, B. G. (2012). Field Reliability of the SAVRY with Juvenile Probation Officers. *Law and Human Behavior, 36*(3), 225-236.

6. **Fusco, S. L.**, & Platania, J. (2011). Understanding perceptions of hypnotically recovered memories in a civil sexual abuse case. *Journal of Forensic Psychology Practice, 11*(4), 330-350.

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Book Chapters and Other Publications

1. Viljoen, J. L., Nicholls, T. L., Cruise, K. R., Beneteau-Douglas, J., Desmarais, S. L., Barone, C. C., Petersen, K., **Morin, S. L.**, & Webster, C. D. (2016). *START: AV knowledge guide: A research compendium on the START:AV strength and vulnerability items.* Burnaby, BC: Simon Fraser University.

2. Cruise, K. R., **Morin, S. L.**, & Affleck, K. (2015). Residential interventions with justice involved youth. In K. Heilbrun, D. DeMatteo, & N. Goldstein (Eds.), *Handbook of psychology and juvenile justice.* Washington, DC: American Psychological Association.

3. Models for Change Juvenile Diversion Workgroup (2011). *Juvenile Diversion Guidebook.* Models for Change: Systems Reform in Juvenile Justice.

CONFERENCE PRESENTATIONS

1. **Morin, S. L.**, Barrett, J. G., & Janopaul-Naylor, E. (2018, March). *Mental health and service use outcomes of a pre-complaint police-based juvenile diversion program.* Paper presented at the 2018 Annual Conference of the American Psychology-Law Society, Memphis, Tennessee.

2. Barrett, J. G., **Morin, S. L.**, & Janopaul-Naylor, E. (2018, March). *Effectiveness of a pre-complaint police-based juvenile diversion program in reducing recidivism.* Poster presented at the 2018 Annual Conference of the American Psychology-Law Society, Memphis, Tennessee.

3. **Morin, S. L.**, & Cruise, K. R. (2017, March). *Determining treatment needs and recidivism risk of juveniles with sexual offense adjudications: Primary and secondary C-U traits*. Poster presented at the 2017 Annual Conference of the American Psychology-Law Society, Seattle, Washington.

4. Holloway, E. D., Cruise, K. R., **Morin, S. L.**, Hinz, H., & Viljoen, J. L. (2017, March). *An application of the adherence checklist for the evaluation and reduction of risk (ACERR) to evaluate case plans developed by juvenile probation officers.* Paper presented at the 2017 Annual Conference of the American Psychology-Law Society, Seattle, Washington.

5. Holloway, E. D., Cruise, K. R., **Morin, S. L.**, Hinz, H., & Steele, R. (2016, June). *Risk assessment and case planning by juvenile probation officers: investigating the role of trauma as a responsivity factor.* Paper presented at the 2016 Annual Conference of the International Association of Forensic Mental Health Services, New York, New York.

6. **Morin (Fusco), S. L.**, Cruise, K. R., Hinz, H., Holloway, E., Chapman, J., & Duran, T. (2014, March). *Content, structure, and usefulness of juvenile predisposition psychological evaluations.* Poster presented at the 2014 Annual Conference of the American Psychology-Law Society, New Orleans, Louisiana.

7. Gamache, K., Weipert, R., & **Morin (Fusco), S. L.** (2014, March). *Active shooters: The predictive utility of critical factors on the magnitude of the event.* Symposium presented at the 2014 Annual Conference of the American Psychology-Law Society, New Orleans, Louisiana.

8. **Fusco, S. L.**, Affleck, K. C., Cruise, K. R., Gaveras, G. (2013, March). *Examining co-occurring mental health/risk management needs in at-risk youth: Do parents and youth agree?* Paper presented at the 2013 Annual Conference of the American Psychology-Law Society, Portland, Oregon.

9. **Fusco, S. L.**, Guy, L. S., Nelson, R., Conti, K., Bennet, M. M., Dowd, L., & Vincent, G. (2012, March). *Female perpetrated aggression: Characteristics and treatment needs of anger management group*

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participants. Poster presented at the 2012 Annual Conference of the American Psychology-Law Society, San Juan, Puerto Rico.

10. **Fusco, S. L.**, Cook, N. E., & Maney, S. (2012, March). *Mental health symptoms among Hispanic youth in juvenile justice: Language and gender differences.* Symposium presented at the 2012 Annual Conference of the American Psychology-Law Society, San Juan, Puerto Rico.

11. Conti, K., Guy, L. S., Nelson, R., & **Fusco, S. L.** (2012, March). *Investigating the URICA-DV-R among women in anger management group treatment.* Poster presented at the 2012 Annual Conference of the American Psychology-Law Society, San Juan, Puerto Rico.

12. Gamache, K., Weipert, R. E., Griffen, K., & **Fusco, S. L.** (2012, March). *"I don't like Mondays": An explorative look at the characteristics of Active Shooters*. Poster presented at the 2012 Annual Conference of the American Psychology-Law Society, San Juan, Puerto Rico.

13. Nelson, R., Guy, L. S., Conti, K., & **Fusco, S. L.** (2012, March). *Female perpetrated intimate partner violence and treatment attrition.* Poster presented at the 2012 Annual Conference of the American Psychology-Law Society, San Juan, Puerto Rico.

14. Guy, L. S., **Fusco, S. L.,** Hilterman, E., & Vincent, G. M. (2011, June). Experiences using the SAVRY in the field: A comparison of Spanish clinicians and American probation officers. In, *SAVRY risk management, one step ahead of risk assessment*. Symposium presented at the 11th Annual Conference of the International Association of Forensic Mental Health Services (IAFMHS), Barcelona, Spain.

15. **Fusco, S. L.**, Perrault, R. T., Paiva, M., Cook, N. E., & Vincent, G. M. (2011, March). *Probation officer perceptions of gender differences in youth offending and implications for practice in the field*. Paper presented at the 2011 meeting of the American-Psychology-Law Society, Miami, FL.

16. Paiva, M., **Fusco, S. L.**, & Vincent, G. M. (2011, March). *Socioeconomic Status: Does it affect juvenile compliance while on probation?* Poster presented at the 2011 meeting of the American-Psychology-Law Society, Miami, FL.

17. Cook, N. E., **Fusco, S. L.**, Guy, L. S., & Vincent, G. M. (2011, March). Decision making and use of risk/needs assessment tools in juvenile probation. In, *Use of the SAVRY and YLS/CMI in Juvenile Probation: Implementation Study.* Symposium presented at the 2011 meeting of the American-Psychology-Law Society, Miami, FL.

18. Guy, L. S., **Fusco, S. L.**, Cook, N. E., & Vincent, G. M. (2010, August). Juvenile probation officers' experiences using risk/needs assessment tools in the field. In, E.P. Mulvey & C.A. Schubert (Chairs), *Empirically Based Approaches for Improving the Juvenile Justice System.* Symposium presented at the 118th meeting of the American Psychological Association, San Diego, CA.

19. Guy, L.S., **Fusco, S. L.**, Cook, N. E., & Vincent, G. M. (2010, May). *Juvenile probation officers' decision-making processes and experiences using risk/needs assessment tools in the field*. Paper presented at the 10th Annual meeting of the International Association of Forensic Mental Health Services, Vancouver, Canada.

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20. Gamache, K., Weipert, R., **Fusco, S. L.,** Rowback, J., & Paiva, M. (2009, August). *"She had it coming": A comparative look at domestic violence blame attributions.* Poster presented at the 117th meeting of the American Psychological Association, Toronto, Canada.

21. **Fusco, S. L.,** & Platania, J. (2009, March). *Understanding perceptions of hypnotically-recovered memories in a civil sexual abuse case.* Poster presented at the meeting of the American Psychology-Law Society, San Antonio, TX.

22. Platania, J., Small, R., **Fusco, S. L.,** Miller, M., & Perrault, R. (2008, August). Investigating legal safeguards against prosecutorial misconduct in closing argument. In, V. Stinson (Chair), *Death Penalty.* Paper session conducted at the 116th meeting of the American Psychological Association, Boston, MA.

23. **Fusco, S. L.,** & Finn, P. (2007, March). *Critical incident stress debriefing (CISD): A comparison of law enforcement/arson professionals and college students seeking careers in arson/law enforcement.* Poster presented at the meeting of the Eastern Psychological Association, Philadelphia, PA.

PROFESSIONAL AFFILIATIONS

2013 to Present	Society for a Science of Clinical Psychology (SSCP)
2011 to Present	Association for Psychological Science (APS)
2007 to Present	American Psychological Association (APA): Divisions 12, 41, 53, and 56
2006 to Present	Eastern Psychological Association (EPA)

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ARUN KRISHNAN MD

[redacted]

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EDUCATION:

Brookdale Hospital and Medical Center
* Child and Adolescent Psychiatry Fellowship — Jul 2014- Jun 2016

Brookdale Hospital and Medical Center
* Residency in Adult Psychiatry (categorical) — Jul 2011- Jun 2014

Medical College Thiruvananthapuram, India
MBBS (*Bachelor of Medicine & Bachelor of Surgery*) — Sep 2000- 2006

PROFESSIONAL EXPERIENCE:

Child And Adolescent Psychiatrist (Dec 2018 – present)
Sunnu Youth Service Center/ Dartmouth Hitchcock Medical Center
1056 N. River Road, Manchester, NH 03104

Psychiatrist (Aug 2018- present)
Counseling Center of New England
15 trafalgar Sq, Suite 202, Nashua, NH 03063

Psychiatrist (Jul 2016- present)
Elliot Hospital
1 Elliot way, Manchester, NH 03103

Child Psychiatry Fellowship Training (Jul 2014 – Jun 2016)
Brookdale UHospital and Medical Center, Brooklyn, NY

Adult Psychiatry Residency Training (Jul 2011 - Jun 2014)
Brookdale Hospital and Medical Center, Brooklyn, NY

VOLUNTEER ACTIVITIES

Research: **Voluntary research assistant** (Apr 2009- Sep 2010)
Geriatric Psychiatry fellowship program, SUNY Downstate Medical Center, Brooklyn, NY

- Data collection and interviewing patient's with memory problems and their family.
- Assisted fellows in making posters and in research.

PROFESSIONAL MEMBERSHIPS

- AMA — 2019-present
- APA — 2011- 2021

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ACTIVITIES:

- Chief resident for Adult Psychiatry resident July 2013- June 2014.
- Member of House Staff safety council in Brookdale hospital
- Received scholarship to attended Telluride Patient Safety Summer Camp in July 2015.
- Presented poster " Working together to create change:- House staff safety council that create change " as a part of House Staff safety Council at GNYHA Conference Center NY during Symposium on Engaging Residents in Health Care Transformationin January 2016.
- Presented poster in Brookdale health week in October, 2015 on "Patient Safety Event Reporting in Child & Adolescent Psychiatry".
- Delegate for CIR (Committee for Interns and Residents), advocated in using patient care fund for audio video equipment, attending national CIR conference during training.
- Coordinator for QI project aimed at increasing patient compliance to medication by discussing about sexual side effect of medication.
- Attending hospital resident's forum, GME meeting and Departmental meeting and advocated for residents and patient's safety.
- Attended various GMEC meeting and open residents forum in Brookdale Hospital.
- Actively involved in CLER visit in 2013 and 2015 and represented residents.

CERTIFICATION:

• Board certified in Adult Psychiatry	2015- present
• Board certified in Child and Adolescent Psychiatry	2016- present
• Medical License in Connecticut medical board	2015 -2017
• DEA	2016 - present
• Medical License in New Hampshire medical board	2016 - present
• Medical License in Massacheussetts	2017 - present

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Initial Header: Curriculum Vitae

Name: Mary F. Brunette

Office addresses:

[redacted]

Date prepared: March 2020

I. Education

Dates	Institution	Degree
1987-1991	Oregon Health Sciences University School of Medicine	M.D.
1981-1985	Lewis and Clark College	B.A. Biology

II. Postdoctoral (or Highest Degree) Training

Dates	Institution	Specialty
1995-1999	Dartmouth-NH Psychiatric Research Center	Research Trainee
1991-1995	Dartmouth-Hitchcock Medical Center	Psychiatry Residency

III. Academic Appointments:

a. Current Dartmouth/Geisel affiliations

Title	Institution	Dates
Associate Professor of Psychiatry	Geisel School of Medicine at Dartmouth (Formerly Dartmouth Medical School)	2006- Present

b. All other current academic affiliations: NA

Title	Institution	Dates

c. Past academic affiliations

Title	Institution	Dates
Assistant Professor of Psychiatry	Dartmouth Medical School	1996-2006
Instructor in Psychiatry	Dartmouth Medical School	1994-1996
Research Associate	Dartmouth Medical School	1994- 2016

IV. Institutional Leadership Roles

Title	Institution	Dates
Director, SYNERGY Community Engagement in Research Core	Geisel School of Medicine at Dartmouth	2018 -2020

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V. Licensure and Certification

Date	Title of Licensure and/or Certification
2008, 2018	Recertified in addiction psychiatry
2007, 2017	Recertified in psychiatry
1998	Board certified in addiction psychiatry
1996	Board certified in psychiatry
1993	NH state medical license

VI. Hospital or Health System Appointments

Position/Title	Institution/Organization	Date
Clinical Associate	Mary Hitchcock Memorial Hospital Dartmouth-Hitchcock Health	1995- Present

VII. Other Professional Positions

Position/Title	Institution/Organization	Date
Medical Associate	Westbridge, Inc	2008- 2013
Medical Director	Bureau of Behavioral Health, Department of Health and Human Services, State of New Hampshire	2006- Present
Clinical Associate	Womankind Counseling Center	2001-2006
Clinical Director	Dual Diagnosis Services Mental Health Center of Greater Manchester	1998- 2001
Teacher	Sea Pines High School Faistenau-Bei-Salzberg, Austria (Algebra, Biology Physics, Chemistry)	1986- 1987

VIII. Professional Development Activities

Dates	Sponsoring Organization / Institution	Name of Program	Duration of Program and Role	Certificate / # Credits / any other information
1995-1999	Dartmouth Medical School Psychiatric Research Center	NIMH –R24 Research Infrastructure Support Program:	Research Trainee	None

		Services for people with serious mental illness		

IX. Teaching Activities

A. Undergraduate teaching ("college" students): NA

Name of course	Dates taught	Institution where offered	Your specific role	Your scheduled hours/year	# of students per year

B. Undergraduate Medical Education (UME; "med student") *Classroom* teaching: NA

Name of course	Dates taught	Institution where offered	Your specific role	Your scheduled hours/year	# of students per year
Scientific Basis of Medicine, Psychiatry Course 3rd year	1996-1998	Geisel School of Medicine at Dartmouth	Director	8 hours/wk all year	~75
Scientific Basis of Medicine, Psychiatry lectures 3rd year	1995-2017	Geisel School of Medicine at Dartmouth	Lecturer	4-12 hours/yr	~75
Psychopharmacology Series 3rd year offering	1994 - 1995	Geisel School of Medicine at Dartmouth	Instructor	4 hours/wk 3 months/yr	~75

C. Undergraduate Medical Education (UME; "med student") *Clerkship or other Clinical* teaching

Name of course	Dates taught	Institution where offered	Your specific role	Your scheduled hours/year	# of students per year
Research Elective 4th Year Course offering	1998-Present	Geisel School of Medicine at Dartmouth	Supervisor	2 hours/wk 4 months/yr	0-3
Community Psychiatry 3rd year offering	1999-2001	Geisel School of Medicine at Dartmouth	Supervisor	5 hours/wk all year	1-2
Scientific Basis of Medicine Substance Abuse Fellowship	1996 – 1998	Geisel School of Medicine	Director	2 hours/wk 3 months/yr	1-2
Psychiatry Clerkship, Clinical Interviewing 3rd year offering	1993 - 1994	Geisel School of Medicine at Dartmouth	Instructor	4 hours/wk 3 months/yr	4-8

Psychiatry Clerkship Rotation 3rd Year Offering	1991-1998	Geisel School of Medicine at Dartmouth	Supervisor	10 hours/wk all year	1-3

D. Graduate Medical Education (GME) teaching: Inclusive of instruction of residents and fellows during clinical practice

Name of course	Dates taught	Institution where offered	Your specific role	Your scheduled hours/year	# of students per year
Co-occurring disorders T32 Post Doc Seminar	2014 - Present	Dartmouth Hitchcock Medical Center	Instructor	2-6 hours/yr	4-10
Psychiatry Residents, Research Seminar PGY-3	2013-Present	Dartmouth Hitchcock Medical Center	Instructor	2 hours/yr	8-15
Addiction Fellows, Community mental health, women and addiction, research, neurobiology modules	1999-Present	Dartmouth Hitchcock Medical Center	Instructor	8-16 hours/yr	2
Psychiatry Residents, Community Mental Health Module PGY2-4	1999-Present	Dartmouth Hitchcock Medical Center	Instructor	2-4 hours/yr	8-15
Psychiatry Residents, Substance Abuse Module PGY-2	1998-2000	Dartmouth Hitchcock Medical Center	Instructor	2-4 hours/yr	8-15
Family Practice and Internal Medicine Residents Outpatient Psychiatry PGY-3	1997-1998	Dartmouth Hitchcock Medical Center	Supervisor	4 hours/wk all year	1-2
Ob-Gyn Psychiatry Module PGY-3	1997 - 2000	Geisel School of Medicine at Dartmouth	Supervisor	5 hours/wk 3 months/yr	1-2

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Psychiatry Residents, Anxiety Disorders Module PGY-2-4	1997	Dartmouth Hitchcock Medical Center	Instructor	6 hours/yr	8-15
Psychiatry Residents, Psychopharmacology Module PGY2-4	1996-1999	Dartmouth Hitchcock Medical Center	Instructor	6 hours/yr	8-15
Psychiatry Residents Longitudinal Team (Inpatient, consultation, and outpatient clinic) PGY1-4	1995-1998	Dartmouth Hitchcock Medical Center	Team Leader	10 hours/wk all year	1-4
Psychiatry Resident Introductory Module PGY-1	1994-99	Dartmouth Hitchcock Medical Center	Instructor	1 hour/week 2 months/yr	8
Psychiatry Residency	1993-2001	Dartmouth Medical School	Clinical Supervisor	2-10 hours/wk all year	1-2

E. Other clinical education programs (e.g., PA programs): NA

Name of course	Dates taught	Institution where offered	Your specific role	Your scheduled hours/year	# of Students per year

F. Graduate teaching (post-college students enrolled in advance degree-granting programs, e.g., MS, MPH, PhD): NA

Name of course	Dates taught	Institution where offered	Your specific role	Your scheduled hours/year	# of Students per year

G. Other professional/academic programs (e.g., teaching in courses at MBL or Cold Spring Harbor)

Name of course	Dates taught	Institution where offered	Your specific role	Your scheduled hours/year	# of students per year
Integrated Care learning network	2018-Present	NH Department of	Developer/ Director	2 hours/mo 9 months/yr	15-30

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series for New Hampshire community mental health and primary care providers		Health and Human Services			
Assertive Community Treatment quality improvement series for community mental health medical staff	2017-2018	NH Department of Health and Human Services	Developer/ Director	4 hrs/month	10
Behavioral Health Research Seminar	2016-Present	Geisel & D-H Department of Psychiatry and Center for Technology and Behavioral Health	Clinical Director	2 hours/wk 9 months/yr	15-30
Quitline Web Training for Physicians Developed video and text content to train medical, substance abuse and mental health treatment providers on skills for smoking cessation treatment	2015-2016	Vermont Department of Health and Human Services Quitline	Consultant /Contractor	1 hour/week all year	Unknown
Clinical training to integrated physical and behavioral health team	2015-2016	Massachusetts Mental Health Center	Consultant /Contractor	1 hour/month	20
Smoking cessation skills training for in community mental health medical staff. Developed and led a quality improvement program using academic detailing ad	2012-2014	NH Department of Health and Human Services	Developer, Director & Instructor	1 hour/week	100

audit and feedback for New Hampshire community mental health medical staff					
Antipsychotic prescribing skills training Quality improvement series for community mental health medical staff. Developed and led a quality improvement program using academic detailing and audit and feedback for New Hampshire community mental health medical staff	2008-2012	NH Department of Health and Human Services	Developer, Director & Instructor	1 hour/week	100
Psychiatric Research Seminar - focused on research related to treatment and services for people with serious mental illnesses and addictions	2006-2016	Geisel School of Medicine at Dartmouth Dartmouth Psychiatric Research Center, Department of Psychiatry	Clinical Director	2 hours/week 9 mo/year	15-30
Trainings related to integrated treatment of severe mental illness and substance use disorders to organizations across the country	2001-2009	Dartmouth Medical School	National Trainer	1 hour/week Total 50	20-40
Evidence-Based Practice Project Supervised state trainers (Kansas, Ohio, Indiana) for	2001-2005	West Institute, Dartmouth Medical School	National Trainer & Supervisor of Trainers	1 hour/week Total 50	1-50

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integrated treatment of severe mental illness and substance use disorders					

X. **Primary Research Advising**

A. **Undergraduate Students: NA**

Name of Advisee / Mentee	Dates	Name of Program

B. **Graduate Students: NA**

Name of Advisee / Mentee	Dates	Name of Program

C. **Medical Students (directed research)**

Name of Advisee / Mentee	Dates	Name of Program
Jordan Wong	2018 - Present	Psychiatry Research (Student Elective)
Nathan Kung	2018 - Present	Psychiatry Research (Student Volunteer)

D. **Residents/Fellows (directed research)**

Name of Advisee/Mentee	Dates	Name of Program
Minda Gowarty MD	2018-Present	Primary Care T32 Fellowship
Cybele Arsen MD	2018-Present	Psychiatry Residency - DHMC
Elizabeth Schwartz MD	2017-Present	Psychiatry Residency - DHMC
Jeff Reed MD	2016-2018	Psychiatry Residency - DHMC
Robert Cotes MD	2013-2014	Psychiatry Residency - DHMC
Hilary Alvarez MD	2012-2013	Concord Family Medicine Residency
Joelle Ferron	2008-2014	Postdoctoral Fellowship Dartmouth PRC

E. **Others (define)**

Name of Advisee/Mentee	Dates	Name of Program
Andrew Matz	2019-Present	TDI Masters in Public Health
Cornel Stanciu MD Psychiatry Faculty Dartmouth Hitchcock Medical Center	2018-Present	None

Lisa Mistler MD Psychiatry Faculty Dartmouth Hitchcock Medical Center	2016-Present	None
Mary Hynes, RN Psychiatry Research Associate – Geisel School of Medicine	2016-Present	None
Sarah Pratt PhD Psychiatry Faculty Dartmouth Hitchcock Medical Center	2015-Present	None
Sara Hickey, BA Psychiatry Research Associate – Geisel School of Medicine	2015-Present	None
Samual Kosydar, MS Psychiatry Research Associate – Geisel School of Medicine Research volunteer	2015-Present	None
Kelly Aschbrenner PhD Psychiatry Faculty Dartmouth Hitchcock Medical Center	2015-2019	None
Amy Harrington MD Faculty UMass/Community Health	2015-2017	None
Rob Cotes MD Faculty Emory Psychiatry	2014-2018	None
Jen McLaren MD Psychiatry Faculty Dartmouth Hitchcock Medical Center	2014-2018	None

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Laurie Waterman RA Psychiatry Research Associate – Geisel School of Medicine	2014-2018	None
Ann Taggert, BA Psychiatry Research Associate – Geisel School of Medicine	2014-2016	None
Lucas Daniels BA Psychiatry Research Associate – Geisel School of Medicine	2014	None
MaryAnn Greene, MS Psychiatry Research Associate – Geisel School of Medicine	2013-2017	None
Tovah Lieberman Thresholds Research Associate	2013-2015	None
Patricia Calixte-Civil Robert Wood Johnson-Rutgers Research Associate	2013-2015	None
Nino Dzabisachvali PhD Psychiatry Research Associate – Geisel School of Medicine	2013-2015	None
Alison Berest NorthShore Health Research Associate	2013-2015	None
Eric Riley MA Psychiatry Research Associate – Geisel School of Medicine	2011-2018	None
Rosemarie Wolfe, MS	2010-2018	None

Psychiatry Research Associate – Geisel School of Medicine at Dartmouth		
Wendy Martin MD Psychiatry Faculty Dartmouth Hitchcock Medical Center	2010-2012	None
Joelle Ferron PhD Dartmouth MS Psychiatry Research Associate	2009-2014	None
Karen Swain, MA Psychiatry Research Associate – Geisel School of Medicine	2009-2012	None
Pamela Geiger BA Psychiatry Research Associate – Geisel School of Medicine	2007-2018	None
Christopher O'Keefe, MA Psychiatry Research Associate – Geisel School of Medicine	2005-2016	None

XI. Advising/Mentoring (other)

A. Undergraduate Students: NA

Name of Advisee/Mentee **Dates** **Name of Program**

B. Graduate Students:

Name of Advisee/Mentee	Dates	Name of Program
Andrew Matz, MD	2019- Present	The Dartmouth Institute MPH Program
Helen Newton	2018- Present	The Dartmouth Institute PhD program
Jacob Borodovsky	2014-2018	Data Sciences/Co-occurring T32 Training Center

Dustin Lee	2014-16	Data Sciences/Co-occurring T32 Training Center
Saira Nawaz	2010-2012	The Dartmouth Institute PhD Program Dartmouth PRC
Anna Adachi	1999-2002	PhD Training program Dartmouth PRC

C. Medical: NA

Name of Advisee/Mentee **Dates** **Name of Program**

D. Residents/Fellows

Name of Advisee/Mentee	Dates	Name of Program
Jeff Reed MD DH Psychiatry Resident	2015-2017	Psychiatry Residency
Sunny Kim PhD	2015-2017	Dartmouth Data Sciences, CTBH Post Doctoral Fellow
Dustin Lee PhD	2014-2016	Co-occurring disorders T32 Post Doctoral Fellow
Sarah Akerman MD DH Psychiatry Resident	2012-2014	Psychiatry Residency
Julie Frew MD DH Psychiatry Resident	1998-2000	Psychiatry Residency
Ruby Bhangu MD DH Psychiatry Resident	1997-1999	Psychiatry Residency
Wendy Dean MD DH Psychiatry Resident	1996-1998	Psychiatry Residency

E. Non-degree Program Students: NA

Name of Advisee/Mentee **Dates** **Name of Program**

F. Faculty

Name of Advisee/Mentee	Dates	Name of Program
Joelle Ferron PhD Dept of Psychiatry	2014-Present	None
Kelly Aschbrenner PhD Dept of Psychiatry	2014-Present	None

Sarah Akerman PhD Dept of Psychiatry	2014-2016	None
Sarah Pratt PhD Dept of Psychiatry	2012-Present	None
Jeff Fetter MD Dept of Psychiatry	2010-2013	None
Julie Frew MD Dept of Psychiatry	2006-2008	None
Lisa Mistler MD Dept of Psychiatry	2003-2006	None

G. Others (define): NA

Name of Advisee/Mentee	Dates	Name of Program

XII. Engagement, Community Service/Education

Dates	Institution / Organization	Course or Activity Title	Your Role	Hours / Year
2015-2016	Vermont Department of Public Health	Vermont Quitline service website content renovation (provided content to educate providers about tobacco cessation in people with behavioral health conditions)	Leader	120
2006-2008	NH Governors Commission	10-year plan for Mental Health	Member	48

XIII. Research Activities

A. Sponsored Activity (grants and contracts) Present and Past

Dates (start and stop) Project title and award number	Your role % FTE	Sponsoring agency	Annual direct costs of award
2018-2023 **ProHealth NH: New Hampshire Partnerships to Improve Health**	**Science PI 20%** **Admin PD: L'Esperance**	**SAMHSA**	**$1,993634**

& Wellness for Young People with SED and SMI **1H79SM080245-01**			
2018-2021 ACT Together: Using Technology to Facilitate Service Integration for Individuals with Psychiatric Disabilities #90IFDV0005	Co-I 5% PI: S. Lord	NIDDLR	$249,000
2018-2021 Comparative effectiveness of integrated vs. referral-based care for pregnant women with opioid use disorder MAT-2017C2-7717	CO-I 5% PI: S. Lord, D. Goodman	PCORI	$1,060,092
2016-2020 Mental Health Care Under New Payment Strategies 5R01MH109531-03	Consultant and Steering Committee Member PI: Meara	NIMH	$403,109
2016-2020 CSC On Demand - Training for First Episode Psychosis Treatment Teams 4R44MH111283	CO-I 6% PI: Ferrierra	NIMH SBIR	$34,690 TOTAL SUB
2016-2020 The Appeal and Impact of E-cigarettes in Smokers with Serious Mental Illness 1R01DA041416-01A1	CO-I 15% PI- Pratt	NIDA	$461,546

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2016-2017 Connecting Patients and Researchers to Engage in Patient-Centered Vascular Disease Research # 2493-DARTMOUTH	CO-I 2% PI: Faerber	PCORI	$58,489
2015-2020 Northeast Node of the National Drug Abuse Clinical Trials Network 1UG1DA040309-01	CO-I 5% PI: L. Marsch	NIH/NIDA	$467,961
2015-2019 Health Promotion Research Center U48DP005018	Co-I 5% PI: Bartels	CDC	$576,552
2015-2016 Randomized, Double Blind, Placebo-Controlled Trial of the Safety and Efficacy of HORIZANT® (Gabapentin Enacarbil) Extended-Release Tablets for the Treatment of Alcohol Use Disorder LLD HHSN27500003-1061-NCIG6	CO-I 10% PI: Green	NIAAA/Fast-Track Drugs & Biologics	$350,519
2014-2016 **ALK3831-401: A Phase 2, Randomized, Double-blind Study to Evaluate ALKS 3831 in**	**PI (Site PI)** 8%	Alkermes	$120,000

Subjects with Schizophrenia and Alcohol Use Disorder - The Breakaway Study #CTO F14134			
2014-2016 Smoking Cessation Care Management Program VINFEN	Co-I - Consultant 5% PI –Viron	Massachusetts Department of Mental Health	$29,043 SUB-AWARD
2013-2018 **RCT of a Motivational Decision Support System for Smokers with SMI** **R01 R01CA168778**	**PI** **15-30% effort, varying with year**	**NCI**	**$484,632**
2013-2021 Cannabis, schizophrenia and reward: Self-Medication and agonist 1R01DA034699-01	CO-I 10-15% PI: Green	NIDA	$551,367
2013-2016 Improving quality and reducing cost in schizophrenia care with new technologies and new personnel 1C1CMS331052-01-00	CO-I 20% PI: Kane	CMMI	$184,002
2012-2017 Clozapine for cannabis use disorder in schizophrenia R01 DA032533	Co-I 10-15% PI: Green	NIDA	$499,160
2012-2016	CO-I 2-5%	NIDA	$260,454

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Targeting Tobacco Cessation during Treatment for Cannabis Use Disorders R01DA032243	PI: Budney		
2012-2015 **Decision support for smoking cessation in young adults with severe mental illness** **1R21CA158863-01A1**	**PI** **15%**	**NCI**	**$163,488**
2012-2013 **Community Partnership for Computerized Decision Support to Engage Disadvantaged Smokers into Cessation Treatment** **#UL1TR001086**	**PI** **10%**	**SYNERGY Dartmouth**	**$49,854**
2012-2013 Supplement to P50 -Dissecting heterogeneity of treatment response of first episode schizophrenia P50MH080173	CO-I 20% PI: Malhotra	NIMH	$125,472
2011-2020 Family Smoking Prevention and Tobacco Control Act National Longitudinal Study NIDA-11-5568	CO-I 12% PI: J. Sargent	FDA	$270,865
2011 – 2016 **Technology-based Treatments for Substance Use Disorders Pilot #4 Development of a**	**Pilot PI** **5%** **PI: Marsch**	**NIDA**	**$20,000**

prototype smoking cessation website for smokers with schizophrenia **P30DA029926**			
2011-2016 Medicaid Incentives for Prevention of Chronic Diseases 1B1CMS330880-01-00	Co-I 10% PI: Cappuchino & Bartels	Centers for Medicare & Medicaid Services	$1,170,370
2011-2013 Alcoholism and Schizophrenia: A Translational Approach to Treatment R21 AA019534	CO-I 5% PI: Green	NIAAA	$427,053
2011-2012 **A randomized trial of an Electronic decision support system with vs. without carbon monoxide monitor feedback, within Center Grant** **DED H133B100028**	**PI (of Center Pilot)** **10%** **PI COOK**	**NIDRR**	**$99,574** **Sub Award**
2010-2012 A Phase 2, Double – Blind, Placebo Controlled Multisite Trial to Assess the Efficacy of Varenicline Tartrate for Alcohol Dependence in Very Heavy Drinkers NCIG 003	CO-I 10% PI: Litten	NIAAA CSP	$899,973
2010-2012 **An electronic decision support system to reduce smoking-**	**PI** **20%**	**Bristol Meyers Squib Foundation**	**$222,122**

related health disparities among minorities with serious mental illness			
2009-2015 RAISE – Recovery After an Initial Schizophrenia Episode DMS01	Co-I 10% SITE PI: Mueser PI: Kane	NIMH	$307,266
2009-2015 Statewide intervention to reduce early mortality in persons with mental illness R01MH089811	CO-I 10% PI: Bartels	NIMH	$490,000
2009-2012 Cannabis and schizophrenia: Self-medication and Agonist Treatment? R01DA26799	Co-I 15% Pi: Green	NIDA	$498,500
2009-2011 A Phase 2, Double – Blind, Placebo Controlled Multisite Trial to Assess the Efficacy of Levitaciram Extended Release in Very Heavy Drinkers NCIG-002	CO-I 10% PI: Litten	NIAAA CSP	$523,193
2007-2009 Double – Blind, Placebo Controlled Multisite Trial of Quetiapine for the Treatment of Alcohol Dependence	CO-I 10% PI: Litten	NIAAA CSP – 1027	$486,000

CSP-1027			
2006-2010 Interventions for Persons with Severe Mental Illness and Co-Occurring Substance Use Disorders	CO-I 15% PI: Drake	West Foundation	$6,853,723
2004-2010 Risperidone Long-Acting for Alcohol and Schizophrenia Treatment	CO-I 15% PI: Green	Janssen Investigator-Initiated Study	$683,000
2009-2011 A Phase 2, Double – Blind, Placebo Controlled Multisite Trial to Assess the Efficacy of Levitaciram Extended Release in Very Heavy Drinkers NCIG-002	CO-I 10% PI: Litten	NIAAA CSP	$523,193
2005-2008 The STIRR Intervention for Dually Diagnosed Clients R01MH072556	CO-I 15% PI: Rosenberg	NIMH	$495,000
2003-2006 Efficacy of Quetiapine in Treating Patients with Active Substance Use Disorder and Schizophrenia	CO-I 10% PI: Green	Astrozenica Investigator-Initiated Study	$180,000
2003-2007 Schizophrenia and Cannabis: Clozapine vs. Risperidone	CO-I 20% PI: Green	NIDA	$499,000

R01			
2001-2006 The West Institute at the New Hampshire – Dartmouth Psychiatric Research Center 5-37192	National Trainer 15% PI: Gorman	The West Foundation	$1,370,774
2001-2003 The tolerability, management, and neuro-psychiatric side effects of antiviral treatment (PEG Interferon alfa-2b plus Ribavirin) of chronic hepatitis C in persons with SMI	CO-I 10% PI: Rosenberg	Schering-Plough Investigator-Initiated Study	$80,000
2000-2005 National Evidence-Based Practice Project	CO-I PI: Drake	Center for Mental Health Services SAMSHA	$421,417
2000-2003 Integrated Infectious Disease and Dual Disorder Treatment	CO-I 20% PI: Rosenberg	NIMH	$149,000
2000-2002 Parenting Rehabilitation for Women with Severe Mental Illness	PI 20%	National Association for Research on Schizophrenia and Depression Young Investigator Award	$19,000

B. <u>Pending submissions</u>:

Dates (start and stop) **Project title and award number**	**Your role** **%FTE**	**Sponsoring agency**	**Annual direct costs of the award**
Stemming the Tide: The Role of Payment and Delivery System Reform in Combating the Opioid Epidemic 4R01-DA049757-01A1	Co-I PI: Colla	NIDA – R01	$499,683

C. **Clinical Faculty: NA**

XIV. Program Development: NA

XV. Entrepreneurial Activities: NA

XVI. Major Committee Assignments

A. **National/International**

Dates	**Committee Name**	**Your Role**	**Institution/Organization**
2020 – Present	Research DSMB R33 - Persistence targeted smoking cessation in schizophrenia PI- M. Steinberg	Chairperson	RWJ/Rutgers
2018-Present	Medical Director Council	Regional Representative	National Association of State Mental Health Directors
2018	Grant Review Committee Special Emphasis Panel/Scientific Review Group 2018/10 ZCA1 RPRB-Z (O3) S 6/14/2018, National Cancer Institute	Member	NIH
2017 – 2019	Research DSMB R21/33 Varenicline for smoking relapse prevention in schizophrenia	Chairperson	Brown University

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	PI- J. Tidey		
2017	Mental Health Grant Review Committee	Ad Hoc Reviewer 4/2017	The Netherlands Organisation for Health, Research and Development (ZonMw)
2017	Grant Review Committee Special Emphasis Panel/Scientific Review Group 2016/05 Interventions to Prevent and Treat Addictions (IPTA)	Ad Hoc Reviewer 02/11-12/2016; 10/6-7/2016	NIH
2016 -2020	Research DSMB R34 MySafeRx System to opiate replacement therapy PI: Schuman-Olivier	Committee member	Harvard Medical School
2016	Grant Review Committees Special Emphasis Panel/Scientific Review Group 2016/05 Interventions to Prevent and Treat Addictions (IPTA)	Ad Hoc Reviewer 02/11-12/2016	NIH
2016	Grant Review Committees Special Emphasis Panel/Scientific Review Group 2016/05 Interventions to Prevent and Treat Addictions (IPTA)	Ad Hoc Reviewer 10/6-7/2016	NIH
2015	Grant Review Committee National Cancer Institute Program Project Meeting II (P01)	Member	NIH
2015-2018	SRNT 2016 Speaker Review Committee	Member	Society for Nicotine and Tobacco Research
2015	Psychiatric Services, Journal Editor Search Committee	Member	American Psychiatric Association

2013	Review Committee Leveraging existing natural experiments to advance the health of people with severe mental illness (R24)	Member	NIMH
2007-2011	National Advisory Board NIMH IP-RISP grant Recovery Oriented Assertive Community Treatment ACT Center of Indiana	Member	NIMH

B. Regional

Dates	Committee Name	Your Role	Institution/Organization
2010-Present	Committee for the Protection of Human Subjects	Chairperson	State of NH Department of Health and Human Services
2010-2014	Drug Utilization Review Board	Member	State of New Hampshire
2007-2010	Pharmacy and Therapeutics Advisory Committee	Member	State of New Hampshire
2006-2010	Committee for the Protection of Human Subject	Member	State of New Hampshire Department of Health and Human Services
2006-2010	Commission to Develop a Comprehensive State Mental Health Plan	Member	State of New Hampshire Department of Health and Human Services

C. Institutional

Dates	Committee Name	Your Role	Institution/Organization
2019 - Present	T32 Steering Committee	Member	Dartmouth-Hitchcock Medical Center

	HRSA-funded National Research Service Award Postdoctoral Training Program		
2019-2020	SYNERGY Executive Committee	Member	Dartmouth-Hitchcock Medical Center
2019 - Present	SYNERGY Community Engaged Research Community Board	Member	Dartmouth-Hitchcock Medical Center
2017-Present	Grand Rounds Committee Department of Psychiatry	Member	Dartmouth-Hitchcock Medical Center
2017	SYNERGY Community Engagement Research proposal review committee	Member	Geisel School of Medicine at Dartmouth
2013	Gary Tucker Junior Faculty Research Award Department of Psychiatry	Review committee member	Dartmouth-Hitchcock Medical Center
2012 - Present	Pilot Studies Proposals grant review committee Department of Psychiatry	Member	Dartmouth-Hitchcock Medical Center
2006 – Present	Research Committee Department of Psychiatry	Member	Dartmouth-Hitchcock Medical Center
2005 – 2006	Community Education Planning Committee - Dartmouth Evidence-Based Practice Center	Member	Dartmouth Medical School
1998 - 2001	Substance Abuse Committee	Member	Mental Health Center of Greater Manchester
1996 - 1997	Infectious Disease/Psychiatry Liaison Work Group	Member	Dartmouth Medical School

1995 - 1998	OB-GYN /Psychiatry Liaison Work Group	Member	Dartmouth Medical School
1995 - 1996	DRG Work Group	Member	Dartmouth Medical School
1995 - 1996	Curriculum Subcommittee, Graduate Education Committee Department Psychiatry	Member	Dartmouth Medical School
1994 - 1997	Graduate Education Committee Department Psychiatry	Member	Dartmouth Medical School

XVII. Memberships, Office and Committee Assignments in Professional Societies

Dates	Committee Name	Your role	Institution/Organization
2018 – Present	Medical Director Council	Regional representative to Executive Committee	National Association of State Mental Health Program Directors
2016 - Present		Member	International Society of Internet Research
2015 - Present		Member	Schizophrenia International Research Society
2006 – Present		Member	National Association of State Mental Health Medical Directors
2006 - Present		Member	Society for Nicotine and Tobacco Research
1991 - Present		Member	American Medical Association
1991 - Present		Member	American Psychiatric Association

XVIII. Institutional Center or Program Affiliations:

Dates	Committee Name	Your Role	Institution/Organization
2018-Present	Laboratory of Clinical and Translational Neuropsychopharmacology	Medical Director	Dartmouth-Hitchcock Geisel School of Medicine at Dartmouth
2017-Present	The C. Everett Koop Institute at Dartmouth	Member and research faculty	Geisel School of Medicine
2015-Present	Northeast Node Clinical Trials Network	Faculty and co-Investigator	Geisel School of Medicine
2011-Present	Center for Technology and Behavioral Health	Faculty and co-Investigator	Geisel School of Medicine
2006-2018	Psychopharmacology Research Group	Medical Director	Dartmouth-Hitchcock Department of Psychiatry
2005 - 2015	NH-Dartmouth Psychiatric Research Center	Faculty	Geisel School of Medicine

XIX. Editorial Boards

Dates	Society/Journal	Your role
2010-Present	Journal of Dual Diagnosis	Associate Editor
2006-2010	Mental Health and Substance Use: Dual Diagnosis	Associate Editor

XX. Journal Referee Activity

Dates	Society/Journal	Your Role	Frequency of Review
2018-Present	Preventive Medicine	Reviewer	1-2x yearly
2018-Present	Journal of Smoking Cessation	Reviewer	1x yearly
2017-Present	Experimental and Clinical Psychopharmacology	Reviewer	1-2x yearly
2017-Present	Patient Preference and Adherence	Reviewer	1x yearly
2017-Present	Neuropsychiatric Disease and Treatment	Reviewer	1x yearly
2015-Present	Internet Interventions	Reviewer	1x yearly
2015-Present	Journal of Medical Internet Research (JMIR)	Reviewer	1-3x yearly

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2015-Present	Early Intervention in Psychiatry	Reviewer	1-3x yearly
2013 – Present	JAMA Psychiatry	Reviewer	1-3x yearly
2012 – Present	Addiction	Reviewer	1-2x yearly
2010-Present	Drug and Alcohol Dependence	Reviewer	1-4x yearly
2010-Present	Journal of Psychopharmacology	Reviewer	1-2X yearly
2009-Present	Journal of Addiction Medicine	Reviewer	1-2x yearly
2009-Present	Schizophrenia Research	Reviewer	1-4x yearly
2008-Present	Nicotine and Tobacco Research	Reviewer	1-6x yearly
2006–2010	Mental Health and Substance Use: Dual Diagnosis	Reviewer	1-6x yearly
2007–Present	Progress in Neuro-Psychopharmacology & Biological Psychiatry	Reviewer	1x yearly
2007–Present	Alcohol and Drug Review	Reviewer	1-2x yearly
2006-Present	Human Psychopharmacology: Clinical and Experimental	Reviewer	1-2x yearly
2006-Present	American Journal of Psychiatric Rehabilitation	Reviewer	1-2x yearly
2006-Present	American Journal of Preventive Medicine	Reviewer	1-2x yearly
2005-Present	Journal of Dual Diagnosis	Reviewer	6x yearly
2004-Present	Psychopharmacology	Reviewer	1x yearly
2004-Present	Psychiatric Services	Reviewer	1-4x yearly
2004-Present	Medical Care	Reviewer	1x yearly
2004-Present	Journal of Substance Abuse Treatment	Reviewer	1-4x yearly
2004-Present	Journal of Mental Health	Reviewer	1x yearly

2004-Present	Journal of Community Psychology	Reviewer	1x yearly
2004-Present	International Journal for Quality in Health Care	Reviewer	1x yearly
2000-Present	Community Mental Health Journal	Reviewer	1-2x yearly

XXI. Awards and Honors

Date	Award name
2014	New Hampshire Psychiatric Society Leadership Award
2013	2012 Teaching Excellence in Continuing Medical Education Award
1999	Red Ribbon Award for HIV Research, nominated by NH Division of Behavioral Health, Awarded by Granite State AIDs Consortium
1998	Teacher of the Year, Dartmouth Hitchcock Medical Center, Department of Psychiatry, Residency Training Program
1997	Invited Participant-American Psychiatric Association Research Colloquium for Young Investigators
1991	Outstanding Young Women of America
1990	Tartar Fellowship in Psychiatry, Oregon Health Sciences University
1988	J. M. Scholars in Alcoholism and Drug Dependencies Scholarship, Oregon Health Sciences University

XXII. Invited Presentations

Indicate with an asterisk (*) those presentations to which you, individually, were extended an invitation to present.

Indicate with a hashtag (#) those presentations that were meetings where you may have presented a poster/talk, but not following a personalized invitation (i.e., at a large society meeting).

Indicate with a carat (^) if the talk/presentation was applicable as a CME activity.
Feel free to provide further annotation if you wish: for example, an invited presentation was a keynote talk or distinguished lecture.

A. International

Date	Topic/Title	Sponsoring Organization	Location

2019	*^ Digital approaches to address tobacco use disorder in schizophrenia and SMI" (Part of "Tobacco in Schizophrenia, Still a Burning Problem" symposium)	Schizophrenia International Research Society (SIRS) 4/11/19	Orlando, FL
2017	#^ Simple computerized strategies for young adult smokers with severe mental illness	Society for Research on Nicotine and Tobacco	Florence, Italy
2016	# How do people with mental illness engage with technology treatment tools?	International Society of Research on Internet Interventions (ISRII) Annual Conference 4/2016	Seattle, WA
2015	#^ Improving antipsychotic pharmacotherapy via educational outreach to prescribers across a state mental health system	American Psychiatric Association	Toronto, Canada
2015	#^ Implementing coordinated specialty care for persons with first episode psychosis in community clinics.	American Psychiatric Association	Toronto, Canada
2015	#^ Using technology to improve access, quality and outcomes: tobacco treatment in mental health settings	12th Workshop on Costs and Assessment in Psychiatry Mental Health Policy and Economics Research: Improving Access, Quality and Outcomes	Venice, Italy
2015	# ^ Preventing the progression of tobacco use disorder in schizophrenia	15th International Congress on Schizophrenia Research	Colorado Springs, CO, USA
2015	^ Facilitators and Barriers to Implementation	15th International Congress on	Colorado Springs, CO, USA

		Schizophrenia Research	
2009	*^ Co-occurring chronic psychosis and substance use disorder	CINP Thematic meeting	Edinburgh, Scotland
2006	*^ Implementing integrated dual disorder treatment for persons with co-occurring severe mental illness and substance use disorder	NIAAA symposium at Meeting of the American Psychiatric Association	Montreal Canada
2004	*^ Integrated Dual Disorder Treatment	McGill University Medical School	Montreal, Canada
1999	*^ Double Trouble - Treatment Issues for Persons with Dual Disorders	Link 99 Regional Psychiatry Conference	Prince Edward Island, Canada
1999	*^ Treatment of Women with Dual Disorders	Regional Substance Abuse Conference	Prince Edward Island, Canada

B. National

Date	Topic/title	Sponsoring Organization	Location
2020	Integrated care for young people with serious mental illness	National Association of Mental Health Medical Directors	Webinar
2020	#^Tobacco use and respiratory symptoms among US adults: Findings from the Population Assessment of Tobacco and Health Study Longitudinal Study	Society for Nicotine and Tobacco Research, 3/14/2020	New Orleans, LA
2019	#^ Novel Approaches to Reach Disadvantaged Smokers with Serious Mental Illnesses in Community Settings " (Part of "Reaching Underserved Smokers: New Strategies and How to Implement Them" panel)	College on Problems in Drug Dependence (CPDD) 6/15/2019	San Antonio, TX

2019	A multicomponent intervention for smoking cessation among young people with serious mental health conditions.	Addiction2019 Conference 11/1/19	Tampa FL
2019	* Facts about medical marijuana and mental illness	National Association of State Mental Health Program Directors (NASMHPD) National Webinar Series 2/26/19	
2018	* ^ Treating tobacco use disorder in disadvantaged populations	UVM VT Center for Health and Behavior, 11/2018	Burlington, VT
2018	* Treating co-occurring disorders for people with schizophrenia-spectrum disorders	Research Questions and Opportunities related to treatment and recovery in Severe Mental Illness, Sponsored by NIMH and SAMHSA 11/23-4/18	Bethesda, MD
2018	*^ Incentives for smoking cessation among people with serious mental illness (Part of "An Empirical and Practical Look at Medicaid Incentives to Encourage Healthy Behaviors: What We Do and Don't Know," Panel)	Policy Roundtables Panel, presentation at the 2018 Annual Research Meeting of the Academy Health, 6/24-26/18	Seattle, WA
2018	*^ Smokers with psychiatric comorbidities (Part "Today's Smokers: New Challenges in a Changing Population" Preconference Workshop)	Society for Research on Nicotine and Tobacco Research, 2/2018	Baltimore, MD
2018	*^ First Episode Psychosis: On the Ground Lessons Learned	The National Council for Behavioral Health	Washington DC

		Natcon18 conference, 3/2018	
2016	#^ Technology interventions for disadvantaged populations	Society for Behavioral Medicine 3/2016	Washington DC
2015	* Comprehensive integrated treatment for first episode psychosis: Implementing coordinated specialty care	Substance Abuse and Mental Illness Administration-sponsored Webinar series Strategies for Funding Coordinated Specialty Care Initiatives 6/30/2015	Webinar
2015	*^ Myths about smoking in people with mental health conditions	University of Minnesota, Treatment for People with Co-occurring Disorders Webinar series, 3/2015	Webinar
2015	#^ Are people with schizophrenia responsive to tobacco regulation efforts?	Annual meeting of the Society for Research on Nicotine and Tobacco Research (SRNT) 3/2015	Philadelphia, PA
2015	*^ Technology tools to improve smoking cessation outcomes in people with mental Illness	Grand Rounds UMDNJ-Rutgers Department of Psychiatry 2/2015	Brunswick, NJ
2014	#^ Academic detailing with audit and feedback to decrease prescribing of high weight gain antipsychotic medications	At the 7th Annual Conference on the Science of Dissemination and Implementation 12/2014	Bethesda, MD
2014	#^ Electronic cigarettes: Friend, foe, or uneasy ally to the addiction psychiatrist?	American Academy of Addiction Psychiatry Annual Meeting 12/2014	Miami, FL
2014	Electronic Decision Support to motivate smoking cessation treatment in people with serious mental illness	State-of-the Science Conference University of Illinois at Chicago, 10/2014	Chicago, IL

2014	^ Changing Organizational Culture, Physician Prescribing, and Consumer Engagement in a System-wide Health Promotion Intervention to Reduce Early Mortality in High Risk Adults with Serious Mental Illness and Obesity	Research In Pursuit of a Learning Mental Health Care System Symposium MHSR 4/2014	Bethesda, MD
2014	Improving health through innovative approaches to treating tobacco in the mental health setting	Research In Pursuit of a Learning Mental Health Care System Symposium MHSR 4/2014	Bethesda, MD
2013	*^ Web-based decision support for smokers with schizophrenia	National Institutes of Health, Improving smoking cessation treatment for people with schizophrenia conference	Rockville, MD
2012	*^ Developing electronic tools for addiction in people with cognitive impairments	Annual meeting for American Academy of Addiction Psychiatry	Miami, FL
2012	Group academic detailing to improve antipsychotic prescribing in a community mental health system	Academic Detailing Exchange Teleconference– Use of data to identify and target interventions	Boston MA
2012	*^ Computerized decision support promotes smoking cessation treatment among adults with mental illness	Association for Psychological Science Symposium Technology-Based Approaches to Assessment and Treatment of Substance Use and Mental Health Disorders: State of the Empirical Evidence	Chicago IL
2011	*^ Computerized treatment and decision support: Implications for dissemination"	NIH 4th Annual Conference on the Science of Dissemination and Implementation: Policy and Practice	Bethesda MD

2010	* Helping Clients Manage Medication	Hazelden Co-Occurring Disorders National Webinar	Webinar
2010	* Stages of change in addiction treatment	New York State Office of Mental Health Educational Program	Webinar
2010	* Biological aspects of co-occurring mental illness and substance use disorders	Continuing Educational Program, Community Connections	Washington DC
2009	Implementation of Integrated Dual Disorder Treatment: A Qualitative Analysis.	Symposium Integration of Services for Co-Occurring Mental Health and Substance Use Disorders. Conference on Integrating Services, Integrating Research for Co-Occurring Conditions	Florida
2009	* Recovery After Initial Schizophrenia Episode – the EQUIP Intervention	National Association of State Mental Health Program Directors (NASMHPD) Winter 2009 Commissioners Meeting	Washington DC
2009	* Smoking cessation for patients with serious mental illness	Thresholds, Chicago continuing education phone conference	Illinois
2008	* Co-occurring ADHD and stimulant use disorders	Connecticut State Mental Health Medical Staff phone case conference.	Connecticut
2008	* Co-occurring bipolar and opiate use disorders	Connecticut State Mental Health Medical Staff phone case conference	Connecticut
2008	* Co-occurring bipolar and alcohol use disorders	Connecticut State Mental Health Medical Staff phone case conference	Connecticut

2008	* Co-occurring psychotic and substance use disorders	Connecticut State Mental Health Medical Staff phone case conference	Connecticut
2008	* Mental health & illness	NH District Court Judge's Conference	Portsmouth, NH
2008	*^ Integrated treatment of people with co-occurring serious mental illness and substance use disorders: Skills for prescribers	Connecticut State Mental Health Medical Staff conference	Hartford CT
2007	*^ Integrated treatment of people with co-occurring serious mental illness and substance use disorder: Information for prescribers.	Kansas Community Mental Health Association Annual Meeting	Wichita, KS
2007	*^ Innovations in the treatment of individuals with co-occurring serious mental illness and substance use disorders	Thresholds Science, Service and Recovery Conference	Chicago, IL
2007	* Integrated treatment of co-occurring severe mental illness and substance use disorder – Information for and about prescribers	SAMHSA Cosig Treatment Planning and Approaches Workgroup, Phone Lecture	
2005	* Recruitment and retention in dual disorder medication trials	National Institute of Alcohol Abuse and Alcoholism "Methodology of Conducting Pharmacologic Clinical Trials in Patients with Alcohol/Drug Dependence and Psychiatric Comorbidity" Workshop	Bethesda, MD
2005	*^ Treatment of dual disorders in residential settings" and "Psychopharmacology for dual disorder	Boulder Community Mental Health Center	Boulder, CO

2005	*^ Integrated Dual Disorder Treatment Overview and Psychopharmacology	Continuing education for community mental health prescribers	Minneapolis, MN
2005	*^ Integrated Dual Disorder Treatment: Medication Treatment for Persons with Dual Disorders	Continuing education for prescribers in public mental health programs,	New Haven and Hartford, CT
2005	^...A Public Health Approach to Infectious Disease in Persons with SMI and Substance Use Disorders (Presidential Symposium: Addressing Hepatitis C and Related Blood-Borne Diseases in Persons with Severe Mental Illness)	American Psychiatric Association Annual Meeting	Atlanta, GA
2005	^ Dual Diagnosis: The Scope of the Problem (Psychosocial Intervention for Dual Diagnosis Panel)	American Psychiatric Association Annual Meeting	Atlanta, GA
2005	Implementing Integrated Dual Diagnosis Treatment: Lessons Learned	SAMHSA/CSAT/CMHS Treatment for homeless program Technical Assistance Workshop	Bethesda, MD
2005	*^ "Integrated Dual Disorder Treatment, Motivational Interviewing, and Prescribing for Persons with Severe Mental Illness and Substance Use Disorders	Continuing education for community mental health prescribers	New Jersey
2005	*^ Psychopharmacology for the Treatment of Co-Occurring Mental Illness and Substance Use Disorders	American Psychiatric Nurse Association's Clinical Psychopharmacology Institute	Boston, MA
2004	* Relapse Prevention Counseling for Persons with Severe Mental Illness and Substance Use Disorders	Long Island Mental Health Centers Continuing education	Islet, NY

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2004	^ Integrated Dual Disorder Treatment.	Annual Meeting of the American Psychiatric Association	New York, NY
2004	* Integrated Dual Disorder Treatment: Overview and Implementation Planning	Boulder Community Mental Health Center Continuing education	Boulder, CO
2004	* Integrated Dual Disorder Treatment: Information for Prescribers	Continuing education for prescribers in community mental health centers	Bridgeport and Middletown, CT
2003	* Substance Abuse Counseling for Persons with Severe Mental Illness and Substance Use Disorders	Long Island Mental Health Centers Continuing education	Islet, NY
2003	Management and Treatment of Hepatitis C in Patients with Severe Mental Illness	Schizophrenia and Medical Comorbidity Conference Chesapeake Health Education Program	Baltimore, MD
2003	Attending to the Nuisance Variables at the Outset: Developing and Disseminating EBPs for Parents with Mental Illness and Their Families.	National Association of State Mental Health Program Directors Research Institute, Inc Developing an Evidence-Based Culture to Reform Systems meeting	Baltimore, MD
2003	The National Evidenced Based Practices Project	National Association of State Mental Health Program Directors Research Institute, Inc; Developing an Evidence-Based Culture to Reform Systems	Baltimore, MD
2003	Depression in the Treatment of Hepatitis C	Cape Cod Hospital Grand Rounds	Cape Cod, MA

2003	* Integrated Dual Disorder Treatment; Psychopharmacology in Integrated Dual Disorder Treatment; and Motivational Interviewing	Indiana University-Purdue University	Indianapolis, IN
2003	* Best Practices in the Treatment of Persons with Co-Occurring Mental Illness and Substance Abuse * Cognitive-Behavioral Substance Abuse Counseling	Wellspring Continuing Education Meeting	Louisville, KY
2002	Integrated Dual Disorder Treatment: Recovery	At Recovery Works! Implementing A Recovery-Oriented System of Care Conference	Hartford, CT
2002	Hepatitis and HIV in Public Mental Health	National Association of State Mental Health Program Directors Research Institute Annual Meeting	Baltimore, MD
2002	* Integrated Dual Disorder Treatment: Train the Trainers	West Institute	Cleveland, OH
2002	* Treatment of Hepatitis C in Persons with Severe Mental Illness	National Institute on Drug Abuse (NIDA) Co-occurring Hepatitis C, Substance Abuse, and Psychiatric Illness: Addressing the Issues and Developing Integrated Models of Care	Washington DC
2001	* Integrated Treatment of Substance Abuse and Mental Illness	Statewide conference on Evidence-Based Practice	Springfield, IL

C. Regional/Local

Date	Topic/title	Sponsoring Organization	Location
2020	First episode psychosis and suicide	Youth Suicide Prevention Assembly	Webinar

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2020	Tobacco, vaping and COVID-19	Integrated Care: New Hampshire Integrated Delivery Network and ProHealth NH	Web-based conference
2020	Population health strategies to improve treatment engagement and outcomes	ProHealth New Hampshire	Webinar
2019	* Using disease registries to improve health care outcomes	New Hampshire Integrated Delivery Network Learning Community, 11/2019	Concord NH
2019	*^ There's an app for that, but is it usable? Apps for smoking cessation among young people with mental illness (with Minda Gowarty)	KOOP Conference 9/27/2019	Lebanon, NH
2019	Update on Vaping and Marijuana – how to effectively intervene among young people	ProHealth NH conference, 9/18/19	Concord, NH
2019	* Community-Engaged Research at Dartmouth SYNERGY	YouthMove, 4/2019	Concord, NH
2019	*^ Medical Marijuana and People with Behavioral Health Conditions	New Hampshire Hospital Grand Rounds, 4/2019	Concord, NH
2019	* Smoking cessation - What's new?	Co-Op Regional Primary Care Network, January 26, 2019	Stowe, VT
2018	* Treatments for substance use disorders: Alcohol, cannabis and tobacco	NH Behavioral Health Summit, December 10-2018	Manchester, NH
2018	* Implementation of an online smoking cessation engagement tool	Implementation Science and Digital Therapeutics, December 18, 2018	Hanover NH
2018	* Technology tools for tobacco use disorder	Ninth Annual Thematic Meeting on Addiction, September 28, 2018	Lebanon, NH

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2018	*^ Treating Alcohol Use Disorder in Women	New England Perinatal substance use learning collaborative lecture series, July 2018	Webinar
2018	Comorbid cannabis use disorder and mental illness - Medical and Recreational Marijuana: Pandemic or Panacea?	NH DHHS series 4/12/2018	Concord, NH
2018	*^ Pharmacotherapy of Alcohol Use Disorde"	Clinical Trials Network Regional Learning Webinar, 3/2018	Webinar
2018	*^ Evidence-based use of antipsychotics in children Presented with Jennifer McLaren	Annual Northeast Regional Psychiatric Nursing Conference, 4/2018	Concord, NH
2018	*^ Tobacco and SMI – What's the harm?	Grand Rounds, Mental Health Center Greater Manchester, 1/2018	Manchester, NH
2017	* Treating tobacco use disorder in opioid dependent pregnant women	OB-GYN regional learning collaborative Webinar 7/2017	Webinar
2016	*^ E-cigarettes - FDA Regulation and Harm Reduction	8th Annual Koop Tobacco Treatment Conference 9/2016	Lebanon NH
2016	* Myths about smoking and mental illness - having the conversation	NAMI NH Annual Conference, 4/2016	Concord, NH
2016	Substance abuse in first episode psychosis.	Psychiatric Research Seminar 6/2016	Lebanon NH
2015	*^ Debunking the myths of treating nicotine dependence in the mental health population	6th Annual Koop Tobacco Treatment Conference, 9/2015	Fairlee VT

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2014	* Mental health in our community	Riverbend Community Mental Health Center Town Hall 9/2014	Concord, NH
2014*	Web-based motivational decision support and tobacco treatment."	10th Annual Dartmouth Symposium on Substance Use "Emerging Technologies to Advance Prevention & Recover,"	Hanover, NH
2014	Tobacco control in schizophrenia	Department of Psychiatry Grand Rounds 10/2014	Dartmouth Hitchcock Medical Center, Lebanon, NH
2013	*...Tobacco in mental illness: Motivation, treatment and technology	Norris Cotton Cancer Center Grand Rounds, Dartmouth Hitchcock Medical Center	Lebanon, NH
2013	*^ Smoking and quitting: Patients with HIV, mental illness, and addictions	AIDs seminar, Dartmouth Hitchcock Medical Center	Lebanon, NH
2012	*^ Helping smokers with mental illness quit	Grand Rounds, New Hampshire Hospital	Concord, NH.
2012	*^ Smoking cessation in outpatient mental health practice	Dartmouth Hitchcock Medical Center Department of Psychiatry, Half day seminar	Lebanon, NH
2012	Nicotine dependence in severe mental illness: Motivation, treatment and technology.	Dartmouth Hitchcock Medical Center, Psychiatry Grand Rounds	Lebanon, NH
2012	*^ Engaging disadvantaged smokers into cessation treatment	NH Public Health Association Fall Forum	Concord, NH
2011	Your health: common problems, their causes, and what to do about them	NH Bureau of Behavioral Health, DHHS Live Long Feel Great Consumer Conference	Concord, NH

2011	* Mental illness and substance use disorders - Information for legal professionals	NH Public Defender Continuing Education Conference	Concord, NH
2010	* What does nicotine have to do with mental health?	Dartmouth Hitchcock Medical - Healthy Minds Across American 2010, Discovering Hope Through Science	Lebanon, NH.
2010	* Mental illness – Information for Mental Health Courts	Rockingham County Mental Health Council	Brentwood, NH
2010	* Health Promotion and Antipsychotic Prescribing Quality Improvement for High-Risk Disparity Population	ONE MHSIP (Mental Health Statistics Improvement Program) Regional Meeting	Exeter, NH
2009	*^ Identification and integrated treatment of co-occurring mental illness in patients with substance use disorders	NH Alcohol and Drug Abuse Counselors Association Annual Meeting	Manchester, NH
2009	*...Co-occurring mental illness and substance use disorder	New Hampshire Legislative Executive Departments and Administration Committee hearing	Concord, NH.
2009	*^ Medication efficacy in the treatment of patients with co-occurring disorders	New Hampshire Hospital Grand Rounds	Manchester, NH
2009	Helping patients with serious mental illness quit smoking – Electronic decision support systems	Psychiatric Research Seminar	Lebanon, NH
2009	^ Antipsychotic effect on substance use in schizophrenia	Dartmouth Medical School - Toward Optimal Treatment for Schizophrenia and Co-	Fairlee, VT

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		Occurring Alcohol Use Disorder conference	
2008	^ Treatment of psychosis: the landscape in 2008 and beyond	Dartmouth Medical School Update on Antipsychotics	Hanover, NH
2008	^...Co-occurring substance use disorder in schizophrenia	Dartmouth Medical School Update on Antipsychotics	Hanover, NH
2007	"Randomized trial of telephone medical management for alcohol dependence"	Dartmouth Medical School Dartmouth Psychiatric Research Center Research Seminar	Lebanon, NH
2007	"Nicotine dependence in serious mental illness"	Dartmouth Medical School Dartmouth Psychiatric Research Center Research Seminar	Lebanon, NH
2007	"Nicotine dependence in serious mental illness"	Dartmouth Medical School Dartmouth Psychiatric Research Center Research Seminar	Lebanon, NH.
2003	* Assessing, Monitoring, and Stages of Change in Dual Disorders	Riverbend Community Mental Health Center	Concord, NH.
2002	What is Integrated Family Treatment and Why Should You Provide It?	NH DHHS Statewide conference for community mental health organizations: Mental illness and parenting: Supports for families	Manchester, NH

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2002	* Integrated Family Treatment	University of Massachusetts Meeting for the Center for Mental Health Services Research	Worcester, MA
2002	* Integrated Dual Disorder Treatment; Substance Abuse Counseling"	Mental Health Center Greater Manchester Community Mental Health Grand Rounds	Manchester, NH
2001	* Mental Illness and Parenting – Supports for Families, Legal Rights for Families	NAMI NH Conference and Annual Meeting	Manchester, NH
2001	* Mental Illness and Parenting	New Hampshire Bar Association Meeting, Family Law Section	Concord, NH
2000	* Integrated Family Treatment"	University of Massachusetts Consortium for Treatment for Parents with Mental Illness	Worcester, MA
2000	Integrated Treatment for Infectious Disease and Dual Disorders: Developing A Model Intervention	3rd New Hampshire HIV/AIDs, Chemical Dependency, Mental Illness & Housing Conference	Waterville Valley, NH
1999	* Pharmacotherapy of Anxiety in Persons with Severe Mental Illness	Mental Health Center of Greater Manchester Staff Development and Training Seminar	Manchester, NH
1999	*^ Treatment Issues for Women with Dual Disorders	New Hampshire Hospital, Grand Rounds	Concord NH

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1999	* Eating Disorders - Identification, Assessment and Treatment	Mental Health Center of Greater Manchester, Grand Rounds	Manchester, NH
1999	*^ Postpartum Depression	Dartmouth Medical School Continuing Education Conference for OB-Gyn providers	Hanover, NH
1998	Postpartum Depression - Identification and Treatment	Gifford Memorial Hospital OB-GYN and Family Practice Meeting	Randolph, VT
1998	*^ Substance Abuse During Pregnancy	Dartmouth Hitchcock Medical Center OB/GYN CME Conference	Lebanon, NH
1998	* Postpartum Depression	Dartmouth Medical School OB-GYN Grand Rounds	Lebanon, NH
1997	* Faces of Depression - Depression During the Menopause	Dartmouth Medical School Panel Discussions	Hanover, NH
1997	*^ HIV Risk in Persons with Severe Mental Illness	Dartmouth Medical School Psychiatry Grand Rounds	Lebanon, NH
1997	* More About Prozac	Dartmouth College Health Awareness Program	Hanover, NH
1996	* Current Assessment and Treatment of Women with Eating Disorders	Dartmouth Medical School Panel Discussions	Lebanon, NH

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1996	*^ Recognition and Treatment of Depression in Primary Care	Upper Valley Society of Nurse Practitioners	Lebanon, NH
1995	*^ Dissociation in Labor and Delivery	Dartmouth Medical School OB-GYN Conference	Lebanon, NH
1995	* Social Skills Training	Dartmouth Medical School Department of Psychiatry Continuing Education Seminar	Lebanon, NH
1995	* Women and Alcohol	Dartmouth Medical School Internal Medicine Seminar	Lebanon, NH

XXIII. Bibliography

Provide information as indicated below:

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).

1. **Brunette** MF, Ferron JC, McGurk SR, Williams JM, Harrington A, Devitt T, Xie H. Randomized trial of brief, web-based interventions to motivate smokers with schizophrenia. JMIR Mental Health. 7(2):e16524. Feb 8, 2020. doi:10.2196/16524 PMID: 30135797

   This work demonstrates the ability of tailored digital interventions to engage smokers with schizophrenia into effective cessation treatment as effectively as in- person interventions. Such interventions provide a cost-effective, alternative approach to increase smoking cessation activity in this difficult-to-engage population with high health morbidity and early mortality due to smoking.

2. **Brunette** MF, Cotes R, DeNesnera A, McHugo G, Dzebisashvili N, Xie H, Bartels S. Use of academic detailing with audit and feedback to improve antipsychotic pharmacotherapy. Psychiatric Services. 69(9): 1021-1028, 2018 Jun 8. doi: 10.1176/2018 PMID 29879874.

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This work provides the field with an evidence- based strategy for improving antipsychotic pharmacotherapy to reduce cardiometabolic burden among patients in community practice. It also identifies subpopulations among whom changing treatments may be most feasible.

3. **Brunette** MF, Pratt S, Sigmon SC, Scherer E, Kosydar S, Ferron JC, Williams G, Santos M, Wolfe R, Lotz D, Bartels S, Cappuchino K. Interventions for smoking cessation among Medicaid beneficiaries with severe mental illness. Psychiatric Services. 69(3):274-280. Published online: November 15, 2017. doi.org/10.1176/appi.ps.201700245
   This is the only large randomized controlled trial demonstrating the benefit of financial incentives added to smoking cessation treatment among people with serious mental illness in real world community practices. We showed that adding incentives to community treatment is a safe, effective approach to enhance outcomes, providing key evidence to support use of this technique more broadly.

4. **Brunette** MF, Ferron JC, Robinson DR, Coletti D, Geiger P, Greene M, Ziedonis D, Drake R, McHugo GJ. Brief web-based interventions for young adult smokers with severe mental illnesses. Nicotine & Tobacco Research. 20(10):1206-1214. Online October 14, 2017. doi.org/10.1093/ntr/ntx190
   This study was one of the first to demonstrate the readiness of young adult smokers with serious mental illness to address their smoking. This is important, as young people stand to benefit the most for quitting smoking prior to the development of chronic health conditions.

5. **Brunette** MF, Mueser KT, Meyer-Kalos P, Rosenheck R, Babbin S, Correll CU, Cather C, Robinson DG, Schooler NR, Penn DL, Addington J, Estroff SE, Marcy P, Robinson J, Severe J, Klein C. Azrin, S.Heinssen, R. Kane JM. Demographic and Clinical Correlates of Substance Use Disorders in First Episode Psychosis. Schizophrenia Research. 194:4-12, 2018 Apr. doi: 10.1016/j.schres.2017.06.039. Epub 2017 Jul 8. PMID:28697856
   This large study provides a current estimate of the prevalence of substance use and use disorders among American patients with first episode psychosis. As the U.S. is rapidly expanding treatment for this population, this work provides important data for planning how to address problematic substance use in this population.

2. All other publications (excluding any listed in part 1) as noted in b-d below:
   b. Original peer-reviewed articles.
   MUST in indexed journals (e.g., Web of Science, PubMed etc.).

In press/Under review

Wong J, Pratt SI, Ferron JC, Gowarty M, Brunette MF. Characteristics and reasons for e-cigarette use among smokers with schizophrenia/schizoaffective disorders. Under Review, Psychiatric Services

Pratt SI, Brunette MF, Santos M, Ferron JC, Sargent J, Xie H Randomized trial to evaluate the appeal and impact of e-cigarette provision on cigarette smoking in smokers with serious mental illness. Under review, American Journal of Psychiatry

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*Newton H, Busch SH, **Brunette** M, Maust DT, O'Malley, J, Meara ER. Innovations in Care Delivery for Patients with Serious Mental Illness Among Accountable Care Organizations. Under Review, Psychiatric Services*

*Homan P, Schooler N, **Brunette** MF, Rotondi A, Ben-Zeev D, Gottlieb, JD, Muser KT, Achtyes ED, Gingerich S, Marcy P, Meyer-Kalos P, Hauser M, Majnu J, Robinson DG, Kane JM. Relapse prevention through health technology reduces hospitalization in schizophrenia. Under Review, JAMA.*

*Newton H, Busch S, Maust D, **Brunette** M, O'Malley J, Meara E. After 15 years of evidence to support collaborative care to treat depression and anxiety in primary care settings, just 17 percent of ACOs are using collaborative care models. Under review, Medicine.*

*Robinson DG, Schooler NR, Marcy P, Gibbons RD, Brown CH, Kim JB, John M., Mueser KT, Penn DL, Rosenheck RA, Addington J, **Brunette** MF, Correll CC, Estroff SU, Meyer-Kalos P, Gottlieb JD, Glynn SM, Lynde DW, Gingerich S, Pipes R, Miller, AL, Severe, JB, Robinson J, Severe JB, Kane JM. Outcomes during and after early intervention services for first-episode psychosis: Results over five years from the RAISE-ETP cluster randomized trial Under Review, American Journal of Psychiatry.*

6. Gowarty, MA, Kung NJ, Maher AE, Longacre MR, **Brunette** MF. Perceptions of Mobile Apps for Smoking Cessation Among Young People in Community Mental Health Care: Qualitative Study JMIR Formative Research, October 2020.

7. **Brunette** MF, Correll CU, O'Malley S, McDonnell D, DiPetrillo L, Jiang Y, Simmons A, Silverman BL, Citrome L, Green AI. ALKS 3831 in schizophrenia and comorbid alcohol use disorder: A phase 2 randomized clinical trial. Journal of Clinical Psychiatry. 81(2):19m12786. March 20, 2020. Doi: 10.4088/JCP.19m12786.

8. Aschbrenner KA, Naslund, JA, Tomlinson EF, Kinney A, Pratt SI, & **Brunette** MF. Adolescents' use of digital technologies and preferences for mobile health coaching in mental health settings. Frontiers in Public Health. 7:178. July 2019. doi:10.3389/fpubh.2019.00178 PMID 31312629

9. Bianco C, Pratt S, Ferron JC, **Brunette** MF. Electronic cigarette use during smoking cessation treatment among smokers with mental illness. Journal of Dual Diagnosis. 15(3): 184-191. Published online June 6, 2019. doi: 10.1080/15504263.2019.1620400.

10. Pratt SI, **Brunette** MF, Wolfe RS, Scherer EA, Xie H, Bartels S, Ferron JC, Capuchino, K. Incentivizing healthy lifestyle behaviors to reduce cardiovascular risk in people with serious mental illness: An equipoise randomized controlled trial of the wellness incentives program. Contemporary Clinical Trials. 18:1-10. Published online April 13, 2019. doi: 10.1016/j.cct.2019.04.005.

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d. Books/book chapters/monographs

Indicate by (*) any works that are serial revisions of an original contribution (i.e., with successive editions. If the work involves substantive updates of the information, this should be noted.

1. Schwartz E, **Brunette** MF, Green AI. Co-occurring substance use disorder and schizophrenia. In: Textbook of Substance Abuse, 6th Ed. Brady KT, Levin FR, Galanter M, and Kleber HD. American Psychiatric Press, In Press for 2020

2. Pratt SE, Bennett M, **Brunette** MF. Co-occurring substance use and other psychiatric disorders. In: Essentials of Schizophrenia. Edited by JA Lieberman, S Stroup, D Perkins, and L Dixon. American Psychiatric Press, 2019 (Updated from 2011)

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B. Other scholarly work in print or other media:

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1. Editorially-reviewed publications (e.g., Op-Ed pieces, Letters to the Editor)
2. Print resources (e.g., workshops)
3. Electronic resources (e.g., MOOCs, educational websites, modules, videos, virtual patients).
4. Large-team publications on which you have a role that is not author(define/describe contribution)
5. White papers/position papers
6. Others (define)

Include all pertinent information for each (e.g., all authors, your contribution; dates and sites) and for educational media provide names of schools/institutions in which they are utilized, as well usage numbers (e.g., downloads, 'hits') if available.

1. Talley RM, **Brunette** MF, Adler DA, Dixon LB, Berlant J, Erlich MD, Goldman B, First MB, Koh S, Osline DW, Siris SG. Telehealth and the Community SMI Population. J Nerv Ment Dis. Published online 7 October 2020. https://pubmed.ncbi.nlm.nih.gov/33003053/.

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C. Abstracts (include both oral, exhibit and poster presentations):
Indicate with (#) abstracts that were reviewed (e.g., by a professional society) prior to being accepted for presentation.

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1. *#**Brunette** MF, Pratt SI, Gowarty M, Capuchino K. Community smoking cessation treatment for disadvantaged Medicaid beneficiaries: Estimated costs and projected health care savings. Society for Nicotine and Tobacco Research Annual Meeting New Orleans LA, 2020*
2. *#Gowarty M, **Brunette** MF. Usability and Acceptability of the NCI's Smoking Cessation Apps among Young People in Community Mental Health Care. Society for Nicotine and Tobacco Research Annual Meeting, New Orleans LA, 2020*
3. #Gowarty M, Kung N, Maher A, **Brunette** MF· Evaluating Mobile Apps for Smoking in Young People In Community Mental Health Care. Poster presentation for Vermont Center on Behavior and Health Conference, Burlington VT, Oct 11, 2019
4. #Halenar MJ, Edwards KC, **Brunette** MF, Woloshin S, Schwartz L, Emond J, Tanski S, Taylor KA, Cummings KM, Hyland A, Liu J, Pierce J, Goniewicz M, Niaura R, Travers M, Anic G, Chen Y, Callahan-Lyon P, Gardner LD, Thekkudan T, Borek N, Kimmel HL, & Sargent JD. Tobacco use and respiratory symptoms among US adults: Findings from the Population Assessment of Tobacco and Health Study Longitudinal Study. Poster presentation for the Tobacco Regulatory Science Meeting, Bethesda, MD 2019
5. # **Brunette** MF, Gowarty M, Sigmon S, Xie H, Wolfe R, Pratt SI. Abstinence incentives with community treatment: impact on relapse among disadvantaged smokers with mental illness. Poster presentation for the annual meeting of the Society for Research on Nicotine and Tobacco, San Francisco, CA, 2019
6. # Achtyes E, Pratt SI, Stilwell K, Opperman M, **Brunette** M. Technology use among patient with severe mental illness in community settings. Poster presentation for the annual meeting of the American Society of Community Psychiatry, 2018
7. # Bianco, C. Pratt SI, **Brunette** MF, Ferron J. Relationship between cognition and nicotine dependence in smokers with mental illness. Poster presentation for Annual meeting of the Society for Neuroscience, 2018
8. # Ferron J, Aschbrenner K, Geiger P, **Brunette** MF, Society Why don't young adult smokers with severe mental illnesses use cessation treatment? Attitudes, social norms, perceived behavioral control Poster presentation for the Annual Meeting of the Society for Research on Nicotine and Tobacco, 2018
9. # Ferron, JC, Kelly, S, Pratt, SI, Adachi-Mejia, A, & Brunette, MB (2018). Mobile App Pilot for Low Income Smokers Trying to Quit. Poster Presentation at the Koop Conference, 2018
10. # Whitton AE, Green AI, Pizzagalli DA, Williams J, **Brunette** MF. Poster presentation for the Annual Meeting of the Society for Biological Psychiatry, 2017
11. # **Brunette,** MF, Correll, CU, Silverman, BL, Simmons, A, Jiang, Y, DiPetrillo, L, McDonnell, D, Green AI. A Phase 2, Randomized, double-blind study of ALKS 3831 in Schizophrenia and co-occurring alcohol use disorder. Poster presentation for American College of Neuropsychopharmacology, 2017

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12. # Aschbrenner KA, Schneider A, Nasland J, **Brunette** MF, O'Malley J. Smoking in the social networks of adults with serious mental illness enrolled in cessation treatment at mental health centers. Society of Behavioral Medicine, 2017

13. # Ferron, JC, Aschbrenner, K, **Brunette,** MF, Pratt, SI, & Scherer, E (2017) Do Social Context And Social Support Help Financially Disadvantaged Smokers With Severe Mental Illness Quit? Poster Presentation at the Annual Meeting for the Society for Research on Nicotine and Tobacco, 2017

14. # **Brunette** MF, Ferron J, Robinson D, Colletti D, Devitt T, Geiger P, Greene MA, Gottlieb J, Ziedonis D and McHugo G. Brief web-based motivational decision support For young adult smokers with severe mental illnesses. Society for Research on Nicotine and Tobacco, 2017

15. # **Brunette** MF, Pratt S, Scherer E, Capuchino K, Lotz D, Ferron JC, Sigmon S, Kosydar S, Bartels SJ. Cash to Quit? Treatment with incentives for cessation in disadvantaged Medicaid recipients with mental illness. Society for Research on Nicotine and Tobacco, 2017

16. # Pratt SI, **Brunette** MF, Santos M, Sargent J. What's e-cigarettes got to do with it? Electronic cigarette use among smokers with severe mental illness SRNT Society for Research on Nicotine and Tobacco, 2017

17. # Ferron, JC, **Brunette,** MF, McHugo, GJ, Adachi-Mejia, A, & Bartels, S. Are top-rated quit smoking mobile Apps usable by people with Schizophrenia? Poster Presentation at the Annual Meeting for the Society for Research on Nicotine and Tobacco, 2016

18. # **Brunette** MF, Robinson D, Tidey J. Do people with schizophrenia respond to tobacco regulatory efforts? Society for Research on Nicotine and Tobacco, 2015

19. # Brunette MF, Ferron J, Robinson D, Colletti D, Devitt D, Geiger P, Greene MA, Gottlieb J, Ziedonis D, and McHugo G. Brief web-based motivational decision support for young adult smokers with severe mental illnesses. Society for Research on Nicotine and Tobacco, 2015

20. # Pratt S, Sargent J, Santos M, Gilbert N, **Brunette** M. Pilot study of E-cigarette Use Among Chronic Cigarette Smokers with Schizophrenia or Bipolar Disorder. Society for Research on Nicotine and Tobacco, 2015

21. # **Brunette** M, Robinson D, Coletti D, Malhotra A. Tobacco product use among young people with recent onset schizophrenia. Annual Conference on Tobacco Regulatory Science, 2014

22. # McLaren J, **Brunette** MF, McHugo G, Daviss WB. Metabolic Monitoring of Children on Antipsychotics: A National Survey of Child Psychiatrists. Poster presentation at the American Psychiatric Association, 2014

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23. # **Brunette** MF, Akerman, S, Ferron JC, Dzebisashvili, N Xie H, Bartels S. Improving cessation pharmacotherapy via videoconference educational outreach to prescribers. Poster presentation at the Annual Meeting of the Society for Research on Nicotine and Tobacco, Seattle 2014

24. # Fischer, A. Green AI, Rother R, **Brunette** M. Effects of Smoked Cannabis and Oral Delta-9-tetrahydrocannabinol on Functional Connectivity of Reward Circuitry in Patients with Schizophrenia. Poster presentation at the 24th Annual Meeting of the American Neuropsychiatric Association, Boston 2013

25. # **Brunette** MF, Akerman S, Dawsen R, Leonardo R, O'Keefe C, Green AI. Quetiapine-mirtazapine for alcohol use disorder. Poster presentation at American Society of Clinical Psychopharmacology (formerly NCDEU), 2013

26. # Green A, Fischer A, Roth R, Whitfield-Gabrieli S, Gulick D, **Brunette** M. Developing treatments for schizophrenia and co-occurring substance use disorder: targeting brain reward circuitry. Poster presentation at the American Society of Clinical Psychopharmacology (formerly NCDEU), 2013

27. # Ferron JC, **Brunette,** MF. Use of Community Based Treatment and Abstinence after a Motivational Intervention for Smoking Cessation among adults with Serious Mental Illness. Poster Presentation at the Annual Meeting for the Society for Research on Nicotine and Tobacco, 2013

28. Fischer AS, Whitfield-Gabrieli S, Roth RM, **Brunette** MF, Barton KA, O'Keefe C, Green AI. The Effects of Cannabis and Dronabinol on Resting State Connectivity of the Brain Reward Circuit in Patients with Schizophrenia and Cannabis Use Disorder. Poster presentation at the annual Neuroscience Day, Dartmouth Medical School, 2012

29. #**Brunette** MF, O'Keefe C, Narasimhan M, Noordsy D, Wojcik J, Green AI. Randomized trial of clozapine for cannabis use disorder in schizophrenia. Poster presentation at the International Congress on Schizophrenia Research, 2011

30. # **Brunette** MF, Ferron JC, Drake RE, McHugo G. Web-based motivational interviewing and decision support. Poster presentation at the 4th Annual NIH Conference on the Science of Dissemination & Implementation, Baltimore, 2011

31. # Ferron JC, **Brunette** MF A Website Designed to Motivate and Educate Adults with Severe Mental Illness to Quit Smoking. Poster presentation at the Annual Conference of the Society for Social Work and Research, Tampa, 2011

32. # **Brunette,** M., Dawson R, O'Keefe, C.D., Noordsy, DL, Green, A. Clozapine vs. other antipsychotics for schizophrenia and co-occurring cannabis use disorder. Poster presentation for the International Congress on Schizophrenia Research, and abstract in Schizophrenia Bulletin, 37(1): 297, 2010

33. Narasimhan M, **Brunette** MF, Dawson R, O'Keefe CD, Weeks MH, Buckley PF, Green AI. Long-acting Risperidone for Schizophrenia and Co-Occurring alcohol Use Disorder. Poster

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and Abstract for the 12th International Congress on Schizophrenia Research. Schizophrenia Bulletin, 35(suppl 1): 343, 2009

34. Green AI, **Brunette** MF, Dawson R, Narasimhan M, Wallace A, Herz M, Sommi R, Buckley P, R-LAST Study Team. Oral vs. Long-acting Injectable Risperidone in Schizophrenia and Co-Occurring Alcohol Use Disorder. Poster presentation at the American College of Neuropsychopharmacology Annual Meeting and Abstract in Neuropsychopharmacology, 34, 2009

35. **Brunette** MF, Green AI, Buckley P, O'Keefe C. Quetiapine for the treatment of patients with schizophrenia and Alcohol disorder. Poster presentation for the International Congress on Schizophrenia Research and abstract in Schizophrenia Bulletin, 2009

36. # Ferron, JC & **Brunette** MF. Usability Pilot of a Smoking Cessation Decision Support Tool for People with Serious Mental Illness. Poster Presentation at the Conference on Integrating Services, Integrating Research for Co-Occurring Conditions, 2009

37. # **Brunette** M, Drake RE, McHugo G, Green AI. Clozapine Use and Relapses of Substance Use Disorder Among Patients with Co-occurring Schizophrenia and Substance Use Disorders. Poster presentation at the Annual meeting of the American Psychiatric Association, 2006

38. # Roston D, Schorr M, Neal R.M, Dion M, Bailey G, Kirk E, **Brunette** M. Challenges and outcomes of an obstetrics & gynecology/Psychiatry Liason group. Poster presentation at the annual meeting of the American Society for Psychosocial Obstetrics and Gynecology, Feb 1996

XXIV. Personal Statement (March 2020)

The overarching goals driving my work at Geisel are: 1) to promote high quality clinical care through mental health administration and medical education, and 2) to develop scientific knowledge that will improve treatments for people with co-occurring serious mental illness (SMI), substance use disorders, and chronic health conditions.

As a half-time administrator, I lead innovations in community mental health administration that improve clinical care for co-occurring chronic health conditions and addiction in SMI. I am interested in developing, testing and implementing novel, scalable ways to promote whole health recovery for people with SMI. My work as Medical Director of the Bureau of Mental Health Services in the New Hampshire (NH) Department of Health and Human Services (DHHS) has advanced community mental health administration in the U.S and internationally by demonstrating novel approaches to promote physical health and addiction recovery in community clinics serving people with SMI. For example, to address the many untimely deaths due to cardiovascular and pulmonary diseases in this group, I initiated a novel, statewide educational outreach program for clinicians to mitigate medication side effects on health. I demonstrated that this intervention improved side effect monitoring and reduced polypharmacy in key populations. In addition, using a randomized controlled trial, I demonstrated that this educational outreach method for improving clinical care was effective when delivered via videoconference. My work has demonstrated models to improve system-wide care that can be used nationally and internationally.

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To address poor access and quality of physical health care among people with SMI in NH, I led a state committee to recommend models of integration of community mental health and primary care clinical services. This work informed a Medicaid waiver to implement Integrated Delivery Networks that are improving quality of clinical care for people with SMI in NH. In 2018, I obtained a $10 million, 5-year grant from the Substance Abuse and Mental Health Administration (SAMHSA) for the state of NH to implement and study "reverse integration" of primary care in community mental health clinics. Our program is the first to address integration among transitional age youth and young adults with SMI, including a special focus on LGBTQ young people. Additionally, I have established a novel, national integration learning community with leaders from all 13 states with SAMHSA integration grants. This work facilitates state integration efforts across the U.S. and will provide the field with novel information on how integrated care is implemented by states.

I lead a novel research program aimed at harnessing digital innovation to improve and expand treatment for tobacco use disorder in people with SMI. Smoking is an important driver of early mortality in this group that was barely addressed when I began my career. Since then I have conducted novel, independent research with national colleagues to develop and test usable, effective, and scalable digital treatments for tobacco use disorder in schizophrenia and SMI. We deployed extensive user engagement to better understand the attitudes, beliefs, illness impairments, and user requirements of SMI smokers. This informed the design of the first easily usable computer or smart phone interfaces developed for tobacco interventions for disadvantaged smokers with SMI in community clinics. After completing a series of studies on our motivational education intervention, I am partnering with a small business on an STTR application to transform our research interventions into a commercial product that can be marketed to health systems and Medicaid insurances. Additionally, I am interested in determining effective strategies for young people with SMI -- within our SAMHSA award, we are now testing community coaching and incentives with cessation apps from NCI for young smokers with SMI who have grown up using smartphone technology. My work in tobacco treatment for people with SMI has increased the field's readiness to test and use digital innovations to address tobacco use disorder in this group.

I advance the field's understanding of tobacco use disorder in SMI by conducting research examining previously unexplored patterns of tobacco product use and their impact on health, cessation and persisting addiction. The U.S. Population Assessment of Tobacco and Health (PATH) survey study provides tremendous opportunity for learning about the interplay between mental health, physical health, addiction and tobacco product use trajectories. I participate in national teams conducting this type of work. However, the PATH study may not reach people with SMI and did not evaluate whether people had SMI. I have therefore deployed components of this survey in my own research in people with SMI – allowing my team to conduct novel investigations of tobacco flavors and product use, patterns of use, and addiction in SMI smokers. My work, and that of a handful of researchers mostly in the U.S. and Australia, has pushed the field forward to better and more fully address tobacco use disorder in people with SMI.

I contribute unique skills and perspectives to national teams conducting large or complex clinical trials aimed at improving treatment for SMI. Engaging administrators, clinicians and patients in teams with researchers enhances the quality and relevance of research. I have participated on such teams from these perspectives. For example, I was member of the leadership team for the NIMH-funded Recovering After Initial Schizophrenia Episode – Early Treatment Program (RAISE-ETP) study of a coordinated specialty care for people with first episode psychosis. In another example of team science, I brought together researchers, including many RAISE-ETP partners, to test a suite of digital treatments for schizophrenia. In this large, Center for Medicaid and Medicare Innovation (CMMI)-funded study, we found that these treatments reduced re-

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hospitalization compared to usual care. Additionally, as research medical director, I led a series of studies in which we tested medications aimed at reducing substance abuse in people with schizophrenia, with the goal of ameliorating a hypothesized underlying brain reward function deficit associated with this disorder. In each of these areas, I provided a unique community engagement perspective as well as expertise in co-occurring disorders in designing studies, writing the proposals, engaging community organizations, implementing the research, interpreting the findings, conducting secondary analyses and presenting the work.

I provide unique contributions to medical education in community mental health, research, traditional clinical training and community engagement. Regarding community mental health education, I have published three practical clinician handbooks designed to educate community clinicians, two of which were components of larger toolkits for organizations implementing integrated treatment for people with co-occurring addiction and mental illness. The third is a handbook designed to help community behavioral health providers improve their ability to address co-occurring physical health conditions in patients with behavioral health disorders. Additionally, as Medical Director in NH DHHS, I have developed and delivered educational programs for medical staff and state leaders and received a NH Psychiatric Leadership Award, in part for these activities. Both the RAISE-ETP and CMMI projects described above led to a new partnership with Center for Social Innovation (CSI). With CSI, we developed and are testing a multimedia, distance-learning program for first episode psychosis treatment teams.

In the realm of research education, I teach and supervise students, residents, fellows and junior faculty, resulting in trainee co-authorship on over 20 papers. I am a faculty member on two T32 research training programs and serve on the leadership team of one of these programs. I have received awards for teaching and maintained excellence in this area; in a recent grand rounds, attendees rated my ability to deliver information effectively a 4.8 out of 5.

In recognition of my expertise in engaging stakeholders in research, I was appointed Director of the Dartmouth SYNERGY Clinical and Translational Science Award (CTSA) community engagement core. I work with other core leaders, our Community Advisory Board, and our core team to implement a variety of activities that train, engage, support and catalyze various stakeholders (clinicians, patients, etc) in Dartmouth research, and that also will advance the science of community engagement and multidisciplinary teams in research more broadly.

Leading efforts in both administration and research has created synergies benefiting all aspects of my work. My experiences in community mental health administration in NH, and with collaborators nationally, steers my research towards developing evidence that fuels practical solutions to improve community treatments. Likewise, my academic endeavors have enhanced my administrative approaches to maintain and improve the quality of clinical services for people with SMI and co-occurring conditions. Both activities foster my capacity to provide and develop resources for high quality medical education that supports excellent clinical care.

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CHRISTINE M. POWERS, LICSW, MLADC

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Professional Summary

Licensed social worker with an array of experience including direct care in the community mental health setting, inpatient care at the state psychiatric hospital, private practice clinician, and a consultant supporting, monitoring, and training direct care staff and other state stakeholders.

Education & Credentials

Southern New Hampshire University — Received May 2005
Bachelor of Liberal Arts: Psychology — GPA: 3.63 Psych GPA: 3.89

University of New Hampshire — Received May 2009
Master in Social Work, Clinical concentration — GPA: 3.70

NH Licensed Independent Clinical Social Worker (LICSW) #1619
NH Master Licensed Alcohol & Drug Counselor (MLADC) #1158

Work History

Dartmouth-Hitchcock Medical: *Program Director for EBP Services* **2017 – present**

- Provides consultation, training & fidelity reviews regarding EBPs of Supported Employment (SE), Assertive Community Treatment (ACT), & Illness Management and Recovery (E-IMR)
- Conducts and coordinates training, consultation and fidelity evaluation for Community Mental Health Center administrators, supervisors and direct service staff for above EBPs
- Provides ongoing consultation to the NH Bureau of Mental Health Services regarding strategies for facilitating the sustained implementation of Evidence Based Practices.

Christine M. Powers, LICSW, LLC: *Owner / Clinician* **2011 - present**

- Provide independent family and individual counseling to adults, children, and families.
- Trained in many evidence-based practices to provide care
- Provide consult and LICSW supervision

New Hampshire Hospital: *Senior Psychiatric Social Worker* **2010 - 2017**

- Social worker on adult and children admission units w
- Provided group therapy, family meetings, assessments, admission/discharge planning, legal proceeding assistance, & collaborated w/community providers and other State programs daily
- Provided supervision to MSW students, and trained new MSW employees

Riverbend CMHC: *FIT Clinician/Case Manager* **2009 - 2010**

- Family therapist and intensive case manager of FIT (Family Intensive Team) working with families and children who have severe mental illnesses and are prone to hospitalization
- Carried out office and home-based family and individual therapy, community outreach, parenting work, crisis management, & collaboration with other community providers

Pine Haven Boys Center: *Residential Counselor* **2005 – 2009**

- Residential counselor at a therapeutic group home with boys ages 7 to 14
- Helped to develop structure & growth, managed behavior, & communicated with families
- "Staff-in-charge," providing supervision to staff from 10/2007-5/2009

Riverbend CMHC: *MSW Clinician Intern* **2007 – 2008**

- Practicum intern as an outpatient child clinician, maintaining an ongoing caseload
- Offered counseling to child, adolescents and families, carried out intakes and assessments, developed treatment plans, & facilitated girl's social skills groups

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Kathryn McDonnell, MSW

[redacted]

Professional Summary

MSW with over 30 years of experience working in community mental health in NH, most of which involved supervision and management of clinical teams, incorporation and dissemination of evidenced based practices, and clinical review and consultation in complex situations.

Work History

DARTMOUTH HITCHCOCK MEDICAL CENTER

Trainer and Consultant for NH Community Mental Health Centers (CMHC) **2020 - present**

Provide training and consultation in evidenced-based practices (EBPs) to NH CMHC staff. Responsible for conducting fidelity reviews of the EBPs at the 10 CMHCS. Provide written evaluation and targeted trainings to improve practices within the NH State mental health system.

Public Awareness Coordinator, Dartmouth Trauma Interventions Research Center **2019**

Worked as part of a research team on increasing the community's ability to identify, engage and serve at-risk and trauma-affected families with evidence-based early intervention services.

WEST CENTRAL BEHAVIORAL HEALTH

Instructor – Mental Health First Aid **2013 - present**

Certified instructor of an education program designed to enhance mental health literacy, combat stigma, and help participants recognize and respond to warning signs of a mental health challenge. Certified to teach the Youth, Adult, Higher-Education, Public Safety, and Older Adult modules of this course.

Director of Clinical Quality Improvement **2006 - 2018**

Responsible for tracking, analyzing and reporting on clinical outcomes of EBPs and quality improvement efforts within the organization. Provided agency-wide trainings on evidenced based practices. Reviewed all clinical adverse events and consulted on high-risk cases. Worked with Senior Management and the Board of Directors on identifying areas to target for improvement and setting the organization's Strategic Planning goals.

Program Director **1995 - 2006**

Responsible for the day to day oversight of a community mental health program treating roughly 250 adults with severe and persistent mental illness. Provided supervision and training to all clinical and administrative staff, established and monitored program budget, and worked to ensure quality and effective services.

Case Manager **1990 – 1995**

Education

Master of Social Work **1999**

University of New Hampshire, Durham, NH

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Bachelor of Science, Psychology **1990**

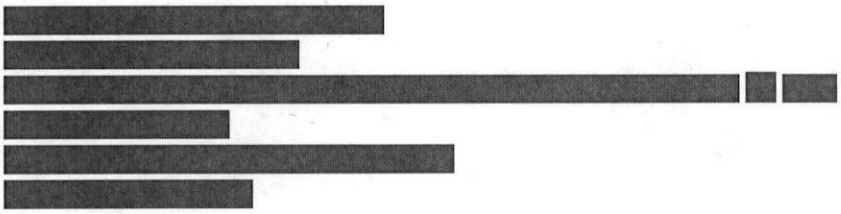
St. Lawrence University, Canton, NY

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CURRICULUM VITAE

Name: Erin R. Barnett, Ph. D.

Address:



Date prepared: January 13, 2022

I. Education

2008-2009 Clinical Psychology Pre-Doctoral Intern, Dartmouth Medical School

2006-2009 University of Missouri-St. Louis Ph.D., Clinical Psychology

2004-2006 University of Missouri-St. Louis M.A., Clinical Psychology

2000-2004 University of Nebraska-Omaha B.A., Psychology

II. Post-doctoral training

2009-2010 Dartmouth Medical School / VA's National Center for PTSD

III. Academic appointments

2013-current Department of Psychiatry, Geisel School of Medicine at Dartmouth, Assistant Professor

2017-current The Dartmouth Institute for Health Policy and Clinical Practice, Assistant Professor

IV. Institutional Leadership Roles NA

V. Licensure and certification

2015 Certified Trauma-Focused Cognitive Behavioral Therapy clinician

2014 Rostered Child Parent Psychotherapy clinician

2010 Licensed clinical psychologist NH #1206

VI. Hospital Appointments

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2016-current Psychologist, Dartmouth-Hitchcock Medical Center

VII. Other professional positions

2009-2013 VA's National Center for PTSD Research Psychologist

2009-present West Central Behavioral Health Psychologist/Clinician (15% FTE)

VIII. Professional Development

Completed NIH grant writing workshop, by J. Robertson, 2018

Completed Writing Seminar hosted by TDI, R. Drake, S. Woloshin, L. Schwartz, 2018

Certified in Trauma Focused Cognitive Behavioral Therapy, an evidence-based treatment for children experiencing trauma, 2015

Rostered in Child Parent Psychotherapy, an evidence-based treatment for young children and caregivers with trauma and attachment problems, 2013

IX. Teaching activities

A. Undergraduate Medical Education NA

B. Graduate Education

2018	Geisel School of Medicine The Dartmouth Institute for Health Policy and Clinical Practice	Master's of Public Health	Co-director, Social and Behavioral Determinants of Health, 55 students

C. Undergraduate Medical Education NA

D. Graduate Medical Education

2019	Geisel School of Medicine at Dartmouth	Building shared decision making in child psychiatry	Seminar lecturer, 60 min
2012-present	Geisel School of Medicine at Dartmouth	Early childhood trauma and attachment	Seminar lecturer, 60 min Annual
2012-present	Geisel School of Medicine at Dartmouth	PTSD in children and adolescents	Seminar lecturer, 60 min Annual
2009-2017	Geisel School of Medicine at Dartmouth	Acceptance and Commitment Therapy	Seminar lecturer, 60 min Annual

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2009-present	Geisel School of Medicine at Dartmouth	Trauma Seminar for psychology interns	Facilitator, 90 min weekly seminar

E. Other Clinical Education

2021-present	CBT supervision Juliette Madan, Psychiatry Fellow	Clinical Supervisor	Bi-monthly supervision
2016-present	Trauma-Informed Early Childhood Services	Developer, Presenter	Nine 6-hour trainings
2013-2017	Trauma-Focused Cognitive Behavioral Therapy	Co-presenter	Four 2-day trainings
2013-2017	Child-Parent Psychotherapy	Co-presenter	Four 2-day trainings
2012-2017	Clinical supervisor, clinical psychology interns (4) and doctoral fellows (1)	Clinical Supervisor	Dept. of Psychiatry, Geisel West- Central Behavioral Health

F. Graduate Teaching

2018	Social Determinants of Health	Co-course director	The Dartmouth Institute MPH residential program

G. Other Professional/Academic Programs

2010-2011 UNH/ Granite State College, Taught two 12 hour courses and one 6 hour course to foster parents and professionals on child trauma and traumatic stress

X. Primary Research Advising

A. Undergraduate students

2019	Brendon Lee, BS	Research advisor for summer internship	Carleton College

B. Graduate students

2021-2022	TDI MPH Independent Learning Experience, Accelerated Master's Urvya Iyer	Thesis Research Advisor	The Dartmouth Institute
2021	TDI MPH spring intern Philip Hession	Preceptor/ Research Advisor	The Dartmouth Institute

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2020	TDI MPH spring intern Kieshan Amarakaran	Preceptor/ Research Advisor	The Dartmouth Institute
2019	TDI MPH spring intern Chibuzo Aguwa	Preceptor/ Research Advisor	The Dartmouth Institute
2018	TDI MPH spring intern Tanya Butt	Preceptor/ Research Advisor	The Dartmouth Institute
2017-2019	TDI MPH student Alissa Trepman	Research Advisor	The Dartmouth Institute
2017-2018	Capstone Research Advisor, TDI MPH program 10 students	Research Advisor (10% FTE)	The Dartmouth Institute

C. Medical students

D. Residents/Fellows

2016-2017	Sarah Cleary, post-doctoral fellow	Research Supervisor	Dept of Psychiatry, Geisel
2014-2015	Katrin Neubacher, post-doctoral fellow	Research Supervisor	Dept of Psychiatry, Geisel

XI. Advising/Mentoring

A. Undergraduate

2021	Joslin Wainwright, BA	Senior spring internship supervisor	Colby-Sawyer College
2016	Aubree Kozie, BA	Senior spring internship supervisor	Bennington College

B. Graduate students

C. Medical students

D. Residents/Fellows

2020-2021	Christina Moore, MS	pre-doctoral intern Professional development advisor	Dept. of Psychiatry, Geisel
2019-2020	Rachel Herman, MS	pre-doctoral intern Professional development	Dept. of Psychiatry, Geisel

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advisor

E. Faculty

2021-current	Kaitlyn Ahlers, PhD	Junior faculty Professional development, Named mentor on foundation grant application	Dept. of Psychiatry, Geisel
2020-current	James T. Craig, PhD	Junior faculty Mentored NIH R34 proposal	Dept. of Psychiatry, Geisel

XII. Engagement, Advocacy, Community Service, Community Education

2021	Presented to The Vermont Collaborative on Adverse Childhood Experiences. The Collaborative is a community-based organization that engages VT middle and high school youth aiming to learn about and prevent substance misuse in themselves and others. 1.5 hours.
2020	Videography interview for *TIME documentary, The Opioid Diaries: Born in Withdrawal*, with Diane Tsai, producer. 4 hours.
2020	Partnered with NH New Futures child advocate Cheryl Avery to draft and support NH legislative bill, proposed by Rep William Marsh to promote improved oversight around the use of psychotropic medications for NH children in foster care
2018-Current	Invited to present to the Leadership Upper Valley on Adverse Childhood Experiences and the Workplace, Annual. 1 hour.
2019	Content expert for the Public Health Council of the Upper Valley legislative meeting with 30+ bi-state legislators focused on child abuse and neglect, 2 hours
2018	Interviewed for *Psychology Today* for a piece about over-medication of youth in foster care in NH following release of the DHHS Office of the Inspector General report naming NH as having one of the top 5 highest prescription rates to this population, by Devon Frye. 1 hour
2018	Interviewed for *Slate Magazine* for a piece about over-medication of immigrant/refugee children detained at Shiloh treatment center at the border, by D. Engber. 1 hour
2018	Led community support initiative at the Claremont Recovery Center through partnership with local church. 2 hours
2017	Led community fundraiser for West-Central Behavioral Health Child Claremont Clinic through partnership with local business. 3 hours
2017	Panel expert following *Resilience* documentary, with focus on child and community trauma. The Red River Theater, Concord, NH. 3 hours

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2016 Interviewed for the *Dartmouth Alumni Magazine* for a piece about trauma and PTSD, After the Fire, S. Spencer-Rendahl. 1 hour

2009-2010 US DHHS SAMHSA's National Child Traumatic Stress Network, Breakthrough Series Collaborative to improve placement stability for local children in foster care. 34 hours (2 two day meetings; monthly community meetings, bimonthly consultation calls)

XIII. Research Activities

A. Sponsored Activity (Grants and Contracts)

CURRENT

1. Key personnel

US Department of Health and Human Services, Administration for Children Youth and Families Children's Bureau
90CU0109-01-00 Jankowski & Barnett (co/m-PIs) 10/1/19 – 9/30/24
Partners to Promote Safety, Permanency and Well-Being for Families Affected by Substance Use (P2P)
The primary goals of P2P are to improve the safety, permanency, well-being, and family functioning of children 0-18 yrs in or at-risk for being placed outside the home due to parental substance use, and to improve engagement and addiction treatment outcomes for parents and caregivers. The target region for P2P activities spans two rural neighboring counties (Grafton and Sullivan) of New Hampshire.
Role: Co/Multi Principal Investigator, 25% FTE $460,000 annual directs ($2.0 million total direct)

US Department of Health and Human Services, Substance Abuse and Mental Health Administration
1H79SM082302-01 Jankowski (PI) 9/1/19 – 8/30/24
Project Launch Upper Valley: Promoting a Healthy Start for Young Children and their Families
We aim to increase our community's ability to identify, engage and serve at-risk and trauma-affected families with evidence-based early intervention services, with an eventual goal of influencing early childhood policy and practice in two Northern New England states. Project Launch UV will focus activities at four tiered levels by raising public awareness and decrease stigma for young children's BH needs; screening of children 0-8 and their caregivers in six primary care clinics, and providing trauma-informed care training to the workforce (e.g., early education and care, health, BH); providing targeted supports to enhance engagement and increase access to care, and provide expert BH consultation for our professional workforce that serves young children and their caregivers; and building capacity for two evidence-based parenting interventions
Role: Co-investigator, 25% FTE $524,000 annual directs ($2.6 million total directs)

DHHS Administration for Children and Families Jankowski and Barnett (co-m/PIs) 10/1/21 – 9/30/26
90CO1099/01
Improving Care for Children and Youth in NH with Trauma and Intellectual and Developmental Disabilities
Our goal is to improve outcomes for children and youth ages 0-21 with intellectual and developmental disabilities, including autism (IDD) who are affected by trauma, across the state of New Hampshire.
Role: co/m-Principal Investigator, 30% FTE $260,000 annual directs ($1.3 million total directs)

PAST

US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration
1H79SM081151-01 Barnett (PI) 10/1/18-9/30/21
Upstream Upper Valley: Increasing early childhood mental health and trauma awareness among community health and service providers

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The *Upstream* project will provide evidence-based mental health and trauma training and consultation to health, community, and service professionals serving young children and families across 3 counties in NH and VT. Our primary goal is to increase the capacity for identification of trauma and mental health needs in young children and link families to needed services.
Role: Principal Investigator, 20% FTE $113,000 annual directs ($342,000 total directs)

US Department of Justice, Office of Justice Programs, Office for Victims of Crime Barnett (PI)
Moving Upstream: Building a Trauma-Informed Community Response for Our Youngest Victims of the Opioid Crisis in Cheshire County
2018-V3-GX-0078 Barnett (PI) 10/1/18-9/30/21
Our overall goal is to enhance our community response to children ages 0-8 years victimized by our opioid crisis through expert training, consultation and coalition activities that implement trauma-sensitive practices across multiple sectors serving young children and families across the county.
Role: Principal Investigator, 15% FTE $133,000 annual directs ($366,000 total directs)

Patient-Centered Outcomes Research Institute Barnett (PI) 8/1/17 – 7/31/18
5093717-012
Developing Patient-Driven Research to Improve the Psychiatric Care of Youth in Foster Care
The goal of this PCORI project is to build community engagement and capacity toward the generation of comparative effectiveness research ideas that build and evaluate patient-driven psychiatric practices for youth in foster care.
Pipeline to Proposal: Tier II.
Role: Principal Investigator, 8% FTE $20,000 directs

DHHS Administration for Children and Families Mullen, Jankowski (co/m-PIs) 10/1/13 – 9/30/18
90C01115/01
The NH Adoption Preparation and Preservation Project
The goal of this 5-year demonstration grant is to improve adoption stability for youth in NH through trauma-informed workforce development.
Role: co-investigator, 30% FTE $290,000 annual direct ($1.5 million total direct)

DHHS Administration for Children and Families Jankowski (PI) 10/1/12 – 9/30/17
90CO1099/01
The Partners for Change Project: Improving Well-Being for Youth in the NH Child Welfare System
The goal of this 5-year demonstration grant is to improve the well-being of children in the NH child welfare and juvenile justice system through trauma-informed workforce development with child welfare and mental health staff.
Role: co-investigator, 30% FTE $429,000 annual directs ($2.1 million total directs)

Patient-Centered Outcomes Research Institute Barnett (PI) 8/1/16 – 4/30/17
Developing Patient-Driven Research to Improve the Psychiatric Care of Youth in Foster Care
The goal of this PCORI project is to build community engagement and capacity toward the generation of comparative effectiveness research ideas that build and evaluate patient-driven psychiatric practices for youth in foster care. Pipeline to Proposal: Tier 1.
Role: Principal Investigator, 8% FTE $12,000 directs

Neil and Louise Tillotson Foundation Barnett (PI) 7/1/16 – 6/30/17
Building a model of coordinated care toward safe and effective psychotropic medications for vulnerable children in Coos County

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The goal of the study is to develop and pilot-test a protocol that facilitates team discussions and decisions centered on individual children regarding the use of psychotropic medications and other wellness topics.
Role: Principal Investigator, 20% FTE $45,000 directs

Gary Tucker Jr Award, Psychiatry, Dartmouth Barnett (PI) 7/1/15 – 6/30/16
Our Minds Our Choice: Developing and Piloting an Option Grid around Interventions for Complex Behavior Problems in Children
The goal of this project was to develop - with parents, clinicians, and stakeholders - and pilot-test a 1 page Option Grid decision aid to improve decision-making related to the use of various classes of medications and therapy for children's complex behavior problems.
Role: Principal Investigator, 8% FTE $20,000 directs

2. Non-key personnel

NH Innovation Research Ctr, Granite State Tech. Innovation Grant Stanger (PI) 11/1/17 – 6/30/18
UNH 18-014
Integrating Coaches to Promote Engagement with an M-Health Collaborative Care App
The research collaboration seeks to test such a modification of an existing m-health collaborative care app (Proxi) to include Mobile Coaches (MCs) to promote user engagement and maximize its utility for use with youth aging out of foster care.
Role: content expert, 5% FTE $46,000 directs

B. Pending Submissions

C. Clinical Faculty

2009-present West-Central Behavioral Health, Claremont and Lebanon, NH, child and family clinician, 15% FTE

XIV. Program Development

Vulnerable Children's Research Group, Founding Member. With encouragement and guidance from Drs. R. Drake, S. Woloshin, and L. Schwartz, I was a founding member of the Vulnerable Children's Research Group, anchored in Geisel's TDI. This group was created in 2017 in response to aligning research interests of TDI, Psychiatry, and Pediatrics faculty members around the judicious use of psychotropic medications in children. TDI has a long history of studying over-treatment and quaternary prevention. Psychiatry, too, has had a remarkable history in promoting shared decision making in adults with severe mental illness. However, no research team within Geisel has aligned these two areas of study and applied them to child psychiatry. Even more novel is this group's focus on deprescribing high risk psychotropic medications in children, an area of inquiry that is just taking root in the field, and in which I am leading within the VCRG team. One measure of our progress is in multidisciplinary grant proposals and publications. Our team has written several grant proposals, including a submission to NIH's NICHD (not funded, but highly scored) and to the Hood Foundation (not funded, but invited to the final round). We have published, to date, 4 peer-reviewed papers, with 2 additional papers in progress.
Role: Co-founder with R. Drake (TDI, Geisel), S. Woloshin (TDI, Geisel), L. Schwartz (TDI Geisel), J. McLaren, (Psychiatry, Pediatrics, TDI, Geisel), 2017-present

NH SafeRx: Working together for safe and effective psychotropic medications for NH children, Founding Member. NH SafeRx brought together a multidisciplinary team, anchored within the Dept of Psychiatry and NH DHHS, with the task of providing oversight to children in NH foster care. The goals of our program spanned advocacy,

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research, and clinical domains. Members of NH SafeRx included leaders within NH DHHS Medicaid, Division of Children Youth and Families, Bureau of Children's Behavioral Health, and Geisel's Dept of Psychiatry. We gathered data about the use of high risk medications and atypical antipsychotic monitoring in NH foster children; developed resources for families and clinicians, including training (with CMEs offered) to prescribing clinicians serving this population and a new NH DHHS webpage to manage these resources. We measured our success by policy and practice changes. Our team instituted a new NH DCYF policy providing safety and monitoring expectations to prescribing clinicians and child welfare workers, and, we established contracts between NH DHHS and the two NH Medicaid MCOs to provide audit and monitoring services.
Role: Co-founder with W. B. Daviss (Psychiatry, Geisel), E. Ungarelli (NH DHHS), M. Donati (NH DHHS), 2012-2018

Creating a Trauma-Informed Mountain, Youth Residential Center and Special Needs School, Co-Developer. I co-developed a train-the-trainer program, with expert training, consultation, and reflective practice groups to develop trauma-informed policies and practices at Crotched Mountain Rehabilitation Center, NH. This educational and research activity included 3 years of policy and practice analysis, leadership collaboration, staff trainings, and staff consultation. We measured our success through policy and practice changes (e.g., requirement of all staff to receive trauma-informed care training) as well as changes in crises, restraints, and seclusions. See Barnett, Yackley, & Licht, 2018.
Role: Co-developer with C. Yackley (Psychiatry, Geisel), 2014-2017

Trauma-Informed Early Childhood Services, Co-Developer. Sponsored by the NH DHHS Maternal and Child Health, I co-developed a state-wide train-the-trainer program and curriculum for early childhood professionals focused on understanding and sensitively providing child care to young children and their families experiencing trauma and attachment disturbances. We measured our success by the number of trainers trained in the curriculum as well as number of child care providers, state-wide, receiving the training.
Role: Co-developer with C. Yackley (Psychiatry, Geisel), 2014-2016

XV. Entrepreneurial activities NA

XVI. Major Committee Assignments

National/international

SAMHSA review committee, SM-20-005, National Child Traumatic Stress Initiative, Category III Site Applications, 2020

SAMHSA review committee, SM-17-009, Resiliency in Communities After Stress and Trauma, 2018

Regional NA

Institutional NA

XVII. Memberships, office and committee assignments in professional societies NA

XVIII. Editorial Boards

2019-present	*Psychological Trauma: Theory, Research, and Practice*	Editorial Review Board
2004-2006	*Society for the Psychology of Women*	Assistant Editor

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XIX. Journal Referee Activity

2013 – present	*Child Abuse & Neglect*	Ad hoc Reviewer
2019 – present	*Child Maltreatment*	Ad hoc Reviewer
2013 – present	*Child & Adolescent Mental Health*	Ad hoc Reviewer
2013 – present	*Children & Youth Services Review*	Ad hoc Reviewer
2018 – present	*Administration and Policy in Mental Health*	Ad hoc Reviewer
2015 – present	*Journal of Traumatic Stress*	Ad hoc Reviewer
2015 – present	*Journal of Clinical Psychology*	Ad hoc Reviewer
2007 – present	*Psychology of Women Quarterly*	Ad hoc Reviewer

XX. Awards and Honors

2019	Co-authored "Article of the Year" for the *Child Maltreatment* journal
2016	Gary Tucker Junior Investigator Award, Geisel School of Medicine's Department of Psychiatry, $20,000
2012	Exceptional Contributions to Research and Education, National Center for PTSD, $900
2011	Exceptional Contributions to Research and Education, National Center for PTSD, $1000
2007	Lou Sherman Graduate Student Award, UM–St. Louis, $2000

XXI. Invited Presentations (selected)

*Indicates personal invitation, # indicates accepted at national meeting or conference,
^ indicates applicable as a CME/CEUs activity

International location:

*^**Barnett, E.R.** & Seely, L. (October 2020). *Building a Trauma-informed Community Response to our Youngest Victims of the Opioid Crisis*. Presented as a webinar to the Canadian Practice and Research Together (PART) Trauma Informed Care and Trauma-Informed Practice Child Welfare series.

*^**Barnett, E.R.** (May 2018). Psychotropic Medications for Youth in Child Welfare: Two Tools to Support Shared Decision Making. Presented as a webinar to the Canadian Practice and Research Together (PART) series.

National location:

#^**Barnett, E. R.,** McLaren, J. L., & Zayas - Concepcion, M. (May 2022). Shared Decision-Making in Child Psychiatry ar Beyond: A Close Look at the Practice, Evidence, and Tools. Accepted for the 2022 American Psychiatric Association annual conference, New Orleans, LA.

#^Lohr, W. D., **Barnett, E. R.,** & Bellonci, C. (March 2020). Deprescribing in child psychiatry. Accepted for the 33rd annual Research and Policy Conference On Child, Adolescent, and Young Adult Behavioral Health, Tampa FL. (Conference cancelled).

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*^**Barnett, E.R.** (April 2019). Supporting shared decision making in child psychiatry. Presented as a webinar for the Excellence in Mental Health Foundation continuing education series.

#^**Barnett, E. R.,** Murphy, D. M., Kerns, S., Jankowski, M. K., Scheeringa, M. S. (March 2018). *A tale of two states: Outcomes from two state-wide demonstration projects to expand evidence-based psychotherapies for traumatized youth.* Symposium presented at the 31st Annual Research and Policy Conference on Children's Behavioral Health, Tampa FL.

#^**Barnett, E. R.,** Neese-Todd, S., Masseli, B., Concepcion-Zayas, M., & Bellonci, C. (March 2018). *"But if I don't take , I can't get up outta here": Where is youth voice in decisions related to psychotropic medications?* Symposium proposal submitted to the 31st Annual Research and Policy Conference on Children's Behavioral Health, Tampa FL.

#^Scheeringa, M., Barto, B., **Barnett, E. R.** (November 2015). *Using Innovative Strategies to Meet the Needs of Traumatized Children in Child Welfare.* Presented at the annual International Society for Traumatic Stress Studies. New Orleans, LA.

#^Bernardy, N., **Barnett, E. R.,** & Jenkyn, A. (November 2015). *Factors that Influence PTSD Treatment Decisions among Prescribing Providers in the Department of Veterans Affairs.* Presented at the annual International Society for Traumatic Stress Studies. New Orleans, LA.

#^Ake, G., **Barnett, E. R., &** Barto, E. (2012). *Screening and Assessment of Children in Child Welfare.* National Child Traumatic Stress Network, Child Welfare Learning Community Webinar.

Regional/local location

***^Barnett. E. R., &** Douglas, L. (April 2021). *"Trauma-informed care for the whole family,"* presented for DHMC CHA Shield our Children from Harm annual conference. Lebanon, NH

***^Barnett. E. R.** (September 2019). *"Adversity during childhood: impacts on the mind, body, and soul,"* Presented for the DHMC NE Alliance for Nursing conference. Lebanon, NH

***^Barnett. E. R.** (July 2019). *"Adversity and resiliency during childhood,"* presented for DHMC CHAD Shield our Children from Harm annual conference. Lebanon, NH

***^Barnett. E. R.** (2018). Lunch 'N Learn "Trauma-Informed Care," presented for DHMC Strong Families Strong Starts, Pediatric Clinics, DHMC, Valley Regional Hospital, Alice Peck Day. 3 1-hour trainings. Lebanon and Claremont, NH.

***Barnett. E. R.** (2018-current, annual). *"Adverse childhood experiences,"* presented for the DHMC partnership with community business leaders. Lebanon, NH

^#Barnett. E. R. (August 2019). Infusing attachment, play, music, and art into TF-CBT. Presented at the Child and Adolescent Complex Trauma Conference, Manchester, VT.

***Barnett. E. R.** (May 2019). Trauma-Informed Care: Supporting families, communities, and workforce through the opioid epidemic. Maine CDC Maternal Child Health Substance Exposed Infant Conference, Bangor, ME.

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*__Barnett, E. R.__ (August 2019). The shifting landscape of education: Building resiliency and trauma-sensitive strategies in the classroom. Presented at the annual Southwest NH Summer Educators Institute, Keene State College, Keene, NH.

*__Barnett, E. R.__ (October 2018). Looking through the Trauma Lens: Understanding and helping traumatized children in schools. Presented at the NH National Educator Association Annual Conference, Manchester, NH.

*__Barnett, E. R.__ (May 2017). Neurobiology of Trauma. Presented at the annual New England Head Start Conference, North Conway, NH.

*__Barnett, E. R.__ (May 2017). Effects of Domestic Violence on Young Children. Presented at the annual New England Head Start Conference, North Conway, NH.

^#__Barnett, E. R.__ (May 2016). Safe and effective psychotropic medications for children: Decision-making, coordination, and oversight. Presented at the Dartmouth Psychiatric Research Center Research Presentation Series, Lebanon, NH.

^Robb, M., Yackley, C., __Barnett, E. R.,__ Neubacher, K. (2014-2016). Four 2-day trainings delivered to clinicians across NH in the delivery of Child Parent Psychotherapy, and evidence-based psychotherapy for traumatized children 0-6 years and caregivers. *Child Parent Psychotherapy,* Concord, NH.

^Robb, M., Stearns, S., __Barnett, E. R.,__ Neubacher, K. (2014-2016). Four 2-day trainings delivered to clinicians across NH in the delivery of Trauma-Focused Cognitive Behavioral Therapy, an evidence based therapy for traumatized children ages 4-18. *Trauma-Focused Cognitive Behavioral Therapy,* Concord, NH.

*__Barnett, E. R.__ (June 2014). Webinar presented for the NH Children's Behavioral Health Collaborative Workforce Development Foundational Training Webinar Series. *Foundations of Trauma.*

^__Barnett, E. R.__ (September 2013). Presented at the NH annual Infant Mental Health Association Conference. *Early childhood trauma: impact, your role, and screening.* Plymouth, NH.

__Barnett, E. R.__ and Jankowski, K. (May 2013). Presented at the annual DCYF conference. *Critical issues when providing services to children involved with child welfare.* Concord, NH.

__Barnett, E. R.__ and Jankowski, K. (October 2012). *Looking through the trauma lens.* Presented at the NH Mental He and Schools Conference. Concord, NH.

__Barnett, E. R.__ (November 2011). *Early childhood trauma.* Presented to New Hampshire Early Supports and Service directors. Concord, NH.

XXII. Bibliography

*trainees underlined

A. Peer-reviewed publications in print or other media

1. Most significant original articles:

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a. list of most significant articles

1. **Barnett, E. R.,** Jankowski, M. K., & Trepman, A. (2019). State-wide implementation of evidence-based psychotherapies for youth exposed to trauma. *Psychological Trauma: Theory, Research, Practice, and Policy, 11(7),* 775-783. doi: 10.1037/tra0000444. PMID: 30816774

2. Jankowski, M. K., Schifferdecker, K. E., Butcher, R. L., Foster-Johnson, L., **Barnett, E. R.** (2019). Effectiveness of a trauma informed care initiative in a state child welfare system: A randomized study. *Child Maltreatment*. Epub ahead of print: 1077559518796336. PMID: 30200774

Papers 1 and 2 are associated with a 5-year state-wide project to infuse trauma-informed care into two child-serving state systems. **The 2019 *Child Maltreatment*** paper demonstrates efficacy of a system-wide trauma-informed care program implemented and tested by our team within the NH state child welfare system in a randomized controlled trial. Alongside this work, we implemented state-wide training and consultation in two evidence-based therapies for child trauma within the NH children's community mental health system. These implementation outcomes are demonstrated in the **2019 *Psychological Trauma*** paper. The outcomes from these two studies had major impacts, ultimately leading to two state policies while building a culture of trauma-informed, evidence-based care and improving the lives of vulnerable children and families.

3. **Barnett, E. R.,** Trepman, A. Z., Fuson, H. A., Aquilano, S. C., McLaren, J. L., Woloshin, S., & Leyenaar, J. K. (2020). Deprescribing psychotropic medications in children: Results of a national qualitative study. *BMJ Quality and Safety,* **29**:655-663 PMID: 31836627

4. **Barnett, E. R.,** Boucher, E. A., Daviss, W. B., Drake, R. E., Elwyn, G. (2017). Supporting shared decision making for children's complex behavior problems: Development and user-testing of an Option Grid decision aid. *Community Mental Health Journal, 54,* 7-16. PMID: 28401416

Papers 3 and 4 reflect innovation in the psychiatric care of children that have helped shift the status quo from one that traditionally adds psychotropic mediations to one that considers removing them. The **2020 *BMJ Quality and Safety*** paper describes findings from a nationally representative sample of pediatric primary care and mental health specialty providers regarding their perspectives on the over-use of psychotropic medications with children and deprescribing. No other study has examined attitudes and practices around deprescribing in children's psychiatric care, a novel concept and practice that our team has spear-headed in the field. This paper also facilitated the development of our deprescribing protocol. The **2017 Community Mental Health Journal** paper highlights another innovative and complementary tool to improve the quality of children's psychiatric care. This paper demonstrates the feasibility of an Option Grid decision aid to support shared decision-making in real practice with parents of children with behavior problems presenting to clinical prescribers.

2. <u>All other publications:</u>

b. Original peer review

5. McLaren, J.L., **Barnett, E. R.**, Acquilano, S.C., Zayas, M.T., Drake, R.E., & Leyenaar, J.K. (in press). Psychotropic Polypharmacy and Antipsychotics in Children: A Survey of Caregiver's Perspectives. *Community Mental Health Journal*, doi:10.1007/s10597-021-00845-2. PMID: 34057662

5. Cleary, S. E., **Barnett, E. R.,** Butcher, R. L., Huckins, J., & Jankowski, M. K. (2018). A

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comparison of foster and adoptive parent satisfaction and commitment. *Children & Youth Services Review,* **88**, 205-210. PMID: 29723028

6. **Barnett, E. R.,** Cleary, S. E., & Donnelly, C. L. (2018). Psychotropic medications for youth in child welfare: Developing and pilot-testing a field guide for team decision-making. *Journal of Public Child Welfare, 12,* 492-513. PMID: not available

7. **Barnett, E. R.,** Cleary, S. E., Butcher, R. L., & Jankowski, M. K. (2019). Child behavior problems and satisfaction of foster and adoptive parents: Do trauma-informed services make a difference? *Psychological Trauma: Theory, Research, and Practice, 11,1,* 73-81. PMID: 29723028

8. **Barnett, E. R.,** Jankowski, M. K., Butcher, R. L., Meister, C., Parton, R. L., & Drake, R. E. (2017). Foster and adoptive parent perspectives of needs and services: A mixed methods study. *Journal of Behavioral Health Services & Research, 45,* 74-89. PMID: 22852992

9. **Barnett, E. R.,** Yackley, C. R., & Licht, E. S. (2018). Developing, implementing, and evaluating a trauma-informed care program in a youth residential treatment center and special needs school. *Journal of Residential Treatment for Youth, 35, 95-113.* PMID: not available

10. **Barnett, E. R.,** Boucher, E.A., Neubacher, K., & Carpenter-Song, E. A. (2016). Decision-making around psychotropic medications for children in foster care: Perspectives from foster parents. *Children & Youth Services Review, 70,* 206-213. PMID: not available

11. **Barnett, E., R.,** Butcher, R., Neubacher, K., Jankowski, M. K., Daviss, W. B., Carluzza, K., & Yackley. C. (2016). Psychotropic medications in child welfare: From federal mandate to direct care. *Children & Youth Services Review, 66,* 9-17. PMID: not available

12. **Barnett, E. R.,** Bernardy, N., Jenkyn, A., Lund, B., Alexander, B., & Friedman, M. (2014). Prescribing clinician's perspectives on evidence-based psychotherapies for post-traumatic stress disorder. *Behavioral Sciences, 4(4), 410-22.* PMID: 25431445

13. **Barnett, E. R.,** Rosenberg, H., Osofsky, J., Rosenberg, S., & Wolford, G. (2014). Dissemination and implementation of Child-Parent Psychotherapy in rural public health settings. *Child and Adolescent Mental Health, 19(3), 215-18.* PMID: 328783736

c. Reviews/Systematic Reviews (each reviewed by peers and editor):

14. **Barnett, E. R.,** Knight, E., Herman, R. J., Amarakaran, K., & Jankowski, M. K. (2021). Difficult binds: A systemati review of facilitators and barriers to treatment among mothers with substance use disorders. *Journal of Substance Abuse Treatment, 126.* PMID: Available soon

15. McLaren, J. L., **Barnett, E. R.,** Concepcion-Zayas, M. T., Lichtenstein, J., Acquilano, S. C., Schwartz, L. M., Woloshin, S., Drake, R. E. (2018). Psychotropic medications for highly vulnerable children. *Expert Opinion on Pharmacotherapy,* 19, 547-560. PMID: 29596008.

16. **Barnett, E. R.,** Concepcion-Zayas, M. T., Zisman-Ilani, Y., Bellonci, C. (2018). Psychiatric care for youth in foster care: A systematic and critical review of patient-centered care. *Journal of Public Child Welfare, 13,2,* 1-28. PMID: not available

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17. Zisman-Ilani, Y., Harik, J. M., **Barnett, E. R.,** Pavlov, A., & O'Connell, M. (2017). Expanding the concept of shared decision-making in mental health: Systematic search and scoping review of interventions. *The Mental Health Review Journal, 22,3,* 191-213. PMID: not available

d. Book chapters:

18. **Barnett, E. R.**, Cleary, S., Neubacher, K., Daviss, W. B. (2017). Post-traumatic stress disorder and attention deficit hyperactivity disorder. In W. B.Daviss (Ed.), *Moodiness in Patients with ADHD: Optimizing Assessment and Treatment (pp.* 55-72*).* New York, NY: Springer Press.

19. Hamblen, J. L., **Barnett, E. R.,** Hermann, B., Schnurr, P. (2013). Overview of PTSD treatment research: The impact of trial design. In J. G. Beck & D. M. Sloan (Eds.), *The Oxford Handbook of Traumatic Stress Disorders (pp. 415-426).* New York, NY: Oxford University Press.

20. Hamblen, J. L., **Barnett, E. R.,** & Norris, F. H. (2012). Long term mental health treatment for adult disaster survivors. In, J. Framingham and M. Teasley (Eds.), *Behavioral health response to disasters (pp. 301-318).* Boca Raton, FL: CRC Press.

21. Greco, L. A., **Barnett, E. R.,** Blomquist, K. K., & Gevers, A. (2008). Body image, acceptance, and health in adolescence. In L. A. Greco & S. C. Hayes (Eds.), *Acceptance and mindfulness Interventions for children, adolescents, and families (pp. 187-214).* Reno, NV: Context Press-New Harbinger.

B. Other scholarly publications in print or other media, including editorials

1. Editorial reviews

22. **Barnett, E. R.** & Concepcion-Zayas, M. T. (2019). High-risk psychotropic medications for U.S. Children with Trauma Sequelae. *Epidemiology and Psychiatric Sciences, 28(4),* 360-364. PMID: 30392479. PMC: 6998973

23. Daviss, W. B., **Barnett, E.R.,** Neubacher, K., Drake, R.E. (2016). Use of antipsychotics for non-psychotic children. *Psychiatric Services, 67(3):* 339-41. PMID: 26725298

24. **Barnett, E. R.,** & Neubacher, K. A. (2014). Traumatic stress in very young children. The Carlat Report: Child Psychiatry. Special Issue: From Birth to Preschool: Psychiatry in Young Children. Carlat Publishing, LLC.

2. Print Resources NA

3. Electronic resources

25. **Barnett, E. R.,** & Hamblen, J. (2012). Trauma, attachment, and PTSD in young children. Fact Sheet for the VA's National Center for PTSD. Available at: https://www.ptsd.va.gov/professional/treat/specific/attachment_child.asp

26. Hamblen, J. & **Barnett, E.R.** (2012). PTSD in children and adolescents. Fact Sheet for the VA's National Center for PTSD. Available at: https://www.ptsd.va.gov/professional/treat/specific/ptsd_child_teens.asp

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4. Large team publications NA

5. White papers NA

6. Other NA

C. Abstracts NA

XXIII. Personal Statement

My career as a clinical psychologist has focused on improving mental health services for vulnerable children and families. My work employs a mix of qualitative and quantitative research methods, community-based participatory strategies, program development, and implementation science, as well as teaching, training, mentoring, clinical care, and service. I am a thought leader in the arenas of trauma-informed child welfare practices and shared decision-making and deprescribing in child psychiatry. Through this work I have changed practices and policies within multiple child-serving systems while building the evidence base for interventions and programs and improving the skills of hundreds of students, trainees, and professionals.

My research accomplishments have developed through two research teams at Geisel. I have supported my own and our team's research and scholarly careers through seven grants as PI or m-PI, six of which were extramural, managing $2.8 million in direct costs. Through my work at the Dartmouth Trauma Interventions Research Center in the Department of Psychiatry, I have filled a major gap in the research landscape of trauma-informed care. *Trauma-informed care* is a buzz-word in our field and yet lacks operational processes, metrics, and evidence. I was part of Dr. Kay Jankwoski's team that led a randomized controlled trial of a statewide effort to install trauma-informed processes within the NH state child welfare (foster and adoptive care) and mental health systems. Within this study, I led the implementation and evaluation of two evidence-based treatments within the NH children's mental health system. I am also leading the design and execution of a randomized controlled trial of a Wraparound model for high-risk children and families affected by addiction (m-PI with Dr. Jankowski). Distinct from Dr. Jankowski, I systematically created and studied the only training program in the United States with an evidence-base focused on early childhood trauma. In addition, I led the installation and evaluation of a 3-year trauma-informed care program within a youth residential treatment center, demonstrating increased knowledge and skills among staff and fewer youth restraints and seclusions after the program was implemented.

The Vulnerable Children's Research Group, which I co-founded within The Dartmouth Institute, is the leading international research team that is actively studying and publishing on shared decision-making and deprescribing in child psychiatry. I led the development and testing of two tools – the first of their kind - to increase shared decision-making in child psychiatry. One of these tools is currently being disseminated into two NH community mental health centers. I led a nationally representative study of clinical prescribers to understand the use of high-risk psychotropics and the potential for deprescribing, and our team developed and pilot-tested a deprescribing protocol targeting off-label antipsychotics.

As an outgrowth of my research, my impact as a scholar has shifted philosophies within the field while facilitating the learning of trainees, students, and community professionals. I developed a training program designed to increase trauma-informed knowledge and skills among community professionals working with very young children. The program has expanded and reached over 500 multidisciplinary professionals. I also transformed a large residential treatment center into one that views children and behaviors through the lens

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of trauma and adversity rather than willful behaviors by training 100 residential staff and developing programming for the center. Additionally, our team enhanced trauma-informed processes within the NH child welfare system by operationalizing constructs, applying standard metrics, and delivering consultation to ~200 NH child welfare staff, ultimately shifting the way this system interacts with children and families. We also implemented two evidence-based therapies within the NH mental health system, training ~300 NH therapists and driving a culture of evidence-based practice. My efforts to promote safe and effective psychotropic medications have helped alter the status quo in child psychiatry to one that considers *removing* psychotropic medications while providing guidance on how to do so. Our work has also led to partnerships with the Deprescribing Clinical Update workgroup within the American Academy of Child and Adolescent Psychiatry. In culmination, my scholarly work demonstrates thought leadership in the field, as evidenced by invitations to partner and present with national psychiatry and psychology leaders and by co-authorship on Dr. Kay Jankowski's award-winning paper in *Child Maltreatment,* to which I contributed leadership in the design, implementation, and evaluation.

In my role as a scholar/educator, I have taught, trained, and mentored psychologists and counselors in training, psychiatry residents and fellows, public health students, and other professionals (e.g., pediatric nurses, childcare providers) both within and outside of Geisel. I co-designed and co-directed *Social and Behavioral Determinants of Health* in Geisel's TDI residential MPH program and have advised numerous MPH students on their *Capstone* projects. I have provided research mentorship to Geisel pre- and post-doctoral psychology interns and fellows, TDI MPH students, and undergraduates from various institutions, as well as professional development mentorship to Geisel pre-doctoral psychology interns. These relationships have been collaborative and nurturing for mentees, as demonstrated by co-authorships with Geisel mentees on 11 peer-reviewed publications. In addition, I am a sought-after authority trainer on child trauma, attachment, and parental substance use, as evidenced by invitations to present across New England, including the Maine CDC, New England Head Start Association, and New England Alliance for Nursing.

I have also made a strong impact through clinical work and service, which integrate cohesively with my research and scholarly pursuits. For the past 12 years, I have provided clinical care to the neediest families at a local community mental health center. I am certified in two evidence-based treatments, including one specific to very young children, a unique niche in mental health service. I am a "go-to" therapist for children severely abused and neglected in the NH region. I have developed specialized skills in hundreds of child therapists across NH through training and consultation in two evidence-based treatments.

My service activities have impacted state policy, legislation, and peer review processes and have led to the co-foundation of a state committee and research team. I helped install a NH child welfare (foster and adoptive care) policy to support trauma screening for youth and instituted revised language in state contracts with mental health providers to require trauma expertise among those treating youth in foster care. I co-founded and led a 5-year psychotropic medications oversight committee for NH youth in foster care. This committee installed a NH child welfare policy to regulate and monitor psychotropic medications and revised state contracts with Medicaid managed care organizations towards this same aim. I am an (uncompensated) advisor to a NH advocacy group focused on legislation to support safe and effective psychotropic medications for children in foster care. In this role, I provide background literature and collaboration with child welfare leaders, clinicians, and parent groups to promote evidence-based, patient-centered legislation. I also serve on the editorial board for a journal and as a referee for many more, and I provide peer reviews for federal grant applications to the Substance Abuse and Mental Health Services Administration. Finally, I co-founded the Vulnerable Children's Research Group. This Group brings together faculty members from several departments at Geisel in one shared effort to build safe and effective pharmacological practices for vulnerable children.

My work has led to real impact on policy and practice and on the lives of children and families. My next steps

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are to expand my research and scholarly endeavors nationally and to sustain meaningful mentorship and leadership roles within Geisel as a leader in the field.

Updated January 13, 2022

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Name: **Mary K. Jankowski**

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Date prepared: June 2021

I. Education

Dates	Institution	Degree
1997-1999	Geisel School of Medicine at Dartmouth Hanover, NH	Pre-Doctoral Internship
1993-1999	University of Vermont Burlington, VT	Ph.D. Clinical Psychology
1986-1990	Pomona College Claremont, CA	B.A. Psychology

II. Postdoctoral (or Highest Degree) Training

Dates	Institution	Specialty
1999-2001	Geisel School of Medicine at Dartmouth Hanover, NH and National Center for PTSD White River Jct. VT	Clinical Psychology

III. Academic Appointments:

a. Current Dartmouth/Geisel affiliations

Title	Institution	Dates
Associate Professor of Psychiatry	Geisel School of Medicine at Dartmouth	May, 2021- present
Assistant Professor of Psychiatry	Geisel School of Medicine at Dartmouth	September 2004 – April, 2021

b. All other current academic affiliations: NA

c. Past Academic Affiliations

Title	Institution	Dates
Instructor of Psychiatry	Geisel School of Medicine at Dartmouth	July 2001- August 2004

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IV. Institutional Leadership Roles

Title	Institution	Dates
Co-Director of Outpatient Services	Dartmouth Hitchcock Medical Center	September 2019 to present
Director of Psychology Services	Dartmouth Hitchcock Medical Center	January 2019 to present
Director	Dartmouth Trauma Interventions Research Center	July 2016 to present
Associate Director	Dartmouth Trauma Interventions Research Center	September 2014 – June 2016

V. Licensure and Certification

Date	Title of Licensure and/or Certification
2017 - present	Licensed Doctorate Psychologist in VT (#048.0128136)
1999 – present	Licensed Doctorate Psychologist in NH (#921)

VI. Hospital or Health System Appointments

Position/Title	Institution/Organization	Date
Psychologist	Dartmouth Hitchcock Medical Center	July 2016 – present
Psychologist	Dartmouth Hitchcock Psychiatric Associate	2005 –June 2016

VII. Other Professional Positions

Position/Title	Institution/Organization	Date
Research Assistant	Dana-Farber Cancer Institute, Boston, MA Department of Epidemiology	1990 – 1993

VIII. Professional Development Activities

Dates	Sponsoring Organization / Institution	Name of Program	Duration of Program and Role	Certificate / # Credits
May 2019	William James College and Beth Israel Deaconess Hospital	Psychodynamic Psychotherapy Conference	3 days Attendee	18
January 2019	Dartmouth-Hitchcock Medical Center	Circle of Security Early Intervention Training	4 days Participant	24
September 2018	Allegheny Children's Hospital	Trauma Focused CBT Trainers' Meeting	2 days Participant	12

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April 2018	Dartmouth-Hitchcock Medical Center	Mental Health Needs of Transgender Youth	1 day Participant	6
March 2018	William James College and Beth Israel Deaconess Hospital	The Strategic Use of Internal Family Systems Therapy	1 day Attendee	6
February 2018	PESI	Training in Mindfulness Based Stress Reduction	2 day Participant	12.5
December 2017	The Brattleboro Retreat	Ethical and Confidentiality Issues in Addressing Suicide Risk in Persons with Substance Use and Co-Occurring Mental Health	1 day Attendee	6
March 2017	William James College and Beth Israel Deaconess Hospital	Psychodynamic Psychotherapy Conference	3 days Attendee	15
February 2017	Dartmouth Hitchcock Medical Center	The ABCs of Eating Disorders Conference	1 day Attendee	5.75
July 2016	University of New Hampshire	International Family Violence and Child Victimization Research Conference	1 day Speaker & Attendee	6
March 2014	Massachusetts School of Professional Psychology	Nancy McWilliams, Ph.D. presenting on Treating Personality Disorders	1 day Attendee	6
January 2014	University of Massachusetts Medical School	Using TF-CBT to Treat Complex Trauma	1 day Attendee	6
December 2013	Massachusetts School of Professional Psychology	Bruce Perry, M.D., Ph.D. presenting on the neurobiology of child trauma	1 day Attendee	6

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IX. Teaching Activities

A. Undergraduate teaching ("college" students)

Name of Course and Role	Dates taught	Institution Where Offered	Scheduled Hours/Year	Estimated # of Students
Developmental Psychology Teaching Assistant	1993-1994	University of Vermont	15 Hours per Week	120

B. Undergraduate Medical Education (UME; "med student") *Classroom* teaching:

Name of Course and Role	Dates taught	Institution Where Offered	Scheduled Hours/Year	Estimated # of Students
Patients and Populations Year 2 Guest Lecturer	2021	Geisel School of Medicine	2 Hours	100

C. Undergraduate Medical Education – Clerkship/ Clinical: NA

D. Graduate Medical Education (GME) teaching:

Name of Course and Role	Dates taught	Institution Where Offered	Scheduled Hours/Year	Estimated # of Students
Professional Development Seminar Guest Lecturer	June 2020 – Present	Dartmouth Hitchcock Medical Center	1 hour	12
Research Development Seminar Guest Lecturer	July, 2020	Dartmouth Hitchcock Medical Center	1 hour	12
Practice Parameters for Treating PTSD in Children and Adolescents Guest Lecturer	2012 – Present	Dartmouth Hitchcock Medical Center	1 hour per year	15
Supervision in Clinical Psychology Guest Lecturer	2020 – Present	Dartmouth Hitchcock Medical Center	1 hour per year	15
Trauma Focused Cognitive Behavior Therapy for Children and Adolescents Guest Lecturer	2012 – Present	Dartmouth Hitchcock Medical Center	2 hours per year	15

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What Psychologists Need to Know about Working with Child Welfare Involved Youth Guest Lecturer	2020 – present	Dartmouth Hitchcock Medical Center	1 hour per year	5
Mechanisms of Change in Trauma or Attachment Treatment with Children and Families Guest Lecturer	Jan, 2021 – present	Dartmouth Hitchcock Medical Center	1 hour per year	7
Considerations in Mental Health Care for Transgender and LGB Youth Guest Lecturer	April, 2021 – present	Dartmouth Hitchcock Medical Center	1.5 hours per year	12
The Effects of Caregiver SUD on the Well-Being of Children and Youth Guest Lecturer	June, 2021 - present	Dartmouth Hitchcock Medical Center	1 hour per year	12
Career Development Seminar Guest Lecturer	2011 – 2020	Dartmouth Hitchcock Medical Center	1 hour per year	7
Cognitive Behavior Therapy for Children and Adolescents Guest Lecturer	2010 - 2014	Dartmouth Hitchcock Medical Center	2 hours per year	7
Treating PTSD in People with Severe Mental Illness Guest Lecturer	2007 - 2010	Dartmouth Hitchcock Medical Center	1 hour per year	12
Structured Clinical Interviewing Guest Lecturer	2001-2004	Dartmouth Hitchcock Medical Center	4 hours per year	12

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Assessment of Trauma and PTSD	2000-2002	Dartmouth Hitchcock Medical Center	10 Hours	5
Bi-Monthly Seminar Leader				

E. Other clinical education programs (e.g., PA programs): NA

F. Graduate teaching – Advanced Degrees: NA

G. Other professional/academic programs: NA

X. Primary Research Advising

A. Undergraduate Students (e.g., Honors theses)

Name of Advisee/Mentee	Dates	Name of Program
Andrea Lesser	2008 - 2010	WISP and Presidential Scholar

B. Graduate Students (e.g., MS, PhD): NA

C. Medical Students (directed research):

Name of Advisee/Mentee	Dates	Name of Program
Kathleen Wilson	2021 - present	Summer Research Program

D. Residents/Fellows (directed research)

Name of Advisee/Mentee	Dates	Name of Program
Lauren Vazquez	2021 - Present	Pre-Doc in Clinical Psychology
Christina Moore	2020 - Present	Pre-Doc and Post-Doc in Clinical Psychology
Rachel Herman	2019 – 2020	Pre-Doc in Clinical Psychology
Katrin Neubacher	2014-2015	Post Doc in Clinical Psychology

E. Others (Junior Faculty)

Name of Advisee/Mentee	Dates	Name of Program
Kaitlyn Ahlers, Ph.D.	2021 - Present	Clinical Psychologist
James T. Craig, Ph.D.	2020 - Present	Clinical Psychologist
Ellen Sejkora, Ph.D.	2020- Present	Clinical Psychologist
Erin Barnett, PhD	2010 – Present	Clinical Psychologist

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XI. Advising/Mentoring (other)

A. Undergraduate Students (e.g., WISP, Presidential Scholars)

Name of Advisee/Mentee	Dates	Name of Program
Hannah Haskell (Hamilton College)	2020 – 2022	None
Emily Acker (Tulane University)	May 2016 – December 2016	None
Aubree Kozie (Bennington College)	January 2016 – September 2018	None

B. Graduate Students: NA

C. Medical (UME Learners; roles beyond instructor in official teaching activities)

Name of Advisee/Mentee	Dates	Name of Program
Sarah Kovan (Geisel School of Medicine)	November 2019 – 2021	None

D. Residents/Fellow:

Name of Advisee/Mentee	Dates	Name of program
Lauren Vazquez	2021- Present	Clinical Psychology
Christina Moore	2020 - Present	Clinical Psychology
Rachel Herman	2019 -2020	Clinical Psychology
Oakland Walters	2018 -2021	Psychiatry Residency
Julie Premo	2016-2017	Clinical Psychology
Alicia Autry	2015 - 2016	Clinical Psychology
Joy Gabrielli	2015 - 2016	Clinical Psychology
Katrin Neubaucher	2014 - 2015	Clinical Psychology
Lynn McCormick	2012-2013	Psychiatry Residency
Joan DeGeorge	2012-2013	Clinical Psychology
Kristin Wieneke	2010-2011	Clinical Psychology
Casey Patunoff	2009-2010	Psychiatry Residency
Jennifer McLaren	2009-2010	Psychiatry Residency
Harris Strokoff	2008 – 2009	Psychiatry Residency

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Erin Barnett	2008-2009	Clinical Psychology

E. Non-degree Program Students (e.g., post-baccalaureate or certificate programs)

Name of Advisee/Mentee	Dates	Name of Program
Ava Burnham (Univ. of Michigan and UVM Post Baccalaureate)	June 2019 – August 2019	None

F. Faculty

Name of Advisee/Mentee	Dates	Name of program
2021 – Present	Lauren Ehrlich, Ph.D.	None
2021 – Present	Kaitllyn Ahlers, Ph.D.	None
2019 – Present	James Craig, Ph.D.	None
2020- Present	Ellen Sejkora, Ph.D	None
2021- Present	Lauren Szkodny, PhD	None
2020 – Present	Sivan Rotenberg, PhD	None
2019 – Present	Sarah Roane, PhD	None
2018 – Present	Mirella Maggi, PhD	None
2010 – Present	Erin Barnett, PhD	None

G. Others (define): Research Assistants

2020 – Present	Hannah Haskell	None
2021 – Present	Kady Sternberg	None

XII. Engagement, Community Service/Education

Dates	Institution / Organization	Course or Activity Title	Your Role and Hours per Year
January 2022	Geisel School of Medicine	Special Interest Group: Medical – Community Partnerships	Guest Speaker 2 Hours
November 2021	Geisel School of Medicine	Special Interest Group: Trauma Informed Care	Guest Speaker

			2 Hours
June 2021	Dartmouth Hitchcock Medical Center	The Cure Podcast: A podcast Focused on updates related to COVID-19: COVID-19 and Resilience	Guest Speaker 2 Hours
June 2020	NH Tech Alliance	COVID-19 Best Practices Roundtable Series: Virtual Workplace – Will This Become the New Normal?	Panelist 1.5 Hours
April 2020	Dartmouth Hitchcock Medical Center	Creation of a Three Part Series of Stress First Aid Videos for Employees at DHMC	Creator, Writer 20 Hours
March 2020	Dartmouth Synergy, Dartmouth Hitchcock Medical Center Department of Population Health, Montshire Museum of Science	Health Research Live! Communities and researchers discussing health priorities at the Montshire Muesem of Science	Expert Panel Member 1.5 Hours
August 2019	Dartmouth Hitchcock Medical Center Department of Pediatrics	DHMC Pediatrics sponsored showing of documentary "Downstream: The Effects of Parental Incarceration"	Expert panel member 3 Hours
December 2018 – January, 2019	Dartmouth Hitchcock Medical Center (Departments of Psychiatry and Pediatrics	Substance Abuse and Mental Health Services Administration (SAMHSA) sponsored Pediatric Integrated Care Collaborative	Trauma Specialist 200+ hours (three face-to-face learning sessions; biweekly team meetings; trainings, interim work)
December 2018	Dartmouth Hitchcock Medical Center Department of Pediatrics	DHMC Pediatrics sponsored showing of documentary "Resilience"	Expert Panel Member 3 Hours
September 2018	Dartmouth Hitchcock Medical Center	Interviewed by reporter for New England Psychologist publication for article in	Primary Source 1 Hour

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		October, 2018 edition on effects of trauma related to Supreme Court nominee hearings	
April 2018	Geisel School of Medicine at Dartmouth	Nathan Smith Society "Dinner with a Doc" Program	Invited Speaker 2 Hours
February 2018	Dartmouth Hitchcock Medical Center	Manchester NH based New Hampshire Today Radio Show about Helping Parents Talk to Children about School Shootings	Expert 4 Hours (including prep work)
November 2016	University of North Carolina School of Social Work	Wicked Problems of Child Welfare and Their Incomplete Solutions: Fulfilling the Promise of Permanency. Wicked Problems Institute. Invitation Only Conference aimed at solving "wicked" problems in child welfare. Chicago, IL	Invited Participant Two Day Conference
2014 –2016	State of Connecticut and Connecticut Health and Development Institute	Learning Collaborative to create a trauma-informed juvenile justice system	Lead Faculty and Presenter 7 face to face learning sessions over 24 months; consultation calls 2x/Monthly
January 2013	Geisel School of Medicine at Dartmouth	SAMHSA sponsored roundtable on Treating Posttraumatic Stress in Juvenile Justice Youth	Invited Member Two Day Conference
2012 – 2018	Waypoint of New Hampshire	Counseling Program and Intensive Home-Based Services Program	Consultant 36 Hours per Year
2010-2012	Geisel School of Medicine at Dartmouth	SAMHSA sponsored Breakthrough Series Collaborative to improve	Senior leader

		placement stability for children and youth in foster care using a trauma informed approach Team of approximately 8, consisting of representatives at state and local levels of mental health and child welfare (NH Division for Children, Youth and Families)	4-two day meeting; bi-monthly consultation calls; interim work
2010 – present	NH Division for Children, Youth and Families (NH DCYF)	Child Protective Services	Consultant 20 Hours per Year
2007- 2008	Geisel School of Medicine at Dartmouth	Dartmouth's team in Substance Abuse and Mental Health Services Administration sponsored learning collaborative for training in Trauma-Focused CBT	Team lead Three face-to face meetings and bi-monthly consultations for one year

XIII. Research Activities (reverse chronological order)

A. Sponsored Activities (Present and Past)

Dates (start and stop) and Project title and award #	Your role	% effort	Sponsoring agency	Annual direct costs of award
10/2021 – 9/2025 Improving Care for Children And Youth in NH with Trauma And Developmental Disabilities (Project TIDD) 1H795M084906	Multiple PIs with E. Barnett	20%	Substance Abuse and Mental Health Services Administration	$1,987,883
09/2019 – 08/2024 Project Launch Upper Valley: Promoting a Healthy Start for	PI	35%	Substance Abuse and Mental Health Services Administration	$3,824,522

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Young Children and Their Caregivers 1H79SM082302-01 10/2019-08/2024 Partners to Promote Safety, Permanency and Well-Being for Families Affected by Substance Use 90CU0109-01-00	CO-PIs with Barnett	20%	US Department of Health and Human Services, Administration for Children and Families, Children's Bureau	$2,646.953 federal $3,296,995 total with cost match
6/1/2019 – 11/30/2020 Upper Valley Opiod Impact Consoritum	CO-I (subaward) PI Fjeld-Sparks, K	4.2%	HRSA	$185,185
10/2013 – 09/2019 New Hampshire Adoption Preparation and Preservation Project 90C01115	PI for Contract with the State of New Hampshire PI for Federal Grant: Mullen, E	20-35%	US Department of Health and Human Services, Administration for Children and Families	$2.2 Million
10/2012 – 09/2019 The New Hampshire Partners for Change Project: Improving Child Well-being in New Hampshire's Child Welfare System 90C01099	PI	25-40%	US Department of Health and Human Services, Administration for Children and Families.	$3.2 Milion
7/2015 – 6/2016 The Use of Technology to Engage Traumatized Adolescents in Trauma-Focused Treatment	PI	10%	The Department of Psychiatry Gary Tucker Award	$20,000

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2011 – 2015 Trauma-Focused CBT for Adjudicated Youth in Residential Treatment MH95208	Co-I and Site PI PI – Cohen, Judith	40%	NIMH	$1,469,268
2009 – 2012 The New Hampshire Bridge Project.	Co-I PI – Rosenberg, Stan	50%	Substance Abuse and Mental Health Services Association	$1.2 Million
2004-2006 Pilot Study of Cognitive-Behavioral Treatment for Posttraumatic Stress Disorder in Adolescents	PI		Hitchcock Foundation	$20,000

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B. Pending submissions:

Dates (start and stop) and Project title and award #	Your role	% effort	Sponsoring agency	Annual direct costs of award

C. Clinical Activities for which you have been provided protected time (but not funding): NA

XIV. Program Development

Dartmouth Trauma Interventions Research Center

Type	Research
Stated mission/aim of program	The Center is located within the Department of Psychiatry at Geisel School of Medicine and Dartmouth Hitchcock Medical Center, and pursues innovation in the services and treatment for children, youth, families and adults affected by adversity, trauma, and loss. Our goal is to improve the safety and well-being of vulnerable, disadvantaged, and traumatized children and families in New Hampshire and beyond. Over the past decade, the Center has trained and provided consultation to over 700 community-based behavioral health providers in evidence-based treatments for child trauma and screened thousands of children and youth across different service settings for trauma and mental health symptoms. The Center has helped the New Hampshire child welfare, juvenile justice and family court systems, youth residential and psychiatric facilities, and schools become more trauma-informed through training and consultation, implementation of mental health screening measures, and linkage to effective mental health treatment. Much of our work is action-based and in the field, instituting practices within systems, evaluating the successes of these practices, and providing training and expert consultation to agencies and providers. In my role as Director since 2016 and Associate Director beginning in 2014, I have managed a team of psychologists, clinical social workers and research assistants.
Your role	Founding Member Associate Director 2014 Director since 2016
Relevant dates in which you are/were involved	2014 - Present
Cohort of program (e.g., if students, residents, faculty; participant number)	Faculty and staff (approximately 3-7); Approximately 5 students and residents have trained at our Center

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Assessments by which impact of program has been measured	Continued success in securing external funding

Gender Identity Clinic between the Child Section of the Department of Psychiatry and the Department of Endocrinology at Dartmouth-Hitchcock Medical Center

Type	Clinical
Stated mission/aim of program	The clinic provides comprehensive mental health and gender identity assessment and treatment for children, adolescents and transitional age youth who are questioning their gender identity or wish to medically transition
Your role	I am the psychology lead and have performed the majority of the mental health and gender evaluations during this start-up phase of the clinic. I am integral to establishing new clinical protocols and training clinics for both psychiatry residents and fellows and psychology interns.
Relevant dates in which you are/were involved	Since September 2018
Cohort of program (e.g., if students, residents, faculty; participant number)	Approximately 5 faculty and staff; psychology and psychiatry trainees
Assessments by which impact of program has been measured	None thus far

XV. Entrepreneurial Activities: NA

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XVI. Major Committee Assignments, inclusive of Professional Societies

A. National/International

Dates	Committee Name	Your Role	Institution / Organization
2005- Present	Currently Affiliated Member	Member	SAMHSA sponsored National Child Traumatic Stress Network
2001 – present	None	Member at Large	American Psychological Association

B. Regional

Dates	Committee name	Your Role	Institution / Organization
November, 2021	State of New Hamphsire Early Childhood Scientific Advisory Panel	Invited Member	University of New Hampshire and State of New Hampshire
March 2020 – Present	Upper Valley Young Child Wellness Council	Leader	Public Health Council of the Upper Valley
March 2020 – Present	New Hampshire Early Childhood Care and Education Experts Board	Invited Member	NH Departments of Education and Health and Human Services
March 2018 – September 2019	Child Trauma Therapeutic Service Array Work Group	Co-lead with representative from the State of NH	State of New Hampshire, Division for Children, Youth and Families
January 2011 – Present	Evidence Based Treatment subcommittee and Workforce Development subcommittee	Member	New Hampshire Children's Behavioral Health Collaborative
January 2010 – September 2019	Committee on Organizational Learning	Member	New Hampshire Division for Children, Youth and Families
2005 – present	None	Member at Large	New Hampshire Psychological Association
2002 – 2004	Executive Committee for the Adolescent Resource Center	Member	University of New Hampshire and State of New Hampshire

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C. Institutional

Dates	Committee Name	Your Role	Institution / Organization
November,2021	Awards for Innovation, Researh and Scholarship (AIRS) review committee	Member	Department of Psychiatry, DHMC
September 2020 - present	Executive to the Chair Committee	Member	Dartmouth Hitchcock Medical Center
September 2020 to present	Diversity, Equity and Inclusion Committee	Co-Chair of Subcommittee	Dartmouth Hitchcock Medical Center
September 2020 to present	Mentoring Committee	Member	Dartmouth Hitchcock Medical Center
February 2021	Transgender Care Committee	Member	Dartmouth Hitchcock Medical Center
March 2020 to present	Department of Psychiatry Emergency Management Team	Member	Dartmouth Hitchcock Medical Center
November 2019 to present	DH Council for Partners to Promote Safety, Permanency and Well-Being for Families Affected by Substance Use (P2P)	Co-Leader	Dartmouth Hitchcock Medical Center
March 2019 to present	Search Committee for Hiring New Neuropsychologists	Member	Dartmouth Hitchcock Medical Center
February 2019 – Present	Search Committee for Hiring New Psychologists	Leader	Dartmouth Hitchcock Medical Center
January 2019 to Present	Clinical Leadership Committee	Representative for Psychologists	Dartmouth Hitchcock Medical Center

XVII. Institutional Center or Program Affiliations: NA

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XVIII. Editorial Boards: NA

XIX. Journal Referee Activity

Dates	Society/Journal	Your Role	Frequency of Review
2019 – Present	Child and Family Social Work	Reviewer	1-3 Per year
2017- Present	Child Maltreatment	Reviewer	1-3 Per year
2017- Present	Journal of Public Child Welfare	Reviewer	1-3 Per year
2017- Present	Journal of Traumatic Stress	Reviewer	1-3 Per year
2010 - Present	Community Mental Health Journal	Reviewer	1-3 Per year
2010 – Present	Journal of Adolescent Health	Reviewer	1-3 Per Year
2007 – Present	Journal of Consulting and Clinical Psychology	Reviewer	1-3 Per year

XX. Awards and Honors

Date	Award name
2020	Article of the Year for 2019 by the Child Maltreatment Editorial Board for *Effectiveness of a Trauma-Informed Care Initiative in a State Child Welfare System: A Randomized Study,* published in Child Maltreatment in Feb of 2019
2015	Margaret M. Riggs Distinguished Contributions Award from the New Hampshire Psychological Association. The purpose of this award is to identify and to publicly acknowledge a psychologist who has demonstrated extraordinary skills in teaching, research, or service that has resulted in the advancement of psychology in New Hampshire
1995	Child and Adolescent Psychology Training and Research Inc., private Vermont based fund. In support of study, "Fear of hypoglycemic reactions and long-term complications of diabetes in adolescents with insulin-dependent diabetes mellitus". $3000

XXI. Invited Presentations

- asterisk (*) those presentations to which you, individually, were extended an invitation to present
- hashtag (#) those presentations that were meetings where you may have presented a poster/talk, but not following a personalized invitation (i.e., at a large society meeting).
- carat (^) if the talk/presentation was applicable as a CME activity.

A. International

Defined by both the location or the scope of attendees.

Date	Topic/Title	Sponsoring Organization	Location

July 2016 #^	Trauma related needs of youth involved in child welfare and juvenile justice: Perceptions across different stakeholders	International Family Violence Research Conference	Durham, NH
January 2012 *^	The New Hampshire Bridge Project: Serving Traumatized Children and Youth in the Family Courts, Child Welfare and Juvenile Justice Settings	The 26th Annual San Diego International Conference on Child and Family Maltreatment	San Diego, CA
November 1999 #^	Treatment of PTSD in a Woman with Severe Mental Illness	The 15th Annual Meeting of the International Society for Traumatic Stress Studies	Miami, FL

B. National

Defined by both the location or the scope attendees.

Date	Topic/title	Sponsoring Organization	Location
November 2019 *	Implementing Evidence-Based Practices in Real World Settings	Presentation to Youth Special Interest Group within the National Drug Abuse Treatment Clinical Trials Network (CTN)	Webinar, Lebanon, NH
August 2019 #^	Measuring Implementation and Sustainability: Applying the Consolidated Framework for Implementation Research to Inform and Improve	2019 National Child Welfare Evaluation Summit	Washington, D.C
April 2019 #^	Making Child Welfare More Trauma Informed: A Discussion of Policy Implications for Child Welfare and Behavioral Health Systems	21st National Conference on Child Abuse and Neglect	Washington, D.C

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April 2019 *	NH Partners for Change and New Hampshire Adoption Project: Findings and Lessons Learned	21st National Conference on Child Abuse and Neglect	Washington, D.C.
June 2018 *	New Hampshire Partners for Change Project: Effectiveness of a Trauma Informed Care Initiative in Child Welfare	Annual Grantees Meeting, Administration for Children and Families Annual Grantees Meeting	Washington, D.C.
August 2016 #^	Preventing Adoption Disruption and Dissolution: Preserving Adoptive Placements	North American Council on Adoptable Children Conference	Nashville, TN
June 2015 *	Screening for Trauma in Child Welfare Settings	Annual Grantees Meeting. Administration for Children and Families	Washington, DC
February 2015 #^	Using Implementation Science to Advance Child Well-Being: Advances in Screening for Trauma and Behavioral Health Needs in Child Welfare Settings	28th Annual Research and Policy Conference on Child, Adolescent and Young Adult Behavioral Health	Tampa, FL
January 2013 *^	Expanding Trauma-Informed Services in Child Welfare Systems	Webinar presented by the National Child Welfare Resource Center	
November 2012 *	The New Hampshire Partners for Change Project: Overview	Administration for Children and Families New Grantee Meeting	Washington, D.C.
August 2012 #^	Treating Traumatized Adolescents with Cognitive Restructuring	The 120th American Psychological Association Annual Convention	Orlando, FL
March 2012 #^	From screening to treatment of trauma in juvenile justice populations: Experience in New Hampshire and Ohio	All Network Meeting of the National Child Traumatic Stress Network	Baltimore, MD

August 2010 *^	Can You Hear Me Now: Use of Technology to Spread Evidence Based Practices	Rural Behavioral Health Symposium	Glendale, AZ. (keynote speaker)
November 2007 #^	The New Hampshire Project for Adolescent Trauma Treatment: A web based screen for assessing trauma, PTSD and associated symptoms.	New Grantees Meeting for the National Child Traumatic Stress Network	Richmond, VA
October 2007 *^	Dissemination of evidence-based practices for child trauma related disorders: A case example	TF-CBT Eastern Learning Collaborative	Baltimore, MD
February 2007 #^	Engagement and retention of adolescents in trauma treatment	The National Child Traumatic Stress Network All Network Meeting	Pittsburg, PA
April 2001 #^	Modified PTSD Treatment for People with Severe Mental Illness	The 6th Annual Mastering the Key Connection: Clinical training conference on trauma services in the public mental health system	New York, NY

C. Regional/Local

Date	Topic/Title	Sponsoring Organization	Location
January 2022 *	Special Interest Group: Medical-Community Partnerships	Geisel School of Medicine	Lebanon, NH
January 2022 *	Sexual and Gender Minority Issues	CASA New Hampshire	Concord, NH
November 2021 *	Special Interest Group: Trauma Informed Care	Geisel School of Medicine	Lebanon, NH
September 2021 *	Secondary Stress: Adressing Staff Stress and Burnout	ECHO series for early childhood and education professionals (guest speaker)	Lebanon, NH

August 2021 *	Live Well Work Well: There's No Health Without Mental Health Expert Panel Member	DHMC	Lebanon, NH
September 2020 *^	Trauma and Reproductive Health Care (Goodman, D., Frew, J., Jankowski, M.K., Waters, T)	Department of Obstetrics and Gynecology Grand Rounds, Geisel School of Medicine at Dartmouth	Lebanon, NH
June 2020 *	Trauma Informed Care	ECHO series for Community Health Workers in NH and VT (guest speaker)	Lebanon, NH
January 2020 *	Trauma Informed Care in the High School Setting	ECHO series on Treating Behavioral Health and Substance Use Disorders in High School Age Teens (guest speaker)	Lebanon, NH
March 2020 *^	Trauma Informed Care in the Medical Setting	The 29th Dartmouth Pediatric Conference	Bretton Woods, NH
October 2019 *	Trauma Informed Care in the Medical Setting	Guest speaker for ECHO series on Treating Behavioral Health and Substance Use Disorders in Primary Care	Lebanon, NH.
October 2019 *	Clinic and Community Partnerships: How we design and implement care to improve future health outcomes for complex populations. (Expert Panel Member)	Team Up, Take Action: A Conference on Partnering to Improve Community Health	Lebanon, NH
September 2019 *	Trauma Informed Care in the Medical Setting	New England Alliance for Health (NEAH): Conference on Mental Health	Lebanon, NH
September 2019 *	Gender Identity Disorder in Transitional Age Youth	ProHealth NH Conference 2019:	Concord, NH

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		ProHealth Youth and Young Adults	
September 2019 *	Compassion Fatigue and Secondary Traumatic Stress	Training for Dartmouth Hitchcock's Community Health Workers	Lebanon, NH.
May 2019 *	Principles of Trauma-Informed Care.	Retreat for Dartmouth Hitchcock's Community Health Workers	New London, NH.
March 2019 *^	Trauma-Informed Care in the Medical Setting	Department of General Internal Medicine CME Program, Dartmouth Hitchcock Medical Center	Lebanon, NH
February 2019 *	New Hampshire Partners for Change and NH Adoption Preparation and Preservation: Lessons Learned	NH DCYF Leadership	Concord, NH
November 2018 *^	Effects of Parental Substance Abuse on Children and Youth	Northeast Node of the National Drug Abuse Treatment Clinical Trials Network Science Series	Lebanon, NH
October 2018 *	Trauma-Informed Care in Community Based Settings	Annual meeting for NH Family Resource Centers	Manchester, NH
May 2018 *^	Trauma-Informed Care in the Medical Setting	DHMC Keene, NH CME Program	Keene, NH
April 2018 *	Trauma-Informed Care in the Medical Setting	Geisel student-initiated panel on ACES (Adverse Childhood Events Study)	Hanover, NH.

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January 2018 *^	Trauma and Reproductive Health Care (Goodman, D., Frew, J., Jankowski, M.K., Waters, T)	Department of Obstetrics and Gynecology Grand Rounds, Geisel School of Medicine at Dartmouth	Lebanon, NH.
October 2017 *	Trauma Informed Care Initiatives: Meeting the Needs of Traumatized Children and Families in New Hampshire	Special New Hampshire Legislative Committee Overseeing NH Division for Children, Youth and Families	Concord, NH.
November 2016 *^	Trauma and Substance Abuse	Families in Transition	Manchester, NH
November 2016 *^	Creating Trauma Informed Systems	Families in Transition	Manchester, NH
July 2016 *^	Principles of Trauma-Focused Treatment for Adolescents with Substance Use Disorders	New England ATTC conference on adolescent substance use, "Improving Care of Adolescents with Substance Use Disorders: Effective Approaches to Assessing, Treating, and Engaging Teens."	Lebanon, NH
*^July 2016	Engaging Youth and Families Into Trauma Focused Treatment	State of Connecticut Division for Juvenile Justice,	Hartford, CT
July 2016 *^	Cognitive Processing with Traumatized Youth: The How, What, Why and When	State of Connecticut Division for Juvenile Justice	Hartford, CT
March 2016 *	Foundations of Trauma-Informed Care	Child and Family Services of New Hampshire	Concord, NH
March 2016 *	2015 Youth Health and Risk Behavior Survey Results.	Phillips Exeter Academy	Exeter, NH

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February 2016 *	Trauma Initiatives in New Hampshire	New Hampshire Child Advocacy Centers Summit	Concord, NH
March 2015 *	Mental Health Disorders among Juvenile Justice Youth and Best Practice Treatment Models	NH Division for Children, Youth and Families	Concord, NH.
November 2014 *	Trauma Informed Care for Residential Treatment Centers	Crotched Mountain Treatment and Rehabilitation Center	Greenfield, NH
September 2014 *^	Engaging Youth and Families Into Trauma Focused Treatment	State of Connecticut Division for Juvenile Justice	Hartford, CT
September 2014 *^	Cognitive Processing with Traumatized Youth: The How, What, Why and When	State of Connecticut Division for Juvenile Justice	Hartford, CT
October 2013 *	Getting to Permanency: Understanding the Impact of Trauma in Adoption	NH Division for Children, Youth and Families	Concord, NH
May 2013 *	Critical Issues When Providing Services to Traumatized Children Involved in Child Welfare: What Child Welfare Staff and Other Care Providers Want to Know	Annual New Hampshire DCYF and DJJS Conference	Manchester, NH.
October 2012 *	Providing Trauma Informed Care in Schools: What Teachers and Guidance Counselors Need to Know	NAMI Conference on Addressing Mental Health Issues in Schools	Concord, NH
September 2012 *^	Trauma Focused CBT in Residential Treatment Facilities	State of Connecticut Division for Juvenile Justice.	Hartford, CT

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May 2012 #	The NH Bridge Project and Creating Placement Stability Using a Trauma-Informed Approach to Child Welfare	NH DCYF/DJJS 18th Annual Conference: Engaging Family Voice, Discovering Solutions Together.	Manchester, NH
June 2011 *	Trauma Informed Care for Juvenile Justice Involved Youth	Coalition for Juvenile Justice Northeast Region Conference: Changing the Face of Juvenile Justice	Manchester, N.H.
September 2011 *	Leading Evidence Based Treatments for Traumatized Children and Families: Trauma Focused CBT and Child Parent Psychotherapy	Attorney General's Conference on Child Abuse and Neglect	Manchester, N.H.
November 2010 *	Creating a More Trauma-Informed Child Welfare System. Weaving Family Tapestries: Enriching Lives	NH Foster and Adoptive Parent Annual Conference	Concord, NH (Keynote Speaker)
April 2010 *	Trauma Focused Cognitive Behavioral Therapy (Workshop)	NH Mental Health Symposium.	Manchester, NH
October 2009 *	Trauma Focused-Cognitive Behavioral Therapy (Workshop)	Annual Attorney General's Conference on Child Abuse	Bedford, NH.
October 2009 *	Child Parent Psychotherapy for Traumatized and At-Risk Young Children	Annual New Hampshire Attorney General's Conference on Child Abuse	Bedford, NH.
September 2009 #^	Implementation of the child-parent psychotherapy model in New Hampshire	New Hampshire Infant Mental Health Conference	North Conway, NH
May 2009 *^	Can you see me now? Teaching and disseminating two evidence-based child mental health	Department of Psychiatry Grand Rounds	Lebanon, NH

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	treatments in NH, using videoconferencing		
April 2008 *	Child physical abuse: Prevalence, consequences and treatment	5th Annual Shield our Children from Harm Conference: Physical Abuse: Spanning the Ages and Aspects	Lebanon, NH
March 2008 *	Child trauma: Prevalence, correlates, consequences and treatment.	Trauma 101: A Primer for Educators and Community Service Providers	Laconia, NH (Keynote Speaker)
October 2007 *	The cognitive-behavioral treatment of adolescents with PTSD	Casey Family Services of New Hampshire	Concord, NH
October 2007 *^	Dissemination of evidence-based practices for child trauma related disorders: A case example	TF-CBT Eastern Learning Collaborative	Baltimore, MD
February 2006 *^	Pediatric traumatic stress	The New Hampshire Nurses Association Conference on Pediatric Nursing	Nashua, NH
April 2005 *	Cognitive Behavioral Treatment of Posttraumatic Stress Disorder in Youth (Workshop)	West Central Behavioral Health	Lebanon, NH
March 2005 *^	Cognitive Behavioral Treatment of Posttraumatic Stress Disorder in Youth	Grand Rounds presented at New Hampshire Hospital	Concord, NH
February 2005 *^	Cognitive Behavioral Treatment of Posttraumatic Stress Disorders in Youth	NH Psychological Association and Womankind Counseling Center	Concord, NH
January 2005 *	Risk-taking Behaviors in NH Teens: Findings from the 2001 and 2003 NH	Access to Treatment for Co-Occurring Disorders in	Concord, NH

	Youth Risk Behavior Survey (YRBS)	Adolescents and Young Adults Conference	
May 2003 #	Cognitive-Behavioral Therapy for Posttraumatic Stress Disorder in Persons with Severe Mental Illness	Integrating Trauma, Substance Abuse and Mental Health Conference	Augusta ME
xOctober 2002 #	Patterns of ATOD Initiation and Use in NH Teens: Prevalence, Risk Factors and Policy Implications	New Hampshire Substance Abuse Conference	Whitefield, NH.
November 2001 #	Individual Cognitive Behavioral Treatment for PTSD in Persons with Severe Mental Illness	Connecting Trauma, Substance Abuse, and Mental Health	Augusta ME
August 2001 *	Providing Trauma Services for People with Severe Mental Illness	New Hampshire Homeless Service Providers Conference	North Conway, NH

XXII. Bibliography

A. Peer-reviewed publications in print or other media

1. Most significant publications (3-5):

1. **Jankowski, M.K.**, Knight-Zhang, E., & Butcher, RL. (2022). Differences in trauma exposure, PTSD and child well-being as a function of parental substance misuse in a child welfare sample. *Children and Youth Services Review*, 132, 106326. https://doi.org/10.1016/j.childyouth.2021.106326.

2. Knight, E, Butcher, R.L, & **Jankowski, M.K.** (2021). Toward Improved Identification of Parental Substance Misuse: An examination of current practices and gaps in one US state. Child and Maternal Health. Published online May, 2021.

3. Barnett, E. R., Knight, E., Herman, R. J., Amarakaran, K., & **Jankowski, M. K**. (2021 online). Difficult binds: A systematic review of facilitators and barriers to treatment among mothers with substance use disorders, 126, . *Journal of Substance Abuse Treatment*. https://www.journalofsubstanceabusetreatment.com/article/S0740-5472(21)00067-2/fulltext.

4. Butcher, R.L., **Jankowski, M.K.**, & Slade, E.D. (2020). The costs of implementing and sustaining a trauma and mental health screening tool in a state child welfare system. *Children and Youth Services Review*. Advance online publication DOI: 10.1016/j.childyouth.2020.105011

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5. Barnett, E.R., **Jankowski, M.K.**, & Trepman, A.Z. (2019). Statewide implementation and clinical outcomes associated with evidence-based psychotherapies for traumatized youth. *Psychological Trauma: Theory, Research, Practice and Policy*. Advance online publication DOI:10.1037/tra0000444

6. **Jankowski, M.K.**, Schifferdecker, K.E., Butcher, R.L., Foster-Johnson, L., & Barnett, E.R.. (2019). Effectiveness of a trauma informed care initiative in a state child welfare system: A randomized study. *Child Maltreatment, 24*, 86-97.

7. Cohen, J. A., Mannarino, A. P., **Jankowski, M. K.**, Rosenberg, S., Kodya, S., & Wolford, G. L. (2016). A randomized implementation study of trauma-focused cognitive behavioral therapy for adjudicated teens in residential treatment facilities. *Child Maltreatment, 21(2)* 156-167.

8. Rosenberg, H., **Jankowski, MK**, Fortuna, L, Rosenberg, S, Mueser, K. (2011) "A Pilot Study of a Cognitive Restructuring Program for Treating Posttraumatic Disorders in Adolescents", *Psychological Trauma: Theory, Research and Policy, 3(1)* 94-99.

2. All other publications:

b. Original peer-reviewed articles.

1. Barnett, E. R., Cleary, S. E., Butcher, R. L., & **Jankowski, M. K**. (2019). Child behavior problems and satisfaction of foster and adoptive parents: Do trauma-informed services make a difference? *Psychological Trauma: Theory, Research, and Practice,*1, 73-81. doi: 10.1037/tra0000357

2. Barnett, ER, **Jankowski, MK**, Butcher, RL, Meister, C, Parton, RR, Drake, RE. (2018). Foster and Adoptive Parent Perspective on Needs and Services: A Mixed Methods Study. *Journal of Behavioral Health Services Research, 45* (1), 74-89.

3. Cleary, SE, Barnett, ER, Huckins, JF, Butcher, RL, **Jankowski, MK**. (2018). A comparison of foster and adoptive parent satisfaction and commitment. *Children and Youth Services Review, 88*, 205-210.

4. Barnett, ER, Butcher, RL, Neubaucher, K, **Jankowski, MK**, Daviss, WB, Carluzzo, KL, Ungarelli, EG, Yackley, CR. (2016). Psychotropic Medications in Child Welfare: From federal mandate to direct care. *Children and Youth Services Review*, 66 (9-17).

5. Lu, W, Mueser, K.T., Rosenberg, S.D., and **Jankowski, M.K.** (2008). Correlates of adverse childhood experiences among adults with severe mood disorders. *Psychiatric Services, 59,* 1018-1026.

6. Mueser, K.T., Rosenberg, S.R., Xie, H., **Jankowski, M.K.**, Bolton, E.E., Lu, W., Hamblen, J.L., Rosenberg, H., McHugo, G.J., & Wolfe, R. (2008). A Randomized Controlled Trial of Cognitive-Behavioral Treatment of Posttraumatic Stress Disorder in Severe Mental Illness, *Journal of Consulting and Clinical Psychology. 76:*259-271.

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7. Wolford, G., Rosenberg, S.D., Rosenberg, H.J., Swartz, M.S., Butterfield, M.I., Swanson, J.W. & **Jankowski, M.K**. (2008). A clinical trial comparing interviewer and computer-assisted assessment among clients with severe mental illness. *Psychiatric Services, 59,* 769-775.

8. **Jankowski, M.K**., Rosenberg, H.J., Sengupta, A., Rosenberg, S.D, Wolford, G. (2007). Development of a screening tool to identify adolescents engaged in multiple problem behaviors: The adolescent risk behavior screen (ARBS*). Journal of Adolescent Health, 40,* 180.e19-180.e26.

9. Rosenberg, S.D., Lu, W., Mueser, K.T., **Jankowski, M.K**, and Cournos, F. (2007). Correlates of adverse childhood events among adults with schizophrenia spectrum disorders. *Psychiatric Services, 58, 245-253.*

10. Pratt, S.I., Rosenberg, S.D., Mueser, K.T., Brancato, J., Salyers, M.P., **Jankowski, M.K**., and Descamps, M. (2005). Evaluation of a PTSD psychoeducational program for psychiatric inpatients. *Journal of Mental Health, 14:* 121-127

11. Rosenberg, H.J., **Jankowski, M.K**., Sengupta, A, Wolfe, R.S., Wolford, G.L., & Rosenberg, S.D. (2005). Single and multiple suicide attempts and associated health risk factors in New Hampshire adolescents. *Suicide and Life-Threatening Behavior, 35 (5),* 547-557.

12. Mueser, K. T., Rosenberg, S. D., **Jankowski, M. K**., Hamblen, J. L., and Descamps, M. (2004). A cognitive-behavioral treatment program for posttraumatic stress disorder in persons with severe mental illness. *Psychiatric Rehabilitation Skills, 7,* 107-146.

13. **Jankowski, M. K**., Schnurr, P. P., Adams, G. A., Green, B. L., Ford, J. D., and Friedman, M. J. (2004). A mediational model of PTSD in World War II veterans exposed to mustard gas. *Journal of Traumatic Stress, 17 (4),* 303-310.

14. **Jankowski, M.K**. & Hamblen, J.L. (2004). Cognitive-behavioral treatment for PTSD in people with severe mental illness: Three case studies. *Psychiatric Rehabilitation Skills, 7,* 147-170.

15. Rosenberg, S. D., Mueser, K. T., **Jankowski, M. K**., Salyers, M. P., Acker, K. (2004). Cognitive behavioral treatment of PTSD in people with severe mental illness: Results of a pilot study. *Psychiatric Rehabilitation Skills, 7,* 171-186.

16. Schnurr, P.P., Friedman, M.J., Sengupta, A., **Jankowski, M.K**., & Holmes, T. (2000). PTSD and utilization of medical treatment services among male Vietnam veterans. Journal of Nervous and Mental Disease, 188, 496-504.

17. **Jankowski, M.K**., Leitenberg, H., Coffey, P., and Henning, K. (2002). Parental caring as a possible buffer against sexual revictimization in young adult survivors of childhood abuse. *Journal of Traumatic Stress, 15 (3), 235 – 244.*

18. Rosenberg, S.D., Mueser, K.T., Friedman, M.J., Gorman, P.G., Drake, R.E., Vidaver, R.M., Torrey, W.C., and **Jankowski, M.K**. (2001). Developing best practices for post-traumatic

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19. **Jankowski, M.K.**, Leitenberg, H., Henning, K, and Coffey, P. (1999). Intergenerational transmission of dating aggression as a function of witnessing only same sex parents vs. opposite sex parents vs. both parents as perpetrators of domestic violence. *Journal of Family Violence,14,* 267-278.

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22. O'Leary, J.F., Fairclough, D.L., **Jankowski, M.K.**, and Weeks, J.C. (1995). Comparison of time-tradeoff utilities and rating scale values of cancer patients and their relatives: evidence for a possible plateau relationship. Medical Decision Making, 15 (2): 132-137.

c. Reviews

1. Schnurr, P.P. & **Jankowski, M.K.** (1999). Physical health and posttraumatic stress disorder: Review and synthesis. Seminars in Clinical Neuropsychiatry, 4, 295-304. (invited/reviewed by peers)

d. Books/book chapters/monographs

B. Other scholarly work in print or other media:

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1. **Jankowski, MK**, Butcher, RL, Barnett, ER, Carmelo, A. (2018). Effecting system change in the real world: Implementing and sustaining trauma informed practices in a stressed child welfare system. *American Professional Society on the Abuse of Children (APSAC) Advisor, Vol. 30, Issue 3*, 8-14,

2. Parton, R. R., Barnett, E.R., Meister, C.E., & **Jankowski, M.K.** (2018). Broadening beyond the child: Challenges and strengths in one state's efforts to screen and support family functioning with resource parents. *American Professional Society on the Abuse of Children (APSAC) Advisor, Vol. 30, Issue 3*, 39-42.

3. **Jankowski, M. K.** (1995). Catherine R. Stimpson: Charting the course of women's studies since its inception. *Women and Therapy, 17 (3/4),* 489-494.

Reviews:

1. **Jankowski, M.K.** (2001). [Review of the book Posttraumatic Stress Intervention: Challenges, Issues, and Perspectives]. Journal of Nervous and Mental Disease, 189, 731-732.

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1. **Jankowski, M.K.**, Rosenberg, H.J., Rosenberg, S.D., Mueser, K.T. (2011). Coping with Stress: A CBT Program for Teens with Trauma. Hazelden Press: Center City, MN.

2. McGovern, M.P, Mueser, K.T., Hamblen, J.L, **Jankowski, M.K**. (2010). Cognitive-Behavioral Therapy for PTSD: A Program for Addiction Professionals. Hazelden Press: Center City, MN.

Book Chapters:

1. Rosenberg, H.J. & **Jankowski, M.K**. (2009). Adolescents. In K.T. Mueser, S.D. Rosenberg, & H.J. Rosenberg (Eds.), *Treatment of posttraumatic stress disorder in special populations* (pp. 255-266). Washington, DC: American Psychological Association.

2. **Jankowski, M.K.**, Mueser, K.T., and Rosenberg, S.D. (2006). Psychosis with comorbid PTSD. In W. Larkin & A.P. Morrison (Eds.), Trauma and Psychosis (pp. 75-100). New York: Routledge.

3. Foy, D.W., Glynn, S. M., Schnurr, P. P., **Jankowski, M. K.**, Wattenberg, M., Weiss, D.S., Marmar, C.R., and Gusman, F.D. (2000). Group psychotherapy for posttraumatic stress disorder. T. M. Keane, & M. J. Friedman (Eds.) Effective Treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress (pp. 155-175). New York: Guilford.

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C. Abstracts

1. # Butcher, R.L., Schifferdecker, K.E., **Jankowski, M.K**. (2019, August). Measuring Implementation and Sustainability: Applying the Consolidated Framework for Implementation Research to Inform and Improve. Symposium proposal submitted to the National Child Welfare Evaluation Summit, Washington, D.C.

2. # Collins-Camargo, C, **Jankowski, M.K.**, Baldwin, M. (2019, April). Making Child Welfare More Trauma Informed: A Discussion of Policy Implications for Child Welfare and Behavioral Health Systems. Symposium proposal submitted to the 21st National Conference on Child Abuse and Neglect, Washington, D.C.

3. # Barnett, E. R., Murphy, D. M., Kerns, S., **Jankowski, M. K.**, Scheeringa, M. S. (2018, March). A tale of two states: Outcomes from two state-wide demonstration projects to expand evidence-based psychotherapies for traumatized youth. Symposium proposal submitted to the 31st Annual Research and Policy Conference on Children's Behavioral Health, Tampa FL.

4. # Meister, C and **Jankowski, M.K**. (2016, August). Preventing Adoption Disruption and Dissolution: Preserving Adoptive Placements. North American Council on Adoptable Children Conference. Nashville, TN.

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5. **# Jankowski M.K.** (2016, July). Trauma related needs of youth involved in child welfare and juvenile justice: Perceptions across different stakeholders. International Family Violence Research Conference. Durham, NH.

6. **# Jankowski, M.K.** (2015, February). Using Implementation Science to Advance Child Well-Being: Advances in Screening for Trauma and Behavioral Health Needs in Child Welfare Settings. 28th Annual Research and Policy Conference on Child, Adolescent and Young Adult Behavioral Health. Tampa, FL.

7. Barnett, E. and **Jankowski, M.K.** (2013, May). Critical Issues When Providing Services to Traumatized Children Involved in Child Welfare: What Child Welfare Staff and Other Care Providers Want to Know. Workshop presented at the 2013 Annual DCYF and DJJS Conference. Manchester, NH.

8. **Jankowski, M.K.** and the Breakthrough Series Collaborative New Hampshire Team. (2012, May). The NH Bridge Project and Creating Placement Stability Using a Trauma-Informed Approach to Child Welfare. NH DCYF/DJJS 18th Annual Conference: Engaging Family Voice, Discovering Solutions Together. Manchester, NH.

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10. **# Jankowski, M.K.** (2007, November). The New Hampshire Project for Adolescent Trauma Treatment: A web based screen for assessing trauma, PTSD and associated symptoms. Paper presented at the New Grantees Meeting for the National Child Traumatic Stress Network, Richmond, VA.

11. **# Jankowski, M.**K., Rosenberg, H.R., Lesser A. (2007, February). Engagement and retention of adolescents in trauma treatment. Paper presented at the National Child Traumatic Stress Network All Network Meeting, Pittsburgh, PA.

12. **# Jankowski, M.K.,** Hamblen, J.L., and Acker, K. (2003, May). Cognitive-Behavioral Therapy for Posttraumatic Stress Disorder in Persons with Severe Mental Illness. Paper presented at the Integrating Trauma, Substance Abuse and Mental Health Conference, Augusta ME.

13. # Mueser, K.T., Rosenberg, S.D., **Jankowski, M.K.**, and Hamblen, J.L. (2002, November). Cognitive-Behavioral Treatment of PTSD in Severe Mental Illness: Results of a Pilot Study. In J. DeViva (Chair), Fitting the Treatment to the Patient: Adapting CBT for Patients with Complicated Posttraumatic Presentations. Symposium conducted at the meeting of the Association for the Advancement of Behavior Therapy, Reno. NV.

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19. # Descamps, M.J., Mueser, K.T., Rosenberg, S.D., Salyers, M.P., **Jankowski, M.K.**, Friedman, M.J., Goguen, C. (1999, October). Modification of a Protocol for Treating PTSD in Women with Severe Mental Illness. Presented at the 15th annual meeting of the International Society for Traumatic Stress Studies, Miami, FL.

Personal Statement:

At Geisel, my career has focused on disseminating and implementing evidence-based practices for children, youth and families who have experienced trauma, and translating research into action in order to promote system change. My work has served to enhance care for this population across multiple service sectors from behavioral health to child welfare, juvenile justice, family courts, and other community-based settings. I have led and evaluated large projects that translate research into action and contribute to the understanding of individual practice, as well as larger system change, including participation in multiple breakthrough series and learning collaboratives, focused on creating more trauma informed cultures within health care and social service agencies. My work blends intervention research, program development and evaluation, implementation science, as well as training and consultation across diverse organizations and systems. My roles are also quite diverse, including as principal investigator and co-investigator on numerous federally funded grants, and as educator, clinician, and administrator in the Department of Psychiatry. The range and breadth of my expertise, and combined contributions have had a significant impact locally, regionally and nationally in moving the care of at-risk and trauma-affected children and families forward.

Most recently, I was awarded two large federal grants to promote research into action to improve outcomes for families affected by trauma and/or by caregiver substance use disorders (SUD). The first is a five-year $3.6 million grant from US Department of Health and Human Services Substance Abuse and Mental Health Services Administration as part of their "Linking Actions for Unmet Needs in Children's Health" grant program. This grant is the next step in my research and career progression, as it takes my

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interest and expertise in system change to a new level, that is to community level change. The aim of this project is to increase our community's ability to identify, engage and serve at-risk and trauma-affected families with evidence-based early intervention services, with an eventual goal of influencing early childhood policy and practice in both New Hampshire and Vermont. In this project, we will attempt to engage at-risk and trauma affected families with young children (0-8) in more non-traditional, naturalistic settings ultimately to prevent later more significant trauma related and behavioral health problems. This project brings together sectors of health, education, childcare, and business to implement community-wide system change through delivery of innovative, evidence-based practices for vulnerable children and families. At completion, we hope to increase our community's ability for early identification and intervention to mitigate the deleterious effects of trauma and adversity on young children and their caregivers.

In October, 2019, my colleague and I were awarded a five-year $2.6 million federal Regional Partnership Grant from the Administration of Children, Youth and Families (Jankowski and Barnett, Co-PIs) to develop and test a collaborative and comprehensive approach to meeting the complex needs of multigenerational families affected by caregiver SUD. The project aims to improve the safety, permanency and well-being of children and youth in or at-risk for being placed outside the home due to parental SUD, and to improve engagement and addiction treatment outcomes for caregivers. In our prior work with the NH child welfare system, we saw the unprecedented demands placed on child serving systems in our State due to the opioid epidemic. This grant will expand our community's established collaborative network of state agencies, health and service providers, and test the effectiveness of an individualized, family-driven Wraparound intervention for this population.

Prior to these most recent grants, I led a team that improved services for many of the most traumatized and vulnerable children and youth in our country, those in the child welfare and juvenile justice systems. Through two large demonstration projects funded by the US Department of Health and Human Services, Administration of Children, Youth and Families, Children's Bureau Division, we improved services for adjudicated (through abuse and neglect or delinquency charges) children and youth in New Hampshire with trauma and other behavioral health problems. Outcomes from the Partners for Change Project (Jankowski, P.I.) include: statewide systematic screening for trauma and its effects; data driven case planning; training of over 200 community-based clinicians in two trauma focused EBPs; and improved collaboration across service sectors. One year into Partners for Change, my team collaborated with the NH Department of Health and Human Services to submit another proposal under a similar funding mechanism, and we were awarded the New Hampshire Adoption Preparation and Preservation Project. The State of NH was the official recipient, but my team received 99% of the funds and has executed the project under my leadership. NHAPP focused on improving behavioral health outcomes for pre- and post-adopt children and adoption related outcomes. I am interested in processes that affect implementing trauma informed activities, such as universal screening, in complex and dynamic systems.

I have also partnered in innovative research to better understand change processes at the individual provider level. In collaboration with Trauma Focused Cognitive Behavioral Therapy (TF-CBT) developers, Drs. Judith Cohen and Anthony Mannarino, I was co-investigator and site P.I. on a NIH funded Ro1 to examine the feasibility of delivering TF-CBT to juvenile justice involved youth in residential treatment centers. This was a complicated Ro1, with multiple residential sites across New England. While it was feasible to train clinicians to deliver TF-CBT to youth in residential treatment facilities, and TF-CBT was effective for those who completed treatment, we had high attrition rates. We also learned that clinicians who were trained in person and received ongoing case consultation from a certified TF-CBT

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trainer, as opposed to web based training and consultation, had better outcomes. This study made a valuable contribution to the literature by demonstrating that higher intensity of training (in person vs. web-based only) resulted in better clinical practice (greater fidelity and treatment completion).

In addition to directing large scale demonstration projects, I have been a leader and participant in innovative practice change modalities, including breakthrough series and learning collaboratives, focused on creating more trauma informed cultures within different organizations. For example, I secured funding and was senior leader in a national federally funded Breakthrough Series Collaborative to apply a trauma-informed lens to improving placement stability for children in foster care. The breakthrough series collaborative brought 8 teams together from across the country comprised of a senior leader, representatives from mental health and child welfare, and parents who had been involved in the child welfare system. Subsequently, I became a faculty leader in a two-year learning collaborative sponsored by the State of Connecticut to create a more trauma-informed juvenile justice system. I was responsible for overseeing the collaborative, developing curriculum and training mental health providers, juvenile probation and parole officers and administrators in trauma-informed care and trauma focused CBT. As a result of this project, we transformed the culture of juvenile justice in CT to increase responsiveness to trauma and its effects, where 90% plus of youth involved with the system have been trauma affected. Most recently, I co-led a competitive application process to be one of 12 teams nationally participating in a federally funded learning collaborative to increase responsiveness of pediatric primary care clinics to meet the needs of families affected by trauma and adversity. We are working collaboratively towards creating a more trauma informed culture in General Academic Pediatrics at DHMC.

Although much of my career impact has come in my role as an investigator, it has also come as an educator and trainer. I teach and provide supervision to trainees (psychiatry residents and fellows and psychology interns and post docs) in my department, and also train and consult to community-based clinicians regionally. I am a certified TF-CBT trainer and a trainer of trauma-informed care practices. Over the course of my career, I have trained over 200 clinicians in TF-CBT, and numerous organizations and providers across the region to become more trauma-informed.

I also have had an increasing impact as an administrative leader in my department in my roles as Director of Psychology Services and Co-Director of Outpatient Services at DHMC. As Director of Psychology Services, I am a leader for the discipline of psychology within DHMC, identifying and pursuing opportunities for increased advancement of psychology within the institution, as well as supporting psychologists in their professional development. In my latest role as Co-Director of Outpatient Services, I have been tasked with restructuring current practices and structures in our outpatient psychiatric clinic, to more effectively and efficiently deliver outpatient psychiatric services and increase provider satisfaction.

The impact of my work as a clinical psychologist within the Department of Psychiatry has been significant across multiple roles as investigator, educator, clinician, and administrator. However, above all else and across the length of my career, I have been passionately committed to improving the care of children, youth and families affected by trauma, by training the workforce in trauma-informed care and bringing evidence-based practices to real world settings across a wide range of both health and social service sectors.

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J McLaren

CURRICULUM VITAE

Date Prepared: 01/23/2022

NAME: Jennifer McLaren, M.D.

ADDRESS: [redacted]

I. EDUCATION:

DATE	INSTITUTION	DEGREE
1997-2001	University of Notre Dame	B.A.
2001-2005	University of Medicine and Dentistry of New Jersey: Robert Wood Johnson Medical School	M.D.

II. POSTDOCTORAL TRAINING

DATE	INSTITUTION	SPECIALTY
07/2005-07/2008	Dartmouth Hitchcock Medical Center	Internship and General Psychiatry Residency
07/2008-08/2010	Dartmouth Hitchcock Medical Center	Child and Adolescent Psychiatry Fellowship

III. ACADEMIC APPOINTMENTS:

DATE	INSTITUTION	TITLE
07/2009-08/2010	Geisel School of Medicine at Dartmouth	Instructor in Psychiatry
09/2010-11/2020	Geisel School of Medicine at Dartmouth	Assistant Professor of Psychiatry
07/2017-11/2020	Geisel School of Medicine at Dartmouth	Assistant Professor of The Dartmouth Institute for Health Policy and Clinical Practice

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11/2020	Geisel School of Medicine at Dartmouth	Associate Professor of Psychiatry, Pediatrics and The Dartmouth Institute for Health Policy and Clinical Practice

IV. INSTITUTIONAL LEADERSHIP ROLES:

DATES	INSTITUTION	TITLE
09/2010-present	Neurodevelopmental Psychiatry Clinic at Dartmouth Hitchcock Medical Center	Co-Director
09/2010-present	Autism Spectrum Disorders Clinics in the Department of Psychiatry, Dartmouth Hitchcock Medical Center	Director
07/2014-present	Interdisciplinary Developmental Disabilities Clinics at Dartmouth Hitchcock Medical Center	Director
07/2015-present	Supported Employment Program For Individuals with Autism and Neurodevelopmental Disabilities	Director
1/2018-present	Behavioral and Neurodevelopmental Services at Dartmouth Hitchcock Medical Center	Director

V. LICENSURE AND CERTIFICATION:

DATE	LICENSURE/CERTIFICATION
2008-2010; 2021-	Vermont Medical License: 042.0011508
2010 -	New Hampshire Medical License: 14886
2010	American Board Psychiatry & Neurology: Board Certification in Adult Psychiatry and Neurology
2012	American Board Psychiatry & Neurology: Board Certification in Child and Adolescent Psychiatry
2020	American Board Psychiatry & Neurology: Board Recertification in Adult Psychiatry and Neurology

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VI. HOSPITAL OR HEALTH SYSTEM APPOINTMENTS:

DATES	INSTITUTION	POSITION/TITLE
04/2008-11/2010	Central Vermont Medical Center	Staff Moonlighting Psychiatrist
09/2010-present	Dartmouth Hitchcock Medical Center	Child, Adolescent and Adult Psychiatrist
07/2011-06/2014	Dartmouth Hitchcock Medical Center – Concord, Department of Pediatrics	Consulting Psychiatrist

VII. OTHER PROFESSIONAL POSITIONS:

DATES	INSTITUTION	POSITION/TITLE
09/2010-present	New Hampshire Bureau of Developmental Services	Medical Director
09/2010-06/2011	Wediko; Residential Treatment Facility, Hillsborough, New Hampshire	Consulting Psychiatrist
09/2011-present	New Hampshire Systemic Therapeutic Assessment Respite and Treatment (START) Program	Medical Director
07/2011-06/2014	Dartmouth Hitchcock Medical Center – Concord, Department of Pediatrics	Consulting Psychiatrist
07/2020-present	The National Center for START Services	Chief Medical Advisor

VIII. PROFESSIONAL DEVELOPMENT ACTIVITIES

DATES	INSTITUTION	TITLE	CREDITS
06/2010	University of Vermont Medical School: Leadership and Education Neurodevelopmental Program	Autism Diagnostic Observation Schedule Training	N/A
06/2010	University of Vermont Medical School: Leadership and Education Neurodevelopmental Program	Autism Diagnostic Interview Revised	N/A

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IX. TEACHING ACTIVITIES:

A. UNDERGRADUATE TEACHING: N/A

B. UNDERGRADUATE MEDICAL EDUCATION:

i. CLASSROOM TEACHING:

DATE	TEACHING
2012	Dartmouth Medical School, Research in Psychiatry Elective, Lecturer 1 hr
11/2014-2021	Dartmouth Medical School, Scientific Basis of Medicine Course, Introduction to Autism Spectrum Disorders, Lecturer 1 hr yearly lecture

ii. CLERKSHIP TEACHING: N/A

C. GRADUATE MEDICAL EDUCATION

DATE	TEACHING
2009	Dartmouth Hitchcock Medical Center, Adult Psychiatry Residency Didactics, Lecturer, Anxiety Disorders in Children, 1 hr lecture
2010-Present	Dartmouth Hitchcock Medical Center, Adult Psychiatry Residency Didactics, Lecturer, Caring for Individuals with Autism Spectrum Disorders, Intellectual and Developmental Disabilities, Lecturer 2-3 hrs yearly lectures
2010-Present	Dartmouth Hitchcock Medical Center, Child Psychiatry Fellowship Didactics, Lecturer, Autism Spectrum Disorders, Intellectual and Developmental Disabilities, Lecturer 3 hrs yearly lectures
2015-Present	Dartmouth Hitchcock Medical Center, Neurology Didactics, Lecturer, Autism Spectrum Disorders, Lecturer 1 hr. bi-yearly lecture
11/2017	Dartmouth Hitchcock Medical Center, Neuropsychology Didactics, Autism Spectrum Disorders Overview, Lecturer, 1 hr lecture

D. OTHER CLINICAL EDUCATION PROGRAMS

DATE	TEACHING
2012-Present	Dartmouth Hitchcock Medical Center, Continuing Medical Education Regularly Scheduled Series, Developmental Disabilities Educational Series, Activity Director and Speaker, 8 hrs/year
2013	Dartmouth Hitchcock Medical Center, Continuing Medical Education, ADOS II Training, Activity Director, 2-day conference; Provided a training for providers in New Hampshire and Vermont in how to administer the ADOS.
2014-Present	Dartmouth Hitchcock Medical Center, Continuing Medical Education, START Medical Directors Study Group, National Group Psychiatric Providers Participates in the Regularly Scheduled Series, Activity Director, 4 hr/year; Education series for a group of national psychiatric providers that focuses on best practices in providing

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care for people with intellectual and developmental disabilities.

2014 Dartmouth Hitchcock Medical Center, Continuing Medical Education, Social Thinking and Social Learning: Preschoolers and School Age Children, Activity Director and Speaker, 2 day conference

2015 Dartmouth Hitchcock Medical Center, Continuing Medical Education, Resilience and Supports: Adverse Childhood Events in Children with Autism and Neurodevelopmental Disabilities, Activity Director and Speaker, 2 day conference

2016 Dartmouth Hitchcock Medical Center, Continuing Medical Education, Uniquely Human: A Different Way to See Autism and Create Pathways to Success, Activity Director 8 hrs

2017 Dartmouth Hitchcock Medical Center, Continuing Medical Education, Positive Behavioral Interventions, and Supports: Neurodevelopmental Disabilities, Activity Director 8 hrs.

2018 Dartmouth Hitchcock Medical Center, Continuing Medical Education, Caring for Diverse Children and Youth with Autism and Neurodevelopmental Disabilities, Activity Director 8 hrs

2019 Dartmouth Hitchcock Medical Center, Continuing Medical Education, Neurodevelopmental Effects of Substance Abuse on Young Children, Activity Director 8 hrs

2021 Dartmouth Hitchcock Medical Center, Continuing Medical Education, Healthy Lifestyles for Youth with Neurodevelopmental Disorders, Activity Director 8 hrs

2021 Dartmouth Hitchcock Medical Center: Continuing Medical Education, Live Activity and Enduring Materials: Shared Decision Making for Youth Treated with Psychotropic Medications

X. PRIMARY RESEARCH ADVISING/MENTORING

A. UNDERGRADUATE STUDENTS

DATES	STUDENT'S NAME	PROGRAM
6/2018-8/2018	Alissa Cole	DHMC Internship

B. GRADUATE STUDENTS: N/A
C. MEDICAL STUDENTS: N/A
D. RESIDENTS/FELLOWS: N/A
E. OTHERS: N/A

XI. ADVISING/MENTORING

A. UNDERGRADUATE STUDENTS

DATES	STUDENT'S NAME	PROGRAM
1/2015-3/2015	Molly Chodakewitz	Nathan Smith Society

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4/2015-06/2015	Song Heu Cho	Nathan Smith Society

B. GRADUATE STUDENTS

DATES	STUDENT'S NAME	PROGRAM
08/2016-5/2017	Sarah Bessen	The Dartmouth Institute

C. MEDICAL STUDENTS: N/A

D. RESIDENTS/FELLOWS

DATES	STUDENT'S NAME	PROGRAM
2010-2012	Sarah Walsh, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2010-2012	Linda Call, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2010-2012	Aneek Singh Fisher, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2011-2013	Lynn McCormick, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2011-2013	Karin Reed, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2011-2013	Michael Przydzielski, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2011-2013	Stacey Carloni, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2012-2014	Cynthia Swartz, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2012-2014	Sarah Savage, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2013-2015	Erika Ebert, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2013-2015	Christine Miller, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2014-2016	Paul Bryant, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock

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2014-2016	Heather Shackett, M.D.	Medical Center Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2014-2016	Shazia Savul, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2015-2017	Larry Mitnaul, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2015-2017	Katie Shea, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2016-2018	Antra Bami, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2016-2018	Judith Fernando, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2016-2018	Kish Gosai, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2017-2019	John Ryder, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2017-2019	Rejini Thomas, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2017-2019	Sirin Tapan, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2018-	Tania Sarkaria, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2019-	Stephen Bettweiser, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2019-	Daniel Bigman, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2019-	Joel Peterson, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2019-	Christine Oh, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock

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		Medical Center
2019-	Dinesh Sangroula, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2020-	Omar Shah, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2020-	Sarah Vaithilingam, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2021-	Linda Gao, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2021-	Kat Han, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2021-	Rebecca John, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center
2021-	Sarah Slabaugh, M.D.	Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center

E. FACULTY:

2018-2020	Mirella Maggi, PhD	Child Psychiatry Section: Dartmouth Hitchcock Medical Center
2021-	Katelyn Ahlers, PhD	Child Psychiatry Section: Dartmouth Hitchcock Medical Center

XII. ENGAGEMENT, COMMUNITY SERVICE/EDUCATION

DATE	Institution/Organization	Role	Hours/Year
04/2013	Parenting New Hampshire:	Speaker	4 hours prep; 1 hr lecture
10/2014	Monarch School	Speaker	8 hours prep; 2 hr lecture
04/2015	Lyme Collaborative	Speaker	4 hours prep; 1 hr lecture
2010-	New Hampshire Leadership	Advisor for clinical	Variable time

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Present	Educational Neurodevelopmental Program	trainees	commitment per year based on number of trainees
2010-Present	New Hampshire Care-Path Algorithm: Disseminated throughout New Hampshire	Developer	2010: 25 hours; then 1-2 hours per year updating
2019	Caring For Transition Age Youth with Autism Spectrum Disorder	Director/Speaker of Community Event	2019: 25 hours
2021	Health Care Today Podcast: WDEV Radio	Guest Speaker: Autism Spectrum Disorder	1 hour prep: 1 hour discussion

XIII. RESEARCH FUNDING, GRANTS, PHILANTHROPIC SUPPORT: CURRENT

2021-2026
Continued Expansion of Autism Spectrum Disorder Services in New Hampshire and Vermont
Principal Investigator (C): Mosenthal Pediatric Autism Endowment: Supports the continued running and expansion of the autism services at Dartmouth including multidisciplinary clinics, provider time, and continuing medical education initiatives.
20% of FTE
Thomas Marshall Foundation
$1,00,0000 (Total direct costs)

2020-2021
Continued Expansion of Autism Spectrum Disorder Services in New Hampshire and Vermont
Principal Investigator (C): Supports the expansion of the autism services at Dartmouth including multidisciplinary clinics, provider time, and continuing medical education initiatives.
20% of FTE
Thomas Marshall Foundation
$100,000 (Total direct costs)

2018-Current
Supported Employment Program: Individual Placement and Support Program
Principal Investigator (C) : Continued grant for the supported employment program at a private group home.
Natalia Mental Health Foundation
2.5% of FTE
$78,400 (Total direct costs)

2018-Current
Supported Employment Program: Individual Placement and Support Program
Principal Investigator (C) : Grant to develop a scholarship program for individual with autism spectrum disorder and expand the program

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Private Donors
$65,000 (Total direct costs)

2014-2020
Expanding Autism Spectrum Disorder Services in New Hampshire and Vermont
Principal Investigator (C): Supports the expansion of the autism services at Dartmouth including multidisciplinary clinics, provider time, and continuing medical education initiatives.
20% of FTE
Thomas Marshall Foundation
$1,050,000 (Total direct costs)

2014-Current
Supported Employment Program for People with Autism Spectrum Disorders
Principal Investigator (C) : Funds the evidence-based supported employment program for people with autism spectrum disorders
Private Donor
$150,000 (Total direct costs)

PAST
2017
Supported Employment Program: Individual Placement and Support Program Expansion
Principal Investigator (C): Expansion of supported employment program to a private group home
Natalie Mental Health Foundation
$14,400 (Total direct costs)

2016-2018
Autism Research Initiative at Dartmouth
Co-Principal Investigator (C): Cross-sectional study exploring Psychotropic Medication Use in Children with Developmental Disabilities; Beta testing a support app for people with autism spectrum disorder
10% of FTE
Private Donor
$50,000 (Total direct costs)

2015-2017
Transition Age Care for People with Autism Spectrum Disorders
Principal Investigator (C): Initial support and expansion of medication consultation clinics for children, adolescents and young adults with autism.
Private Donor
$60,000 (Total direct costs)

2012
National Survey of Child and Adolescent Psychiatrists Monitoring of Second Generation Antipsychotics
Principal Investigator (C): Largest national survey investigating child psychiatrists monitoring, knowledge, attitudes, and perceived barriers to monitoring for side effects when prescribing second-generation antipsychotics to children

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5% of FTE
Department of Psychiatry, Geisel School of Medicine, Gary Tucker Junior Investigator Research Award
$20,000 (Total direct costs)

2010-2013
Enhancing Autism Spectrum Disorder Programs in the Dartmouth Region
Co-Principal Investigator: Supported multidisciplinary autism and neurodevelopmental disabilities clinics
Private Donor
$150,000 (Total direct costs)

XIV. PROGRAM DEVELOPMENT

DATES	Role	Program
2010-present	Director	Neurodevelopmental Psychiatry Clinic at Dartmouth Hitchcock Medical Center: (Clinical/Educational): A unique clinic model that provides comprehensive evaluations to children and families throughout New England. Residents, Fellows and LEND Trainees rotate through the clinic and each year the clinic receives evaluations noting it is an excellent training experience.
2011-present	Director	Autism Spectrum Disorders/ADOS Clinic: (Clinical/Educational): Established and supervise this diagnostic clinic for children with autism spectrum disorders.
2012-Present	Activity Director	Continuing Medical Education Series: (Educational) Developed multiple different continuing medical education series that reach a regional and national audience focused on caring for individuals with developmental disabilities. I have received a teaching award for one of these Continuing Medical Education Series.
2015-present	Administrator	Autism Care Clinic: (Clinical) Developed a psychiatric continuity clinic for children and transition age youth with autism spectrum disorders
07/2014-present	Director	Interdisciplinary Developmental Disabilities Clinics at Dartmouth Hitchcock Medical Center: (Clincal/Educational) Developed, organized, and oversee this New Hampshire state funded interdisciplinary clinic that encompasses psychiatry, neuropsychology, internal medicine, neurology, and occupational therapy. This is a unique clinic model, which I have presented at a national conference and consulted with other states (New York, North Carolina and California) to help them replicate our clinic.
07/2015-present	Director	Supported Employment Program For Individuals with Autism and Neurodevelopmental Disabilities: (Clinical) Started and oversee this program that helps people with autism spectrum disorder and

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developmental disabilities obtain and maintain competitive employment. This model of employment for individuals with ASD has received national attention; I was an invited speaker at the Autism Speaks: Thought Leadership Conference regarding how to further disseminate the clinic model nationally.

XV. ENTREPRENEURIAL ACTIVITIES: N/A

XVI. MAJOR COMMITTEE ASSIGNMENTS:

National/International

DATES	COMMITTEE	ROLE	INSTITUTION
2013-2015	Diagnostic Manual Intellectual Disabilities -2: Anxiety Disorders Work Group	Member	National Association of Developmental Disabilities
2013-2015	Diagnostic Manual Intellectual Disabilities -2: ADHD Work Group	Member	National Association of Developmental Disabilities
2014-Present	START Medical Directors Study Group	CME Activity Director	National Center for START Services
2019-Present	Autism and Intellectual Disability Committee	Volunteer Member	American Academy of Child and Adolescent Psychiatry
2020-Present	National Team: National Center for START Services	Chief Medical Advisor	National Center for START Services

Regional

DATES	COMMITTEE	ROLE	INSTITUTION
2010-Present	Medication Review Committee for Individuals with Developmental Disabilities and Acquired Brain Disorders	Chairperson	New Hampshire Bureau of Developmental Services

Institutional

DATES	COMMITTEE	ROLE	INSTITUTION
2007-2008	Adult Psychiatry Residency Curriculum Committee	Resident Representative	Dartmouth Hitchcock Medical Center
2010-Present	Child Psychiatry Fellowship: Program Evaluation Committee	Member	Dartmouth Hitchcock Medical Center
2010-Present	Child Psychiatry Fellowship: Clinical Competency Committee	Member	Dartmouth Hitchcock Medical Center

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2010-Present	Child Psychiatry Fellowship: Interview and Selection Committee	Member	Dartmouth Hitchcock Medical Center
2017-Present	Vulnerable Children's Research Group	Member	The Dartmouth Institute for Health Policy and Clinical Practice

XVII. MEMBERSHIP, OFFICE & COMMITTEE ASSIGNMENTS IN PROFESSIONAL SOCIETIES:

DATES	INSTITUTION	POSITION/TITLE
2005-Present	Gold Humanism Honor Society	Member
2006-Present	American Academy of Child and Adolescent Psychiatry	Member
2006	The New England Council of Child and Adolescent Psychiatry	Member
2006-2010	American Psychiatric Association	Member
2006-2010	New Hampshire Psychiatric Society	Member

XVIII. EDITORIAL BOARDS:

DATES	INSTITUTION	POSITION/TITLE
2008-2009	Resident Editor	American Journal of Psychiatry: Residents' Edition

XIX. JOURNAL REFEREE ACTIVITY

DATES	JOURNAL NAME
2016-Present	Psychiatric Services: Reviewer
2017-Present	Journal of Autism and Developmental Disorders
2017-Present	International Journal of Developmental Disabilities
2017-	Journal of Child and Adolescent Psychopharmacology

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Present	
2018-Present	Expert Opinion on Pharmacotherapy
2018-Present	The Journal of Clinical Psychiatry
2018-Present	Disability and Rehabilitation
2021-Present	Administration and Policy in Mental Health and Mental Health Services Research

XX. AWARDS AND HONORS:

DATE	AWARD
1997	Notre Dame Scholar, University of Notre Dame – top 25% of entering freshman class
1999-2001	Notre Dame Dean's Honor List
2002	Robert Wood Johnson Medical School: Family Medicine Summer Grant Award
2002	Robert Wood Johnson Medical School: Environmental and Community Medicine Proposal Grant Award
2003-2004	Medical School Clerkship Honors: Adult Psychiatry Sub-Internship, Internal Medicine Sub-Internship, Psychiatry, Pediatrics, Internal Medicine, Family Medicine, Neurology, Pain-Medicine and Rehabilitation
2005	Elected to Gold Humanism in Medicine Honor Society
2007	APA/Shire Child and Adolescent Psychiatry Fellowship
2008	Adult Psychiatry Resident Community Psychiatry Award: Dartmouth Hitchcock Medical Center, Department of Psychiatry
2009	Chief Resident Child Psychiatry Fellowship: Dartmouth Hitchcock Medical Center, Department of Psychiatry
2012-2013	Gary Tucker Junior Investigator Award: Geisel School of Medicine, Department of Psychiatry
2014	Clinical Excellence Award: Geisel School of Medicine, Department of Psychiatry
2014	Teaching Excellence Award for Continuing Medical Education Programming at Dartmouth Hitchcock Medical Center

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2017	Clinical/Medical Leadership Award: Caring for Individuals with Developmental Disabilities – START National Program

XXI. INVITED PRESENTATIONS:

(*) presentations invited to present

(#) presentations not individually invited to present (e.g. large society meeting)

(^) presentation applicable as a CME activity.

A. International:

DATE	TOPIC/TITLE	SPONSORING ORGANIZATION	LOCATION
05/2019	*Autism Spectrum Disorders and IPS	International Individual Placement and Support Learning Community	Denver, Colorado
08/2019	#Optimizing psychotropic drug prescribing – from data to practice	International Association Scientific Study of Intellectual and Developmental Disabilities	Glasgow, Scotland

B. National:

DATE	TOPIC/TITLE	SPONSORING ORGANIZATION	LOCATION
05/2008	#^Neurodevelopmental Case Formulation	American Psychiatric Association Conference	Washington, D.C.
03/2016	*Through the Looking Glass: Implications of Current Trends in Psychopharmacologic Treatment in People with Intellectual and Developmental Disabilities	The Center for START Services National Conference	Atlanta, Georgia
03/2016	*Psychopharmacology and What Can Help When Nothing Else Works	The Center for START Services National Conference	Atlanta, Georgia
05/2017	*Searching for the Magic Bullet	The Center for START Services National Conference	Rye Brook, New York
05/2017	*Psychopharmacology of Autism	The Center for	Rye Brook, New York

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	Spectrum Disorders	START Services National Conference	
05/2018	*^ Evidence Based Medicine: What Do We Really Know about Treating People with IDD and Behavioral Health Challenges?	The Center for START Services National Conference	Boston, Massachusetts
05/2018	*^ The Whole Is Greater Than the Sum of its Parts: Benefits of a Multidisciplinary Approach	The Center for START Services National Conference	Boston, Massachusetts
05/2019	*^ Research Discussion Panel	The Center for START Services National Conference	Washington, D.C.
05/2019	*^Diagnostic Overshadowing of Anxiety in Individuals with Intellectual and Developmental Disability	The Center for START Services National Conference	Washington, D.C.
05/2019	*^Why Don't We Practice What We Preach	The Center for START Services National Conference	Washington, D.C.
10/2019	#^On the Clock: The Power of Competitive Employment for Transition Age Youth with Autism Spectrum Disorder	American Academy of Child and Adolescent Psychiatry	Chicago, Illinois
12/2019	*Individual Placement and Support for Individuals with ASD	Autism Speaks: Though Leadership Conference on Health Equity	Washington, D.C.
08/2020	*The Importance of the Biopsychosocial Formulation for Individuals with Intellectual and Developmental Disability	Center for START Services	Virtual Meeting

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10/2020	#^The Chat: How to Help Youth with Intellectual and Developmental Disorder Transition into Adulthood	American Academy of Child and Adolescent Psychiatry	Virtual Meeting
10/2020	*The Cultural Formulation Interview for Individuals with Intellectual and Developmental Disabilities	Center for START Services	Virtual Meeting
08/2021	*Integrated Mental Health Treatment Guidelines for Prescribers in Intellectual and Developmental Disabilities	Mental Health Summit 2021: University Center of Excellence Developmental Disabilities	Virtual Meeting
10/2021	#^The Chat: How to Help Youth with Intellectual and Developmental Disorder Transition into Adulthood	American Academy of Child and Adolescent Psychiatry	Virtual Meeting
10/2021	#^How COVID-19 Impacted the System of Care for Individuals with Intellectual Developmental Disorders (IDD	American Academy of Child and Adolescent Psychiatry	Virtual Meeting
10/2021	#^Caring for Children with Intellectual Developmental Disorers (IDD) Impacted by Trauma	American Academy of Child and Adolescent Psychiatry	Virtual Meeting

C. Regional/Local:

DATE	TOPIC/TITLE	SPONSORING ORGANIZATION	LOCATION
2/2008	*Signs and Symptoms of Substance Use and Abuse	West Central Behavioral Health	Claremont, New Hampshire
4/2009	*Pervasive Developmental Disorder in Children	River Valley Community College, Physical Therapy Association Program	Claremont, New Hampshire

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06/2010	*Psychotic Disorder in Children	West Central Behavioral Health	Lebanon, New Hampshire
04/2011	*Bipolar Affective Disorder in Children with Developmental Disabilities	Institute on Disability	Concord, New Hampshire
04/2011	*Fetal Alcohol Effects and Clinical Consequences: Case Conference	Institute on Disability	Concord, New Hampshire
05/2011	*Managing Irritability and Aggression in People with Developmental Disabilities	Community Council	Nashua, New Hampshire
09/2011	*ADHD in Children with Special Needs	Bureau of Developmental Services/ Special Medical Services	Concord, New Hampshire
03/2013	*^Autism Spectrum Disorders: Psychopharmacology Review	Children's Hospital at Dartmouth	Bretton Woods, New Hampshire
06/2013	*^ Grand Rounds: Mental Health Issues in People with Intellectual Disabilities	New Hampshire Hospital	Concord, New Hampshire
01/2014	*^Monitoring of Second Generation Antipsychotics: National Survey of Child and Adolescent Psychiatrists	Dartmouth Psychiatric Research Center	Lebanon, New Hampshire
03/2014	*Supporting the Needs of Children with Autism Spectrum Disorders and their Families	New Hampshire National Association of Social Workers Conference	Concord, New Hampshire
04/2014	*Perspectives on Autism	New Hampshire Children's Trust, Parenting New Hampshire	Manchester, New Hampshire
05/2014	*^Dartmouth Psychiatry Grand Grounds: Monitoring of Second Generation Antipsychotics: A	Dartmouth Hitchcock Medical Center	Lebanon, New Hampshire

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	National Survey of Child and Adolescent Psychiatrists		
10/2014	*Managing Challenging Behavior in Children with Autism Spectrum Disorders	Monarch School	Rochester, New Hampshire
11/2014	*^Grand Rounds: Autism Through the Lifespan	New Hampshire Hospital	Concord, New Hampshire
04/2015	*Autism Diagnosis: Now What?	Lyme Collaborative	Lyme, New Hampshire
04/2018	*^Evidence-based use of Antipsychotics in Children	St. Anselm College	Concord, New Hampshire
12/2018	*^Grand Rounds: Dual Diagnosis: Mental Health Disorders in Individuals with Intellectual Disability	New Hampshire Hospital	Concord, New Hampshire
07/2019	*Dual Diagnosis: Intellectual Disability and Mental Illness Part I	Community Support Network, Inc.	Concord, New Hampshire
08/2019	*Dual Diagnosis: Intellectual Disability and Mental Illness Part II	Community Support Network, Inc.	Concord, New Hampshire
10/2019	*Recognizing Mental Illness in Individuals with IDD	New Hampshire Bureau of Mental Health Services	Concord, NH
02/2020	*Dual Diagnosis: Intellectual Disability and Mental Illness	Developmental Disabilities Nurses of New Hampshire	Concord, NH
06/2021	*Diagnosing Using the DM-ID-2	Community Crossroads Collaborative Care Series	Virtual Training Series
11/2021	*Behavioral and Neurodevelopmental Services	New Hampshire Autism Council	Virtual Meeting
12/2021	*Autism and Aging	Gateways	Virtual Training Series

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XXII. BIBLIOGRAPHY:

A. **Peer Reviewed Publications** (students and trainees have a double underline)

Original Articles:

1. Millard H, **McLaren JL**, Coffey BJ. Lurisadone Treatment in a Child with Autism Spectrum Disorder with Irritability and Aggression. Journal of Child and Adolescent Psychopharmacology 2014; Aug;24(6):354-6. doi: 10.1089/cap.2014.2462. PubMed PMID: 25137189; PubMed Central PMCID: PMC4137329.

2. **McLaren JL**, Brunette MB, McHugo GJ, Drake RE, Daviss WB. Monitoring of Patients on Second-Generation Antipsychotics: A National Survey of Child Psychiatrists. Psychiatric Services 2017 Sep 1;68(9):958-961. doi: 10.1176/appi.ps.201500553. Epub 2017 Apr 17. PubMed PMID: 28412899.

3. **McLaren JL**, Lichteinstein J, Lynch D, Becker D, Drake RE. Individual Placement and Support for People with Autism Spectrum Disorders: A Pilot Program. Administration and Policy in Mental Health and Mental Health Services Research. 2017 May;44(3):365-37. doi: 10.1007/s10488-017-0792-3. PubMed PMID: 28176032.

4. Cotes RO, Fernandes NK, **McLaren JL,** McHugo GJ, Bartels SJ, Brunette MF. Improving Cardiometabolic Monitoring of Children on Antipsychotics. J Child Adolesc Psychopharmacol. 2017 Dec; 27 (10): 916-919. doi: 10.1089/cap.2017.0034. Epub 2017 Jun 5. PubMed PMID: 28581341

5. Barnett ER, Trepman AZ, Fuson HA, Aquilano SC, **McLaren JL**, Woloshin S, Leyenaar JK. Deprescribing psychotropic medications in children: Results of a national qualitative study. *BMJ Quality and Safety.* 2019 Dec 13. PMID: 31836627

6. McEnany FB, Ojugbele O, Doherty JR, **McLaren JL,** Leyenaar JK. Pediatric Mental Health Boarding. Pediatrics, 2020 Oct;146(4):e20201174. doi: 10.1542/peds.2020-1174. Epub 2020 Sep 22. PMID: 32963020.

7. Charlot LR, Doerfler LA, **McLaren JL**. Psychotropic medications use and side effects of individuals with intellectual and developmental disabilities. J Intellect Disabil Res, 2020 Sep 21; doi: 10.1111/jir.12777. Epub 2020 Sep 21. PMID: 32959471

8. Kalb LG, Beasley JB, Caoili A, **McLaren JL**, Barnhill J. Predictors of Mental Health Crises Among Individuals With Intellectual and Developmental Disabilities Enrolled in the START Program. Psychiatr Serv. 2020 Dec 18:appips202000301. doi: 10.1176/appi.ps.202000301. Epub ahead of print. PMID: 33334153.

9. **McLaren JL**, Lichtenstein JL, Metcalfe JD, Charlot LR, Drake RE, Beasley JB. Psychotropic Use Among Youths With Intellectual and Developmental Disabilities. Psychiatr Serv. pr 22 2021:appips201900465. doi: 10.1176/appi.ps.201900465. Epub ahead of print. PMID: 33882691.

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10. **McLaren, JL**, Barnett, E. R., Acquilano, S.C., Concepcion Zayas, M.T., Drake, R.E., Leyenaar, J.K. Psychotropic Polypharmacy and Antipsychotics in Children: A Survey of Caregiver's Perspectives. Community Mental Health Journal, May 31, 2021.

Most significant publications: I have been particularly interested in the overuse of antipsychotics and psychotropic medications in children and adolescents (particularly vulnerable children such as those with autism and developmental disabilities) and how prescribers monitor children treated with these regimens. These publications document this problem and provide recommendations on how to reduce antipsychotic use and polypharmacy. I have published the largest national cross-sectional study of the use of psychotropic medications in individuals with developmental disabilities. I have also conducted and published the largest national survey of child and adolescent psychiatrists investigating physician monitoring when prescribing second-generation antipsychotics to children. I led the development of a deprescribing tool, to help clinicians safely reduce and discontinue antipsychotics in children. With a team of researchers at The Dartmouth Institute (Glyn Elwyn and Erin Barnett), we submitted an R34 Grant to the NIH to further study the deprescribing tool. Our grant was submitted in June 2021.

A. **McLaren JL**, Brunette MB, McHugo GJ, Drake RE, Daviss WB. Monitoring of Patients on Second-Generation Antipsychotics: A National Survey of Child Psychiatrists. Psychiatric Services 2017 Sep 1;68(9):958-961. doi: 10.1176/appi.ps.201500553. Epub 2017 Apr 17. PubMed PMID: 28412899. (peer reviewed)
B. **McLaren JL**, Barnett ER, Concepcion Zayas MT, Lichtenstein J, Acquilano SC, Schwartz LM, Woloshin S, Drake RE. (2018). Psychotropic medications for highly vulnerable children. Expert Opin Pharmacother, Apr 2018; 19(6): 547-560. doi:10.1080/14656566.2018.1445720 (invited/reviewed by editors)
C. **McLaren JL,** & Lichtenstein JD. The pursuit of the magic pill: the overuse of psychotropic medications in children with intellectual and developmental disabilities in the USA. Epidemiol Psychiatr Sci, Oct 24 2018: 1-4. doi:10.1017/s2045796018000604 (invited/reviewed by editors)
D. **McLaren JL**, Lichtenstein JL, Metcalfe JD, Charlot LR, Drake RE, Beasley JB. Psychotropic Use Among Youths With Intellectual and Developmental Disabilities. Psychiatr Serv. pr 22 2021:appips201900465. doi: 10.1176/appi.ps.201900465. Epub ahead of print. PMID: 33882691.

Most significant body of work: My most significant body of work is in program development. The contributions and significance of this work is reflected in my personal statement and section XIV of this CV.

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Reviews:

1. **McLaren JL.** An Interview with Amy Wallace M.D. Managing a Family and an Academic Career. American Journal of Psychiatry Residents' Edition 2008; 165: A54, 1 (invited/reviewed by editors)

2. **McLaren JL.** The Great Balancing Act: Pregnancy During Residency. American Journal of Psychiatry Residents' Edition 2008; 165: A 54, 2. (invited/reviewed by editors)

3. **McLaren JL.** An Interview with Robert Zipursky M.D. Early Interventions in Psychiatry. American Journal of Psychiatry Residents' Edition 2009; 166: A18, 3-4. (invited/reviewed by editors)

4. **McLaren JL.** Autism Spectrum Disorders: Importance of Early Diagnosis and Intervention. American Journal of Psychiatry Residents' Edition 2009; 166 A18, 7-8. (invited/reviewed by editors)

5. **McLaren JL**, Barnett, ER, Concepcion Zayas, MT, Lichtenstein, J, Acquilano, SC, Schwartz, LM, Woloshin, S, Drake, R. E. (2018). Psychotropic medications for highly vulnerable children. *Expert Opin Pharmacother,* Apr 2018; 19(6): 547-560. doi:10.1080/14656566.2018.1445720 (invited/reviewed by editors)
6. **McLaren JL.,** & Lichtenstein JD. The pursuit of the magic pill: the overuse of psychotropic medications in children with intellectual and developmental disabilities in the USA. *Epidemiol Psychiatr Sci*, Oct 24 2018: 1-4. doi:10.1017/s2045796018000604 (invited/reviewed by editors)
7. Leyenaar JK, & **McLaren JL.** Healthcare Quality for Children and Adolescents with Suicidality Admitted to Acute Care Hospitals in the United States. *J. Hosp. Med* Nov 2018;11;795-796. doi:10.12788/jhm.3092 (invited/reviewed by editors)

Book Chapters:

1. **McLaren JL**, Donnelly C. "Assessment of Post-Traumatic Stress Disorders." *Pediatric Psychopharmacology – Principles and Practice, Second Edition.* Ed. Martin, A, Scahill, L, Kratochvil, C. New York: Oxford University Press, 2011. 561-569 Print.

2. Hellings JA, Reiersen A, Mao A, Arnold LE, Pearson D, Aman M, Handen B, **McLaren, J**. "Attention-Deficit Hyperactivity Disorder." *Diagnostic Manual Intellectual Disabilities-2.* Ed. Fletcher, R, Barnhill, J, Cooper, S. New York: NADD Press, 2016. 115-156. Print.

3. Cooray S, Andrews T, Bailey N, Devapriam J, **McLaren J**, Purandare K, Jaydeokar, Tasse, M, Wijeratne A. "Anxiety Disorders." *Diagnostic Manual Intellectual Disabilities-2.* Ed. Fletcher, R, Barnhill, J, Cooper, S. New York: NADD Press, 2016. 303-328. Print

4. **McLaren JL**, Lichtenstein J, Bessen S, Baldwin F. " Autism Spectrum and Other Developmental Disorders and ADHD." *Moodiness in ADHD.* Ed. Daviss, W. Springer Nature, 2017. Chapter 9. Print.

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B. Other Scholarly Work

1. **McLaren JL**, Schwartz JC. Concerns with an Ethanol Protocol to Prevent Alcohol Withdrawal Symptoms. Journal of the American College of Surgeons. 2007 Jul; 205 (1):190-191. PubMed PMID: 17617352.

2. **McLaren JL**, Cauble S, Barrnett RJ. Aripiprazole Induced Acute Dystonia After Discontinuation of Stimulant Medication. Journal of Clinical Psychopharmacology. 2010 Feb;30(1):77-8. doi: 10.1097/JCP.0b013e3181c92eb2. PubMed PMID: 20075654.

3. **McLaren, JL**. "Depressive Disorders." *Integrated Mental Health Treatment Guidelines for Prescribers in Intellectual and Developmental Disabilities.* Ed. Barnhill, J., Beasley, J, Caoili, A, Hecker, M, Klick, S, 2021.Retrieved from https://centerforstartservices.org/IDD-MH-Prescribing-Guidelines.

4. **McLaren, JL**. "Bipolar and Related Disorders." *Integrated Mental Health Treatment Guidelines for Prescribers in Intellectual and Developmental Disabilities.* Ed. Barnhill, J., Beasley, J, Caoili, A, Hecker, M, Klick, S, 2021.Retrieved from https://centerforstartservices.org/IDD-MH-Prescribing-Guidelines.

5. **McLaren, JL**. "Prescribing in Mental Health Crisis." *Integrated Mental Health Treatment Guidelines for Prescribers in Intellectual and Developmental Disabilities.* Ed. Barnhill, J., Beasley, J, Caoili, A, Hecker, M, Klick, S, 2021.Retrieved from https://centerforstartservices.org/IDD-MH-Prescribing-Guidelines.

C. Abstracts:

1. #**McLaren JL,** Brunette M, McHugo G, Daviss W. Metabolic Monitoring of Second Generation Antipsychotics: National Survey of Child Psychiatrists. American Psychiatric Association Meeting. New York, New York 5/2014.

2. #**McLaren JL,** Brunette M, McHugo G, Daviss W. Monitoring of Second Generation Antipsychotics: National Survey of Child Psychiatrists. Institute on Psychiatric Services. San Francisco, California 10/2014

3. #Haskins AJ, Botch, T, Garcia J, McLaren, J, Robertson C. Measuring Naturalistic Attention in Complex, Real-World Environments in Autism. INSAR, Virtual 5/2021

4. #McLaren J. 25.5 How COVID-19 Impacted the System of Care for Individuals with Intellectual Developmental Disorders (IDD). *J Am Acad Child Adolesc Psychiatry*. 2021;60(10):S38-S39. doi:10.1016/j.jaac.2021.07.170

5. #McLaren J. 67.4 Caring for Children with Intellectual Developmental Disorers (IDD) Impacted by Trauma. *J Am Acad Child Adolesc Psychiatry*. 2021;60(10):S99-S100. doi: 10.1016/j.jaac.2021.07.417

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CURRICULUM VITAE

11/9/2021

JONATHAN DANIEL LICHTENSTEIN, PsyD, MBA

OFFICE ADDRESS: [redacted]

EMAIL: [redacted]

I. EDUCATION:

Dates	Institution	Degree
June 2005	Hampshire College, Amherst, MA	Bachelor of Arts, German Studies
May 2012	Widener University, Chester, PA	Master of Business Administration
June 2012	Widener University, Chester, PA	Doctor of Psychology

PRE-DOCTORAL TRAINING:

Dates	Institution	Specialty
2007-2008	Norristown State Hospital, Norristown, PA	Practicum Student
2008-2009	Neuropsychology and Behavioral Health, Newark, DE & Media, PA	Practicum Student
2009-2010	Montgomery School & Center for Psychological Services, Chester Springs, PA & Paoli, PA	Practicum Student
2010-2012	The Institute for Graduate Clinical Psychology, Chester, PA	Neuropsychology Intern

II. POST-DOCTORAL TRAINING:

Dates	Institution	Specialty
2012-2013	Sports Concussion Center of New Jersey, Lawrenceville, NJ	Neuropsychology Post-Doctoral Resident
2013-2014	Geisel School of Medicine at Dartmouth, Hanover, NH	Pediatric Neuropsychology Post-Doctoral Fellow

III. ACADEMIC APPOINTMENTS:

Dates	Institution	Title
2012-2017	Widener University, Chester, PA	Adjunct Professor of Clinical Psychology
2014-2016	Geisel School of Medicine at Dartmouth	Instructor in Psychiatry
2014-present	Antioch University-New England, Keene, NH	Adjunct Professor of Clinical Psychology

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2016-present	Geisel School of Medicine at Dartmouth	Assistant Professor of Psychiatry
2017-present	Geisel School of Medicine at Dartmouth	Assistant Professor of The Dartmouth Institute
2017-present	Geisel School of Medicine at Dartmouth	Assistant Professor of Pediatrics

IV. PROFESSIONAL DEVELOPMENT ACTIVITIES

Dates	Sponsoring Institution	Title	Credits
May 2014	Collaborative Institutional Training Initiative	Good Clinical Practice	1.00
June 2014	Dartmouth-Hitchcock	Developmental Disabilities Education Series	3.00
June 2014	American Academy of Clinical Neuropsychology	Supervision in Pediatric Neuropsychology: Ethical, Practical, and Structural Issues	3.00
January 2015	Collaborative Institutional Training Initiative	Responsible Conduct of Research	1.00
February 2015	International Neuropsychological Society	INS 43rd Annual Meeting	5.00
May 2015	Brain Injury Association of New Hampshire	BIANH 32nd Annual Conference	5.00
July 2015	Committee on Institutional Cooperation	Big-Ten/Ivy League TBI Research Summit	5.00
April 2016	Genesis Continuing Education Group	Ethical Principles of Psychologists and Code of Conduct	1.00
May 2016	Ce4Less.com	Suicide Assessment and Treatment	3.00
May 2016	Dartmouth-Hitchcock	Faculty Development Session	1.00
July 2016	The Big-Ten Conference	Big-Ten/Ivy League TBI Research Summit	5.00
December 2016	ImPACT Applications, Inc.	ImPACT Training Workshops	3.00
May 2017	Dartmouth-Hitchcock	Positive Behavioral Intervention and Supports for Children and Youth with Neurodevelopmental Disabilities	5.00
July 2017	The Big-Ten Conference	Big-Ten/Ivy League TBI Research Summit	5.00
August 2017	Collaborative Institutional Training Initiative	Human Research, Social/Behavioral Research	1.00
September 2017	Dartmouth-Hitchcock	Safety Behaviors for Error Prevention Training	2.75
September 2017	Dartmouth-Hitchcock	Current Concepts in Sports Concussion	2.75

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May 2018	42nd Williamsburg TBI Conference	Ethics in Inter-disciplinary Care	1.50
May 2018	CE4Less.com	Ethics & Boundary Issues	3.00
July 2018	The Big-Ten Conference	Big-Ten/Ivy League TBI Research Summit	5.00
July 2019	The Big-Ten Conference	Big-Ten/Ivy League TBI Research Summit	5.00
Spring 2021	New Hampshire Listens	Race and Equity Series	6.00
March 2021	Massachusetts Neuropsychology Society	Rehabilitation from COVID-19 in Adults	2.00
April 2021	American Academy of Pediatric Neuropsychology	7th Annual Conference	17.50
Summer 2021	Dartmouth-Hitchcock	Leading at D-HH	20.00

V. DARTMOUTH INSTITUTIONAL LEADERSHIP ROLES:

Dates	Institution	Title
2014-present	Geisel School of Medicine at Dartmouth	Director, Pediatric Neuropsychology
2014-present	Dartmouth-Hitchcock Medical Center	Multidisciplinary Concussion Working Group
2014-present	Dartmouth-Hitchcock Medical Center	Behavioral and Neurodevelopmental Services (BANDS)
2014-present	Dartmouth-Hitchcock Medical Center	Brain Imaging Laboratory, Executive Committee
2018-present	Dartmouth-Hitchcock Medical Center	Director, Sports Neuropsychology
2020-present	Dartmouth-Hitchcock Medical Center	Director, Neuropsychology

VI. LICENSURE AND CERTIFICATION:

Dates	Licensure/Certification
2014-present	NH Psychology License #1320
2014-present	Credentialed ImPACT Consultant ImPACT Applications, Inc. Pittsburgh, PA
2020-present	VT Psychologist – Doctorate 048.0134218

VII. HOSPITAL APPOINTMENTS:

Dates	Institution	Title
2014-present	Dartmouth-Hitchcock Medical Center Lebanon, NH	Director, Pediatric Neuropsychology
2014-2020	New Hampshire Hospital Concord, NH	Director, Pediatric Neuropsychology

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VIII. OTHER PROFESSIONAL POSITIONS:

Dates	Institution	Title
2010-2012	The Center for Psychological Services Paoli, PA & Ardmore, PA	Psychological Associate
2014-2016	Manchester Monarchs Hockey Club Manchester, NH	Team Neuropsychologist
2015-2017	Burke Mountain Academy Burke, VT	Concussion Management Consultant
2014-present	Dartmouth College Hanover, NH	Team Neuropsychologist Dartmouth Athletics
2014-present	St. Anselm's College Manchester, NH	Concussion Management Consultant
2014-present	Pinkerton Academy Derry, NH	Concussion Management Consultant
2014-present	Salem High School Salem, NH	Concussion Management Consultant
2014-present	Proctor Academy Andover, NH	Concussion Management Consultant
2014-present	Brewster Academy Wolfeboro, NH	Concussion Management Consultant
2014-present	Belmont High School Belmont, NH	Concussion Management Consultant
2014-present	Cardigan Mountain School Canaan, NH	Concussion Management Consultant
2014-present	Dover High School Dover, NH	Concussion Management Consultant
2014-present	Hanover High School Hanover, NH	Concussion Management Consultant
2014-present	Hartford Middle and High School Hartford, VT	Concussion Management Consultant
2014-present	John Stark Regional High School Weare, NH	Concussion Management Consultant
2014-present	Kearsarge Regional High School Sutton, NH	Concussion Management Consultant
2014-present	Keene High School Keene, NH	Concussion Management Consultant
2014-present	Kennett Middle School Conway, NH	Concussion Management Consultant
2014-present	Josiah Bartlett Middle School Bartlett, NH	Concussion Management Consultant
2014-present	Kennett High School Conway, NH	Concussion Management Consultant
2014-present	Kingswood Middle School Wolfeboro, NH	Concussion Management Consultant
2014-present	Kingswood High School Wolfeboro, NH	Concussion Management Consultant
2014-present	Lebanon High School Lebanon, NH	Concussion Management Consultant
2014-present	Londonderry High School	Concussion Management Consultant

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	Londonderry, NH	
2014-present	New Hampton School New Hampton, NH	Concussion Management Consultant
2014-present	Newport Middle and High School Newport, NH	Concussion Management Consultant
2014-present	Tilton School Tilton, NH	Concussion Management Consultant
2014-present	Trinity High School Manchester, NH	Concussion Management Consultant
2016-present	White Mountains Regional High School Whitefield, NH	Concussion Management Consultant
2016-present	Kearsarge Regional Middle School Sutton, NH	Concussion Management Consultant
2018-present	Bow School District Bow, NH	Concussion Management Consultant
2019-present	Nashua High School, North & South Nashua, NH	Concussion Management Consultant
2020-present	New England College, Henniker, NH	Concussion Management Consultant

IX. TEACHING ACTIVITIES:

A. UNDERGRADUATE EDUCATION

Dates	Institution	Course	Student's Name
2018	Dartmouth College Hanover, NH	PSYC 88: Independent Research	Kieffer Christianson

B. GRADUATE EDUCATION

Not applicable.

C. UNDERGRADUATE MEDICAL EDUCATION

Not applicable.

D. GRADUATE MEDICAL EDUCATION

Inclusive of instruction of residents and fellows during clinical practice

Dates	Institution	Course Title	Role	Hours/Year
2014-present	Dartmouth-Hitchcock & New Hampshire Hospital	Supervision (fellows)	Supervisor	720
2014-present	Dartmouth-Hitchcock	Supervision (practicum students)	Supervisor	96
2014-present	Dartmouth-Hitchcock	Neuropsychology Seminar & Case Conference	Co-Organizer Presenter	45
2014-present	Dartmouth-Hitchcock	PGY II/III Resident & Fellow Lectures	Presenter	4
2019-present	Geisel School of Medicine at Dartmouth	SBM Psychiatry Course	Lecturer	1

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E. OTHER CLINICAL EDUCATION

Not applicable.

X. ADVISING/MENTORING:

A. UNDERGRADUATE STUDENTS

Dates	Student's Name	Program
2016	Kelsie Atwater	Colgate University
2017	Allison Green	Dartmouth College
2018	Sonia Rowley	Dartmouth College
2018-2019	Alissa Cole	University of Maryland
2018	Ellie Pomer	Ithaca College
2018	Annie Farley	Dartmouth College
2018-2020	Hannah Haile	Dartmouth College
2019	Rebecca Russell	Dartmouth College
2020-2021	Katherine Packard	Dartmouth College
2020-2021	Christin Ealer	Dartmouth College
2020-2021	Caitlin Bowers	Dartmouth College

B. GRADUATE STUDENTS

Dates	Student's Name	Program	Degree
2013-2014	Courtney Condiracci	Antioch University	Psy.D.
2014-2015	Jennifer Amato	Antioch University	Psy.D.
2014-2015	Rachel Roberts	Antioch University	Psy.D.
2014-2015	Joanna Peters	Ferkauf Graduate School of Psychology	Psy.D.
2015-2016	Katherine Gorman	Antioch University	Psy.D.
2015-2016	Courtney Condiracci	Antioch University	Psy.D.
2015-2016	Katie Osborn	Florida School of Professional Psychology	Psy.D.
2016	Kyla Donnelly	The Dartmouth Institute	Ph.D.
2016-2017	Jacqueline Gilbert	Antioch University	Psy.D.
2016-2017	Jennifer Amato	Antioch University	Psy.D.
2017-2018	Zachary Merz	St. Louis University	Ph.D.
2017-2018	Sloane Sheldon	Ferkauf Graduate School of Psychology	Ph.D.
2017-2018	Melanie Sklar	Antioch University	Psy.D.
2018-2019	Katelyn Gettens	University of Connecticut	Ph.D.
2019-2020	Sadie Collagan	Antioch University	Psy.D.
2019-2020	Jennifer Mayette	Antioch University	Psy.D.
2020-2021	Sara Scull	Antioch University	Psy.D.
2020-2021	Kelsea Marschall	Antioch University	Psy.D.
2020-2021	Tiffany Andersen	Eastern Michigan University	Ph.D.
2021-present	Phoebe Lewis	Antioch University	Psy.D.
2021-present	Marilyn Musterait	Antioch University	Psy.D.

C. NON-DEGREE PROGRAM STUDENTS

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Dates	Student's Name	Institution	Program
2020-present	Amanda St. Ivany	Dartmouth-Hitchcock	NIH - LRP

D. MEDICAL STUDENTS

Dates	Student's Name	Program	Degree
2016	Michael Sun	Geisel School of Medicine	M.D.
2017	Erin D'Agostino	Geisel School of Medicine	M.D.
2017-2018	Damien Lazar	Tufts Medical School	M.D.

E. RESIDENT/FELLOWS

Dates	Student's Name	Program	Degree
2014-2016	Stephanie Towns	Neuropsychology	Psy.D.
2014-2016	Maurissa Abecassis	Neuropsychology	Ph.D.
2015-2016	Aimee Beaton	Pediatrics	M.D.
2015	Samuel McWilliams	Pediatrics	M.D.
2015-2017	Jeremy Carmasin	Neuropsychology	Ph.D.
2015-2017	Nichole Miller	Neuropsychology	Ph.D.
2015-2017	Katherine Shea	Child Psychiatry	M.D.
2015-2017	Larry Mitnaul	Child Psychiatry	M.D.
2015-2017	Shazia Savul	Child Psychiatry	M.D.
2015-2017	Christine Miller	Child Psychiatry	M.D.
2015-2017	Paul Bryant	Child Psychiatry	M.D.
2015-2017	Heather Shacket	Child Psychiatry	M.D.
2016	Sydney Hartman	Pediatrics	M.D.
2016	Jennifer Lapin	Pediatrics	M.D.
2016	Sam Ogden	Pediatrics	M.D.
2016-2018	Judith Fernando	Child Psychiatry	M.D.
2016-2018	Kish Gosai	Child Psychiatry	M.D.
2016-2018	John Ryder	Child Psychiatry	M.D.
2016-2018	Antra Bami	Child Psychiatry	M.D.
2016-2018	Jami Halpern	Neuropsychology	Psy.D.
2016-2018	George Lin	Neuropsychology	Ph.D.
2016-2018	Irving Arevalo	Neuropsychology	Ph.D.
2017	Christina Mamolea	Pediatrics	M.D.
2017	Angela Doswell	Pediatrics	M.D.
2017	Zachary Newton	Pediatrics	M.D.
2017	Muhammad Zain-ul-abideen	Pediatrics	M.D.
2017	Carrie Schulmeister	Pediatrics	M.D.
2017-2018	Emile Hasan	Psychiatry	M.D.
2017-2019	Sirin Tapan	Child Psychiatry	M.D.
2017-2019	Rejini Thomas	Child Psychiatry	M.D.
2017-2019	Andrea Jackson	Neuropsychology	Ph.D.
2017-2019	Catherine Williams	Neuropsychology	Ph.D.
2018	Joel Sarmiento	Pediatrics	M.D.
2018	Ashleigh Rushing	Pediatrics	M.D.
2018	Jennifer Lapin	Pediatrics	M.D.
2019-present	Joel Peterson	Child Psychiatry	M.D.
2019-present	Daniel Bigman	Child Psychiatry	M.D.

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2020-present	Dinesh Sangroula	Child Psychiatry	M.D.
2020	Christine Oh	Child Psychiatry	M.D.
2020-present	Omar Shah	Child Psychiatry	M.D.
2020-present	Sarah Vailingham	Child Psychiatry	M.D.
2020-present	Linda Gao	Child Psychiatry	M.D.

F. JUNIOR FACULTY

Dates	Faculty Name	Position
2020-present	Jennifer Amato	Assistant Professor

G. ADDITIONAL INFORMATION

Not applicable.

XI. RESEARCH TEACHING/MENTORING: (primary mentor)

A. UNDERGRADUATE STUDENTS

Dates	Student's Name	Program	Degree
2017-2018	Kieffer Christianson	Dartmouth College, Independent Study	B.A.
2018	Sonia Rowley	Dartmouth College, UGAR Research Grant	B.A.
2020-2021	Katherine Packard	Dartmouth College, Presidential Scholar	B.A.
2021	Katherine Packard	Dartmouth College, UGAR Research Grant	B.A.

B. GRADUATE STUDENTS

Dates	Student's Name	Program	Degree
2014-2015	Katherine Murphy	Widener University, Dissertation	Psy.D.
2015-2016	Jill Fleischer	Widener University, Dissertation	Psy.D.
2016-2018	Courtney Condiracci	Antioch University, Dissertation	Psy.D
2017-2018	Jennifer Amato	Antioch University, Dissertation	Psy.D.
2020-2021	Tiffany Andersen	Eastern Michigan University, Dissertation	Ph.D.
2021-2022	Suraj Patel	The Dartmouth Institute	MPH
2021-2022	Adi Suresh	The Dartmouth Institute	MPH
2021-2022	Rohan Muchintala	The Dartmouth Institute	MPH

C. MEDICAL STUDENTS

Not applicable.

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D. RESIDENT/FELLOWS/RESEARCH ASSOCIATES

Dates	Student's Name	Program	Degree
2014-2016	Kate Linnea	Pediatric Neuropsychology	Ph.D.
2014-2016	Lauren Baird	Pediatric Neuropsychology	Psy.D.
2015-2017	Amy Schmid	Pediatric Neuropsychology	Ph.D.
2016-2018	Emilie Chamard	Pediatric Neuropsychology	Ph.D.
2016-2018	Fern Baldwin	Pediatric Neuropsychology	Ph.D.
2017-2019	Hope Nissirios	Pediatric Neuropsychology	Psy.D.
2018-2020	Jennifer Amato	Pediatric Neuropsychology	Psy.D
2018-2020	Jess Liu	Pediatric Neuropsychology & Sports Neuropsychology	Psy.D
2019-2021	Erica Pollock	Pediatric Neuropsychology	Ph.D.
2020-present	Emily Holding	Pediatric Neuropsychology	Ph.D.
2020-present	Kelsey Grodner	Pediatric Neuropsychology	Psy.D.
2020-present	Janelle Eloi	Sports Neuropsychology	Psy.D.
2020-present	Mark Roberts	Neurology	M.D.
2021-present	Kathleen Barros	Pediatric Neuropsychology	Ph.D.

E. FACULTY

Dates	Faculty's Name	Program
2020-present	Jennifer Amato	Pediatric Neuropsychology

XII. COMMUNITY SERVICE, EDUCATION, AND ENGAGEMENT

Not applicable.

XIII. RESEARCH FUNDING

A. CURRENT SUPPORT

RO1HD0095277 (PI: Buckey) 2018-2023 Effort: 13.5%
NIH/NICHD $3,729,980
"Novel Pediatric Neurocognitive Screening Using Central Auditory Tests"
This research project proposes to evaluate the performance of central auditory tests as a measure of neurocognitive performance, behavior, and literacy in a cross-sectional study focusing on HIV+ children.
Role: Neuropsychologist, Co-I.

NCCC Developmental Funds (Co-PIs: Lyons, Lichtenstein) 2021-2022 Effort: 5%
Norris-Cotton Cancer Center $49,998
"Optimizing Employment Outcomes Among Rural Cancer Survivors: Initiation of a Community-Engaged Research Program"
This translational research project will characterize work-related distress among cancer survivors, elicit stakeholder perceived challenges to employment optimization, and develop implementation strategies to maximize employment outcomes for cancer survivors.
Role: Co-PI.

B. PAST SUPPORT

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Gary Tucker Junior Investigator Award 2019-2020 Effort: 10%
(PI: Lichtenstein)
DHMC/Department of Psychiatry $40,000
"Auditory Biomarkers for Diagnosis and Monitoring in Sports-Related Concussion"
This research project proposes to evaluate the performance of auditory processing tests as a measure of brain health in athletes with and without sports-related concussions.
Role: PI

Gary Tucker Junior Investigator Award 2018-2019 Effort: 10%
(PI: Lichtenstein)
DHMC/Department of Psychiatry $40,000
"Auditory Biomarkers for Diagnosis and Monitoring in Sports-Related Concussion"
This research project proposes to evaluate the performance of auditory processing tests as a measure of brain health in athletes with and without sports-related concussions.
Role: PI

DK066174 (PIs: Munoz, Furth, Warady, & Schwartz) 2014-2018 Effort: In kind
NIH/NIDDK $1,670,687
"CKiD"
The goal of this multi-center project is to understand the cognitive profile in children with chronic kidney disease. Participants of all pediatric ages were followed over 4 years to determine changes in their cognitive functioning over time.
Role: Neuropsychologist

90TBGG008-01-02 (PI: Lichtenstein) 2014-2018 Effort: 26%
ACL $968,991
"Concussion Chalk Talk"
The goal of this demonstration project is to change the culture around concussions in New Hampshire schools by providing education, creating team-based management, and providing neuropsychological oversight.
Role: Program Director, PI.

Hitchcock Pilot Grant (PI: Linnea) 2016-2018 Effort: In kind
Hitchcock Foundation $30,000
"Understanding Neurocognitive Skills in the Context of Social Functioning: A Prospective Study of Pediatric Cancer Survivors."
The goal of this pilot project is to establish the theory that problems in social performance in children with cancer histories is due to executive dysfunction.
Role: Neuropsychologist, Co-PI.

C. PENDING SUPPORT

RO1 (Co-PIs: Buckey, Kraus) 2021-2026 Effort: 15%
NIH/NINDS
"Cortico-subcortical interactions underlying sentence recognition in noise: structure, function, and injury"
This research project proposes to evaluate the mechanisms of sentence-in-noise recognition and determine how those mechanisms and their interactions are disrupted by concussion.
Role: Neuropsychologist, Co-I.

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XIV. PROGRAM DEVELOPMENT

Sports Concussion Clinic, DHMC
Pediatric Neuropsychology Program expansion, DHMC
Pediatric Neuropsychology Didactics Series, DHMC
Several Multi-Disciplinary Clinics, DHMC
Multi-Disciplinary Concussion Group, DHMC
Behavior and Neurodevelopmental Services (BANDS), DHMC
Brain Research Network, DHMC
Sports Neuropsychology Program, DHMC
Post-Acute COVID-19 Syndrome Clinic, DHMC

XV. ENTREPRENEURIAL ACTIVITIES

Not applicable.

XVI. MAJOR COMMITTEE ASSIGNMENTS.

National/International

Dates	Committee	Role	Institution
2014-present	Protocol Working Group	Member	Big-Ten/Ivy League Research Collaboration
2014-present	Assessment Working Group	Member	Big-Ten/Ivy League Research Collaboration
2019-present	SNAPP Committee	Founding Member	Sports Neuropsychology Society

Regional

Dates	Committee	Role	Institution
2019-present	Board of Directors	Member	Brain Injury Association of New Hampshire
2021-present	Planning Committee	Member	New Hampshire Team Up for Sports Safety

Institutional

Dates	Committee	Role	Institution
2014-present	Multi-Disciplinary Concussion Group	Member	Dartmouth-Hitchcock
2015-present	Behavior and Neurodevelopmental Services Group	Member	Dartmouth-Hitchcock
2016-2017	Child Psychologist Search Committee	Member	Dartmouth-Hitchcock
2019	Adult Neuropsychologist Search Committee	Member	Dartmouth-Hitchcock

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2020-present	Department of Psychiatry Emergency Management Team	Member	Dartmouth-Hitchcock
2020-present	Psychiatry Space Committee	Member	Dartmouth-Hitchcock
2020-present	Clinical Leadership Group, Dept of Psychiatry	Member	Dartmouth-Hitchcock
2020-present	Diversity, Equity, & Inclusion Committee, Dept of Psychiatry	Member, Subcommittee Co-Leader	Dartmouth-Hitchcock
2020	Adult Neuropsychologist Search Committee	Chair	Dartmouth-Hitchcock
2021-present	5D Executive Meeting Group	Member	Dartmouth-Hitchcock
2021-present	Post-Acute COVID-19 Syndrome Clinic	Member	Dartmouth-Hitchcock
2021	ECHO Project: PACS	Member/Panelist/Presenter	Dartmouth-Hitchcock
2021	AIRS Advisory Group	Member	Dartmouth-Hitchcock

XVII. MEMBERSHIPS, OFFICE AND COMMITTEE ASSIGNMENTS IN PROFESSIONAL SOCIETIES

Dates	Society	Role
2012-2019	American Psychological Association	Member
2012-2015	American Academy of Clinical Neuropsychology	Member
2014-present	International Neuropsychological Society	Member
2014-present	Sports Neuropsychology Society	Member
2020-present	American Academy of Pediatric Neuropsychology	Member

XVIII. INSTITUTIONAL CENTER OR PROGRAM AFFILIATIONS

Not applicable.

XIX. EDITORIAL BOARDS

Dates	Role	Board Name
2018	Guest Editor, "Performance Validity Assessment in Children"	The Journal of Pediatric Neuropsychology

XX. JOURNAL REFEREE ACTIVITY

Dates	Journal Name
2014-present	Child Neuropsychology
2014-present	Developmental Neuropsychology
2015-present	The Clinical Neuropsychologist
2016-present	Archives of Clinical Neuropsychology

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2017-present	The Journal of the International Neuropsychological Society
2020-present	Brain Injury

XXI. AWARDS AND HONORS

Date	Award Name
2012	Excellence in Empirical Dissertation Award

XXII. INVITED PRESENTATIONS

A. International

Dates	Topic/Title	Sponsoring Organization	Location
February 2019 #	Replacing the Boston Naming Test in Pediatric Neuropsychological Assessment	International Neuropsychological Society	New York, NY
February 2019 #	Phonemic Cueing and Age on the Boston Naming Test in Children	International Neuropsychological Society	New York, NY
March 2017 #	Development of a Curriculum for Concussion Management Training in Schools	World Congress on Brain Injury	New Orleans, LA
February 2017 #	Acceptability of a Return-to-Learn Program for Concussed High School Students	International Neuropsychological Society	New Orleans, LA
February 2017 #	Validation of a Teacher Questionnaire to Assess Concussed Students' Recovery	International Neuropsychological Society	New Orleans, LA
February 2016 #	An Examination of WAIS-IV Digit Span Sequencing in a Clinical Sample	International Neuropsychological Society	Boston, MA
February 2016 #	The Effects of a Yoga and Mindfulness Intervention on Executive Functioning in Traumatic Brain Injury	International Neuropsychological Society	Boston, MA
February 2015 #	Introducing a Forced Choice Recognition Task to the CVLT-C (FCR-Child): Preliminary Findings.	International Neuropsychological Society	Denver, CO

B. National

Dates	Topic/Title	Sponsoring Organization	Location

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August 2021	Psychiatric Sequelae II: Fatigue & Brain Fog	PACS ECHO Dartmouth-Hitchcock	Virtual
July 2021 #	The Effect of Test Setting Upon Test-Retest Reliability of ImPACT Baseline Tests in High School Athletes	American Academy of Neurology	Virtual
July 2019 * ^	Knowledge Competencies for Concussion Management: Theory, Training, and Practice	Big-Ten/Ivy League TBI Research Collaboration	Rosemont, IL
May 2018 * ^	Multimodal Assessment of People with Intellectual and Developmental Disabilities (IDD) and Mental Health Disorders	The Center for Start Services	Boston, MA
May 2018 #	Concussion Chalk Talk: Improving School-based Concussion Management Through Culture Change	Virginia Commonwealth University	Williamsburg, VA
April 2017 * ^ **Keynote Address**	Dazed and Confused: Concussion on Campus	University of Pennsylvania	Philadelphia, PA
July 2017 *	Teach Your Children Well: Systematic Review of SRC in Youth	Big-Ten/Ivy League TBI Research Collaboration	Rosemont, IL
July 2017 *	Neuropsychology: Translating Research to Practice	Big-Ten/Ivy League TBI Research Collaboration	Rosemont, IL
March 2016 #	Performance Differences for Children on Repeat Administrations of a Sustained Attention and Inhibitory Control Task	Southeastern Psychological Association	Atlanta, GA
July 2016 *	Ivy League: An Example of Addressing Player Safety	Big-Ten/Ivy League TBI Research Collaboration	Philadelphia, PA
November 2015 #	Investigating the Signal Detection Performance of the Trail Making Test as an Embedded Validity Indicator in Adolescents: Can Adult Cutoffs be Extended to Younger Examinees?	National Academy of Neuropsychology	Austin, TX
June 2015 #	Wisconsin Card Sorting Test Embedded Validity Indicators Developed for	American Academy of	San Francisco, CA

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	Adults Can Be Extended to Children Clinically Referred for Neuropsychological Assessment	Clinical Neuropsychology	
November 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	National Academy of Neuropsychology	Fajardo, Puerto Rico
June 2014 #	Reliable digit vs. spatial span in a clinical pediatric sample: A visual alternative?	American Academy of Clinical Neuropsychology	New York, NY
June 2014 #	The Global Assessment of School Functioning Scale (GASF): A measure of cognition, executive functioning, and behavior.	American Academy of Clinical Neuropsychology	New York, NY
June 2014 #	Repeating Conners' CPT-II within a test battery increases sensitivity to attention deficit in children.	American Academy of Clinical Neuropsychology	New York, NY
June 2013 #	Frequency of invalid ImPACT baselines in a private practice setting: the implications of age.	American Academy of Clinical Neuropsychology	Chicago, IL
November 2011 #	The relationship between gender and questionable validity of ImPACT baseline scores in college athletes	National Academy of Neuropsychology	Marco Island, FL
November 2011 #	Rates of questionably valid ImPACT baseline scores in college athletes	National Academy of Neuropsychology	Marco Island, FL
November 2011 #	The relationship between history of concussion and questionable validity of ImPACT baseline scores in college athletes	National Academy of Neuropsychology	Marco Island, FL

C. **Regional/Institutional**

Dates	**Topic/Title**	**Sponsoring Organization**	**Location**

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April 2021 ^	Chronic Traumatic Encephalopathy	White River Junction VA	White River Junction, VT (online)
February 2021 * ^	Getting Emotional About Concussion	Dartmouth College Sports Medicine	Hanover, NH (online)
February 2021 * ^	Head Games: Post-Concussion Syndrome in Adolescents	New Hampshire School Nurses Association	Lebanon, NH (online)
January 2021 * ^	Return to Learn after Concussion: What's New?	New Hampshire School Nurses Association	Lebanon, NH (online)
November 2020 ^	Getting Emotional About Concussions	Safe Sports Network	Manchester, NH (online)
May 2020 * ^ Grand Rounds	Psychology and Concussion	Department of Pediatrics, DHMC	Lebanon, NH (online)
April 2020 * ^ Grand Rounds	Concussion Management: Guidance for School and Home	Department of Pediatrics, DHMC	Lebanon, NH (online)
November 2019 * ^	School-based Concussion Management	Vermont School Nurses Association	Quechee, VT
January 2019 ^	Concussion 101	Pediatrics, Dartmouth-Hitchcock Manchester	Manchester, NH
November 2018 * ^	Return to Learn After Concussion	St. Anselm's College	Manchester, NH
September 2017 ^	Neuropsychological Evaluation and Return to Learn	Dartmouth-Hitchcock	Lebanon, NH
September 2017 ^	Chronic Traumatic Encephalopathy	Dartmouth-Hitchcock	Lebanon, NH
August 2017 * ^	Pediatric Neuropsychology	Brain Injury Association of New Hampshire	Concord, NH
November 2016 * ^	Return to Play after Concussion: The Basics	Department of Pediatrics, DHMC	Lebanon, NH
October 2016 * ^	Neuropsychological Evaluations: Who, What, and How	Brain Injury Association of Vermont	Burlington, VT
September 2016 * ^ Grand Rounds	Should I Stay or Should I Go: The Return to School Conundrum in Concussion Management	Department of Pediatrics, DHMC	Lebanon, NH
March 2016 * ^	Return to Learn After Concussion	Dartmouth-Hitchcock	Lebanon, NH
December 2015 * ^	Getting Emotional About Concussion	SERESC	Bedford, NH
November 2015 * ^	Returning to the Classroom Post-Concussion	New Hampshire Association for Health, Physical Education, Recreation, & Dance	Waterville Valley, NH

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November 2015 * ^	Back to School: Returning to Academics Post-Concussion	St. Anselm's College	Manchester, NH
September 2015 *	Returning to the Classroom Post-Concussion	Londonderry High School	Londonderry, NH
August 2015 * ^	Getting Emotional About Concussion	St. Anselm's College	Manchester, NH
May 2015 * ^	The X's and O's of Concussion Management	Brain Injury Association of New Hampshire	Concord, NH
March 2015 * ^	We're All in This Together: The Dos and Don't of School-based Concussion Management	St. Anselm's College	Manchester, NH
November 2014 * ^	Getting Emotional About Concussion: Affective Functioning Post-Injury	SERESC	Bedford, NH
June 2014 * ^	Return to Play and Return to Academics Protocols Following Concussion	Northern New England Athletic Training Association	Portsmouth, NH
March 2014 ^	Heads Up! Let's Talk about Sports Concussion	Hanover/Dresden School District	Hanover, NH
March 2012	Sports Concussion Management and the Student Athlete	Princeton Day School	Princeton, NJ

XXIII. BIBLIOGRAPHY

A. Peer-reviewed publications in print or other media

1. Most significant publications (3-5):

1. **Lichtenstein, J.D.**, Amato, J.T., Holding, E.Z., Grodner, K.D., Pollock, E.P., Marschall, K.P., & Scull, S. (2021). How we work now: preliminary review of a pediatric neuropsychology hybrid model in the era of Covid-19 and beyond. *Archives of Clinical Neuropsychology*, acab041. Advance online publication. httpsL//doi.org/10.1093/arclin/acab041.
2. **Lichtenstein, J.D.**, Erdodi, L., & Linnea, K. (2017). Introducing a forced-choice recognition task to the California Verbal Learning Test – Children's Version. *Child Neuropsychology, 23(3),* 284-299. Doi: 10.1080/09297049.2015.1135422.
3. **Lichtenstein, J.**, Bowers, C., Amato, J., Niemczak, C., Fellows, A., Magohe, A., Haile, H., White-Schwoch, T., Kraus, N., Massawe, E., Moshi, N., & Buckey, J. (2021). Nonverbal cognitive assessment of children in Tanzania with and without HIV. *Child Neuropsychology: a journal on normal and abnormal development in childhood and adolescence*, 1–13. Advance online publication. https://doi.org/10.1080/09297049.2021.1957809
4. **Lichtenstein, J.D.**, Linnea, K., & Maerlender, A.C. (2017). Patterns of referral in high school concussion management programs: a pilot study of consultants from different disciplines. *Applied Neuropsychology: Child*. doi: 10.1080/21622965.2017.1340158. Epub ahead of print.
5. **Lichtenstein, J.D.,** Moser, R.S., & Schatz, P. (2014). Age and test setting affect the prevalence of invalid baseline scores on neurocognitive testing. *American Journal of Sports Medicine, 42(2),* 479-84.

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2. Other publications (excluding any listed in part 1)

a. Original articles:

1. Niemczak, C.*, **Lichtenstein, J.D.***, Magohe, A.*, Amato, J.T., Fellows, A.M., Gui, J., Huang, M., Rieke, C.C., Massawe, E., Boivin, M., Moshi, N., & Buckey, J.C. (in press). The relationship between central auditory tests and neurocognitive domains in adults living with HIV. *Frontiers in Neuroscience*. *connotes shared first authorship
2. Sabell, A., Messa-Hamidi, I., Gromini, L., **Lichtenstein, J.D.**, May, N., & Erdodi, L.A. (in press). Symptom versus performance validity in patients with mild TBI: independent sources of non-credible responding. *Psychological Injury and Law*.
3. McLaren, J.L., **Lichtenstein, J.D.**, Metcalf, J.D., Charlot, L.R., Drake, R.E., & Beasley, J.B. (in press). Psychotropic use among youths with intellectual and developmental disabilities. *Psychiatric Services*.
4. Niemczak, C., Fellows, A., **Lichtenstein, J.D.**, … Buckey, J.C. (in press). Central auditory tests track cognitive function in those with HIV. *JMIR Formative Research.*
5. Messa, I., Holcomb, M., **Lichtenstein, J.D.**, Tyson, B.T., Roth, R.M., & Erdodi, L.A. (2021). They are not destined to fail: a systematic examination of scores on embedded validity indicators in patients with intellectual disability. *Austrian Journal of Forensic Sciences*.
6. Eloi, J., Lee, J., Pollock, E., Towns, S., Holcomb, M., Tayim, F., Tocco, C., Hirst, R., **Lichtenstein, J.D.**, and Roth, R.M. (2021). Boston Naming Test: Lose the Noose. *Archives of Clinical Neuropsychology.*
7. Parent-Nichols, J., Mousseau, A., Cleland, J., **Lichtenstein, J.**, & Maerlender, A. (2020). The effect of in-service methodology on learning transfer for school personnel managing students following concussion. *SAGE Open Nursing*, in press.
8. Maerlender, A., Palamara, J., & **Lichtenstein, J.D.** (2020). The Global Assessment of School Functioning (GASF): criterion validity and interrater reliability. *Psychology in the Schools,* 1-9. https://doi.org/10.1002/pits.22365
9. **Lichtenstein, J.D.** & Merz, Z.C. (2019). Post-exertion neuropsychological testing in the management of sport-related concussion. *Psychological Injury and Law, 12(2),* 146-154.
10. **Lichtenstein, J.D.**, Greenacre, M.K., Cutler, L., Abeare, K., Baker, S.D., Kent, K.J., Ali, S., & Erdodi, L.A. (2019). Geographic variation and instrumentation artifacts: in search of confounds in performance validity assessment in adults with mild TBI. *Psychological Injury and Law.* Published online 20 June 2019. Doi: 10.1007/s12207-019-09354-w.
11. **Lichtenstein, J.D.**, Flaro, L., Baldwin, F., Rai, J., & Erdodi, L.A. (2019). Further evidence for embedded performance validity tests in children within the Conners' Continuous Performance Test – Second Edition. *Developmental Neuropsychology.* Epub ahead of print. Doi: 10.1080/87565641.2019.1565535.
12. Maerlender, A.C., **Lichtenstein, J.D.**, Parent-Nichols, J., Higgins, K., & Reisher, P. (2019). Concussion competencies: a training model for school-based concussion management. *Concussion*. Doi: 10.2217/cnc-2018-0008.
13. **Lichtenstein, J.D.**, Holcomb, M.J., & Erdodi, L.A. (2018). One-minute PVT: further evidence for the utility of the California Verbal Learning Test – Children's Version Forced Choice Recognition trial. *Journal of Pediatric Neuropsychology.* Published online 19 October 2018. Doi: 10.1007/s40818-018-0057-4.
14. Chamard, E. & **Lichtenstein, J.D.** (2018). A systematic review of neuroimaging findings in children and adolescents with sports-related concussion. *Brain Injury*, DOI: 10.1080/02699052.2018.1463106.
15. **Lichtenstein, J.D.**, Erdodi, L., Rai, J., Mazur-Mosiewicz, A., & Flaro, L. (2018). Wisconsin Card Sorting Test embedded validity indicators developed for adults can be extended to children. *Child Neuropsychology, 24(2),* 247-260. DOI:10.1080/09297049.2016.1259402

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16. McLaren, J.L., & **Lichtenstein, J.D.** (2018). The pursuit of the magic pill: the overuse of psychotropic medications in children with intellectual and developmental disabilities in the USA. *Epidemiology and Psychiatric Sciences*. Epub ahead of print. Doi: 10.1017/S2045796018000604.
17. Lazar, D.J., **Lichtenstein, J.D.**, & Tybor, D. (2018). A first look at concussion prevalence in competitive ultimate Frisbee players. *Orthopaedic Journal of Sports Medicine, 6(3)*, DOI: 10.1177/2325967118759051.
18. McLaren, J.L., Barnett, E.R., Concepcion Zayas, M.T., **Lichtenstein, J.D.,** Acquilano, S.C., Schwartz, L.M., Woloshin, S., & Drake, R.E. (2018). Psychotropic medications for highly vulnerable children. *Expert Opinion on Pharmacotherapy, 19(6),* 547-560.
19. Tyson, B., Baker, S., Greenacre, M., Kent, K., **Lichtenstein, J.**, Sabelli, A., Erdodi, L. (2018). Differentiating epilepsy from psychogenic non-epileptic seizures using neuropsychological test data. *Epilepsy & Behavior, 87,* 39-45.
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21. Erdodi, L. A., Abeare, C. A., **Lichtenstein, J. D.,** Tyson, B. T., Kucharski, B., Zuccato, B. G., & Roth, R. M. (2017). Wechsler Adult Intelligence Scale-Fourth Edition (WAIS-IV) Processing Speed Scores as Measures of Noncredible Responding: The Third Generation of Embedded Performance Validity Indicators. *Psychological Assessment*, 29(2), *148-157.* Doi: 10.1037/pas0000319.
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24. McLaren, J., **Lichtenstein, J.D.,** Lynch, D., Becker, D., & Drake, R. (2017). Individual placement and support for people with autism spectrum disorders: a pilot program. *Administration and Policy in Mental Health and Mental Health Services Research, 44(3),* 365-373.
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26. Erdodi, L.A., Tyson, B.T., Abeare, C.A., **Lichtenstein, J.D.**, Pelletier, C., Rai, J., & Roth, R.M. (2016). The BDAE complex ideation material – a measure of receptive language or performance validity? *Psychological Injury and the Law.* Doi: 10.1007/s12207-016-9254-6.
27. Maerlender, A.C., Rieman, W., **Lichtenstein, J.D.,** & Condiracci, C. (2015). Programmed physical exertion in recovery from sport-related concussion. *Developmental Neuropsychology, 40(5)*, 273-278.
28. Moser, R.S., Schatz, P., & **Lichtenstein, J.D.** (2013). The importance of proper administration and interpretation of neuropsychological baseline and post-concussion computerized testing. *Applied Neuropsychology: Child, 4(1),* 41-8. Doi: 10.1080/21622965.2013.
29. Defina, P.A., Moser, R.S., Glenn, M., **Lichtenstein, J.D.,** & Fellus, J. (2013). Alzheimer's disease clinical and research update for health care practitioners. *Journal of Aging Research, vol. 2013, Article ID 207178, 9 pages.*

a. Reviews:

Not applicable.

b. Books/book chapters/monographs:

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1. Erdodi, L.A. & **Lichtenstein, J.D.** (2021). Information Processing Speed Tests as Performance Validity Tests. In Boone, K.B. (Ed.). *Assessment of Feigned Cognitive Impairment: A Neuropsychological Perspective, Second Edition*. Guilford Press: New York.
2. Maerlender, A.C., **Lichtenstein, J.D.**, & Parent-Nichols, J. (2018). *Concussion Competencies: A Framework for School-based Concussion Management*. Syron Press: New York.
3. McLaren, J.L., **Lichtenstein, J.D.**, Bessen, S.Y., & Baldwin, F. (2017). Autism Spectrum and Other Developmental Disorders and ADHD. In Daviss, W.B. (Ed.). *Moodiness in ADHD: A Clinician's Guide*. Springer International Publishing.
4. Lajiness O'Neil, R., Erdodi, L., & **Lichtenstein, J.D.** (2017). Traumatic Brain Injury. In Kauffman, J.M. & Hallahan, D.P. (Eds.). *Handbook of Special Education, Second Edition*. Routledge: New York.

B. Other scholarly work in print or other media

1. Editorially-reviewed publications (e.g., Op-Ed pieces, Letters to the Editor)

Lichtenstein, J.D. (2017, October 9). CTE: Sorting out facts from frenzy. *New Hampshire Union Leader*. Retrieved from: http://www.unionleader.com/apps/pbcs.dll/article?AID=/20171010/NEWS12/171019965/1009/NEWS12

2. Print resources (e.g., workshops)
3. Electronic resources (e.g., MOOCs, educational websites, modules, videos, virtual patients)
4. Others (define)

CNN's *The Lead with Jake Tapper*. Interviewed as part of "Robot helps football players avoid concussions." Retrieved from: https://www.cnn.com/videos/us/2015/09/18/robot-football-players-concussions-orig.cnn

C. Abstracts: Include both oral, exhibit and poster presentations

1. Roberts, M., & **Lichtenstein, J.D.** The Effect of Test Setting Upon Test-Retest Reliability of ImPACT Baseline Tests in High School Athletes. Poster to be presented at American Academy of Neurology Sports Concussion Conference, July 30-31, 2021.
2. Liu, S.S., Silverman, D.H., **Lichtenstein, J.D.**, Eloi, J., Flashman, L.A., & Seltzer, M.A. Alterations in Regional Distribution of Cerebral Amyloid Plaques following Head Trauma in Former College Athletes: Relationship to Long-Term Symptom. Poster presented at Society of Nuclear Medicine and Molecular Imaging Annual Meeting, June 12-15, 2021, Washington DC.
3. Bowers, C., **Lichtenstein, J.D.** …Buckey, J.C. Assessing Cognition in HIV+ and HIV- Children in Tanzania: A Nonverbal Approach. Poster to be presented at the 49th Annual Conference of the International Neuropsychological Society, February 2-5, 2021, San Diego, CA.
4. Holding, E.Z. …**Lichtenstein, J.D.** Executive Functioning and Working Memory: Exploring the Associations among Parent Report and Individual Performance Measures. Poster to be presented at the 49th Annual Conference of the International Neuropsychological Society, February 2-5, 2021, San Diego, CA.
5. Amato, J., **Lichtenstein, J.D.** …Buckey, J.C. Hearing in Noise as a Marker of Brain Health in HIV+ Adolescents. Poster presented at the 48th Annual Conference of the International Neuropsychological Society, February 5-8, 2020, Denver, CO.

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6. Liu, J.R., & **Lichtenstein, J.D.** Cognitive Variation in Microdeletions on 8q22.2: A Case Report. Poster presented at the 48th Annual Conference of the International Neuropsychological Society, February 5-8, 2020, Denver, CO.
7. **Lichtenstein, J.D.**, & Schmid, A. Is That a Tip on Your Tongue? Phonemic Cueing and Age on the Boston Naming Test in Children. Poster presented to the 47th Annual Conference of the International Neuropsychological Society, February 20-23, 2019, New York, NY.
8. **Lichtenstein, J.D.**, Schmid, A., Cole, A., Nissirios, E.H., & Baldwin, F.S. No More Nooses: Replacing the Boston Naming Test in Pediatric Neuropsychological Assessment. Poster to be presented 47th Annual Conference of the International Neuropsychological Society, February 20-23, 2019, New York, NY.
9. Nissirios, E.H., Baldwin, F.S., Maerlender, A.C., & **Lichtenstein, J.D.** How'd We Do? Results of a Brief Satisfaction Survey Following Outpatient Pediatric Neuropsychological Evaluation. Poster presented to the 38th Annual Conference of the National Academy of Neuropsychology, October 17-20, 2018, New Orleans, LA.
10. Maerlender, A., **Lichtenstein, J.**, Parent-Nichols, J., Sibson, K., & Reisher, P. Development of a Curriculum for Concussion Management Training in Schools. Oral presentation presented at the 12th World Congress on Brain Injury, March 29-April 1, 2017, New Orleans, LA.
11. Lazar, D.J., **Lichtenstein, J.D.**, & Tybor, D.J. A Retrospective Study of Concussions in Ultimate Frisbee: A First Step Towards Documenting Lifetime Prevalence. Oral presentation at the 58th Annual National Student Research Forum, Galveston, TX: April 20, 2017.
12. Schmid, A., **Lichtenstein, J.**, Atwater, K., & Linnea, K. Acceptability of a Return-to-Learn Program for Concussed High School Students. Poster presented at the 45th Annual Meeting of the International Neuropsychological Society, February 1-4, 2017, New Orleans, LA.
13. Schmid, A., **Lichtenstein, J.**, Atwater, K., & Linnea, K. Validation of a Teacher Questionnaire to Assess Concussed Students' Recovery. Poster presented at the 45th Annual Meeting of the International Neuropsychological Society, February 1-4, 2017, New Orleans, LA.
14. **Lichtenstein, J.D.,** & Lazar, D. Prevalence Rates of Concussion in Ultimate Frisbee: Preliminary Findings of the Concussion in Ultimate Frisbee Survey (CUFS). Poster presented at: 44th Annual Meeting of the International Neuropsychological Society, February 3-6, 2016, Boston, MA.
15. Schmid, A., Linnea, K., & **Lichtenstein, J.D.** An Examination of WAIS-IV Digit Span Sequencing in a Clinical Sample. Poster presented at: 44th Annual Meeting of the International Neuropsychological Society, February 3-6, 2016, Boston, MA.
16. Linnea, K., Donnelly, K.Z., Grant, D.A., & **Lichtenstein, J.D.** The Effects of a Yoga and Mindfulness Intervention on Executive Functioning in Traumatic Brain Injury. Poster presented at: 44th Annual Meeting of the International Neuropsychological Society, February 3-6, 2016, Boston, MA.
17. Ulbricht, M., Holcomb, M., **Lichtenstein, J.D.**, & Erdodi, L. Performance Differences for Children on Repeat Administrations of a Sustained Attention and Inhibitory Control Task. Poster presented at: 63rd Annual Meeting of the Southeastern Psychological Association, Atlanta, GA.
18. Rai, J.K., Erdodi, L.A., **Lichtenstein, J.D.,** Mazur-Mosiewicz, A., Holcomb, M., & Flaro, L. Investigating the Signal Detection Performance of the Trail Making Test as an Embedded Validity Indicator in Adolescents: Can Adult Cutoffs be Extended to Younger Examinees? Poster presented at: 35th Annual Meeting of the National Academy of Neuropsychology, November 4-7, 2015, Austin, TX.
19. Rai, J.K., Erdodi, L.A., **Lichtenstein, J.D.**, & Flaro, L. Wisconsin Card Sorting Test Embedded Validity Indicators Developed for Adults Can Be Extended to Children Clinically Referred for Neuropsychological Assessment. Poster presented at: 13th Annual Conference of the American Academy of Clinical Neuropsychology, June 17-20, 2015, San Francisco, CA.
20. **Lichtenstein, J.**, Erdodi, L., & Holcomb, M. Introducing a Forced Choice Recognition Task to the CVLT-C (FCR-Child): Preliminary Findings. Poster presented at: 43rd Annual Meeting of the International Neuropsychological Society, 2015 February 3-7, Denver, CO.

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21. Erdodi, L., Pelletier, C., Tyson, B., **Lichtenstein, J.,** Holcomb, M., Condiracci, C., & Roth, R. 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: 34th Annual Conference of the National Academy of Neuropsychology, 2014 November 12-15, Fajardo, Puerto Rico.
22. **Lichtenstein, J.D.,** Holcomb, M.J., Erdodi, L.A., Maerlender, A.C., Condiracci, C., Roth, R.M., & Pelletier, C. Reliable digit vs. spatial span in a clinical pediatric sample: A visual alternative? Poster presented at: 12th Annual Conference of the American Academy of Clinical Neuropsychology, 2014 June 25-28, New York, NY.
23. Condiracci, C., Holcomb, M.J., Maerlender, A.C., **Lichtenstein, J.D**., Erdodi, L.A., & Pelletier, C. The Global Assessment of School Functioning Scale (GASF): A measure of cognition, executive functioning, and behavior. Poster presented at: 12th Annual Conference of the American Academy of Clinical Neuropsychology, 2014 June 25-28, New York, NY.
24. Pelletier, C., Erdodi, L.A., Holcomb, M.J., **Lichtenstein, J.D**., & Condiracci, C. Repeating Conners' CPT-II within a test battery increases sensitivity to attention deficit in children. Poster presented at: 12th Annual Conference of the American Academy of Clinical Neuropsychology, 2014 June 25-28, New York, NY.
25. **Lichtenstein, J.D.**, Moser, R.S., Schatz, P., & Glatts, C. Frequency of invalid ImPACT baselines in a private practice setting: the implications of age. Poster presented at: 11th Annual Conference of the American Academy of Clinical Neuropsychology, 2013 June 19-22, Chicago, IL.
26. **Lichtenstein, J.D**., Lazar, M.F., Goldberg, K.B., Adams-Deutsch, Z., & Fleischer, J.M. The relationship between gender and questionable validity of ImPACT baseline scores in college athletes. Poster presented at: 31st Annual Conference of the National Academy of Neuropsychology, 2011 November 16-19, Marco Island, FL.
27. **Lichtenstein, J.D**., Fleischer, J.M., Lazar, M.F., & Goldberg, K.B. Rates of questionably valid ImPACT baseline scores in college athletes. Poster presented at: 31st Annual Conference of the National Academy of Neuropsychology, 2011 November 16-19, Marco Island, FL.
28. **Lichtenstein, J.D**., Lazar, M.F., Goldberg, K.B., Adams-Deutsch, Z., & Fleischer, J.M. The relationship between history of concussion and questionable validity of ImPACT baseline scores in college athletes. Poster presented at: 31st Annual Conference of the National Academy of Neuropsychology, 2011 November 16-19, Marco Island, FL.

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Dartmouth Hitchcock

Key Personnel

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Jonathan Ballard	Medicaid Medical Director	318,270	100%	318,270
Samantha Morin	Lead Psychologist	145,000	100%	145,000
Arun Krishnan	Child Psychiatrist	141,627	100%	141,627
Mary Brunette	Medical Director	264,000	50%	132,000
Christine Powers	EBP Trainer	87,567	100%	87,567
Kathryn McDonnell	EBP Trainer	86,715	100%	86,715
Erin Barnett	Psychologist	107,400	20%	21,480
Mary Jankowski	Psychologist	124,020	10%	12,020
Jennifer McLaren	Medical Director	277,958	60%	166,775
Jonathan Lichtenstein	Neuropsychologist	145,000	10%	14,500