



Lori A. Weaver  
Interim Commissioner

Patricia M. Tilley  
Director

STATE OF NEW HAMPSHIRE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
*DIVISION OF PUBLIC HEALTH SERVICES*

29 HAZEN DRIVE, CONCORD, NH 03301  
603-271-4501 1-800-852-3345 Ext. 4501  
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June 29, 2023

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, Division of Public Health Services, to enter into a **Retroactive** contract with Mary Hitchcock Memorial Hospital (VC#177160), Lebanon, NH, in the amount of \$900,000 for expert infectious disease clinical consultation services, subject matter expertise to support infectious disease-related public health and healthcare preparedness, and senior-level antibiotic resistance expertise to support healthcare-associated infections and antimicrobial resistance activities, with the option to renew for up to two (2) additional years, effective retroactive to July 1, 2023, upon Governor and Council approval, through June 30, 2027. 47% Federal Funds. 11% General Funds. 42% Other Funds (Pharmaceutical Rebates).

Funds are available in State Fiscal Years 2024 and 2025, and are anticipated to be available in State Fiscal Years 2026 and 2027, upon the availability and continued appropriation of funds in the future operating budget, with the authority to adjust budget line items within the price limitation and encumbrances between state fiscal years through the Budget Office, if needed and justified.

**See attached fiscal details.**

**EXPLANATION**

This request is **Retroactive** because additional time was needed to negotiate and finalize the scope of the work prior to the Contractor and Department reaching mutually acceptable terms. The Department sent the contract to the Contractor in May 2023. The resulting negotiations were not finalized until the end of June 2023. Additionally, the Department is requesting the services retroactive to July 1, 2023 to ensure there is no lapse in these critical services to the Department.

The purpose of this request is for the Department to have twenty-four hour access, every day of the year to a team of physician-level infectious disease and epidemiology experts to provide consultation for infectious disease case and outbreak management, infectious disease prevention, and healthcare system preparedness. These services will ensure the Department has the capacity to respond to infectious disease threats on a daily basis and for strategic planning purposes in order to prepare and prevent threats from emerging and re-emerging infectious diseases.

Excluding COVID-19, the Department receives approximately 8,000 reports of reportable infectious diseases annually. Additionally, the Department averages over 100 outbreaks of reportable infectious diseases, to exclude COVID-19, on an annual basis and anticipates that approximately 8,500 individuals will be served with this contract.

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The Department operates a twenty-four hour, every day of the year system for receiving reports of high-threat infectious diseases allowing the Department to rapidly implement investigation and control measures to protect the public and healthcare workforce. The Contractor will provide physician-level infectious disease expertise to support the Department's frontline public health staff who respond to these reports. In addition to these response activities, the Department requires consultation with the Contractor's infectious disease physicians and epidemiology experts to provide continuously updated infectious disease clinical guidance and education for healthcare providers statewide. Additionally, the Contractor's infectious disease physicians and epidemiology experts will provide consultation for public health and healthcare system emergency response training, education, and planning activities in order to prepare for future public health emergencies.

The Department will monitor services by ensuring the Contractor:

- Completes 90% of infectious disease consultation requests made by the Department within a twenty-four (24) hour time period.
- Participates in 90% of Department Incident Management Team drills.
- Participates in 75% of Outbreak Team, HIV Medical Advisory Board, Healthcare-Associated Infections Technical Advisory Workgroup, and Healthcare-Associated Infections Antimicrobial Resistance Advisory Workgroup meetings.

The Department selected the Contractor through a competitive bid process using a Request for Applications (RFA) that was posted on the Department's website from March 8, 2023 through March 31, 2023. The Department received one (1) response that was reviewed and scored by a team of qualified individuals. The Scoring Sheet is attached.

As referenced in Exhibit A of the attached agreement, the parties have the option to extend the agreement for up to two (2) 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's ability to effectively manage cases and outbreaks of infectious diseases and the capacity to provide clinical outreach and education to the healthcare providers statewide would be significantly diminished.

Area served: Statewide

Source of Federal Funds: Assistance Listing Number (ALN) #93.323, FAIN #NU50CK000522; ALN #93.889, FAIN #U3REP190580; and, ALN #93.069, FAIN #NU90TP922018.

In the event that the Federal or Other Funds become no longer available, additional General Funds will not be requested to support this program.

Respectfully submitted,



Lori A. Weaver  
Interim Commissioner

**05-95-90-903010-1835 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION  
OF PUBLIC HEALTH, BUREAU OF LABORATORY SERVICES, NH ELC  
ALN 93.323 FAIN NU50CK000522 100% FEDERAL FUNDS**

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2024	102-500731	Contracts for Prog Svc	90183524	\$45,000
2025	102-500731	Contracts for Prog Svc	90183524	\$45,000
2026	102-500731	Contracts for Prog Svc	90183524	\$45,000
2027	102-500731	Contracts for Prog Svc	90183524	\$45,000
			<i>Subtotal</i>	<b>\$180,000</b>

**05-95-90-902510-2229 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION  
OF PUBLIC HEALTH, BUREAU OF INFECTIOUS DISEASE CONTROL, PHARMACEUTICAL REBATES  
100% OTHER FUNDS**

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2024	102-500731	Contracts for Prog SVC	90024600	\$95,000
2025	102-500731	Contracts for Prog Svc	90024600	\$95,000
2026	102-500731	Contracts for Prog Svc	90024600	\$95,000
2027	102-500731	Contracts for Prog Svc	90024600	\$95,000
			<i>Subtotal</i>	<b>\$380,000</b>

**05-95-90-903510-1113, HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION  
OF PUBLIC HEALTH, BUREAU OF EMERGENCY PREPARATION, RESPONSE & RECOVERY, HOSPITAL  
PREPAREDNESS  
ALN 93.889 FAIN U3REP190580 100% FEDERAL FUNDS**

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2024	102-500731	Contracts for Prog Svc	90077700	\$15,000
2025	102-500731	Contracts for Prog Svc	90077700	\$15,000
2026	102-500731	Contracts for Prog Svc	90077700	\$15,000
2027	102-500731	Contracts for Prog Svc	90077700	\$15,000
			<i>Subtotal</i>	<b>\$60,000</b>

**05-95-90-903510-1114, HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS:  
DIVISION OF PUBLIC HEALTH, BUREAU OF EMERGENCY PREPARATION, RESPONSE & RECOVERY, PH  
EMERGENCY PREPAREDNESS**

**ALN 93.069 FAIN NU90TP922018 66% FEDERAL FUNDS 34% GENERAL FUNDS**

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2024	102-500731	Contracts for Prog Svc	90077410	\$70,000
2025	102-500731	Contracts for Prog Svc	90077410	\$70,000
2026	102-500731	Contracts for Prog Svc	90077410	\$70,000
2027	102-500731	Contracts for Prog Svc	90077410	\$70,000
			<i>Subtotal</i>	<b>\$280,000</b>
			<i>Total</i>	<b>\$900,000</b>

**New Hampshire Department of Health and Human Services  
Division of Finance and Procurement  
Bureau of Contracts and Procurement  
Scoring Sheet**

**Project ID #** RFA-2024-DPHS-03-INFEC  
**Project Title** Infectins Disease Medical & Epidemiology Consultant Services

	Maximum Points Available	Mary Hitchcock Memorial Hospital
<b>Technical</b>		
Ability (Q1)	100	90
Knowledge and Experience (Q2)	200	175
Capacity (Q3)	100	80
<b>TOTAL POINTS</b>	<b>400</b>	<b>345</b>

<b>TOTAL PROPOSED VENDOR COST</b>	<i>Not Applicable - No Cost Proposal for RFA</i>
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Reviewer Name	Title
1 Ryan Tannian	Administrator IV
2 Megan Heddy	Administrator III
3 Katrina Hansen	Administrator III
4 Darlene Cray	Public Health Program Manager

**Subject: Infections Disease Medical & Epidemiology Consultant Services (RFA-2024-DPHS-03-INFEC-01)**

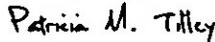
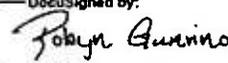
**Notice:** This agreement and all of its attachments shall become public upon submission to Governor and Executive Council for approval. Any information that is private, confidential or proprietary must be clearly identified to the agency and agreed to in writing prior to signing the contract.

**AGREEMENT**

The State of New Hampshire and the Contractor hereby mutually agree as follows:

**GENERAL PROVISIONS**

**1. IDENTIFICATION.**

<b>1.1 State Agency Name</b> New Hampshire Department of Health and Human Services		<b>1.2 State Agency Address</b> 129 Pleasant Street Concord, NH 03301-3857	
<b>1.3 Contractor Name</b> Mary Hitchcock Memorial Hospital		<b>1.4 Contractor Address</b> One Medical Center Drive Lebanon, NH 03756-1000	
<b>1.5 Contractor Phone Number</b> (603) 650-5000	<b>1.6 Account Number</b> 05-95-90-903010-1835, 05-95-90-902510-2229, 05-95-90-903510-1113, 05-95-90-903510-1114	<b>1.7 Completion Date</b> 6/30/2027	<b>1.8 Price Limitation</b> \$900,000
<b>1.9 Contracting Officer for State Agency</b> Robert W. Moore, Director		<b>1.10 State Agency Telephone Number</b> (603) 271-9631	
<b>1.11 Contractor Signature</b> DocuSigned by:  Edward Merrens <small>8ACA3CECA0CC438...</small> Date: 6/28/2023		<b>1.12 Name and Title of Contractor Signatory</b> Edward Merrens Chief clinical officer	
<b>1.13 State Agency Signature</b> DocuSigned by:  Patricia M. Tilley <small>043FB50F59FB406...</small> Date: 6/28/2023		<b>1.14 Name and Title of State Agency Signatory</b> Patricia M. Tilley Director	
<b>1.15 Approval by the N.H. Department of Administration, Division of Personnel (if applicable)</b> By: _____ Director, On: _____			
<b>1.16 Approval by the Attorney General (Form, Substance and Execution) (if applicable)</b> By:  On: 6/28/2023 <small>728734844941480</small>			
<b>1.17 Approval by the Governor and Executive Council (if applicable)</b> G&C Item number: _____ G&C Meeting Date: _____			

Contractor Initials   
 Date 6/28/2023

**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.

**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 omissions of the

Contractor Initials EJM  
Date 6/28/2023

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 <sup>DS</sup> EJM  
Date 6/28/2023

**New Hampshire Department of Health and Human Services  
Infectious Disease Medical & Epidemiology Consultant Services  
EXHIBIT A**

**Revisions to Standard Agreement Provisions**

1. Revisions to Form P-37, General Provisions

1.1. Paragraph 3, Subparagraph 3.1, Effective Date/Completion of Services, is amended as follows:

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 as indicated in block 1.17, this Agreement, and all obligations of the parties hereunder, shall become effective on July 1, 2023, upon Governor and Council approval ("Effective Date").

1.2. 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 two (2) 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.

1.3. 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.

1.4. 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

**New Hampshire Department of Health and Human Services  
Infectious Disease Medical & Epidemiology Consultant Services  
EXHIBIT A**

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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.

- 1.5. 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.
- 1.6. 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.

**New Hampshire Department of Health and Human Services  
Infectious Disease Medical & Epidemiology Consultant Services  
EXHIBIT B**

**Scope of Services**

**1. Statement of Work**

**1.1. Scope of Services**

- 1.1.1. The Contractor must provide expert infectious disease clinical consultation services, subject matter expertise to support infectious disease-related public health and healthcare preparedness, and senior-level antibiotic resistance expertise to support healthcare-associated infections and antimicrobial resistance activities.
- 1.1.2. The Contractor must designate an Infectious Disease Medical Epidemiologist Advisor (ID-MEA) to provide the required services as outlined in this solicitation. The Contractor may designate services to additional ID-MEA(s), if required.
- 1.1.3. The Contractor's ID-MEA(s) must provide technical assistance and consultation to the Department's Bureau of Infectious Disease Control (BIDC) staff at mutually agreed upon times for the following services, which must include, but is not limited to:
  - 1.1.3.1. Urgent and non-urgent disease surveillance.
  - 1.1.3.2. Infectious disease control.
  - 1.1.3.3. Outbreak response issues.
  - 1.1.3.4. Antimicrobial resistance (AR) prevention and response.
  - 1.1.3.5. Public health emergency preparedness (PHEP).
  - 1.1.3.6. Healthcare system preparedness (HSP) capacity.
  - 1.1.3.7. Human Immunodeficiency Virus (HIV) response.
  - 1.1.3.8. Tuberculosis clinical response.
- 1.1.4. The Contractor's ID-MEA(s) must:
  - 1.1.4.1. Have the ability to be physically present at the Department's offices, when requested by the Department, specifically during significant infectious disease incidences or outbreaks to facilitate response and planning activities. Supplies, office equipment, computer, and phone will be provided by the Department.
  - 1.1.4.2. Attend 75% of weekly Outbreak Team meetings to discuss significant cases and outbreaks.

**New Hampshire Department of Health and Human Services  
Infectious Disease Medical & Epidemiology Consultant Services  
EXHIBIT B**

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- 1.1.4.3. Attend 75% of quarterly HIV Medical Advisory Board meetings to provide clinical guidance and provide recommendations.
- 1.1.4.4. Participate as a member of the HIV Planning Group and attend meetings as requested by the Department.
- 1.1.4.5. Participate as a member of the HIV Care Quality Management (QCM) Committee to review and provide guidance on clinical quality management activities. The ID-MEA will provide consultation services on CQM activities in between meetings if requested.
- 1.1.4.6. Co-chair the Communicable Disease Epidemic Control Committee, a group of state public health partners and healthcare providers that is logistically coordinated by the Department and will be established and meet based on a schedule developed by the Department.
- 1.1.4.7. Be available 24/7 by phone for high-priority clinical consultations when not physically present.
- 1.1.4.8. Respond to 100% of high-priority infectious disease consultation requests, as determined by the Department, within one (1) hour and 90% of non-high-priority infectious disease consultation requests within twenty-four (24) hours, every day of the year.
- 1.1.4.9. Participate in after-hours, weekend, and holiday infectious disease physician support to front-line Department staff that are on-call.
- 1.1.4.10. Appoint coverage for periods where the ID-MEA is not available from a qualified infectious disease physician within the Contractor's practice.
- 1.1.5. The Contractor's ID-MEA(s) must assist with drafting and reviewing infectious disease-related healthcare provider communications and clinical guidance and infectious disease-related public communications, which may include but is not limited to health alert releases, website content, fact sheets, and press releases.
- 1.1.6. The Contractor's ID-MEA(s) must provide and assist in the organization of infectious disease-related presentations to Department staff and

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**New Hampshire Department of Health and Human Services  
Infectious Disease Medical & Epidemiology Consultant Services  
EXHIBIT B**

statewide partners at conferences, statewide webinars,, or other appropriate venues.

- 1.1.7. The Contractor's ID-MEA(s) must respond to requests from the media, healthcare providers, and public health partners in collaboration with the Department to inform, investigate and recommend the strategies for disease control measures, public health emergency response, and antimicrobial resistance. The Contractor's ID-MEA(s) must not respond to the media or public health partners on behalf of the Department without written consent from the Department's Public Information Office.

**Public Health and Healthcare Preparedness and Response Services**

- 1.1.8. The Contractor's ID-MEA(s) must participate in infectious disease-related HSP, PHEP, and AR plans for exercises, which include but are not limited to workshops, tabletops, and drills.
- 1.1.9. The Contractor's ID-MEA(s) must assist with writing and implementation of infectious disease-related HSP, PHEP, and AR plans and guidance documents.
- 1.1.10. The Contractor's ID-MEA(s) must serve as a medical subject matter expert as part of the DPHS Incident Management Team.
- 1.1.11. The Contractor's ID-MEA(s) must participate in 90% of drills and respond to 100% of actual infectious disease-related events.
- 1.1.12. The Contractor's ID-MEA(s) must write standing orders for administration of antimicrobial agents or vaccines during infectious disease-related emergencies as requested and in accordance with established guidelines and state and federal regulations.
- 1.1.13. The Contractor's ID-MEA(s) must provide infectious disease-related subject matter expertise to the statewide Health Care Coalition (HCC) to ensure healthcare system readiness and response capacity for infectious disease, especially for high-threat infectious diseases.

**Antimicrobial Resistance and Healthcare-Associated Infections Services**

- 1.1.14. The Contractor's ID-MEA(s) must serve as an antimicrobial resistance (AR) subject matter expert and consultant to foster facility, regional and state-wide antimicrobial stewardship in collaboration with the Department. The Contractor's ID-MEA(s) must:
- 1.1.14.1. Assist healthcare facilities with developing or refining a stewardship program, outbreak response consultation.
- 1.1.14.2. Coordinate with HAI program, as requested by the Department, for a facility site visits if there is a large-scale AR event.

**New Hampshire Department of Health and Human Services  
Infectious Disease Medical & Epidemiology Consultant Services  
EXHIBIT B**

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- 1.1.15. The Contractor's ID-MEA(s) must attend 75% of the Healthcare-Associated Infections (HAI) technical advisory workgroup meetings.
- 1.1.16. The Contractor's ID-MEA(s) must participate as a member and help lead the NH Antimicrobial Resistance Advisory Workgroup (ARAW) in collaboration with the NH Healthcare Associated Infections (HAI) Program.
- 1.1.17. The Contractor's ID-MEA(s) must participate in 75% of internal meetings focused on Antimicrobial Resistance planning and response.
- 1.1.18. The Contractor's ID-MEA(s) must co-chair AR advisory workgroup and attend 75% of the meetings. This includes coordinating with the HAI program to develop meeting agendas, provide meeting facilitation, coordinating and engaging AR members, and presentations.
- 1.1.19. The Contractor's ID-MEA(s) must present on AR surveillance and stewardship to healthcare facilities, healthcare providers, and to Department staff as requested.
- 1.1.20. The Contractor's ID-MEA(s) must develop and review AR and stewardship resources to be distributed by the HAI Program to healthcare facilities and providers.
- 1.1.21. The Contractor's ID-MEA(s) must attend infectious disease AR conferences to provide the most up to date science to HAI Program staff on AR.
- 1.1.22. The Contractor's ID-MEA(s) must help develop and review antibiogram and other statewide AR reports, AR outbreak and cluster investigation reports, Carbapenem-resistant enterobacteriaceae and Clostridium difficile surveillance reports, and antimicrobial use reports.

**Staffing**

- 1.1.23. The Contractor must ensure the ID-MEA(s) meet the following criteria:
  - 1.1.23.1. Individual(s) must be a medical doctor (M.D. or D.O.) and be eligible for and hold a valid New Hampshire medical license. Other qualified licensed healthcare providers may participate after review and approval by the Department.
  - 1.1.23.2. Individual(s) must have completed training in infectious disease as documented through completion of an infectious disease fellowship or similar credentialing program and be board certified through the American Board of Internal Medicine in the specialty of Infectious Disease. Other healthcare providers for consideration will be required to provide documentation to support subject matter expertise in

**New Hampshire Department of Health and Human Services  
Infectious Disease Medical & Epidemiology Consultant Services  
EXHIBIT B**

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the areas of infectious disease and antimicrobial resistance, and may be approved at the discretion of the Department.

1.1.23.2.1. Preference is for a physician who has completed a Master of Public Health degree or similar program, Accredited Preventative Medicine Residency program or the Centers for Disease Control and Prevention (CDC) Epidemic Intelligence Service (EIS) program. Other healthcare providers may be considered at the discretion of the Department.

1.1.24. The Contractor must provide staffing to fulfill the roles and responsibilities to support activities of this contract.

1.1.25. The Contractor must ensure staff funded under this contract are required to attend pertinent technical assistance sessions, progress reviews, and conference calls.

## 1.2. Background Checks

1.2.1. Prior to permitting any individual to provide services under this Agreement, the Contractor must ensure that said individual has undergone:

1.2.1.1. A criminal background check, at the Contractor's expense, and has no convictions for crimes that represent evidence of behavior that could endanger individuals served under this Agreement.

1.2.1.2. A name search of the Department's Bureau of Elderly and Adult Services (BEAS) State Registry, pursuant to RSA 161-F:49, with results indicating no evidence of behavior that could endanger individuals served under this Agreement.

## 1.3. Reporting

1.3.1. The Contractor must submit the following data to monitor program performance:

1.3.1.1. Quarterly reports on program activities and plans for the upcoming quarter, in a format developed and approved by the Department. Reports are due thirty (30) days following the end of each calendar quarter and include the following:

1.3.1.1.1. Narrative of work completed in the past quarter;

1.3.1.1.2. Narrative of the work in process and plans for the upcoming quarter, including challenges or barriers to completing requirements as described in the Scope

**New Hampshire Department of Health and Human Services  
Infectious Disease Medical & Epidemiology Consultant Services  
EXHIBIT B**

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of Work; and

1.3.1.1.3. Documented achievements and work linked to the Scope of Work, including reporting on the required performance measures.

1.3.1.2. Final cumulative report due sixty (60) days following the end of the contract term.

1.3.2. The Contractor must provide other data and metrics to the Department in a format specified by the Department, as requested.

**1.4. Performance Measures**

1.4.1. The Contractor must ensure that following performance indicators are annually achieved and monitored monthly to measure the effectiveness of the agreement:

1.4.1.1. Complete 90% of infectious disease consultation requests made by DPHS within a twenty-four (24) hour time period.

1.4.1.2. Complete 100% of high-priority infectious disease consultation requests made by DPHS within one (1) hour.

1.4.1.3. Participate in 90% of the DPHS Incident Management Team drills.

1.4.1.4. Participate in 100% of actual DPHS infectious disease-related Incident Management Team activations.

1.4.1.5. Participate in 75% of Outbreak Team meetings.

1.4.1.6. Participate in 75% of HIV Medical Advisory Board meetings.

1.4.1.7. Participate in 75% of Healthcare-Associated Infections Technical Advisory Workgroup Meetings.

1.4.1.8. Participate in 75% of Healthcare-Associated Infections Antimicrobial Resistance Advisory Workgroup meetings.

1.4.2. The Contractor must report on progress toward meeting the performance measures, and overall program goals and objectives to demonstrate they have met the minimum required services for the proposal at timeframes specified by the Department.

1.4.3. Notwithstanding Paragraph 8, Event of Default and Paragraph 9, Termination, of the General Provisions of the contract, Form P-37, the Contractor must annually develop and submit a corrective action plan for any performance measure that was not achieved.

**1.5. Privacy Impact Assessment**

1.5.1. Upon request, the Contractor must allow and assist the Department in conducting a Privacy Impact Assessment (PIA) EJM its

**New Hampshire Department of Health and Human Services  
Infectious Disease Medical & Epidemiology Consultant Services  
EXHIBIT B**

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system(s)/application(s)/web portal(s)/website(s) or Department system(s)/application(s)/web portal(s)/website(s) hosted by the Contractor, if Personally Identifiable Information (PII) is collected, used, accessed, shared, or stored. To conduct the PIA the Contractor must provide the Department access to applicable systems and documentation sufficient to allow the Department to assess, at minimum, the following:

- 1.5.1.1. How PII is gathered and stored;
- 1.5.1.2. Who will have access to PII;
- 1.5.1.3. How PII will be used in the system;
- 1.5.1.4. How individual consent will be achieved and revoked; and
- 1.5.1.5. Privacy practices.

1.5.2. The Department may conduct follow-up PIAs in the event there are either significant process changes or new technologies impacting the collection, processing or storage of PII.

**1.6. Department Owned Devices, Systems and Network Usage**

1.6.1. Contractor End Users, as defined in Exhibit K, DHHS Information Security Requirements, authorized by the Department's Information Security Office to use a Department issued device (e.g. computer, tablet, mobile telephone) or access the Department network in the fulfilment of this Agreement, the Contractor must:

- 1.6.1.1. Sign and abide by applicable Department and New Hampshire Department of Information Technology (NH DoIT) use agreements, policies, standards, procedures and guidelines, and complete applicable trainings as required;
- 1.6.1.2. Use the information that they have permission to access solely for conducting official Department business and agree that all other use or access is strictly forbidden including, but not limited, to personal or other private and non-Department use, and that at no time shall they access or attempt to access information without having the express authority of the Department to do so;
- 1.6.1.3. Not access or attempt to access information in a manner inconsistent with the approved policies, procedures, and/or agreement relating to system entry/access;
- 1.6.1.4. Not copy, share, distribute, sub-license, modify, reverse engineer, rent, or sell software licensed, developed, or being evaluated by the Department, and at all times must use utmost care to protect and keep such software strictly

**New Hampshire Department of Health and Human Services  
Infectious Disease Medical & Epidemiology Consultant Services  
EXHIBIT B**

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- confidential in accordance with the license or any other agreement executed by the Department;
- 1.6.1.5. Only use equipment, software, or subscription(s) authorized by the Department's Information Security Office or designee;
- 1.6.1.6. Not install non-standard software on any Department equipment unless authorized by the Department's Information Security Office or designee;
- 1.6.1.7. Agree that email and other electronic communication messages created, sent, and received on a Department-issued email system are the property of the Department of New Hampshire and to be used for business purposes only. Email is defined as "internal email systems" or "Department-funded email systems."
- 1.6.1.8. Agree that use of email must follow Department and NH DoIT policies, standards, and/or guidelines; and
- 1.6.1.9. Agree when utilizing the Department's email system:
- 1.6.1.9.1. To only use a Department email address assigned to them with a "@affiliate.DHHS.NH.Gov".
- 1.6.1.9.2. Include in the signature lines information identifying the End User as a non-Department workforce member; and
- 1.6.1.9.3. Ensure the following confidentiality notice is embedded underneath the signature line:
- 1.6.1.9.4. CONFIDENTIALITY NOTICE: "This message may contain information that is privileged and confidential and is intended only for the use of the individual(s) to whom it is addressed. If you receive this message in error, please notify the sender immediately and delete this electronic message and any attachments from your system. Thank you for your cooperation."
- 1.6.1.10. Contractor End Users with a Department issued email, access or potential access to Confidential Data, and/or a workspace in a Department building/facility, must:
- 1.6.1.10.1. Complete the Department's Annual Information Security & Compliance Awareness Training prior to accessing, viewing, handling, hearing,

**New Hampshire Department of Health and Human Services  
Infectious Disease Medical & Epidemiology Consultant Services  
EXHIBIT B**

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or transmitting Department Data or Confidential Data.

- 1.6.1.10.2. Sign the Department's Business Use and Confidentiality Agreement and Asset Use Agreement, and the NH DoIT Department wide Computer Use Agreement upon execution of the Contract and annually throughout the Contract term.
- 1.6.1.10.3. Agree End User's will only access the Department' intranet to view the Department's Policies and Procedures and Information Security webpages.
- 1.6.1.10.4. Agree, if any End User is found to be in violation of any of the above-Department terms and conditions of the Contract, said End User may face removal from the Contract, and/or criminal and/or civil prosecution, if the act constitutes a violation of law.
- 1.6.1.10.5. Agrees to notify the Department a minimum of three business days prior to any upcoming transfers or terminations of End Users who possess Department credentials and/or badges or who have system privileges. If End Users who possess Department credentials and/or badges or who have system privileges resign or are dismissed without advance notice, the Contractor agrees to notify the Department's Information Security Office or designee immediately.

**1.6.2. Workspace Requirement**

- 1.6.2.1. If applicable, the Department will work with Contractor to determine requirements for providing necessary workspace and State equipment for its End Users.

**1.7. Contract End-of-Life Transition Services**

**1.7.1. General Requirements**

- 1.7.1.1. If applicable, upon termination or expiration of the Contract the Parties agree to cooperate in good faith to effectuate a smooth secure transition of the Services from the Contractor to the Department and, if applicable, the Contractor engaged by the Department to assume the Services previously performed by the

**New Hampshire Department of Health and Human Services  
Infectious Disease Medical & Epidemiology Consultant Services  
EXHIBIT B**

Contractor for this section the new Contractor shall be known as "Recipient". Ninety (90) days prior to the end-of the contract or unless otherwise specified by the Department, the Contractor must begin working with the Department and if applicable, the new Recipient to develop a Data Transition Plan (DTP). The Department shall provide the DTP template to the Contractor.

- 1.7.1.2. The Contractor must use reasonable efforts to assist the Recipient, in connection with the transition from the performance of Services by the Contractor and its End Users to the performance of such Services. This may include assistance with the secure transfer of records (electronic and hard copy), transition of historical data (electronic and hard copy), the transition of any such Service from the hardware, software, network and telecommunications equipment and internet-related information technology infrastructure ("Internal IT Systems") of Contractor to the Internal IT Systems of the Recipient and cooperation with and assistance to any third-party consultants engaged by Recipient in connection with the Transition Services.
- 1.7.1.3. If a system, database, hardware, software, and/or software licenses (Tools) was purchased or created to manage, track, and/or store Department Data in relationship to this contract said Tools will be inventoried and returned to the Department, along with the inventory document, once transition of Department Data is complete.
- 1.7.1.4. The internal planning of the Transition Services by the Contractor and its End Users shall be provided to the Department and if applicable the Recipient in a timely manner. Any such Transition Services shall be deemed to be Services for purposes of this Contract.
- 1.7.1.5. Should the data Transition extend beyond the end of the Contract, the Contractor agrees that the Contract Information Security Requirements, and if applicable, the Department's Business Associate Agreement terms and conditions remain in effect until the Data Transition is accepted as complete by the Department.
- 1.7.1.6. In the event where the Contractor has comingled Department Data and the destruction or Transition of said data is not feasible, the Department and Contractor will jointly evaluate regulatory and professional standards for retention requirements prior to destruction, refer to the terms and conditions of Exhibit K: DHHS Information Security Requirements.

**New Hampshire Department of Health and Human Services  
Infectious Disease Medical & Epidemiology Consultant Services  
EXHIBIT B**

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**1.7.2. Completion of Transition Services**

1.7.2.1. Each service or Transition phase shall be deemed completed (and the Transition process finalized) at the end of 15 business days after the product, resulting from the Service, is delivered to the Department and/or the Recipient in accordance with the mutually agreed upon Transition plan, unless within said 15 business day term the Contractor notifies the Department of an issue requiring additional time to complete said product.

1.7.2.2. Once all parties agree the data has been migrated the Contractor will have 30 days to destroy the data per the terms and conditions of Exhibit K: DHHS Information Security Requirements.

**1.7.3. Disagreement over Transition Services Results**

1.7.3.1. In the event the Department is not satisfied with the results of the Transition Service, the Department shall notify the Contractor, by email, stating the reason for the lack of satisfaction within 15 business days of the final product or at any time during the data Transition process. The Parties shall discuss the actions to be taken to resolve the disagreement or issue. If an agreement is not reached, at any time the Department shall be entitled to initiate actions in accordance with the Contract.

**1. Exhibits Incorporated**

1.1. The Contractor must 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.

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

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

**2. Additional Terms**

**2.1. Impacts Resulting from Court Orders or Legislative Changes**

2.1.1. 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.

**New Hampshire Department of Health and Human Services  
Infectious Disease Medical & Epidemiology Consultant Services  
EXHIBIT B**

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**2.2. Credits and Copyright Ownership**

- 2.2.1. All documents, notices, press releases, research reports and other materials prepared during or resulting from the performance of the services of the Agreement must 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."
- 2.2.2. All materials produced or purchased under the Agreement must have prior approval from the Department before printing, production, distribution or use.
- 2.2.3. The Department must retain copyright ownership for any and all original materials produced, including, but not limited to:
- 2.2.3.1. Brochures.
  - 2.2.3.2. Resource directories.
  - 2.2.3.3. Protocols or guidelines.
  - 2.2.3.4. Posters.
  - 2.2.3.5. Reports.
- 2.2.4. The Contractor must not reproduce any materials produced under the Agreement without prior written approval from the Department.

**3. Records**

- 3.1. The Contractor must keep records that include, but are not limited to:
- 3.1.1. 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 Contract, and all income received or collected by the Contractor.
  - 3.1.2. 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.
- 3.2. During the term of this Agreement and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and

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**New Hampshire Department of Health and Human Services  
Infectious Disease Medical & Epidemiology Consultant Services  
EXHIBIT B**

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any of their designated representatives must have access to all reports and records maintained pursuant to the Agreement for purposes of audit, examination, excerpts and transcripts.

- 3.3. If, upon review of the Final Expenditure Report the Department must disallow any expenses claimed by the Contractor as costs hereunder, the Department retains the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

**New Hampshire Department of Health and Human Services  
Infectious Disease Medical & Epidemiology Consultant Services  
EXHIBIT C**

**Payment Terms**

1. This Agreement is funded by:
  - 1.1. 47% Federal funds:
    - 1.1.1. 20% ELC for Infectious Diseases, as awarded on April 26, 2022, by the CDC, ALN 93.323, FAIN NU50CK000522.
    - 1.1.2. 7% Hospital Preparedness Program, as awarded on July 1, 2023, by the ASPR, ALN 93.889, FAIN U3REP190580.
    - 1.1.3. 20% NH PH Emergency Preparedness, as awarded on July 1, 2023, by the CDC, ALN 93.069, FAIN NU90TP22018.
  - 1.2. 11% General funds.
  - 1.3. 42% Other funds (Pharmaceutical Rebates).
2. For the purposes of this Agreement the Department has identified:
  - 2.1. The Contractor as a Contractor, in accordance with 2 CFR 200.331.
  - 2.2. The 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 Exhibits C-1, Budget through C-4, Budget.
4. The Contractor shall submit an invoice with supporting documentation to the Department no later than the fifteenth (15th) working day of the month following the month in which the services were provided. The Contractor shall ensure each invoice:
  - 4.1. Includes the Contractor's Vendor Number issued upon registering with New Hampshire Department of Administrative Services.
  - 4.2. Is submitted in a form that is provided by or otherwise acceptable to the Department.
  - 4.3. Identifies and requests payment for allowable costs incurred in the previous month.
  - 4.4. Includes supporting documentation of allowable costs with each invoice that may include, but are not limited to, time sheets, payroll records, receipts for purchases, and proof of expenditures, as applicable.
  - 4.5. Is completed, dated and returned to the Department with the supporting documentation for allowable expenses to initiate payment.
  - 4.6. Is assigned an electronic signature, includes supporting documentation, and is emailed to [DPHSContractBilling@dhhs.nh.gov](mailto:DPHSContractBilling@dhhs.nh.gov) or mailed to:

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**New Hampshire Department of Health and Human Services  
Infectious Disease Medical & Epidemiology Consultant Services  
EXHIBIT C**

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

5. The Department shall make payments to the Contractor within thirty (30) days of receipt of each invoice and supporting documentation for authorized expenses, subsequent to approval of the submitted invoice.
6. The final invoice and supporting documentation for authorized expenses 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:
7. 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.
8. Audits
  - 8.1. The Contractor must email an annual audit to [dhhs.act@dhhs.nh.gov](mailto:dhhs.act@dhhs.nh.gov) if any of the following conditions exist:
    - 8.1.1. 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.
    - 8.1.2. 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.
    - 8.1.3. Condition C - The Contractor is a public company and required by Security and Exchange Commission (SEC) regulations to submit an annual financial audit.
  - 8.2. If Condition A exists, the Contractor shall submit an annual Single Audit performed by an independent Certified Public Accountant (CPA) to [dhhs.act@dhhs.nh.gov](mailto:dhhs.act@dhhs.nh.gov) within 120 days after the close of the Contractor's fiscal year, 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.
    - 8.2.1. The Contractor shall submit a copy of any Single Audit findings and any associated corrective action plans. The Contractor shall submit quarterly progress reports on the status of implementation of the corrective action plan.

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**New Hampshire Department of Health and Human Services  
Infectious Disease Medical & Epidemiology Consultant Services  
EXHIBIT C**

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- 8.3. 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.
- 8.4. In addition to, and not in any way in limitation of obligations of the Agreement, 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 Agreement to which exception has been taken, or which have been disallowed because of such an exception.

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Exhibit C-1

RFA-2024-DPHS-03-INFEC-01

New Hampshire Department of Health and Human Services Complete one budget form for each budget period. Contractor Name: <i>Mary Hitchcock Memorial Hospital</i> Budget Request for: <i>Infectious Disease Medical &amp; Epidemiology Consultant Services</i> Budget Period <i>July 1, 2023 - June 30, 2024</i> Indirect Cost Rate (if applicable) <i>31.00%</i>	
Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	\$154,735
2. Fringe Benefits	\$17,021
3. Consultants	\$0
Indirect cost rate cannot be applied to	\$0
5.(a) Supplies - Educational	\$0
5.(b) Supplies - Lab	\$0
5.(c) Supplies - Pharmacy	\$0
5.(d) Supplies - Medical	\$0
5.(e) Supplies Office	\$0
6. Travel	\$0
7. Software	\$0
8. (a) Other - Marketing/ Communications	\$0
8. (b) Other - Education and Training	\$0
8. (c) Other - Other (specify below)	
<i>Other (please specify)</i>	\$0
9. Subrecipient Contracts	\$0
<b>Total Direct Costs</b>	<b>\$171,756</b>
<b>Total Indirect Costs</b>	<b>\$53,244</b>
<b>TOTAL</b>	<b>\$225,000</b>

Contractor Initials 
DS  
**EJM**

Date 6/28/2023

Exhibit C-2

RFA-2024-DPHS-03-INFEC-01

New Hampshire Department of Health and Human Services Complete one budget form for each budget period.	
Contractor Name: <u>Mary Hitchcock Memorial Hospital</u>	
Budget Request for: <u>Infectious Disease Medical &amp; Epidemiology Consultant Services</u>	
Budget Period <u>July 1, 2024 - June 30, 2025</u>	
Indirect Cost Rate (If applicable) <u>31.00%</u>	
Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	\$154,735
2. Fringe Benefits	\$17,021
3. Consultants	\$0
4. Equipment Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.	\$0
5.(a) Supplies - Educational	\$0
5.(b) Supplies - Lab	\$0
5.(c) Supplies - Pharmacy	\$0
5.(d) Supplies - Medical	\$0
5.(e) Supplies Office	\$0
6. Travel	\$0
7. Software	\$0
8. (a) Other - Marketing/ Communications	\$0
8. (b) Other - Education and Training	\$0
8. (c) Other - Other (specify below)	
Other (please specify)	\$0
9. Subrecipient Contracts	\$0
<b>Total Direct Costs</b>	<b>\$171,756</b>
<b>Total Indirect Costs</b>	<b>\$53,244</b>
<b>TOTAL</b>	<b>\$225,000</b>

Contractor Initials 
 DS  
 EJM

Date 6/28/2023

Exhibit.C-3

RFA-2024-DPHS-03-INFEC-01

**New Hampshire Department of Health and Human Services**  
*Complete one budget form for each budget period.*

**Contractor Name:** Mary Hitchcock Memorial Hospital

**Budget Request for:** Infectious Disease Medical & Epidemiology Consultant Services

**Budget Period:** July 1, 2025 - June 30, 2026

**Indirect Cost Rate (if applicable):** 31.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	\$154,735
2. Fringe Benefits	\$17,021
3. Consultants	\$0
4. Equipment Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.	\$0
5.(a) Supplies - Educational	\$0
5.(b) Supplies - Lab	\$0
5.(c) Supplies - Pharmacy	\$0
5.(d) Supplies - Medical	\$0
5.(e) Supplies Office	\$0
6. Travel	\$0
7. Software	\$0
8. (a) Other - Marketing/ Communications	\$0
8. (b) Other - Education and Training	\$0
8. (c) Other - Other (specify below)	
Other (please specify)	\$0
9. Subrecipient Contracts	\$0
<b>Total Direct Costs</b>	<b>\$171,756</b>
<b>Total Indirect Costs</b>	<b>\$53,244</b>
<b>TOTAL</b>	<b>\$225,000</b>

Contractor Initials DS  
EJM

Exhibit C-4

RFA-2024-DPHS-03-INFEC-01

**New Hampshire Department of Health and Human Services**  
 Complete one budget form for each budget period.  
 Contractor Name: Mary Hitchcock Memorial Hospital  
 Budget Request for: Infectious Disease Medical & Epidemiology Consultant Services  
 Budget Period July 1, 2026 - June 30, 2027  
 Indirect Cost Rate (if applicable) 31.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	\$154,735
2. Fringe Benefits	\$17,021
3. Consultants	\$0
4. Equipment Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.	\$0
5.(a) Supplies - Educational	\$0
5.(b) Supplies - Lab	\$0
5.(c) Supplies - Pharmacy	\$0
5.(d) Supplies - Medical	\$0
5.(e) Supplies Office	\$0
6. Travel	\$0
7. Software	\$0
8. (a) Other - Marketing/ Communications	\$0
8. (b) Other - Education and Training	\$0
8. (c) Other - Other (specify below)	
Other (please specify)	\$0
9. Subrecipient Contracts	\$0
<b>Total Direct Costs</b>	<b>\$171,756</b>
<b>Total Indirect Costs</b>	<b>\$53,244</b>
<b>TOTAL</b>	<b>\$225,000</b>

Contractor Initials DS  
EJM

Date 6/28/2023



**New Hampshire Department of Health and Human Services  
Exhibit D**

**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

EJM



New Hampshire Department of Health and Human Services  
Exhibit D

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: Dartmouth-Hitchcock

6/28/2023

Date

DocuSigned by:  
*Edward Merrens*  
 Name: Edward Merrens  
 Title: Chief Clinical Officer

Vendor Initials DS  
EJM  
 Date 6/28/2023



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:

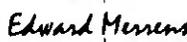
1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection 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: Dartmouth-Hitchcock

6/28/2023

Date

DocuSigned by:  
  
 Name: Edward Merrens  
 Title: Chief Clinical officer

DS  
EJM



New Hampshire Department of Health and Human Services  
Exhibit F

**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



**New Hampshire Department of Health and Human Services  
Exhibit F**

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: Dartmouth-Hitchcock

6/28/2023

Date

DocuSigned by:

*Edward Merrens*

Name: Edward Merrens

Title: Chief Clinical Officer

DS  
EJM

New Hampshire Department of Health and Human Services  
Exhibit G



**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.

Exhibit G

Contractor Initials

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EJM

Certification of Compliance with requirements pertaining to Federal Nondiscrimination, Equal Treatment of Faith-Based Organizations and Whistleblower protections



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: Dartmouth-Hitchcock

DocuSigned by:

*Edward Merrens*

6/28/2023

Date

Name: Edward Merrens

Title: chief clinical officer

Exhibit G

Certification of Compliance with requirements pertaining to Federal Nondiscrimination, Equal Treatment of Faith-Based Organizations and Whistleblower protections

Contractor Initials

DS  
EJM



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: Dartmouth-Hitchcock

6/28/2023

Date

DocuSigned by:  
*Edward Merrens*  
Name: Edward Merrens  
Title: Chief Clinical Officer



## New Hampshire Department of Health and Human Services

## Exhibit I

**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT**  
**BUSINESS ASSOCIATE AGREEMENT**

The Contractor identified in Section 1.3 of the General Provisions of the Agreement agrees to comply with the Health Insurance Portability and Accountability Act, Public Law 104-191 and with the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 applicable to business associates. As defined herein, "Business Associate" shall mean the Contractor and subcontractors and agents of the Contractor that receive, use or have access to protected health information under this Agreement and "Covered Entity" shall mean the State of New Hampshire, Department of Health and Human Services.

**(1) Definitions.**

- a. "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.
- b. "Business Associate" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.
- c. "Covered Entity" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.
- d. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR Section 164.501.
- e. "Data Aggregation" shall have the same meaning as the term "data aggregation" in 45 CFR Section 164.501.
- f. "Health Care Operations" shall have the same meaning as the term "health care operations" in 45 CFR Section 164.501.
- g. "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act, Title XIII, Subtitle D, Part 1 & 2 of the American Recovery and Reinvestment Act of 2009.
- h. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160, 162 and 164 and amendments thereto.
- i. "Individual" shall have the same meaning as the term "individual" in 45 CFR Section 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.501(g).
- j. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.
- k. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR Section 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.



New Hampshire Department of Health and Human Services

Exhibit I

- i. “Required by Law” shall have the same meaning as the term “required by law” in 45 CFR Section 164.103.
- m. “Secretary” shall mean the Secretary of the Department of Health and Human Services or his/her designee.
- n. “Security Rule” shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 164, Subpart C, and amendments thereto.
- o. “Unsecured Protected Health Information” means protected health information that is not secured by a technology standard that renders protected health information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.
- p. Other Definitions - All terms not otherwise defined herein shall have the meaning established under 45 C.F.R. Parts 160, 162 and 164, as amended from time to time, and the HITECH Act.

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

- a. Business Associate shall not use, disclose, maintain or transmit Protected Health Information (PHI) except as reasonably necessary to provide the services outlined under Exhibit A of the Agreement. Further, Business Associate, including but not limited to all its directors, officers, employees and agents, shall not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.
- b. Business Associate may use or disclose PHI:
  - I. For the proper management and administration of the Business Associate;
  - II. As required by law, pursuant to the terms set forth in paragraph d. below; or
  - III. For data aggregation purposes for the health care operations of Covered Entity.
- c. To the extent Business Associate is permitted under the Agreement to disclose PHI to a third party, Business Associate must obtain, prior to making any such disclosure, (i) reasonable assurances from the third party that such PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (ii) an agreement from such third party to notify Business Associate, in accordance with the HIPAA Privacy, Security, and Breach Notification Rules of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.
- d. The Business Associate shall not, unless such disclosure is reasonably necessary to provide services under Exhibit A of the Agreement, disclose any PHI in response to a request for disclosure on the basis that it is required by law, without first notifying Covered Entity so that Covered Entity has an opportunity to object to the disclosure and to seek appropriate relief. If Covered Entity objects to such disclosure, the Business

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EJM



New Hampshire Department of Health and Human Services

Exhibit I

Associate shall refrain from disclosing the PHI until Covered Entity has exhausted all remedies.

- e. If the Covered Entity notifies the Business Associate that Covered Entity has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Business Associate shall be bound by such additional restrictions and shall not disclose PHI in violation of such additional restrictions and shall abide by any additional security safeguards.

**(3) Obligations and Activities of Business Associate.**

- a. The Business Associate shall notify the Covered Entity's Privacy Officer immediately after the Business Associate becomes aware of any use or disclosure of protected health information not provided for by the Agreement including breaches of unsecured protected health information and/or any security incident that may have an impact on the protected health information of the Covered Entity.
- b. The Business Associate shall immediately perform a risk assessment when it becomes aware of any of the above situations. The risk assessment shall include, but not be limited to:
  - o The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
  - o The unauthorized person used the protected health information or to whom the disclosure was made;
  - o Whether the protected health information was actually acquired or viewed
  - o The extent to which the risk to the protected health information has been mitigated.

The Business Associate shall complete the risk assessment within 48 hours of the breach and immediately report the findings of the risk assessment in writing to the Covered Entity.

- c. The Business Associate shall comply with all sections of the Privacy, Security, and Breach Notification Rule.
- d. Business Associate shall make available all of its internal policies and procedures, books and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of Covered Entity to the Secretary for purposes of determining Covered Entity's compliance with HIPAA and the Privacy and Security Rule.
- e. Business Associate shall require all of its business associates that receive, use or have access to PHI under the Agreement, to agree in writing to adhere to the same restrictions and conditions on the use and disclosure of PHI contained herein, including the duty to return or destroy the PHI as provided under Section 3 (l). The Covered Entity shall be considered a direct third party beneficiary of the Contractor's business associate agreements with Contractor's intended business associates, who will be receiving PHI



## New Hampshire Department of Health and Human Services

## Exhibit I

pursuant to this Agreement, with rights of enforcement and indemnification from such business associates who shall be governed by standard Paragraph #13 of the standard contract provisions (P-37) of this Agreement for the purpose of use and disclosure of protected health information.

- f. Within five (5) business days of receipt of a written request from Covered Entity, Business Associate shall make available during normal business hours at its offices all records, books, agreements, policies and procedures relating to the use and disclosure of PHI to the Covered Entity, for purposes of enabling Covered Entity to determine Business Associate's compliance with the terms of the Agreement.
- g. Within ten (10) business days of receiving a written request from Covered Entity, Business Associate shall provide access to PHI in a Designated Record Set to the Covered Entity, or as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR Section 164.524.
- h. Within ten (10) business days of receiving a written request from Covered Entity for an amendment of PHI or a record about an individual contained in a Designated Record Set, the Business Associate shall make such PHI available to Covered Entity for amendment and incorporate any such amendment to enable Covered Entity to fulfill its obligations under 45 CFR Section 164.526.
- i. Business Associate shall document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.
- j. Within ten (10) business days of receiving a written request from Covered Entity for a request for an accounting of disclosures of PHI, Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill its obligations to provide an accounting of disclosures with respect to PHI in accordance with 45 CFR Section 164.528.
- k. In the event any individual requests access to, amendment of, or accounting of PHI directly from the Business Associate, the Business Associate shall within two (2) business days forward such request to Covered Entity. Covered Entity shall have the responsibility of responding to forwarded requests. However, if forwarding the individual's request to Covered Entity would cause Covered Entity or the Business Associate to violate HIPAA and the Privacy and Security Rule, the Business Associate shall instead respond to the individual's request as required by such law and notify Covered Entity of such response as soon as practicable.
- l. Within ten (10) business days of termination of the Agreement, for any reason, the Business Associate shall return or destroy, as specified by Covered Entity, all PHI received from, or created or received by the Business Associate in connection with the Agreement, and shall not retain any copies or back-up tapes of such PHI. If return or destruction is not feasible, or the disposition of the PHI has been otherwise agreed to in the Agreement, Business Associate shall continue to extend the protections of the Agreement, to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate

EJM

3/2014

Contractor Initials

Date 6/28/2023



## New Hampshire Department of Health and Human Services

## Exhibit I

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

**(4) Obligations of Covered Entity**

- a. Covered Entity shall notify Business Associate of any changes or limitation(s) in its Notice of Privacy Practices provided to individuals in accordance with 45 CFR Section 164.520, to the extent that such change or limitation may affect Business Associate's use or disclosure of PHI.
- b. Covered Entity shall promptly notify Business Associate of any changes in, or revocation of permission provided to Covered Entity by individuals whose PHI may be used or disclosed by Business Associate under this Agreement, pursuant to 45 CFR Section 164.506 or 45 CFR Section 164.508.
- c. Covered entity shall promptly notify Business Associate of any restrictions on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

**(5) Termination for Cause**

In addition to Paragraph 10 of the standard terms and conditions (P-37) of this Agreement the Covered Entity may immediately terminate the Agreement upon Covered Entity's knowledge of a breach by Business Associate of the Business Associate Agreement set forth herein as Exhibit I. The Covered Entity may either immediately terminate the Agreement or provide an opportunity for Business Associate to cure the alleged breach within a timeframe specified by Covered Entity. If Covered Entity determines that neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

**(6) Miscellaneous**

- a. Definitions and Regulatory References. All terms used, but not otherwise defined herein, shall have the same meaning as those terms in the Privacy and Security Rule, amended from time to time. A reference in the Agreement, as amended to include this Exhibit I, to a Section in the Privacy and Security Rule means the Section as in effect or as amended.
- b. Amendment. Covered Entity and Business Associate agree to take such action as is necessary to amend the Agreement, from time to time as is necessary for Covered Entity to comply with the changes in the requirements of HIPAA, the Privacy and Security Rule, and applicable federal and state law.
- c. Data Ownership. The Business Associate acknowledges that it has no ownership rights with respect to the PHI provided by or created on behalf of Covered Entity.
- d. Interpretation. The parties agree that any ambiguity in the Agreement shall be resolved to permit Covered Entity to comply with HIPAA, the Privacy and Security Rule. EJM

3/2014

Contractor Initials

6/28/2023  
Date



New Hampshire Department of Health and Human Services

Exhibit I

- e. Segregation. If any term or condition of this Exhibit I or the application thereof to any person(s) or circumstance is held invalid, such invalidity shall not affect other terms or conditions which can be given effect without the invalid term or condition; to this end the terms and conditions of this Exhibit I are declared severable.
- f. Survival. Provisions in this Exhibit I regarding the use and disclosure of PHI, return or destruction of PHI, extensions of the protections of the Agreement in section (3) I, the defense and indemnification provisions of section (3) e and Paragraph 13 of the standard terms and conditions (P-37), shall survive the termination of the Agreement.

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

Department of Health and Human Services

Dartmouth-Hitchcock

The State by:

Name of the Contractor

Patricia M. Tilley

Edward Merrens

Signature of Authorized Representative

Signature of Authorized Representative

Patricia M. Tilley

Edward Merrens

Name of Authorized Representative  
Director

Name of Authorized Representative

Chief Clinical officer

Title of Authorized Representative

Title of Authorized Representative

6/28/2023

6/28/2023

Date

Date

DS  
EJM  
Contractor Initials

6/28/2023  
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 (UEI #)
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: Dartmouth-Hitchcock

6/28/2023

Date

DocuSigned by:

*Edward Merrens*

Name: Edward Merrens

Title: Chief clinical officer

DS  
EJM



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 UEI (SAM.gov) 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?

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: _____

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

**New Hampshire Department of Health and Human Services  
DHHS Security Requirements**



Exhibit K

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

April, 2020

Contractor Initials

EJM

Date 6/28/2023

**New Hampshire Department of Health and Human Services  
DHHS Security Requirements**



Exhibit K

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

**New Hampshire Department of Health and Human Services  
DHHS Security Requirements**



Exhibit K

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

April, 2020

Contractor Initials

DS  
EJM

Date 6/28/2023

**New Hampshire Department of Health and Human Services  
DHHS Security Requirements**



Exhibit K

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

New Hampshire Department of Health and Human Services  
DHHS Security Requirements



Exhibit K

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

April, 2020

Contractor Initials

EJM

Date 6/28/2023

**New Hampshire Department of Health and Human Services  
DHHS Security Requirements**



**Exhibit K**

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/doi/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

April, 2020

Contractor Initials

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EJM

Date 6/28/2023

**New Hampshire Department of Health and Human Services  
DHHS Security Requirements**



Exhibit K

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
- E. DHHS Program Area Contact:  
Christine.Bean@dhhs.nh.gov

# State of New Hampshire

## Department of State

### CERTIFICATE

I, David M. Scanlan, 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: 0006201297

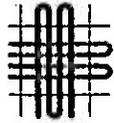


IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed  
the Seal of the State of New Hampshire,  
this 10th day of April A.D. 2023.

A handwritten signature in black ink, appearing to read "David M. Scanlan".

David M. Scanlan  
Secretary of State



Dartmouth Health

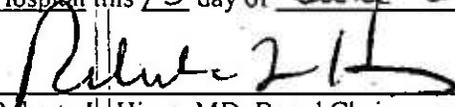
Dartmouth-Hitchcock | Dartmouth-Hitchcock Health

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 23<sup>rd</sup>, 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 as of the date of the agreement executed or action taken in reliance upon this Certificate. This authority shall remain valid for thirty (30) days from the date of this Certificate and the State of New Hampshire shall be entitled to rely upon same, until written notice of modification, rescission or revocation of same, in whole or in part, has been 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 13 day of June 2023

  
 Roberta L. Hines, MD, Board Chair

STATE OF NH

COUNTY OF GRAFTON

The foregoing instrument was acknowledged before me this 13 day of June 2023, by Roberta L. Hines, MD.



  
 Notary Public  
 My Commission Expires Aug 4, 2026

**CERTIFICATE OF INSURANCE** DATE: June 29, 2023

**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		0002023-A	7/1/2023	7/1/2024	EACH OCCURRENCE	\$1,000,000
					DAMAGE TO RENTED PREMISES	\$1,000,000
					MEDICAL EXPENSES	N/A
					PERSONAL & ADV INJURY	\$1,000,000
					GENERAL AGGREGATE	\$3,000,000
<input checked="" type="checkbox"/>	CLAIMS MADE					
	OCCURRENCE					
OTHER					PRODUCTS-COMP/OP AGG	\$1,000,000
PROFESSIONAL LIABILITY		0002023-A	7/1/2023	7/1/2024	EACH CLAIM	\$1,000,000
					ANNUAL AGGREGATE	\$3,000,000
<input checked="" type="checkbox"/>	CLAIMS MADE					
	OCCURRENCE					
OTHER						

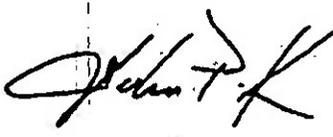
DESCRIPTION OF OPERATIONS/ LOCATIONS/ VEHICLES/ SPECIAL ITEMS (LIMITS MAY BE SUBJECT TO RETENTIONS)  
 Certificate is issued as evidence of insurance.

**CERTIFICATE HOLDER**

NH Department of Health and 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**



**DATE: November 16, 2022**

**CERTIFICATE OF INSURANCE**

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

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.

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

**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	X CLAIMS MADE	0002022-A	7/1/2022	7/1/2023	EACH OCCURRENCE	\$2,000,000
					DAMAGE TO RENTED PREMISES	\$1,000,000
					MEDICAL EXPENSES	N/A
					PERSONAL & ADV INJURY	\$1,000,000
					GENERAL AGGREGATE	\$2,000,000
OTHER					PRODUCTS-COMP/OP AGG	\$1,000,000
PROFESSIONAL LIABILITY	X CLAIMS MADE	0002022-A	7/1/2022	7/1/2023	EACH CLAIM	\$2,000,000
					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.

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**AUTHORIZED REPRESENTATIVES**



## About Dartmouth Hitchcock Medical Center and Dartmouth Hitchcock Clinics

Dartmouth Hitchcock Medical Center and Clinics—members of Dartmouth Health (<https://www.dartmouth-health.org>)—include Dartmouth Hitchcock Medical Center, the state's only academic medical center, and Dartmouth Hitchcock Clinics, which provide primary and specialty care 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.

### Who are Dartmouth Hitchcock Medical Center and Dartmouth Hitchcock Clinics?

#### Dartmouth Hitchcock Medical Center



Dartmouth Hitchcock Medical Center is the state's only academic medical center, and the only Level I Adult and Level II 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. In 2022, Dartmouth Hitchcock Medical Center was named the #1 hospital in New Hampshire by U.S. News & World Report (<https://health.usnews.com/best-hospitals/area/nh>), and recognized as high performing in 2 adult specialties, Cancer and Neurology/Neurosurgery, as well as in 12 common adult procedures and conditions.

#### Dartmouth Hitchcock Clinics



Dartmouth Hitchcock Clinics provide primary and specialty care throughout New Hampshire and Vermont, with major community group practices in Lebanon, Concord, Manchester, Nashua, and Keene, New Hampshire, and Bennington, Vermont.

Children's Hospital at Dartmouth Hitchcock Medical Center

Children's Hospital at Dartmouth Hitchcock Medical Center 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 Dartmouth Hitchcock Medical Center.



Norris Cotton Cancer Care Pavilion Lebanon

Norris Cotton Cancer Care Pavilion Lebanon (<https://cancer.dartmouth.edu/>), one of only 53 NCI-designated Comprehensive Cancer Centers in the nation, is one of the premier facilities for cancer treatment, research, prevention, and education.

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

About Dartmouth Health (<https://www.dartmouth-health.org/>)

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# **Dartmouth-Hitchcock Health and Subsidiaries**

**Consolidated Financial Statements  
June 30, 2022 and 2021**

# Dartmouth-Hitchcock Health and Subsidiaries

## Index

### June 30, 2022 and 2021

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	Page(s)
<b>Report of Independent Auditors</b> .....	1-2
<b>Consolidated Financial Statements</b>	
Balance Sheets .....	3
Statements of Operations and Changes in Net Assets .....	4-5
Statements of Cash Flows .....	6
Notes to Financial Statements .....	7-49
<b>Consolidating Supplemental Information</b>	
Balance Sheets .....	51-54
Statements of Operations and Changes in Net Assets without Donor Restrictions .....	55-58
Note to the Supplemental Consolidating Information .....	59



## Report of Independent Auditors

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

### **Opinion**

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, 2022 and 2021, and the related consolidated statements of operations and changes in net assets and of cash flows for the years then ended, including the related notes (collectively referred to as the "consolidated financial statements").

In our opinion, the accompanying consolidated financial statements present fairly, in all material respects, the financial position of the Health System as of June 30, 2022 and 2021, and the results of its operations, changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

### **Basis for Opinion**

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (US GAAS). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Consolidated Financial Statements section of our report. We are required to be independent of the Health System and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

### **Responsibilities of Management 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, and for 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.

In preparing the consolidated financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Health System's ability to continue as a going concern for one year after the date the consolidated financial statements are issued.

### **Auditors' Responsibilities for the Audit of the Consolidated Financial Statements**

Our objectives are to obtain reasonable assurance about whether the consolidated financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with US GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the consolidated financial statements.



In performing an audit in accordance with US GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the consolidated financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements.
- Obtain an understanding of internal control relevant to the audit 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, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the consolidated financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Health System's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

### ***Supplemental Information***

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The accompanying consolidating information as of and for the years ended June 30, 2022 and 2021 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 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 and cash flows of the individual companies.

A handwritten signature in black ink, appearing to read "PricewaterhouseCoopers LLP".

Boston, Massachusetts  
November 16, 2022

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Balance Sheets**  
**June 30, 2022 and 2021**

<i>(in thousands of dollars)</i>	<u>2022</u>	<u>2021</u>
<b>Assets</b>		
Current assets		
Cash and cash equivalents	\$ 191,929	\$ 374,928
Patient accounts receivable, net (Note 4)	251,250	232,161
Prepaid expenses and other current assets	169,133	157,318
Total current assets	<u>612,312</u>	<u>764,407</u>
Assets limited as to use (Notes 5 and 7)	1,181,094	1,378,479
Other investments for restricted activities (Notes 5 and 7)	175,116	168,035
Property, plant, and equipment, net (Note 6)	764,840	680,433
Right-of-use assets, net (Note 16)	58,925	58,410
Other assets	172,163	177,098
Total assets	<u>\$ 2,964,450</u>	<u>\$ 3,226,862</u>
<b>Liabilities and Net Assets</b>		
Current liabilities		
Current portion of long-term debt (Note 10)	\$ 6,596	\$ 9,407
Current portion of right-of-use obligations (Note 16)	11,319	11,289
Current portion of liability for pension and other postretirement plan benefits (Note 11)	3,500	3,468
Accounts payable and accrued expenses	156,572	131,224
Accrued compensation and related benefits	190,560	182,070
Estimated third-party settlements (Note 3 and 4)	134,898	252,543
Total current liabilities	<u>503,445</u>	<u>590,001</u>
Long-term debt, excluding current portion (Note 10)	1,117,288	1,126,357
Long-term right-of-use obligations, excluding current portion (Note 16)	48,824	48,167
Insurance deposits and related liabilities (Note 12)	78,391	79,974
Liability for pension and other postretirement plan benefits, excluding current portion (Note 11)	228,606	224,752
Other liabilities	154,096	214,714
Total liabilities	<u>2,130,650</u>	<u>2,283,965</u>
Commitments and contingencies (Notes 3, 4, 6, 7, 10, 13, and 16)		
Net assets		
Net assets without donor restrictions (Note 9)	634,297	758,627
Net assets with donor restrictions (Notes 8 and 9)	199,503	184,270
Total net assets	<u>833,800</u>	<u>942,897</u>
Total liabilities and net assets	<u>\$ 2,964,450</u>	<u>\$ 3,226,862</u>

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

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Statements of Operations and Changes in Net Assets**  
**Years Ended June 30, 2022 and 2021**

<i>(in thousands of dollars)</i>	<u>2022</u>	<u>2021</u>
<b>Operating revenue and other support</b>		
Net patient service revenue (Note 4)	\$ 2,243,237	\$ 2,138,287
Contracted revenue	77,666	85,263
Other operating revenue (Note 4)	534,031	424,958
Net assets released from restrictions	15,894	15,201
Total operating revenue and other support	<u>2,870,828</u>	<u>2,663,709</u>
<b>Operating expenses</b>		
Salaries	1,315,407	1,185,910
Employee benefits	322,570	302,142
Medications and medical supplies	649,272	545,523
Purchased services and other	403,862	383,949
Medicaid enhancement tax (Note 4)	82,725	72,941
Depreciation and amortization	86,958	88,921
Interest (Note 10)	32,113	30,787
Total operating expenses	<u>2,892,907</u>	<u>2,610,173</u>
Operating (loss) income	<u>(22,079)</u>	<u>53,536</u>
<b>Non-operating (losses) gains</b>		
Investment (loss) income, net (Note 5)	(78,744)	203,776
Other components of net periodic pension and post retirement benefit income (Note 11 and 14)	13,910	13,559
Other losses, net (Note 10)	(6,658)	(4,233)
Total non-operating (losses) gains, net	<u>(71,492)</u>	<u>213,102</u>
(Deficiency) excess of revenue over expenses	<u>\$ (93,571)</u>	<u>\$ 266,638</u>

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.

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidated Statements of Operations and Changes in Net Assets - Continued**  
**Years Ended June 30, 2022 and 2021**

<i>(in thousands of dollars)</i>	<u>2022</u>	<u>2021</u>
<b>Net assets without donor restrictions</b>		
(Deficiency) excess of revenue over expenses	\$ (93,571)	\$ 266,638
Net assets released from restrictions for capital	1,573	2,017
Change in funded status of pension and other postretirement benefits (Note 11)	(32,309)	59,132
Other changes in net assets	<u>(23)</u>	<u>(186)</u>
(Decrease) increase in net assets without donor restrictions	<u>(124,330)</u>	<u>327,601</u>
<b>Net assets with donor restrictions</b>		
Gifts, bequests, sponsored activities	39,710	30,107
Investment (loss) income, net	(7,010)	19,153
Net assets released from restrictions	<u>(17,467)</u>	<u>(17,218)</u>
Increase in net assets with donor restrictions	<u>15,233</u>	<u>32,042</u>
Change in net assets	(109,097)	359,643
<b>Net assets</b>		
Beginning of year	<u>942,897</u>	<u>583,254</u>
End of year	<u>\$ 833,800</u>	<u>\$ 942,897</u>

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

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidated Statements of Cash Flows

#### Years Ended June 30, 2022 and 2021

<i>(in thousands of dollars)</i>	<u>2022</u>	<u>2021</u>
<b>Cash flows from operating activities</b>		
Change in net assets	\$ (109,097)	\$ 359,643
Adjustments to reconcile change in net assets to net cash provided by operating and non-operating activities		
Depreciation and amortization	87,006	88,904
Amortization of bond premium, discount, and issuance cost, net	(2,764)	(2,820)
Amortization of right-of-use asset	9,270	10,034
Payments on right-of-use lease obligations - operating	(9,190)	(9,844)
Change in funded status of pension and other postretirement benefits	32,309	(59,132)
(Gain) loss on disposal of fixed assets	(523)	592
Net realized gains and change in net unrealized gains on investments	86,652	(228,489)
Restricted contributions and investment earnings	(20,151)	(3,445)
Proceeds from sales of donated securities	10,665	-
Changes in assets and liabilities		
Patient accounts receivable, net	(19,089)	(48,342)
Prepaid expenses and other current assets	(9,915)	4,588
Other assets, net	2,517	(39,760)
Accounts payable and accrued expenses	17,104	1,223
Accrued compensation and related benefits	8,490	39,079
Estimated third-party settlements	(120,117)	9,787
Insurance deposits and related liabilities	(1,583)	2,828
Liability for pension and other postretirement benefits	(28,422)	(40,373)
Other liabilities	(56,687)	11,267
Net cash (used in) provided by operating activities	<u>(123,525)</u>	<u>95,740</u>
<b>Cash flows from investing activities</b>		
Purchase of property, plant, and equipment	(160,855)	(122,347)
Proceeds from sale of property, plant, and equipment	613	316
Purchases of investments	(65,286)	(95,943)
Proceeds from maturities and sales of investments	137,781	75,071
Net cash used in investing activities	<u>(87,747)</u>	<u>(142,903)</u>
<b>Cash flows from financing activities</b>		
Proceeds from line of credit	30,000	-
Payments on line of credit	(30,000)	-
Repayment of long-term debt	(9,116)	(9,183)
Repayment of finance leases	(3,253)	(3,117)
Payment of debt issuance costs	-	(230)
Restricted contributions and investment earnings	20,151	3,445
Net cash provided by (used in) financing activities	<u>7,782</u>	<u>(9,085)</u>
Decrease in cash and cash equivalents	(203,490)	(56,248)
Cash and cash equivalents, beginning of year	396,975	453,223
Cash and cash equivalents, end of year	<u>\$ 193,485</u>	<u>\$ 396,975</u>
<b>Supplemental cash flow information</b>		
Interest paid	\$ 42,867	\$ 41,819
Construction in progress included in accounts payable and accrued expenses	9,407	16,192
Donated securities	10,665	-

The following table reconciles cash and cash equivalents on the consolidated balance sheets to cash, cash equivalents and restricted cash on the consolidated statements of cash flows.

	<u>2022</u>	<u>2021</u>
Cash and cash equivalents	\$ 191,929	\$ 374,928
Cash and cash equivalents included in assets limited as to use	1,350	18,500
Restricted cash and cash equivalents included in other investments for restricted activities	206	3,547
Total of cash, cash equivalents, and restricted cash shown in the consolidated statements of cash flows	<u>\$ 193,485</u>	<u>\$ 396,975</u>

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

## **Dartmouth-Hitchcock Health and Subsidiaries**

### **Notes to Consolidated Financial Statements**

#### **June 30, 2022 and 2021**

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#### **1. Organization and Community Benefit Commitments**

Dartmouth-Hitchcock Health (D-HH), its Members, and their Subsidiaries (the Health System) is a system of hospitals, clinics, and other healthcare service providers across New Hampshire and Vermont. The Health System's mission is to 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. The Health System seeks to achieve the healthiest population possible, leading the transformation of health care in the region and setting the standard for the nation. The Health System's expanding network of services are the fabric of its commitment to serve the region with exceptional medical care.

Dartmouth-Hitchcock Health (D-HH) serves as the sole corporate member of the following entities: Dartmouth-Hitchcock Clinic (DHC) and Subsidiaries, Mary Hitchcock Memorial Hospital (MHMH) and Subsidiaries, (DHC and MHMH together are referred to as D-H), The New London Hospital Association, Inc. (NLH), Windsor Hospital Corporation (d/b/a-Mt. Ascutney Hospital and Health Center) (MAHHC) and Subsidiaries, The Cheshire Medical Center (Cheshire) and Subsidiaries, Alice Peck Day Memorial Hospital (APD) and Subsidiary, and Visiting Nurse and Hospice for Vermont and New Hampshire (VNH) and 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 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, DHC, MHMH, NLH, Cheshire, and APD are NH not-for-profit corporations exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code (IRC). MAHHC and VNH 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 parties submitted filings with the Federal Trade Commission and the New Hampshire Attorney General's Office, seeking regulatory clearance of the proposed transaction. On May 13, 2022, D-HH and GOH ended their pursuit of regulatory approval of the transaction and terminated the Combination Agreement.

#### **Community Benefits**

Consistent with its 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 seeks to work collaboratively with other area healthcare providers to improve the health status of the region. As a component of an integrated

## Dartmouth-Hitchcock Health and Subsidiaries

### Notes to Consolidated Financial Statements

#### June 30, 2022 and 2021

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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 Improvement 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* includes costs, in excess of awards, for numerous health research and service initiatives within the Health System.
- *Cash and In-Kind Contributions* occur outside of the System through various financial contributions of cash, in-kind donations, and grants to local organizations.
- *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.
- *Charity Care* includes losses, at-cost, incurred by providing health care services to persons qualifying for hospital financial assistance programs.
- *The Uncompensated Cost of Care for Medicaid* patients reported in the unaudited Community Benefits Reports for 2021 was approximately \$198,859,000. The 2022 Community Benefits Reports are expected to be filed in February 2023.

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**June 30, 2022 and 2021**

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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, 2021:

*(in thousands of dollars)*

Uncompensated cost of care for Medicaid	\$ 198,859
Health professional education	41,554
Subsidized health services	16,785
Charity care	12,678
Community health improvement services	13,589
Research	4,839
Cash and In-Kind Contributions	4,741
Community building activities	<u>2,885</u>
Total community benefit value	<u>\$ 295,930</u>

In fiscal years 2022 and 2021, funds received to offset or subsidize charity care costs provided were \$452,000 and \$848,000, respectively.

For fiscal year 2022, Medicare costs exceeding reimbursement totaled \$105,460,000.

**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, 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.

## **Dartmouth-Hitchcock Health and Subsidiaries**

### **Notes to Consolidated Financial Statements**

#### **June 30, 2022 and 2021**

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#### **(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 (loss) income on investments of net assets without donor restrictions, which are utilized to provide charity and other operational support. Peripheral activities, including realized gains/losses on sales of investment securities and changes in unrealized gains/losses on investments are reported as non-operating (losses) gains.

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 qualifying 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, which consists primarily of revenue from retail pharmacy, specialty pharmacy, and contract pharmacy, is recorded in the amounts to which it expects to be entitled in exchange for the prescriptions. Other revenue also includes Coronavirus Aid, Relief, and Economic Securities Act (CARES Act Provider Relief Funds)

## **Dartmouth-Hitchcock Health and Subsidiaries**

### **Notes to Consolidated Financial Statements**

#### **June 30, 2022 and 2021**

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from the Department of Health and Human Services (HHS), operating agreements, grant revenue, cafeteria sales, and other support service revenue (Note 3 and 4).

#### **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), which would be considered level 1 investments under the fair value hierarchy. All short-term, highly liquid, investments included within the Health System's endowment and similar investment pools, otherwise qualifying as cash equivalents, are classified as investments at fair value and, therefore, are excluded from cash and cash equivalents in the Consolidated Statements of Cash Flows.

#### **Investments and Investment (Loss) 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 revenue over expenses.

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.

## **Dartmouth-Hitchcock Health and Subsidiaries**

### **Notes to Consolidated Financial Statements**

#### **June 30, 2022 and 2021**

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- 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 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 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.

## **Dartmouth-Hitchcock Health and Subsidiaries**

### **Notes to Consolidated Financial Statements**

#### **June 30, 2022 and 2021**

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#### **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 \$8,885,000 and \$9,403,000 as intangible assets as of June 30, 2022 and 2021, 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 March 2020, January 2021, and April 2022, the FASB issued standard updates on Reference Rate Reform in response to the planned discontinuation of the London Inter-Bank Offered Rate (LIBOR), a key interbank reference rate. The standard provides accounting relief to contract modifications and optional expedients for applying U.S. GAAP to contracts and other transactions that reference LIBOR or other reference rates that are expected to be discontinued because of rate reform. The Health System is currently in the process of evaluating the impact of adoption of these standards on the financial statements.

### **3. The COVID-19 Pandemic**

On March 11, 2020, the World Health Organization designated COVID-19 as a global pandemic resulting in an extraordinary disruption to our nation's healthcare system. In response to COVID-19, the Coronavirus Aid Relief and Economic Security (CARES) Act was enacted which provided different types of economic support to a wide variety of organizations and individuals. The Health System employed several CARES Act provisions, with the most significant impacts summarized below.

#### **Health and Human Services Provider Relief Funds**

The Health System received \$100,346,000 and \$65,600,000 in CARES Act Provider Relief Funds for the years ended June 30, 2022 and 2021, respectively. The Health System will continue to pursue Provider Relief Funds as available, and as needed, to support the Health System.

In July 2020, HHS issued reporting requirements for CARES Act Provider Relief Funds, requiring recipients to identify healthcare-related expenses that remain unreimbursed by another source, attributable to the COVID-19 pandemic. If those expenses do not exceed the funding received, recipients will need to demonstrate that the remaining funds were used to compensate for a negative variance in patient service revenue. HHS is entitled to recoup Provider Relief Funds

## **Dartmouth-Hitchcock Health and Subsidiaries**

### **Notes to Consolidated Financial Statements**

#### **June 30, 2022 and 2021**

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awarded in excess of expenses attributable to the COVID-19 pandemic that were not reimbursed by another source plus losses incurred due to the decline in patient care revenue. There have been no recoupments through June 2022.

#### **Medicare and Medicaid Services (CMS) Accelerated and Advance Payment Program**

The Health System received CMS prepayment advances, related to the CARES Act, totaling \$245,200,000. In addition, the Health System accumulated payroll tax deferrals of \$33,100,000. Repayment of funds commenced in April 2021. The balances of CMS prepayment advances and accumulated payroll tax deferrals at June 30, 2022 were \$54,890,000 and \$16,550,000, respectively, and are included in estimated third party settlements and accrued compensation and related benefits on the Consolidated Balance Sheets.

The Health System continues to address the challenges and impacts of the COVID-19 pandemic including protecting the health and safety of employees and patients as well as assessing the availability of personal protective equipment and other needed supplies to be better positioned for potential surges. Additionally, the Health System continues to evaluate the impact of new or changes to laws and regulations at the federal, state, and local levels and the potential effect on Health System staffing and operations. At this time, the Health System cannot accurately predict the full extent to which the COVID-19 pandemic will affect the Health System's future finances and operations.

#### **4. Net Patient Service Revenue and Accounts Receivable**

The Health System reports net 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

## **Dartmouth-Hitchcock Health and Subsidiaries**

### **Notes to Consolidated Financial Statements**

#### **June 30, 2022 and 2021**

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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 NH and 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.

## **Dartmouth-Hitchcock Health and Subsidiaries**

### **Notes to Consolidated Financial Statements**

#### **June 30, 2022 and 2021**

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- 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 (MCPs) 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 MCPs 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 MCPs 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 Vermont annual net patient revenue. In fiscal years 2022 and 2021, home health provider taxes paid were \$627,000 and \$623,000, respectively.

#### **Implicit Price Concessions**

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

## **Dartmouth-Hitchcock Health and Subsidiaries**

### **Notes to Consolidated Financial Statements**

#### **June 30, 2022 and 2021**

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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, 2022 and 2021, the Health System had reserves of \$134,898,000 and \$252,543,000, respectively, recorded in estimated third-party settlements. As of June 30, 2022 and 2021, estimated third-party settlements includes \$54,880,000 and \$179,382,000, respectively, of Medicare accelerated and advanced payments, received as working capital support during the novel coronavirus ("COVID-19") outbreak.

For the years ended June 30, 2022 and 2021, additional increases in revenue of \$19,743,000 and \$4,287,000, respectively, were recognized due to changes in estimates of implicit price concessions for performance obligations satisfied in prior years.

Net operating revenues 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.

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**June 30, 2022 and 2021**

The table below shows the Health System's sources of total operating revenue and other support presented at the net transaction price for the years ended June 30, 2022 and 2021.

<i>(in thousands of dollars)</i>	<b>2022</b>		
	<b>PPS</b>	<b>CAH</b>	<b>Total</b>
<b>Hospital</b>			
Medicare	\$ 542,292	\$ 99,976	\$ 642,268
Medicaid	158,121	15,739	173,860
Commercial	809,736	81,395	891,131
Self-pay	7,027	902	7,929
Subtotal	<u>1,517,176</u>	<u>198,012</u>	<u>1,715,188</u>
Professional	470,559	40,186	510,745
Subtotal	<u>1,987,735</u>	<u>238,198</u>	<u>2,225,933</u>
Home based care			<u>17,304</u>
Subtotal			<u>2,243,237</u>
Other revenue			528,762
Provider Relief Funds			<u>98,829</u>
Total operating revenue and other support			<u>\$ 2,870,828</u>

<i>(in thousands of dollars)</i>	<b>2021</b>		
	<b>PPS</b>	<b>CAH</b>	<b>Total</b>
<b>Hospital</b>			
Medicare	\$ 526,114	\$ 81,979	\$ 608,093
Medicaid	144,434	11,278	155,712
Commercial	793,274	73,388	866,662
Self-pay	4,419	(721)	3,698
Subtotal	<u>1,468,241</u>	<u>165,924</u>	<u>1,634,165</u>
Professional	446,181	37,935	484,116
Subtotal	<u>1,914,422</u>	<u>203,859</u>	<u>2,118,281</u>
Home based care			<u>20,006</u>
Subtotal			<u>2,138,287</u>
Other revenue			462,517
Provider Relief Funds			<u>62,905</u>
Total operating revenue and other support			<u>\$ 2,663,709</u>

**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

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**June 30, 2022 and 2021**

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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) 2021 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, 2022 and 2021, the Health System received DSH payments of approximately, \$77,488,000 and \$67,940,000, respectively. DSH payments are subject to audit and, therefore, for the years ended June 30, 2022 and 2021, the Health System recognized as revenue DSH receipts of approximately \$75,988,000 and approximately \$61,602,000, respectively.

During the years ended June 30, 2022 and 2021, the Health System recorded \$82,725,000 and \$72,941,000, respectively, of State of NH MET and State of VT provider taxes. 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.

**Accounts Receivable**

The following table categorizes payors into four groups based on their respective percentages of patient accounts receivable as of June 30, 2022 and 2021:

	<u>2022</u>	<u>2021</u>
Medicare	38%	34%
Medicaid	12%	13%
Commercial	38%	41%
Self Pay	12%	12%
Total	<u>100%</u>	<u>100%</u>

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**June 30, 2022 and 2021**

**5. Investments**

The composition of investments at June 30, 2022 and 2021 is set forth in the following table:

<i>(in thousands of dollars)</i>	<u>2022</u>	<u>2021</u>
<b>Assets limited as to use</b>		
Internally designated by board		
Cash and short-term investments	\$ 31,130	\$ 24,692
U.S. government securities	126,222	157,373
Domestic corporate debt securities	234,490	322,616
Global debt securities	68,610	74,292
Domestic equities	198,742	247,486
International equities	63,634	81,060
Emerging markets equities	34,636	52,636
Global equities	73,035	79,296
Real Estate Investment Trust	2	422
Private equity funds	138,605	110,968
Hedge funds	55,069	-
Subtotal	<u>1,024,175</u>	<u>1,150,841</u>
<b>Investments held by captive insurance companies (Note 12)</b>		
U.S. government securities	27,242	26,759
Domestic corporate debt securities	7,902	5,979
Global debt securities	7,595	6,617
Domestic equities	10,091	11,396
International equities	4,692	6,488
Subtotal	<u>57,522</u>	<u>57,239</u>
<b>Held by trustee under indenture agreement (Note 9)</b>		
Cash and short-term investments	99,397	170,399
Total assets limited as to use	<u>1,181,094</u>	<u>1,378,479</u>
<b>Other investments for restricted activities</b>		
Cash and short-term investments	8,463	13,400
U.S. government securities	27,600	28,330
Domestic corporate debt securities	37,343	40,676
Global debt securities	10,059	8,953
Domestic equities	34,142	33,634
International equities	10,698	9,497
Emerging markets equities	5,587	5,917
Global equities	11,153	8,755
Real Estate Investment Trust	19	21
Private equity funds	21,166	12,251
Hedge funds	8,852	6,557
Other	34	44
Total other investments for restricted activities	<u>175,116</u>	<u>168,035</u>
Total investments	<u>\$ 1,356,210</u>	<u>\$ 1,546,514</u>

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**June 30, 2022 and 2021**

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.

The following tables summarize the investments by the accounting method utilized as of June 30, 2022 and 2021. Accounting standards require disclosure of additional information for those securities accounted for using the fair value method, as shown in Note 7.

<i>(in thousands of dollars)</i>	<b>2022</b>		
	<u>Fair Value</u>	<u>Equity</u>	<u>Total</u>
Cash and short-term investments	\$ 138,990	\$ -	\$ 138,990
U.S. government securities	181,064	-	181,064
Domestic corporate debt securities	118,642	161,093	279,735
Global debt securities	57,558	28,706	86,264
Domestic equities	191,767	51,208	242,975
International equities	47,631	31,393	79,024
Emerging markets equities	298	39,926	40,224
Global equities	-	84,187	84,187
Real Estate Investment Trust	21	-	21
Private equity funds	-	159,771	159,771
Hedge funds	443	63,478	63,921
Other	34	-	34
<b>Total investments</b>	<b>\$ 736,448</b>	<b>\$ 619,762</b>	<b>\$ 1,356,210</b>

<i>(in thousands of dollars)</i>	<b>2021</b>		
	<u>Fair Value</u>	<u>Equity</u>	<u>Total</u>
Cash and short-term investments	\$ 208,491	\$ -	\$ 208,491
U.S. government securities	212,462	-	212,462
Domestic corporate debt securities	191,112	178,159	369,271
Global debt securities	55,472	34,390	89,862
Domestic equities	225,523	66,993	292,516
International equities	55,389	41,656	97,045
Emerging markets equities	1,888	56,665	58,553
Global equities	-	88,051	88,051
Real Estate Investment Trust	443	-	443
Private equity funds	-	123,219	123,219
Hedge funds	446	6,111	6,557
Other	44	-	44
<b>Total investments</b>	<b>\$ 951,270</b>	<b>\$ 595,244</b>	<b>\$ 1,546,514</b>

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**June 30, 2022 and 2021**

For the years ended June 30, 2022 and 2021, investment (loss) income is reflected in the accompanying Consolidated Statements of Operations and Changes in Net Assets as other operating revenue of approximately \$857,000 and \$930,000, respectively, and as non-operating (losses) gains of approximately (\$78,744,000) and \$203,776,000, respectively.

Private equity limited partnership shares are not eligible for redemption from the fund or general partner. 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 agreements expire. 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, 2022 and 2021, the Health System has outstanding commitments of \$75,070,000 and \$47,419,000, respectively.

**6. Property, Plant, and Equipment**

Property, plant, and equipment consists of the following at June 30, 2022 and 2021:

<i>(in thousands of dollars)</i>	<u>2022</u>	<u>2021</u>
Land	\$ 40,749	\$ 40,749
Construction in progress	163,145	80,231
Land improvements	44,834	43,927
Buildings and improvements	984,743	955,094
Equipment	<u>1,042,582</u>	<u>993,899</u>
Subtotal property, plant, and equipment	2,276,053	2,113,900
Less accumulated depreciation	<u>1,511,213</u>	<u>1,433,467</u>
Total property, plant, and equipment, net	<u>\$ 764,840</u>	<u>\$ 680,433</u>

As of June 30, 2022, construction in progress primarily consists of three projects; an in-patient tower, an emergency department (ED) expansion, and a central pharmacy/supply chain facility renovation. The estimated cost to complete the in-patient tower is \$52,400,000 with an anticipated completion date occurring in the fourth quarter of fiscal 2023. The estimated cost to complete the ED expansion is \$2,000,000 with an expected completion date occurring in the first quarter of fiscal 2023. The estimated cost to complete the central pharmacy/supply chain facility is \$1,600,000 with an expected completion date occurring in the first quarter of fiscal 2023.

The construction in progress as of June 30, 2021, included the Manchester Ambulatory Surgical Center (ASC) and the in-patient tower in Lebanon, NH. The ASC was fully operational in October 2021.

Capitalized interest of \$6,853,000 and \$5,127,000 is included in construction in progress as of June 30, 2022 and 2021, respectively.

Depreciation expense included in operating and non-operating activities was \$83,661,000 and \$86,011,000 for 2022 and 2021, respectively.

## **Dartmouth-Hitchcock Health and Subsidiaries**

### **Notes to Consolidated Financial Statements**

#### **June 30, 2022 and 2021**

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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 and cash which will be used for future investment opportunities.

##### **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).

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**June 30, 2022 and 2021**

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, 2022 and 2021:

<i>(in thousands of dollars)</i>	2022			
	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
<b>Assets</b>				
<b>Investments</b>				
Cash and short term investments	\$ 138,990	\$ -	\$ -	\$ 138,990
U.S. government securities	181,064	-	-	181,064
Domestic corporate debt securities	1,768	116,874	-	118,642
Global debt securities	24,745	32,813	-	57,558
Domestic equities	187,063	4,704	-	191,767
International equities	47,631	-	-	47,631
Emerging market equities	298	-	-	298
Real estate investment trust	21	-	-	21
Hedge funds	443	-	-	443
Other	-	34	-	34
<b>Total fair value investments</b>	<b>582,023</b>	<b>154,425</b>	<b>-</b>	<b>736,448</b>
<b>Deferred compensation plan assets</b>				
Cash and short-term investments	8,053	-	-	8,053
U.S. government securities	36	-	-	36
Domestic corporate debt securities	10,874	-	-	10,874
Global debt securities	964	-	-	964
Domestic equities	33,742	-	-	33,742
International equities	4,911	-	-	4,911
Emerging market equities	19	-	-	19
Real estate	12	-	-	12
Multi strategy fund	57,964	-	-	57,964
<b>Total deferred compensation plan assets</b>	<b>116,575</b>	<b>-</b>	<b>-</b>	<b>116,575</b>
<b>Beneficial interest in trusts</b>	<b>-</b>	<b>-</b>	<b>16,051</b>	<b>16,051</b>
<b>Total assets</b>	<b>\$ 698,598</b>	<b>\$ 154,425</b>	<b>\$ 16,051</b>	<b>\$ 869,074</b>

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**June 30, 2022 and 2021**

<i>(in thousands of dollars)</i>	2021			
	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
<b>Assets</b>				
<b>Investments</b>				
Cash and short term investments	\$ 208,491	\$ -	\$ -	\$ 208,491
U.S. government securities	212,462	-	-	212,462
Domestic corporate debt securities	36,163	154,949	-	191,112
Global debt securities	27,410	28,062	-	55,472
Domestic equities	220,434	5,089	-	225,523
International equities	55,389	-	-	55,389
Emerging market equities	1,888	-	-	1,888
Real estate investment trust	443	-	-	443
Hedge funds	446	-	-	446
Other	9	35	-	44
<b>Total fair value investments</b>	<b>763,135</b>	<b>188,135</b>	<b>-</b>	<b>951,270</b>
<b>Deferred compensation plan assets</b>				
Cash and short-term investments	6,099	-	-	6,099
U.S. government securities	48	-	-	48
Domestic corporate debt securities	10,589	-	-	10,589
Global debt securities	1,234	-	-	1,234
Domestic equities	37,362	-	-	37,362
International equities	5,592	-	-	5,592
Emerging market equities	39	-	-	39
Real estate	15	-	-	15
Multi strategy fund	65,257	-	-	65,257
Guaranteed contract	-	-	-	-
<b>Total deferred compensation plan assets</b>	<b>126,235</b>	<b>-</b>	<b>-</b>	<b>126,235</b>
<b>Beneficial interest in trusts</b>	<b>-</b>	<b>-</b>	<b>10,796</b>	<b>10,796</b>
<b>Total assets</b>	<b>\$ 889,370</b>	<b>\$ 188,135</b>	<b>\$ 10,796</b>	<b>\$ 1,088,301</b>

The following tables set forth the financial instruments classified by the Health System within Level 3 of the fair value hierarchy defined above as of June 30, 2022 and 2021.

	2022
<i>(in thousands of dollars)</i>	
Beginning of year balance	\$ 10,796
Net realized/unrealized gains	5,255
End of year balance	<u>\$ 16,051</u>

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**June 30, 2022 and 2021**

<i>(in thousands of dollars)</i>	<u>2021</u>		
	<u>Beneficial Interest in Perpetual Trust</u>	<u>Guaranteed Contract</u>	<u>Total</u>
Beginning of year balance	\$ 9,202	\$ 92	\$ 9,294
Net realized/unrealized gains (losses)	1,594	(92)	1,502
End of year balance	<u>\$ 10,796</u>	<u>\$ -</u>	<u>\$ 10,796</u>

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, 2022 and 2021.

**8. Net Assets with Donor Restrictions**

Net assets with donor restrictions are available for the following purposes at June 30, 2022 and 2021:

<i>(in thousands of dollars)</i>	<u>2022</u>	<u>2021</u>
Investments held in perpetuity	\$ 84,117	\$ 64,498
Healthcare services	36,123	38,869
Health education	27,164	26,934
Research	27,477	24,464
Charity care	12,155	15,377
Other	8,639	7,215
Purchase of equipment	3,828	6,913
Total net assets with donor restrictions	<u>\$ 199,503</u>	<u>\$ 184,270</u>

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

**9. Board Designated and Endowment Funds**

Net assets include 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 Health System 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)

## **Dartmouth-Hitchcock Health and Subsidiaries**

### **Notes to Consolidated Financial Statements**

#### **June 30, 2022 and 2021**

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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, 2022 and 2021.

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**June 30, 2022 and 2021**

Endowment net asset composition by type of fund consists of the following at June 30, 2022 and 2021:

	<u>2022</u>		
<i>(in thousands of dollars)</i>	<u>Without Donor Restrictions</u>	<u>With Donor Restrictions</u>	<u>Total</u>
Donor-restricted endowment funds	\$ -	\$ 107,590	\$ 107,590
Board-designated endowment funds	41,344	-	41,344
Total endowed net assets	<u>\$ 41,344</u>	<u>\$ 107,590</u>	<u>\$ 148,934</u>

	<u>2021</u>		
<i>(in thousands of dollars)</i>	<u>Without Donor Restrictions</u>	<u>With Donor Restrictions</u>	<u>Total</u>
Donor-restricted endowment funds	\$ -	\$ 108,213	\$ 108,213
Board-designated endowment funds	41,728	-	41,728
Total endowed net assets	<u>\$ 41,728</u>	<u>\$ 108,213</u>	<u>\$ 149,941</u>

Changes in endowment net assets for the years ended June 30, 2022 and 2021 are as follows:

	<u>2022</u>		
<i>(in thousands of dollars)</i>	<u>Without Donor Restrictions</u>	<u>With Donor Restrictions</u>	<u>Total</u>
Beginning of year balances	\$ 41,728	\$ 108,213	\$ 149,941
Net investment return	(1,065)	(3,998)	(5,063)
Contributions	-	12,950	12,950
Transfers	795	(7,105)	(6,310)
Release of appropriated funds	(114)	(2,470)	(2,584)
End of year balances	<u>\$ 41,344</u>	<u>\$ 107,590</u>	<u>\$ 148,934</u>
End of year balances		107,590	
Beneficial interest in perpetual trusts		<u>14,903</u>	
Net assets with donor restrictions		<u>\$ 122,493</u>	

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**June 30, 2022 and 2021**

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	<u>2021</u>		
	<u>Without Donor Restrictions</u>	<u>With Donor Restrictions</u>	<u>Total</u>
<i>(in thousands of dollars)</i>			
Beginning of year balances	\$ 33,714	\$ 80,039	\$ 113,753
Net investment return	7,192	17,288	24,480
Contributions	894	13,279	14,173
Transfers	-	418	418
Release of appropriated funds	(72)	(2,811)	(2,883)
End of year balances	<u>\$ 41,728</u>	<u>\$ 108,213</u>	<u>\$ 149,941</u>
End of year balances		108,213	
Beneficial interest in perpetual trusts		<u>9,721</u>	
Net assets with donor restrictions		<u>\$ 117,934</u>	

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**June 30, 2022 and 2021**

**10. Long-Term Debt**

A summary of obligated group debt at June 30, 2022 and 2021 is as follows:

<i>(in thousands of dollars)</i>	<u>2022</u>	<u>2021</u>
<b>Variable rate issues</b>		
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
<b>Fixed rate issues</b>		
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	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	99,165
Series 2018C, principal maturing in varying annual amounts, through August 2030 (5)	23,950	24,425
Series 2012, principal maturing in varying annual amounts, through July 2039 (6)	22,605	23,470
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
Series 2014A, principal maturing in varying annual amounts, through August 2022 (7)	4,810	12,385
<b>Note payable</b>		
Note payable to a financial institution due in monthly interest only payments through May 2035 (9)	125,000	125,000
Total obligated group debt	<u>\$ 1,044,722</u>	<u>\$ 1,053,637</u>

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**June 30, 2022 and 2021**

A summary of long-term debt at June 30, 2022 and 2021 is as follows:

<i>(in thousands of dollars)</i>	<u>2022</u>	<u>2021</u>
<b>Other</b>		
Mortgage note payable to the US Dept of Agriculture; monthly payments of \$10,892 include interest of 2.375% through November 2046	\$ 2,417	\$ 2,489
Note payable to a financial institution with entire principal due June 2034; collateralized by land and building. The note payable is interest free	247	273
Note payable to a financial institution payable in interest free monthly installments through December 2024; collateralized by associated equipment	55	147
Total nonobligated group debt	2,719	2,909
Total obligated group debt	1,044,722	1,053,637
Total long-term debt	1,047,441	1,056,546
Add: Original issue premium and discounts, net	83,249	86,399
Less: Current portion	6,596	9,407
Debt issuance costs, net	6,806	7,181
Total long-term debt, net	<u>\$ 1,117,288</u>	<u>\$ 1,126,357</u>

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

<i>(in thousands of dollars)</i>	<u>2022</u>
2023	\$ 6,596
2024	15,207
2025	19,362
2026	20,209
2027	20,915
Thereafter	965,152
Total	<u>\$ 1,047,441</u>

**Dartmouth-Hitchcock Obligated Group (DHOG) Debt**

MHMH established the DHOG for the 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.

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

## **Dartmouth-Hitchcock Health and Subsidiaries**

### **Notes to Consolidated Financial Statements**

#### **June 30, 2022 and 2021**

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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 mature in variable amounts through 2037 and were used primarily to refund a portion of Series 2015A and Series 2016A revenue bonds. The Series 2018B revenue bonds mature in variable amounts through 2048, and were used primarily to refund a portion of Series 2015A and Series 2016A revenue bonds, revolving line of credit, Series 2012 bank loan, and the Series 2015A and Series 2016A swap terminations. The interest on the Series 2018A revenue bonds is variable, with a current interest rate of 5.00%. 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 Series 2020A revenue bonds mature in variable amounts through 2059 and the proceeds 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%.

#### **(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 mature in variable amounts through 2040 and were used primarily to refund Series 2009 and Series 2010 revenue bonds. The Series 2017B revenue bonds mature in variable amounts through 2031 and were used to refund Series 2012A and Series 2012B revenue bonds. The interest on the Series 2017A revenue bonds is fixed, with an interest rate of 5.00%. The interest on the Series 2017B revenue bonds is fixed, with an interest rate of 2.54%.

#### **(4) Series 2019A Revenue Bonds**

The DHOG issued NHHEFA Revenue Bonds, Series 2019A, in October 2019. The Series 2019A revenue bonds mature in variable amounts through 2043 and were 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%.

#### **(5) Series 2018C Revenue Bonds**

The DHOG issued NHHEFA Revenue Bonds, Series 2018C, in August 2018. The Series 2018C revenue bonds mature in variable amounts through 2030 and were used primarily to refinance

## **Dartmouth-Hitchcock Health and Subsidiaries**

### **Notes to Consolidated Financial Statements**

#### **June 30, 2022 and 2021**

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the Series 2010 revenue bonds. The interest on the Series is fixed, with an interest rate of 3.22%.

#### **(6) Series 2012 Revenue Bonds**

The DHOG issued NHHEFA Revenue Bonds, Series 2012, in November 2012. The Series 2012 revenue bonds mature in variable amounts through 2039 and were used to refund 1998 and 2009 Series revenue bonds, finance the settlement cost of the interest rate swap, and finance the purchase of certain equipment and renovations. The revenue bonds have fixed interest coupon rates ranging from 2.0% to 5.0% (a net interest cost of 3.96%).

#### **(7) Series 2014A and Series 2014B Revenue Bonds**

The DHOG issued NHHEFA Revenue Bonds, Series 2014A and Series 2014B, in August 2014. The Series 2014A revenue bonds mature in 2022. The Series 2014B revenue bonds mature at various dates through 2033. The proceeds from the Series 2014A and 2014B revenue bonds were used partially to 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%. Interest on the Series 2014B revenue bonds is fixed, with an interest rate of 4.00%.

#### **(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 mature at various dates through 2045 and were used to finance certain 2016 projects. The Series 2016B is fixed, with an interest rate of 1.78%.

#### **(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 note matures at various dates through 2035 and is fixed, with an interest rate of 2.56%.

Outstanding joint and several indebtedness of the DHOG at June 30, 2022 and 2021 is \$1,044,722 and \$1,053,637, respectively.

The Health System indenture agreements require establishment and maintenance of debt service reserves and other trustee held funds. Trustee held funds of \$99,397,000 and \$170,399,000 at June 30, 2022 and 2021, respectively, are classified as assets limited as to use in the accompanying Consolidated Balance Sheets (Note 5). In addition, debt service reserves of approximately \$6,674,000 and \$8,035,000 at June 30, 2022 and 2021, 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, 2022 and 2021.

For the years ended June 30, 2022 and 2021 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 \$32,113,000 and \$30,787,000, respectively, and other non-operating losses of \$3,782,000 and \$3,782,000, respectively, net of amounts capitalized.

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**June 30, 2022 and 2021**

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**11. Employee Benefits**

Eligible employees of the Health System are covered under various defined benefit and/or defined contribution plans. In addition, certain members provide postretirement medical and life insurance benefit plans to certain active and former employees who meet eligibility requirements. The postretirement medical and life plans are not funded.

The Health System's defined benefit plans have been frozen and, therefore, there are no remaining participants earning benefits in any of the Health System's defined benefit plans.

For the year ended June 30, 2021, the Health System executed 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 expense, in the Consolidated Statements of Operations and Changes in Net Assets, is comprised of the following components for the years ended June 30, 2022 and 2021:

<i>(in thousands of dollars)</i>	<u>2022</u>	<u>2021</u>
Interest cost on projected benefit obligation	\$ 36,722	\$ 36,616
Expected return on plan assets	(65,917)	(63,261)
Net loss amortization	<u>13,139</u>	<u>14,590</u>
Total net periodic pension expense	<u>\$ (16,056)</u>	<u>\$ (12,055)</u>

The following assumptions were used to determine net periodic pension expense as of June 30, 2022 and 2021:

	<u>2022</u>	<u>2021</u>
Discount rates	3.30%	3.00 - 3.10%
Rate of increase in compensation	N/A	N/A
Expected long-term rates of return on plan assets	7.50%	7.50%

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**June 30, 2022 and 2021**

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, 2022 and 2021:

<i>(in thousands of dollars)</i>	<u>2022</u>	<u>2021</u>
<b>Change in benefit obligation</b>		
Benefit obligation, beginning of year	\$ 1,140,221	\$ 1,209,100
Interest cost	36,722	36,616
Benefits paid	(54,864)	(52,134)
Actuarial loss	(183,193)	(22,411)
Settlements	-	(30,950)
	<u>938,886</u>	<u>1,140,221</u>
Benefit obligation, end of year		
<b>Change in plan assets</b>		
Fair value of plan assets, beginning of year	958,864	929,453
Actual return on plan assets	(169,405)	87,446
Benefits paid	(54,864)	(52,134)
Employer contributions	12,500	25,049
Settlements	-	(30,950)
	<u>747,095</u>	<u>958,864</u>
Fair value of plan assets, end of year		
Funded status of the plans	(191,791)	(181,357)
Less: Current portion of liability for pension	-	(46)
Long-term portion of liability for pension	(191,791)	(181,311)
Liability for pension	<u>\$ (191,791)</u>	<u>\$ (181,357)</u>

As of June 30, 2022 and 2021, 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 \$519,946,000 and \$481,073,000 of net actuarial loss as of June 30, 2022 and 2021, respectively.

The estimated amounts to be amortized from net assets without donor restrictions into net periodic pension expense in fiscal year 2022 for net actuarial losses is \$13,139,000.

The accumulated benefit obligation for the defined benefit pension plans was \$939,000,000 and \$1,140,000,000 at June 30, 2022 and 2021, respectively.

## Dartmouth-Hitchcock Health and Subsidiaries

### Notes to Consolidated Financial Statements

#### June 30, 2022 and 2021

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The following table sets forth the assumptions used to determine the accumulated benefit obligation at June 30, 2022 and 2021:

	<u>2022</u>	<u>2021</u>
Discount rates	4.40 - 5.10%	3.30%
Rate of increase in compensation	N/A	N/A

The primary investment objective for the defined benefit plans' 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 pension plan's liabilities. As of June 30, 2022, it is expected that the LDI strategy will hedge approximately 70% of the interest rate risk associated with pension liabilities. As of June 30, 2021, the expected LDI hedge was approximately 75%. To achieve the appreciation and hedging objectives, the pension plans utilize a diversified structure of asset classes. The asset classes are 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:

	<u>Range of Target Allocations</u>	<u>Target Allocations</u>
Cash and short-term investments	0-5%	3%
U.S. government securities	0-10	5
Domestic debt securities	20-58	42
Global debt securities	6-26	4
Domestic equities	5-35	17
International equities	5-15	7
Emerging market equities	3-13	4
Global Equities	0-10	6
Real estate investment trust funds	0-5	1
Private equity funds	0-5	0
Hedge funds	5-18	11

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

## Dartmouth-Hitchcock Health and Subsidiaries

### Notes to Consolidated Financial Statements

#### June 30, 2022 and 2021

The Boards of Trustees of the Health System, as plan sponsors, oversee the design, structure, and prudent professional management of the Health System's pension 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 pension plans own interests in both private equity and hedge funds rather than in securities underlying each fund and, therefore, the Health System generally considers such investments as Level 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 pension plans' investments and deferred compensation plan assets that were accounted for at fair value as of June 30, 2022 and 2021:

<i>(in thousands of dollars)</i>	2022				Redemption or Liquidation	Days' Notice
	Level 1	Level 2	Level 3	Total		
<b>Investments</b>						
Cash and short-term investments	\$ -	\$ 16,030	\$ -	\$ 16,030	Daily	1
U.S. government securities	124,686	-	-	124,686	Daily-Monthly	1-15
Domestic debt securities	17,530	226,107	-	243,637	Daily-Monthly	1-15
Global debt securities	-	24,136	-	24,136	Daily-Monthly	1-15
Domestic equities	104,070	31,324	-	135,394	Daily-Monthly	1-10
International equities	15,558	20,406	-	35,964	Daily-Monthly	1-11
Emerging market equities	-	25,487	-	25,487	Daily-Monthly	1-17
Global equities	-	54,787	-	54,787	Daily-Monthly	1-17
REIT funds	-	-	-	-	Daily-Monthly	1-17
Private equity funds	-	-	14	14	See Note 5	See Note 5
Hedge funds	-	-	86,960	86,960	Quarterly-Annual	60-96
Total investments	\$ 261,844	\$ 398,277	\$ 86,974	\$ 747,095		

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**June 30, 2022 and 2021**

<i>(in thousands of dollars)</i>	2021				<u>Redemption or Liquidation</u>	<u>Days' Notice</u>
	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>		
<b>Investments</b>						
Cash and short-term investments	\$ -	\$ 53,763	\$ -	\$ 53,763	Daily	1
U.S. government securities	52,945	-	-	52,945	Daily-Monthly	1-15
Domestic debt securities	140,029	296,709	-	436,738	Daily-Monthly	1-15
Global debt securities	-	40,877	-	40,877	Daily-Monthly	1-15
Domestic equities	144,484	40,925	-	185,409	Daily-Monthly	1-10
International equities	17,767	51,819	-	69,586	Daily-Monthly	1-11
Emerging market equities	-	43,460	-	43,460	Daily-Monthly	1-17
Global equities	-	57,230	-	57,230	Daily-Monthly	1-17
REIT funds	-	3,329	-	3,329	Daily-Monthly	1-17
Private equity funds	-	-	15	15	See Note 5	See Note 5
Hedge funds	-	-	15,512	15,512	Quarterly-Annual	60-96
<b>Total investments</b>	<b>\$ 355,225</b>	<b>\$ 588,112</b>	<b>\$ 15,527</b>	<b>\$ 958,864</b>		

The following tables present additional information about the changes in Level 3 assets measured at fair value for the years ended June 30, 2022 and 2021:

<i>(in thousands of dollars)</i>	2022		
	<u>Hedge Funds</u>	<u>Private Equity Funds</u>	<u>Total</u>
Beginning of year balances	\$ 15,512	\$ 15	\$ 15,527
Purchases	81,400	-	81,400
Sales	(2,152)	-	(2,152)
Net unrealized losses	(7,800)	(1)	(7,801)
End of year balances	\$ 86,960	\$ 14	\$ 86,974

<i>(in thousands of dollars)</i>	2021		
	<u>Hedge Funds</u>	<u>Private Equity Funds</u>	<u>Total</u>
Beginning of year balances	\$ 47,351	\$ 17	\$ 47,368
Sales	(38,000)	-	(38,000)
Net unrealized gains (losses)	6,161	(2)	6,159
End of year balances	\$ 15,512	\$ 15	\$ 15,527

The total aggregate net unrealized (losses) gains included in the fair value of the Level 3 investments as of June 30, 2022 and 2021 were approximately (\$543,000) and \$7,635,000, respectively. There were transfers out of Level 3 measurements during the years ended June 30, 2022 and 2021. The hedge funds' liquidation will be completed by the end of Fiscal Year 2023.

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, 2022 and 2021.

## Dartmouth-Hitchcock Health and Subsidiaries

### Notes to Consolidated Financial Statements

#### June 30, 2022 and 2021

The weighted average asset allocation, by asset category, for the Health System's pension plans is as follows at June 30, 2022 and 2021:

	<u>2022</u>	<u>2021</u>
Cash and short-term investments	2 %	6 %
U.S. government securities	17	5
Domestic debt securities	33	46
Global debt securities	3	4
Domestic equities	18	19
International equities	5	7
Emerging market equities	3	5
Global equities	7	6
Hedge funds	12	2
Total	<u>100 %</u>	<u>100 %</u>

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 \$12,500,000 to the Plans in 2023 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)*

2023	\$ 124,252
2024	56,264
2025	57,774
2026	59,040
2027	60,176
2028 – 2032	310,262

The Cheshire Medical Center plan was terminated effective June 30, 2022, pending regulatory approvals. Following regulatory approval, the plan sponsor intends to distribute assets and settle plan obligations through a lump sum offering to active and terminated vested participants and a group annuity contract will be purchased for any participant that doesn't elect the lump sum, along with all participants currently in pay status. It is anticipated that benefits will be distributed by June 30, 2023. The benefit obligation for the plan reflects anticipated disbursement costs and a terminal cash contribution to fully fund benefits will be made at that time. The obligations reflect the cost of providing the lump sums and group annuity, described above, as well as administrative costs and a terminal contribution which will be necessary to fund all of the costs of terminating the plan. It is expected that the obligations will be settled by June 30, 2023 and the plan termination liability will reflect economic conditions, lump sum election rates and annuity pricing at that time. As a result, the final plan termination liability may be different from the amounts shown in this report.

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**June 30, 2022 and 2021**

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**Defined Contribution Plans**

The Health System has an employer-sponsored 401(a) plan for certain of its members, under which the employer makes base match contributions based on specified percentages of compensation and employee deferral amounts. Total employer contributions to the plan of approximately \$64,946,000 and \$60,268,000 in 2022 and 2021, respectively, are included in employee benefits expenses 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 2022 and 2021.

**Postretirement Medical and Life Insurance Benefits**

The Health System has postretirement medical and life insurance 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, 2022 and 2021:

<i>(in thousands of dollars)</i>	<u>2022</u>	<u>2021</u>
Service cost	\$ 456	\$ 533
Interest cost	1,394	1,340
Net prior service income	-	(3,582)
Net loss amortization	752	738
Total	<u>\$ 2,602</u>	<u>\$ (971)</u>

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**June 30, 2022 and 2021**

The following table sets forth the accumulated postretirement medical and life insurance benefit obligation amounts recognized in the Health System's consolidated financial statements at June 30, 2022 and 2021:

<i>(in thousands of dollars)</i>	<u>2022</u>	<u>2021</u>
<b>Change in benefit obligation</b>		
Accumulated benefit obligation, beginning of year	\$ 46,863	\$ 48,078
Service cost	456	533
Interest cost	1,394	1,340
Benefits paid	(3,401)	(3,439)
Actuarial loss	(4,964)	383
Employer contributions	<u>(33)</u>	<u>(32)</u>
Accumulated benefit obligation, end of year	<u>40,315</u>	<u>46,863</u>
Current portion of liability for postretirement medical and life benefits	\$ (3,500)	\$ (3,422)
Long-term portion of liability for postretirement medical and life benefits	<u>(36,815)</u>	<u>(43,441)</u>
Funded status of the plans and liability for postretirement medical and life benefits	<u>\$ (40,315)</u>	<u>\$ (46,863)</u>

As of June 30, 2022 and 2021, the liability for postretirement medical and life insurance 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 income for the postretirement medical and life insurance benefit plans, included in the change in net assets without donor restrictions, are as follows:

<i>(in thousands of dollars)</i>	<u>2022</u>	<u>2021</u>
Net actuarial loss	<u>4,445</u>	<u>9,981</u>
Total	<u>\$ 4,445</u>	<u>\$ 9,981</u>

The estimated amount of net losses that will be amortized from net assets without donor restrictions into net periodic postretirement income in fiscal year 2023 is approximately \$62,000.

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**June 30, 2022 and 2021**

The following future benefit payments, which reflect expected future service, as appropriate, are expected to be paid for the years ending June 30, 2022 and thereafter:

*(in thousands of dollars)*

2023	\$ 3,500
2024	3,721
2025	3,725
2026	3,720
2027	3,700
2028-2032	16,820

In determining the accumulated benefit obligation for the postretirement medical and life insurance plans, the Health System used a discount rates of 5.10% in 2022, and an assumed healthcare cost trend rate of 7.00%, trending down to 5.00% in 2029 and thereafter.

**12. Professional and General Liability Insurance Coverage**

D-H, along with Dartmouth College, Cheshire, NLH, APD, MAHHC, and VNH 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. RRG cedes the majority of this risk to Hamden Assurance Company Limited (HAC), a captive insurance company domiciled in Bermuda, and HAC cedes a portion of this risk to a variety of commercial reinsurers. D-H has majority ownership interest in both HAC and RRG. The insurance program provides coverage to the covered institutions, named insureds and their employees 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, 2022 and 2021, are summarized as follows:

	2022		
	<u>HAC</u>	<u>RRG</u>	<u>Total</u>
<i>(in thousands of dollars)</i>			
Assets	\$ 79,831	\$ 2,245	\$ 82,076
Shareholders' equity	13,620	50	13,670
	2021		
	<u>HAC</u>	<u>RRG</u>	<u>Total</u>
<i>(in thousands of dollars)</i>			
Assets	\$ 71,772	\$ 3,583	\$ 75,355
Shareholders' equity	13,620	50	13,670

## **Dartmouth-Hitchcock Health and Subsidiaries**

### **Notes to Consolidated Financial Statements**

#### **June 30, 2022 and 2021**

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#### **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.

##### **Line of Credit**

The Health System has entered into a loan agreement with a financial institution, establishing access to revolving loans ranging from \$10,000,000 up to \$30,000,000. Interest is variable and determined using the Bloomberg Short-Term Bank Yield Index or the Wall Street Journal Prime Rate. The loan agreement is due to expire March 29, 2023. There was no outstanding balance under the line of credit as of June 30, 2022 and 2021. Interest expense was approximately \$91,000 and \$28,000, 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.

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**June 30, 2022 and 2021**

Operating expenses of the Health System by functional and natural basis are as follows for the year ended June 30, 2022:

	<b>2022</b>			
<i>(in thousands of dollars)</i>	<b><u>Program Services</u></b>	<b><u>Management and General</u></b>	<b><u>Fundraising</u></b>	<b><u>Total</u></b>
<b>Operating expenses</b>				
Salaries	\$ 1,129,572	\$ 184,533	\$ 1,302	\$ 1,315,407
Employee benefits	281,455	40,887	228	322,570
Medical supplies and medications	645,437	3,835	-	649,272
Purchased services and other	255,639	142,241	5,982	403,862
Medicaid enhancement tax	82,725	-	-	82,725
Depreciation and amortization	42,227	44,675	56	86,958
Interest	9,116	22,987	10	32,113
Total operating expenses	<b><u>\$ 2,446,171</u></b>	<b><u>\$ 439,158</u></b>	<b><u>\$ 7,578</u></b>	<b><u>\$ 2,892,907</u></b>
<b>Non-operating income</b>				
Employee benefits	\$ 12,144	\$ 1,755	\$ 11	\$ 13,910
Total non-operating income	<b><u>\$ 12,144</u></b>	<b><u>\$ 1,755</u></b>	<b><u>\$ 11</u></b>	<b><u>\$ 13,910</u></b>

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**June 30, 2022 and 2021**

Operating expenses of the Health System by functional and natural basis are as follows for the year ended June 30, 2021:

	<b>2021</b>			
<i>(in thousands of dollars)</i>	<b><u>Program Services</u></b>	<b><u>Management and General</u></b>	<b><u>Fundraising</u></b>	<b><u>Total</u></b>
<b>Operating expenses</b>				
Salaries	\$ 1,019,272	\$ 164,937	\$ 1,701	\$ 1,185,910
Employee benefits	212,953	88,786	403	302,142
Medical supplies and medications	540,541	4,982	-	545,523
Purchased services and other	252,705	125,931	5,313	383,949
Medicaid enhancement tax	72,941	-	-	72,941
Depreciation and amortization	38,945	49,943	33	88,921
Interest	8,657	22,123	7	30,787
Total operating expenses	<u>\$ 2,146,014</u>	<u>\$ 456,702</u>	<u>\$ 7,457</u>	<u>\$ 2,610,173</u>
	<b><u>Program Services</u></b>	<b><u>Management and General</u></b>	<b><u>Fundraising</u></b>	<b><u>Total</u></b>
<b>Non-operating income</b>				
Employee benefits	\$ 9,200	\$ 4,354	\$ 5	\$ 13,559
Total non-operating income	<u>\$ 9,200</u>	<u>\$ 4,354</u>	<u>\$ 5</u>	<u>\$ 13,559</u>

**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 Sheets may not be available for general expenditure within one year of the balance sheet date.

## Dartmouth-Hitchcock Health and Subsidiaries

### Notes to Consolidated Financial Statements

#### June 30, 2022 and 2021

The Health System's financial assets available at June 30, 2022 and 2021 to meet cash needs for general expenditures within one year of June 30, 2022 and 2021, are as follows:

<i>(in thousands of dollars)</i>	<u>2022</u>	<u>2021</u>
Cash and cash equivalents	\$ 191,929	\$ 374,928
Patient accounts receivable	251,250	232,161
Assets limited as to use	1,181,094	1,378,479
Other investments for restricted activities	175,116	168,035
Total financial assets	<u>\$ 1,799,389</u>	<u>\$ 2,153,603</u>
Less: Those unavailable for general expenditure within one year:		
Investments held by captive insurance companies	57,522	57,239
Investments for restricted activities	175,116	168,035
Bond proceeds held for capital projects	99,397	178,434
Other investments with liquidity horizons greater than one year	159,792	111,390
Total financial assets available within one year	<u>\$ 1,307,562</u>	<u>\$ 1,638,505</u>

The Health System generated cash flow from operations of approximately \$(123,525,000) and \$95,740,000 for the years ended June 30, 2022 and June 30, 2021, 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

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. The Health System uses the implicit rate noted within the contract. If not readily available, the Health System uses an 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, rather the Health System recognizes lease expense for these leases on a straight-line basis, over the lease term, within lease and rental expense.

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. 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 the Health System's sole discretion. When

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**June 30, 2022 and 2021**

determining the lease term, management includes options to extend or terminate the lease when it is reasonably certain that the Health System will exercise that option.

Certain lease agreements for real estate include payments based on actual common area maintenance expenses and/or rental payments adjusted periodically for inflation. These variable lease payments are recognized in other occupancy costs in the Consolidated Statements of Operations and Changes in Net Assets, but are not included in the right-of-use asset or liability balances in our Consolidated Balance Sheets. Lease agreements do not contain any material residual value guarantees, restrictions, or covenants.

The components of lease expense for the years ended June 30, 2022 and 2021 are as follows:

<i>(in thousands of dollars)</i>	<u>2022</u>	<u>2021</u>
Operating lease cost	\$ 9,573	\$ 10,381
Variable and short term lease cost (a)	10,894	8,019
Total lease and rental expense	<u>\$ 20,467</u>	<u>\$ 18,400</u>
Finance lease cost:		
Depreciation of property under finance lease	\$ 3,345	\$ 3,408
Interest on debt of property under finance lease	448	533
Total finance lease cost	<u>\$ 3,793</u>	<u>\$ 3,941</u>

(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 years ended June 30, 2022 and 2021 are as follows:

<i>(in thousands of dollars)</i>	<u>2022</u>	<u>2021</u>
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flows from operating leases	\$ 9,952	\$ 10,611
Operating cash flows from finance leases	448	533
Financing cash flows from finance leases	3,255	3,108
Total	<u>\$ 13,655</u>	<u>\$ 14,252</u>

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**June 30, 2022 and 2021**

Supplemental balance sheet information related to leases as of June 30, 2022 and 2021 are as follows:

<i>(in thousands of dollars)</i>	<u>2022</u>	<u>2021</u>
<b>Operating Leases</b>		
Right-of-use assets - operating leases	\$ 61,165	\$ 51,410
Accumulated amortization	(21,222)	(15,180)
Right-of-use assets - operating leases, net	<u>39,943</u>	<u>36,230</u>
Current portion of right-of-use obligations	8,314	8,038
Long-term right-of-use obligations, excluding current portion	<u>32,207</u>	<u>28,686</u>
Total operating lease liabilities	<u>40,521</u>	<u>36,724</u>
<b>Finance Leases</b>		
Right-of-use assets - finance leases	27,963	27,940
Accumulated depreciation	(8,981)	(5,760)
Right-of-use assets - finance leases, net	<u>18,982</u>	<u>22,180</u>
Current portion of right-of-use obligations	3,005	3,251
Long-term right-of-use obligations, excluding current portion	<u>16,617</u>	<u>19,481</u>
Total finance lease liabilities	<u>\$ 19,622</u>	<u>\$ 22,732</u>
<b>Weighted Average remaining lease term, years</b>		
Operating leases	7.73	6.75
Finance leases	19.77	18.73
<b>Weighted Average discount rate</b>		
Operating leases	2.24%	2.12%
Finance leases	2.17%	2.14%

The System obtained \$8.9 million and \$0.1 million of new and modified operating and financing leases, respectively, during the year ended June 30, 2022.

The System obtained \$7.6 million and \$2.1 million of new and modified operating and financing leases, respectively, during the year ended June 30, 2021.

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Notes to Consolidated Financial Statements**  
**June 30, 2022 and 2021**

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Future maturities of lease liabilities as of June 30, 2022 are as follows:

<i>(in thousands of dollars)</i>	<u>Operating Leases</u>	<u>Finance Leases</u>
Year ending June 30:		
2023	\$ 9,121	\$ 3,395
2024	7,971	2,297
2025	5,083	1,261
2026	3,750	882
2027	3,357	800
Thereafter	15,096	15,713
Total lease payments	44,378	24,348
Less: Imputed interest	3,857	4,726
Total lease obligations	<u>\$ 40,521</u>	<u>\$ 19,622</u>

**17. Subsequent Events**

The Health System has assessed the impact of subsequent events through November 16, 2022, 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.

**Consolidating Supplemental Information**

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidating Balance Sheets

#### June 30, 2022

<i>(in thousands of dollars)</i>	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
<b>Assets</b>											
<b>Current assets</b>											
Cash and cash equivalents	\$ 2,056	\$ 66,827	\$ 20,165	\$ 38,416	\$ 28,467	\$ 11,327	\$ -	\$ 167,258	\$ 24,671	\$ -	\$ 191,929
Patient accounts receivable, net	-	206,400	18,106	9,817	9,175	5,360	-	248,858	2,392	-	251,250
Prepaid expenses and other current assets	23,561	161,262	19,580	3,522	4,452	1,472	(31,119)	182,730	(11,372)	(2,225)	169,133
<b>Total current assets</b>	<b>25,617</b>	<b>434,489</b>	<b>57,851</b>	<b>51,755</b>	<b>42,094</b>	<b>18,159</b>	<b>(31,119)</b>	<b>598,846</b>	<b>15,691</b>	<b>(2,225)</b>	<b>612,312</b>
<b>Assets limited as to use</b>											
Notes receivable, related party	301,000	858,919	12,665	14,680	16,005	25,753	(98,848)	1,130,174	50,920	-	1,181,094
Other investments for restricted activities	842,052	11,557	-	803	-	-	(853,609)	803	(803)	-	-
Property, plant, and equipment, net	490	118,082	16,422	727	3,925	6,846	-	146,492	28,624	-	175,116
Right-of-use assets, net	-	585,064	63,067	24,757	45,973	15,526	-	734,387	30,453	-	764,840
Other assets	1,362	35,321	1,830	14,892	166	5,249	-	58,820	105	-	58,925
<b>Total assets</b>	<b>\$ 1,171,202</b>	<b>\$ 2,189,948</b>	<b>\$ 153,022</b>	<b>\$ 122,005</b>	<b>\$ 114,736</b>	<b>\$ 76,516</b>	<b>\$ (983,576)</b>	<b>\$ 2,843,853</b>	<b>\$ 122,822</b>	<b>\$ (2,225)</b>	<b>\$ 2,964,450</b>
<b>Liabilities and Net Assets</b>											
<b>Current liabilities</b>											
Current portion of long-term debt	\$ -	\$ 4,810	\$ 865	\$ 800	\$ 23	\$ -	\$ -	\$ 6,498	\$ 98	\$ -	\$ 6,596
Current portion of right-of-use obligations	559	8,514	689	852	172	473	-	11,259	60	-	11,319
Current portion of liability for pension and other postretirement plan benefits	-	3,500	-	-	-	-	-	3,500	-	-	3,500
Accounts payable and accrued expenses	147,626	100,110	16,607	4,883	4,843	8,693	(129,967)	152,795	6,002	(2,225)	156,572
Accrued compensation and related benefits	-	169,194	-6,817	4,431	4,507	4,434	-	189,383	1,177	-	190,560
Estimated third-party settlements	3,002	68,876	22,999	17,488	21,886	647	-	134,898	-	-	134,898
<b>Total current liabilities</b>	<b>151,187</b>	<b>355,004</b>	<b>47,977</b>	<b>28,454</b>	<b>31,431</b>	<b>14,247</b>	<b>(129,967)</b>	<b>498,333</b>	<b>7,337</b>	<b>(2,225)</b>	<b>503,445</b>
Notes payable, related party	-	808,602	-	-	27,437	17,570	(853,609)	-	-	-	-
Long-term debt, excluding current portion	1,044,845	25,084	21,867	23,060	32	(110)	-	1,114,778	2,510	-	1,117,288
Right-of-use obligations, excluding current portion	803	27,359	1,233	14,499	-	4,885	-	48,779	45	-	48,824
Insurance deposits and related liabilities	-	76,678	623	373	401	250	-	78,325	66	-	78,391
Liability for pension and other postretirement plan benefits, excluding current portion	-	220,350	7,774	-	-	481	-	228,605	1	-	228,606
Other liabilities	-	129,092	1,109	300	1,749	-	-	132,250	21,846	-	154,096
<b>Total liabilities</b>	<b>1,196,835</b>	<b>1,642,169</b>	<b>80,583</b>	<b>66,686</b>	<b>61,050</b>	<b>37,323</b>	<b>(983,576)</b>	<b>2,101,070</b>	<b>31,805</b>	<b>(2,225)</b>	<b>2,130,650</b>
<b>Commitments and contingencies</b>											
<b>Net assets</b>											
Net assets without donor restrictions	(25,638)	418,255	53,646	54,590	48,974	31,078	-	580,905	53,352	40	634,297
Net assets with donor restrictions	5	129,524	18,793	729	4,712	8,115	-	161,878	37,665	(40)	199,503
<b>Total net assets</b>	<b>(25,633)</b>	<b>547,779</b>	<b>72,439</b>	<b>55,319</b>	<b>53,686</b>	<b>39,193</b>	<b>-</b>	<b>742,783</b>	<b>91,017</b>	<b>-</b>	<b>833,800</b>
<b>Total liabilities and net assets</b>	<b>\$ 1,171,202</b>	<b>\$ 2,189,948</b>	<b>\$ 153,022</b>	<b>\$ 122,005</b>	<b>\$ 114,736</b>	<b>\$ 76,516</b>	<b>\$ (983,576)</b>	<b>\$ 2,843,853</b>	<b>\$ 122,822</b>	<b>\$ (2,225)</b>	<b>\$ 2,964,450</b>

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidating Balance Sheets**  
**June 30, 2022**

<i>(in thousands of dollars)</i>	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH	MAHHC and Subsidiaries	APD and Subsidiary	VNH and Subsidiaries	Eliminations	Health System Consolidated
<b>Assets</b>									
<b>Current assets</b>									
Cash and cash equivalents	\$ 2,056	\$ 68,075	\$ 32,500	\$ 28,467	\$ 11,631	\$ 47,894	\$ 1,306	\$ -	\$ 191,929
Patient accounts receivable, net	-	206,400	18,106	9,175	5,431	9,817	2,321	-	251,250
Prepaid expenses and other current assets	23,561	161,508	8,296	4,452	1,499	2,678	483	(33,344)	169,133
Total current assets	25,617	435,983	58,902	42,094	18,561	60,389	4,110	(33,344)	612,312
<b>Assets limited as to use</b>									
Notes receivable, related party	301,000	884,007	13,183	16,005	26,979	14,680	24,088	(98,848)	1,181,094
Other investments for restricted activities	842,052	11,557	-	-	-	-	-	(853,609)	-
Other investments for restricted activities	490	125,614	37,124	3,925	6,846	1,031	86	-	175,116
Property, plant, and equipment, net	-	587,739	66,385	45,973	16,947	42,436	5,360	-	764,840
Right-of-use assets, net	-1,362	35,321	1,830	166	5,248	14,892	106	-	58,925
Other assets	681	146,699	8,316	6,573	2,526	7,292	76	-	172,163
Total assets	\$ 1,171,202	\$ 2,226,920	\$ 185,740	\$ 114,736	\$ 77,107	\$ 140,720	\$ 33,826	\$ (985,801)	\$ 2,964,450
<b>Liabilities and Net Assets</b>									
<b>Current liabilities</b>									
Current portion of long-term debt	\$ -	\$ 4,810	\$ 865	\$ 23	\$ 26	\$ 800	\$ 72	\$ -	\$ 6,596
Current portion of right-of-use obligations	559	8,514	689	172	472	852	61	-	11,319
Current portion of liability for pension and other postretirement plan benefits	-	3,500	-	-	-	-	-	-	3,500
Accounts payable and accrued expenses	147,626	100,617	16,726	4,843	8,831	5,481	4,640	(132,192)	156,572
Accrued compensation and related benefits	-	169,194	6,817	4,507	4,490	4,735	817	-	190,560
Estimated third-party settlements	3,002	68,876	22,999	21,886	647	17,488	-	-	134,898
Total current liabilities	151,187	355,511	48,096	31,431	14,466	29,356	5,590	(132,192)	503,445
Notes payable, related party	-	808,602	-	27,437	17,570	-	-	(853,609)	-
Long-term debt, excluding current portion	1,044,845	25,084	21,867	32	110	23,005	2,345	-	1,117,288
Right-of-use obligations, excluding current portion	803	27,359	1,233	-	4,885	14,499	45	-	48,824
Insurance deposits and related liabilities	-	76,678	623	401	250	373	66	-	78,391
Liability for pension and other postretirement plan benefits, excluding current portion	-	220,350	7,774	-	482	-	-	-	228,606
Other liabilities	-	129,092	1,109	1,749	-	22,146	-	-	154,096
Total liabilities	1,196,835	1,642,676	80,702	61,050	37,763	89,379	8,046	(985,801)	2,130,650
<b>Commitments and contingencies</b>									
<b>Net assets</b>									
Net assets without donor restrictions	(25,638)	447,013	56,674	48,974	31,231	50,308	25,695	40	634,297
Net assets with donor restrictions	5	137,231	48,364	4,712	8,113	1,033	85	(40)	199,503
Total net assets	(25,633)	584,244	105,038	53,686	39,344	51,341	25,780	-	833,800
Total liabilities and net assets	\$ 1,171,202	\$ 2,226,920	\$ 185,740	\$ 114,736	\$ 77,107	\$ 140,720	\$ 33,826	\$ (985,801)	\$ 2,964,450

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidating Balance Sheets

#### June 30, 2021

<i>(in thousands of dollars)</i>	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
<b>Assets</b>											
<b>Current assets</b>											
Cash and cash equivalents	\$ 1,826	\$ 226,779	\$ 35,146	\$ 41,371	\$ 26,814	\$ 18,350	\$ -	\$ 350,286	\$ 24,642	\$ -	\$ 374,928
Patient accounts receivable, net	-	196,350	13,238	6,779	6,699	6,522	-	229,588	2,573	-	232,161
Prepaid expenses and other current assets	23,267	151,336	20,932	2,012	4,771	1,793	(35,942)	168,169	(10,634)	(217)	157,318
<b>Total current assets</b>	<b>25,093</b>	<b>574,465</b>	<b>69,316</b>	<b>50,162</b>	<b>38,284</b>	<b>26,665</b>	<b>(35,942)</b>	<b>748,043</b>	<b>16,581</b>	<b>(217)</b>	<b>764,407</b>
Assets limited as to use	380,020	1,039,327	19,016	15,480	16,725	20,195	(169,849)	1,320,914	57,565	-	1,378,479
Notes receivable, related party	845,157	11,769	-	1,010	-	-	(856,926)	1,010	(1,010)	-	-
Other investments for restricted activities	248	111,209	12,212	1,128	4,266	7,699	-	136,762	31,273	-	168,035
Property, plant, and equipment, net	-	501,640	64,101	22,623	47,232	15,403	-	650,999	29,434	-	680,433
Right-of-use assets	1,233	32,343	2,396	16,104	360	5,819	-	58,255	155	-	58,410
Other assets	2,431	146,226	1,315	14,380	7,282	5,172	-	176,806	292	-	177,098
<b>Total assets</b>	<b>\$ 1,254,182</b>	<b>\$ 2,416,979</b>	<b>\$ 168,356</b>	<b>\$ 120,887</b>	<b>\$ 114,149</b>	<b>\$ 80,953</b>	<b>\$ (1,062,717)</b>	<b>\$ 3,092,789</b>	<b>\$ 134,290</b>	<b>\$ (217)</b>	<b>\$ 3,226,862</b>
<b>Liabilities and Net Assets</b>											
<b>Current liabilities</b>											
Current portion of long-term debt	\$ -	\$ 7,575	\$ 865	\$ 777	\$ 91	\$ -	\$ -	\$ 9,308	\$ 99	\$ -	\$ 9,407
Current portion of right-of-use obligations	354	8,369	656	1,078	197	550	-	11,204	85	-	11,289
Current portion of liability for pension and other postretirement plan benefits	-	3,468	-	-	-	-	-	3,468	-	-	3,468
Accounts payable and accrued expenses	207,566	99,374	11,911	2,455	4,968	5,858	(205,791)	126,341	5,100	(217)	131,224
Accrued compensation and related benefits	-	156,073	8,648	5,706	4,407	5,343	-	180,177	1,893	-	182,070
Estimated third-party settlements	-	160,410	31,228	27,008	26,902	6,230	-	251,774	769	-	252,543
<b>Total current liabilities</b>	<b>207,920</b>	<b>435,269</b>	<b>53,306</b>	<b>37,022</b>	<b>36,565</b>	<b>17,981</b>	<b>(205,791)</b>	<b>582,272</b>	<b>7,946</b>	<b>(217)</b>	<b>590,001</b>
Notes payable, related party	-	811,563	-	-	27,793	17,570	(856,926)	-	-	-	-
Long-term debt, excluding current portion	1,047,659	29,846	22,753	23,558	55	(115)	-	1,123,756	2,601	-	1,126,357
Right-of-use obligations, excluding current portion	879	24,463	1,876	15,351	172	5,357	-	48,098	69	-	48,167
Insurance deposits and related liabilities	-	78,528	475	325	388	218	-	79,934	40	-	79,974
Liability for pension and other postretirement plan benefits, excluding current portion	-	218,955	5,286	-	-	511	-	224,752	-	-	224,752
Other liabilities	-	179,497	4,224	4,534	4,142	-	-	192,397	22,317	-	214,714
<b>Total liabilities</b>	<b>1,256,458</b>	<b>1,778,121</b>	<b>87,920</b>	<b>80,790</b>	<b>69,115</b>	<b>41,522</b>	<b>(1,062,717)</b>	<b>2,251,209</b>	<b>32,973</b>	<b>(217)</b>	<b>2,283,965</b>
<b>Commitments and contingencies</b>											
<b>Net assets</b>											
Net assets without donor restrictions	(2,524)	526,153	65,224	38,969	39,557	29,838	-	697,217	61,370	40	758,627
Net assets with donor restrictions	248	112,705	15,212	1,128	5,477	9,593	-	144,363	39,947	(40)	184,270
<b>Total net assets</b>	<b>(2,276)</b>	<b>638,858</b>	<b>80,436</b>	<b>40,097</b>	<b>45,034</b>	<b>39,431</b>	<b>-</b>	<b>841,580</b>	<b>101,317</b>	<b>-</b>	<b>942,897</b>
<b>Total liabilities and net assets</b>	<b>\$ 1,254,182</b>	<b>\$ 2,416,979</b>	<b>\$ 188,356</b>	<b>\$ 120,887</b>	<b>\$ 114,149</b>	<b>\$ 80,953</b>	<b>\$ (1,062,717)</b>	<b>\$ 3,092,789</b>	<b>\$ 134,290</b>	<b>\$ (217)</b>	<b>\$ 3,226,862</b>

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidating Balance Sheets

#### June 30, 2021

<i>(in thousands of dollars)</i>	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD and Subsidiary	VNH and Subsidiaries	Eliminations	Health System Consolidated
<b>Assets</b>									
<b>Current assets</b>									
Cash and cash equivalents	\$ 1,826	\$ 227,402	\$ 44,165	\$ 26,814	\$ 18,609	\$ 50,451	\$ 5,661	\$ -	\$ 374,928
Patient accounts receivable, net	-	196,350	13,238	6,699	6,620	6,779	2,475	-	232,161
Prepaid expenses and other current assets	23,267	151,677	10,195	4,771	1,808	1,418	341	(36,159)	157,318
Total current assets	25,093	575,429	67,598	38,284	27,037	58,648	8,477	(36,159)	764,407
<b>Assets limited as to use</b>									
Notes receivable, related party	380,020	1,066,781	20,459	16,725	21,533	15,480	27,330	(169,849)	1,378,479
Other investments for restricted activities	845,157	11,769	-	-	-	-	-	(856,926)	-
Property, plant, and equipment, net	248	119,371	34,921	4,266	7,698	1,501	30	-	168,035
Right-of-use assets, net	-	504,315	67,543	47,232	16,932	41,218	3,193	-	680,433
Other assets	1,233	32,343	2,396	360	5,820	16,104	154	-	58,410
Total assets	2,431	146,408	10,286	7,282	2,715	7,534	442	-	177,098
Total assets	<u>\$ 1,254,182</u>	<u>\$ 2,456,416</u>	<u>\$ 203,203</u>	<u>\$ 114,149</u>	<u>\$ 81,735</u>	<u>\$ 140,485</u>	<u>\$ 39,626</u>	<u>\$ (1,062,934)</u>	<u>\$ 3,226,862</u>
<b>Liabilities and Net Assets</b>									
<b>Current liabilities</b>									
Current portion of long-term debt	\$ -	\$ 7,575	\$ 865	\$ 91	\$ 26	\$ 777	\$ 73	\$ -	\$ 9,407
Current portion of right-of-use obligations	354	8,369	656	197	550	1,078	85	-	11,289
Current portion of liability for pension and other postretirement plan benefits	-	3,468	-	-	-	-	-	-	3,468
Accounts payable and accrued expenses	207,566	99,682	12,032	4,968	5,983	2,920	4,081	(206,008)	131,224
Accrued compensation and related benefits	-	156,073	8,648	4,407	5,385	6,116	1,441	-	182,070
Estimated third-party settlements	-	160,410	31,226	26,902	6,231	27,006	768	-	252,543
Total current liabilities	207,920	435,577	53,427	36,565	18,175	37,897	6,448	(206,008)	590,001
Notes payable, related party	-	811,563	-	27,793	17,570	-	-	(856,926)	-
Long-term debt, excluding current portion	1,047,659	29,846	22,753	55	131	23,496	2,417	-	1,126,357
Right-of-use obligations, excluding current portion	879	24,463	1,876	172	5,357	15,351	69	-	48,167
Insurance deposits and related liabilities	-	78,528	476	388	218	325	39	-	79,974
Liability for pension and other postretirement plan benefits, excluding current portion	-	218,955	5,286	-	511	-	-	-	224,752
Other liabilities	-	179,497	4,223	4,142	-	26,852	-	-	214,714
Total liabilities	<u>1,256,458</u>	<u>1,778,429</u>	<u>88,041</u>	<u>69,115</u>	<u>41,962</u>	<u>103,921</u>	<u>8,973</u>	<u>(1,062,934)</u>	<u>2,283,965</u>
<b>Commitments and contingencies</b>									
<b>Net assets</b>									
Net assets without donor restrictions	(2,524)	557,101	68,586	39,557	30,181	35,063	30,623	40	758,627
Net assets with donor restrictions	248	120,886	46,576	5,477	9,592	1,501	30	(40)	184,270
Total net assets	<u>(2,276)</u>	<u>677,987</u>	<u>115,162</u>	<u>45,034</u>	<u>39,773</u>	<u>36,564</u>	<u>30,653</u>	<u>-</u>	<u>942,897</u>
Total liabilities and net assets	<u>\$ 1,254,182</u>	<u>\$ 2,456,416</u>	<u>\$ 203,203</u>	<u>\$ 114,149</u>	<u>\$ 81,735</u>	<u>\$ 140,485</u>	<u>\$ 39,626</u>	<u>\$ (1,062,934)</u>	<u>\$ 3,226,862</u>

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidating Statements of Operations and Changes in Net Assets without Donor Restrictions

#### Year Ended June 30, 2022

<i>(in thousands of dollars)</i>	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
<b>Operating revenue and other support</b>											
Patient service revenue	\$ -	\$ 1,751,093	\$ 238,645	\$ 99,403	\$ 79,754	\$ 59,040	\$ -	\$ 2,225,935	\$ 17,302	\$ -	\$ 2,243,237
Contracted revenue	209	133,928	165	21	22	3,521	(60,573)	77,293	458	(85)	77,666
Other operating revenue	38,568	492,455	23,736	4,146	7,527	2,754	(50,711)	518,475	16,731	(1,175)	534,031
Net assets released from restrictions	249	13,299	779	435	190	204	-	15,156	738	-	15,894
<b>Total operating revenue and other support</b>	<u>39,026</u>	<u>2,390,775</u>	<u>261,325</u>	<u>104,005</u>	<u>87,493</u>	<u>65,519</u>	<u>(111,284)</u>	<u>2,836,859</u>	<u>35,229</u>	<u>(1,260)</u>	<u>2,870,828</u>
<b>Operating expenses</b>											
Salaries	-	1,091,601	135,083	43,266	40,219	28,960	(45,229)	1,293,900	20,422	1,085	1,315,407
Employee benefits	-	268,795	31,761	10,302	7,537	8,240	(5,842)	318,793	3,514	263	322,570
Medications and medical supplies	-	578,561	43,203	12,266	9,946	4,127	-	648,123	1,149	-	649,272
Purchased services and other	25,638	312,373	42,723	15,951	13,068	17,383	(32,862)	394,274	11,368	(1,810)	403,862
Medicaid enhancement tax	-	64,036	9,468	3,980	2,834	2,407	-	82,725	-	-	82,725
Depreciation and amortization	-	64,643	8,771	3,519	4,819	2,359	-	84,111	2,847	-	86,958
Interest	32,536	25,365	914	876	1,073	493	(29,530)	31,727	386	-	32,113
<b>Total operating expenses</b>	<u>58,174</u>	<u>2,403,394</u>	<u>271,823</u>	<u>90,160</u>	<u>79,496</u>	<u>63,969</u>	<u>(113,463)</u>	<u>2,853,653</u>	<u>39,716</u>	<u>(462)</u>	<u>2,892,907</u>
<b>Operating (loss) margin</b>	<u>(19,148)</u>	<u>(12,619)</u>	<u>(10,598)</u>	<u>13,845</u>	<u>-7,997</u>	<u>1,550</u>	<u>2,179</u>	<u>(16,794)</u>	<u>(4,487)</u>	<u>(798)</u>	<u>(22,079)</u>
<b>Non-operating (losses) gains</b>											
Investment losses, net	(8,026)	(58,973)	(2,068)	(795)	(1,114)	(1,555)	(210)	(72,741)	(6,003)	-	(78,744)
Other components of net periodic pension and post retirement benefit income	-	11,902	2,008	-	-	-	-	13,910	-	-	13,910
Other (losses) income, net	(3,540)	(1,641)	(542)	-	1	169	(1,969)	(7,522)	66	798	(6,658)
<b>Total non-operating (losses) gains, net</b>	<u>(11,566)</u>	<u>(48,712)</u>	<u>(602)</u>	<u>(795)</u>	<u>(1,113)</u>	<u>(1,386)</u>	<u>(2,179)</u>	<u>(66,353)</u>	<u>(5,937)</u>	<u>798</u>	<u>(71,492)</u>
<b>(Deficiency) excess of revenue over expenses</b>	<u>(30,714)</u>	<u>(61,331)</u>	<u>(11,200)</u>	<u>13,050</u>	<u>8,884</u>	<u>164</u>	<u>-</u>	<u>(83,147)</u>	<u>(10,424)</u>	<u>-</u>	<u>(93,571)</u>
<b>Net assets without donor restrictions</b>											
Net assets released from restrictions for capital	-	678	52	-	480	233	-	1,423	150	-	1,573
Change in funded status of pension and other postretirement benefits	-	(27,860)	(4,496)	-	-	48	-	(32,308)	(1)	-	(32,309)
Net assets transferred to (from) affiliates	7,600	(19,385)	4,066	2,571	2,096	795	-	(2,257)	2,257	-	-
Other changes in net assets	-	-	-	-	(23)	-	-	(23)	-	-	(23)
<b>(Decrease) increase in net assets without donor restrictions</b>	<u>\$ (23,114)</u>	<u>\$ (107,898)</u>	<u>\$ (11,578)</u>	<u>\$ 15,621</u>	<u>\$ 9,417</u>	<u>\$ 1,240</u>	<u>\$ -</u>	<u>\$ (118,312)</u>	<u>\$ (8,018)</u>	<u>\$ -</u>	<u>\$ (124,330)</u>

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Consolidating Statements of Operations and Changes in Net Assets without Donor Restrictions**  
**Year Ended June 30, 2022**

<i>(in thousands of dollars)</i>	<b>Dartmouth- Hitchcock Health</b>	<b>D-H and Subsidiaries</b>	<b>Cheshire and Subsidiaries</b>	<b>NLH</b>	<b>MAHHC and Subsidiaries</b>	<b>APD and Subsidiary</b>	<b>VNH and Subsidiaries</b>	<b>Eliminations</b>	<b>Health System Consolidated</b>
<b>Operating revenue and other support</b>									
Patient service revenue	\$ -	\$ 1,751,093	\$ 236,645	\$ 79,754	\$ 59,041	\$ 99,403	\$ 17,301	\$ -	\$ 2,243,237
Contracted revenue	209	134,388	165	21	3,521	21	-	(80,859)	77,666
Other operating revenue	38,568	494,363	23,794	7,527	4,370	14,587	2,708	(51,886)	534,031
Net assets released from restrictions	249	13,873	821	190	204	548	9	-	15,894
<b>Total operating revenue and other support</b>	<b>39,026</b>	<b>2,393,717</b>	<b>261,425</b>	<b>87,492</b>	<b>67,136</b>	<b>114,558</b>	<b>20,018</b>	<b>(112,545)</b>	<b>2,870,828</b>
<b>Operating expenses</b>									
Salaries	-	1,091,801	135,118	40,219	29,729	47,352	15,534	(44,144)	1,315,407
Employee benefits	-	266,795	31,770	7,537	8,361	11,169	2,517	(5,579)	322,570
Medications and medical supplies	-	578,581	43,203	9,946	4,126	12,297	1,123	(4)	649,272
Purchased services and other	25,638	315,589	42,938	13,067	18,072	18,915	4,313	(34,670)	403,862
Medicaid enhancement tax	-	64,036	9,469	2,834	2,406	3,980	-	-	82,725
Depreciation and amortization	-	64,843	8,895	4,819	2,483	5,595	523	-	86,958
Interest	32,536	25,365	914	1,073	493	1,204	58	(29,530)	32,113
<b>Total operating expenses</b>	<b>58,174</b>	<b>2,406,610</b>	<b>272,305</b>	<b>79,495</b>	<b>65,670</b>	<b>100,512</b>	<b>24,068</b>	<b>(113,927)</b>	<b>2,892,907</b>
<b>Operating (loss) margin</b>	<b>(19,148)</b>	<b>(12,893)</b>	<b>(10,880)</b>	<b>7,997</b>	<b>1,466</b>	<b>14,047</b>	<b>(4,050)</b>	<b>1,382</b>	<b>(22,079)</b>
<b>Non-operating (losses) gains</b>									
Investment losses, net	(8,026)	(61,039)	(2,163)	(1,114)	(1,663)	(1,373)	(3,155)	(211)	(78,744)
Other components of net periodic pension and post retirement benefit income	-	11,902	2,008	-	-	-	-	-	13,910
Other (losses) income, net	(3,540)	(1,841)	(542)	1	179	-	56	(1,171)	(6,658)
<b>Total non-operating losses, net</b>	<b>(11,566)</b>	<b>(50,778)</b>	<b>(697)</b>	<b>(1,113)</b>	<b>(1,484)</b>	<b>(1,373)</b>	<b>(3,099)</b>	<b>(1,382)</b>	<b>(71,492)</b>
<b>(Deficiency) excess of revenue over expenses</b>	<b>(30,714)</b>	<b>(63,671)</b>	<b>(11,577)</b>	<b>6,884</b>	<b>(18)</b>	<b>12,674</b>	<b>(7,149)</b>	<b>-</b>	<b>(93,571)</b>
<b>Net assets without donor restrictions</b>									
Net assets released from restrictions for capital	-	834	53	460	226	-	-	-	1,573
Change in funded status of pension and other postretirement benefits	-	(27,860)	(4,496)	-	47	-	-	-	(32,309)
Net assets transferred to (from) affiliates	7,600	(19,391)	4,108	2,098	795	2,571	2,221	-	-
Other changes in net assets	-	-	-	(23)	-	-	-	-	(23)
<b>(Decrease) increase in net assets without donor restrictions</b>	<b>\$ (23,114)</b>	<b>\$ (110,088)</b>	<b>\$ (11,912)</b>	<b>\$ 9,417</b>	<b>\$ 1,050</b>	<b>\$ 15,245</b>	<b>\$ (4,928)</b>	<b>\$ -</b>	<b>\$ (124,330)</b>

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidating Statements of Operations and Changes in Net Assets without Donor Restrictions

#### Year Ended June 30, 2021

<i>(in thousands of dollars)</i>	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
<b>Operating revenue and other support</b>											
Patient service revenue	\$ -	\$ 1,683,612	\$ 230,810	\$ 82,373	\$ 61,814	\$ 59,686	\$ -	\$ 2,118,295	\$ 19,992	\$ -	\$ 2,138,287
Contracted revenue	7,266	129,880	379	-	162	2,963	(55,753)	84,897	390	(14)	85,263
Other operating revenue	29,784	404,547	6,775	1,905	4,370	1,175	(37,287)	411,269	15,490	(1,801)	424,958
Net assets released from restrictions	197	12,631	1,182	61	200	201	-	14,472	729	-	15,201
<b>Total operating revenue and other support</b>	<b>37,247</b>	<b>2,230,870</b>	<b>239,146</b>	<b>84,339</b>	<b>66,546</b>	<b>64,025</b>	<b>(93,040)</b>	<b>2,628,933</b>	<b>36,591</b>	<b>(1,815)</b>	<b>2,663,709</b>
<b>Operating expenses</b>											
Salaries	-	988,595	118,678	40,567	33,611	29,119	(42,565)	1,168,005	16,800	1,105	1,185,910
Employee benefits	-	251,774	29,964	7,141	6,550	7,668	(5,159)	297,958	3,877	307	302,142
Medications and medical supplies	-	481,863	41,669	9,776	7,604	3,275	(85)	544,102	1,421	-	545,523
Purchased services and other	19,503	291,364	33,737	12,396	16,591	14,884	(18,065)	370,410	15,395	(1,856)	383,949
Medicaid enhancement tax	-	57,312	8,315	3,075	2,523	1,716	-	72,941	-	-	72,941
Depreciation and amortization	10	67,666	8,623	3,366	4,364	2,617	-	86,646	2,275	-	88,921
Interest	32,324	24,158	936	875	1,077	510	(29,495)	30,385	402	-	30,787
<b>Total operating expenses</b>	<b>51,837</b>	<b>2,162,732</b>	<b>241,942</b>	<b>77,196</b>	<b>72,320</b>	<b>59,789</b>	<b>(95,369)</b>	<b>2,570,447</b>	<b>40,170</b>	<b>(444)</b>	<b>2,610,173</b>
<b>Operating (loss) margin</b>	<b>(14,590)</b>	<b>67,938</b>	<b>(2,796)</b>	<b>7,143</b>	<b>(5,774)</b>	<b>4,236</b>	<b>2,329</b>	<b>58,486</b>	<b>(3,579)</b>	<b>(1,371)</b>	<b>53,536</b>
<b>Non-operating gains (losses)</b>											
Investment income (losses), net	1,223	172,461	3,546	2,495	4,506	3,875	(137)	187,969	15,807	-	203,776
Other components of net periodic pension and post retirement benefit income	-	13,028	547	-	-	(16)	-	13,559	-	-	13,559
Other (losses) income, net	(3,540)	(653)	(332)	-	2	194	(2,192)	(6,521)	917	1,371	(4,233)
<b>Total non-operating (losses) gains, net</b>	<b>(2,317)</b>	<b>184,836</b>	<b>3,761</b>	<b>2,495</b>	<b>4,508</b>	<b>4,053</b>	<b>(2,329)</b>	<b>195,007</b>	<b>16,724</b>	<b>1,371</b>	<b>213,102</b>
<b>(Deficiency) excess of revenue over expenses</b>	<b>(16,907)</b>	<b>252,774</b>	<b>965</b>	<b>9,638</b>	<b>(1,266)</b>	<b>8,289</b>	<b>-</b>	<b>253,493</b>	<b>13,145</b>	<b>-</b>	<b>266,638</b>
<b>Net assets without donor restrictions</b>											
Net assets released from restrictions for capital	-	1,076	600	-	108	224	-	2,008	9	-	2,017
Change in funded status of pension and other postretirement benefits	-	43,047	16,007	-	-	78	-	59,132	-	-	59,132
Net assets transferred to (from) affiliates	8,859	(13,548)	(42)	-	4,557	-	-	(174)	174	-	-
Other changes in net assets	-	(20)	(35)	(120)	-	-	-	(175)	(11)	-	(186)
<b>(Decrease) increase in net assets without donor restrictions</b>	<b>\$ (8,048)</b>	<b>\$ 283,329</b>	<b>\$ 17,495</b>	<b>\$ 9,518</b>	<b>\$ 3,399</b>	<b>\$ 8,591</b>	<b>\$ -</b>	<b>\$ 314,284</b>	<b>\$ 13,317</b>	<b>\$ -</b>	<b>\$ 327,601</b>

## Dartmouth-Hitchcock Health and Subsidiaries

### Consolidating Statements of Operations and Changes in Net Assets without Donor Restrictions

#### Year Ended June 30, 2021

<i>(in thousands of dollars)</i>	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD and Subsidiary	VNH and Subsidiaries	Eliminations	Health System Consolidated
Operating revenue and other support									
Patient service revenue	\$ -	\$ 1,683,612	\$ 230,810	\$ 61,814	\$ 59,672	\$ 82,373	\$ 20,006	\$ -	\$ 2,138,287
Contracted revenue	7,266	130,261	379	161	2,963	-	-	(55,767)	85,263
Other operating revenue	29,784	406,911	6,862	4,370	2,839	11,997	1,283	(39,088)	424,958
Net assets released from restrictions	197	13,290	1,196	199	201	118	-	-	15,201
<b>Total operating revenue and other support</b>	<b>37,247</b>	<b>2,234,074</b>	<b>239,247</b>	<b>66,544</b>	<b>65,675</b>	<b>94,488</b>	<b>21,289</b>	<b>(94,855)</b>	<b>2,663,709</b>
Operating expenses									
Salaries	-	988,595	118,711	33,611	29,986	44,240	12,227	(41,460)	1,185,910
Employee benefits	-	251,774	29,994	6,550	7,820	7,884	2,972	(4,852)	302,142
Medications and medical supplies	-	481,863	41,669	7,604	3,270	9,784	1,418	(85)	545,523
Purchased services and other	19,505	294,228	33,912	16,589	15,395	15,455	8,786	(19,921)	383,949
Medicaid enhancement tax	-	57,312	8,315	2,523	1,716	3,075	-	-	72,941
Depreciation and amortization	10	67,666	8,752	4,364	2,741	5,003	385	-	88,921
Interest	32,324	24,158	936	1,077	510	1,217	60	(29,495)	30,787
<b>Total operating expenses</b>	<b>51,839</b>	<b>2,165,596</b>	<b>242,289</b>	<b>72,318</b>	<b>61,438</b>	<b>86,658</b>	<b>25,848</b>	<b>(95,813)</b>	<b>2,610,173</b>
Operating (loss) margin	(14,592)	68,478	(3,042)	(5,774)	4,237	7,830	(4,559)	958	53,536
Non-operating gains (losses)									
Investment income (losses), net	1,223	179,357	6,317	4,506	4,066	2,472	5,972	(137)	203,776
Other components of net periodic pension and post retirement benefit income	-	13,028	547	-	(16)	-	-	-	13,559
Other (losses) income, net	(3,540)	(653)	(346)	2	207	-	918	(821)	(4,233)
<b>Total non-operating (losses) gains, net</b>	<b>(2,317)</b>	<b>191,732</b>	<b>6,518</b>	<b>4,508</b>	<b>4,257</b>	<b>2,472</b>	<b>6,890</b>	<b>(958)</b>	<b>213,102</b>
(Deficiency) excess of revenue over expenses	(16,909)	260,210	3,476	(1,266)	8,494	10,302	2,331	-	266,638
Net assets without donor restrictions									
Net assets released from restrictions for capital	-	1,085	600	108	224	-	-	-	2,017
Change in funded status of pension and other postretirement benefits	-	43,047	16,007	-	78	-	-	-	59,132
Net assets transferred to (from) affiliates	8,859	(13,548)	-	4,557	-	-	132	-	-
Other changes in net assets	-	(20)	(46)	-	-	(120)	-	-	(186)
<b>(Decrease) increase in net assets without donor restrictions</b>	<b>\$ (8,050)</b>	<b>\$ 290,774</b>	<b>\$ 20,037</b>	<b>\$ 3,399</b>	<b>\$ 8,796</b>	<b>\$ 10,182</b>	<b>\$ 2,463</b>	<b>\$ -</b>	<b>\$ 327,601</b>

**Dartmouth-Hitchcock Health and Subsidiaries**  
**Note to Supplemental Consolidating Information**  
**June 30, 2022 and 2021**

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**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 significant 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.

**MARY HITCHCOCK MEMORIAL HOSPITAL (MHMH)/  
DARTMOUTH HITCHCOCK CLINIC (DHC)  
DARTMOUTH HEALTH**

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**Effective: January 1, 2023**

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One Medical Center Drive, Lebanon, NH 03756*

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MHMH/DHC Trustee  
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MHMH/DHC Trustee  
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MHMH/DHC Boards' Chair | Dartmouth Health Trustee  
*Nicholas M. Greene Professor and Chair, Dept. of Anesthesiology, Yale School of Medicine*

**Jennifer L. Moyer, MBA**  
MHMH/DHC/ Dartmouth Health Trustee  
*Managing Director & CAO, White Mountains Insurance Group, Ltd*

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

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MHMH/DHC Board Secretary | Dartmouth Health Trustee  
*Retired President & COO, JBG SMITH*

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MHMH/DHC/ Dartmouth Health Trustee  
MHMH/DHC Boards' Treasurer  
Dartmouth Health Board Treasurer & Secretary  
  
*Retired Investment Banker*

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MHMH/DHC Trustee  
*President & CEO, Northeast Delta Dental*

**Mark S. Speers, MBA**  
MHMH/DHC Trustee  
*Co-founder & Senior Advisor, Health Advances, LLC*

**Edward Howe Stansfield, III, MA**  
MHMH/DHC Trustee  
Dartmouth Health Trustee & Board Chair  
*Retired Senior Financial Advisor, Resident Director,  
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**Paul A. Taheri, MD, MBA**  
MHMH/DHC Trustee  
*Clinical Partner – Welsh Carson Anderson and  
Stowe*

**Pamela Austin Thompson, MS, RN, CENP,  
FAAN**  
MHMH/DHC/ Dartmouth Health Trustee  
*Chief executive officer emeritus of the American  
Organization of Nurse Executives (AONE)*

**Sandra L. Wong, MD, MS**  
MHMH/DHC Trustee  
*William N. and Bessie Allyn Professor of Surgery,  
Chair of the Department of Surgery at Dartmouth-  
Hitchcock Medical Center (DHMC) and the Geisel  
School of Medicine at Dartmouth, and senior vice  
president of the Surgical Service Line at D-HH*

**Member of Dartmouth Health, not a member of MHMH & DHC:**

**Richard J. Powell, MD**  
Dartmouth Health Trustee  
*Section Chief, Vascular Surgery; Professor of Surgery  
and Radiology*

## CURRICULUM VITAE

March 2023

**Name:** Bryan John Marsh

**Education:**  
1976-1980 Dartmouth College. B.A., 1980  
1981-1985 University of Chicago, Department of Anthropology. M.A., 1983.  
1986-1990 University of Chicago Pritzker School of Medicine. M.D., 1990.

**Postdoctoral Training:**

Internship and Residency

1990-1991 Internship in Internal Medicine: Dartmouth-Hitchcock Medical Center, Lebanon NH  
1991-1993 Residency in Internal Medicine: Dartmouth-Hitchcock Medical Center, Lebanon NH.

Fellowship

1993-1995 Fellowship in Infectious Diseases: Dartmouth-Hitchcock Medical Center, Lebanon NH.

Additional Training

February, 1996 Hartford Hospital Antibiotic Management Program.  
May, 1995 Training Course in Hospital Epidemiology: The Society for Hospital Epidemiology of America.  
2008-2009 Executive Education Program for Section Chiefs and Practice Managers. Tuck School of Business.

**Licensure and Certification:**

1993 State of New Hampshire, License no. 8898  
1993-2017 Diplomate, American Board of Internal Medicine.  
1996-present Diplomate, American Board of Internal Medicine, Subspecialty of Infectious Disease, American Board of Internal Medicine.  
2004 Credentialed, American Academy of HIV Medicine HIV Specialist

**Academic Appointments:**

1995-1997 Instructor in Medicine: Dartmouth Medical School.  
1997-2006 Assistant Professor of Medicine: Dartmouth Medical School.  
2006-present Associate Professor of Medicine: Dartmouth Medical School

**Hospital Appointments:**

1993-1995 Affiliate Clinical Staff, Mary-Hitchcock Memorial Hospital, Lebanon NH.  
1995-1997, 1999 Consultant Physician, Brattleboro Memorial Hospital, Brattleboro VT.  
1995-1997 Associate Clinical Staff, Mary-Hitchcock Memorial Hospital, Lebanon NH.  
1997-present Clinical Staff, Mary-Hitchcock Memorial Hospital, Lebanon NH.  
2002-present Voting Member, The Hitchcock Clinic.

**Other Professional Positions and Major Visiting Appointments:**

- 1995-1997 Program Director, Lyndonville VT Outreach Clinic of the Infectious Disease Section, Dartmouth-Hitchcock Medical Center, Lebanon NH.
- 1996-present Program Director, Manchester-Hitchcock Outreach clinic of the Infectious Disease Section, Dartmouth-Hitchcock Medical Center, Lebanon NH.

**Hospital and Health Care Organization Clinical Responsibilities:**

- 1995-present Attending Physician, Infectious Disease Section, Dartmouth-Hitchcock Medical Center, Lebanon NH
- 1997-2021 Program Director, Comprehensive Antimicrobial Program of Dartmouth-Hitchcock Medical Center, Lebanon NH.
- 7/99-2/00 Hospital Epidemiologist, Dartmouth-Hitchcock Medical Center, Lebanon NH

**Major Administrative Responsibilities:**

- 7/99-2/00 Acting Chief, Infectious Disease Section, Dartmouth-Hitchcock Medical Center, Lebanon NH
- 2002-present Medical Director, Hitchcock Clinic HIV Program.
- 2007-2014 Acting Chief, Section of Infectious Disease and International Health, Dartmouth-Hitchcock Medical Center, Lebanon NH
- 2014-present Chief, Section of Infectious Disease and International Health, Dartmouth-Hitchcock Medical Center, Lebanon NH

**Major Committee Assignments:**

**International:**

- 2003 Consultant, Kosovo HIV/AIDS Prevention Project (sponsored by Population Services International).
- 2005 Consultant, Guyana national HIV/AIDS Program.
- 2010 Consultant, Haiti national HIV/AIDS Program

**National and Regional:**

- 2001 Member and New Hampshire representative, ad hoc founding committee of the New England division of the American Academy of HIV Medicine.
- 2001-present Member and New Hampshire representative, New England Board of the American Academy of HIV Medicine.
- 2002 Consultant responsible for development of guidelines for the management of Hepatitis C infections, New Hampshire Department of Corrections.
- May 11, 2004 Member, White Coat Day (physician lobbying effort for HIV funding, organized by AAHIVM and HIVMA), Washington D.C..
- 2004-present Member, Medical Advisory Committee to the New Hampshire AIDS Drug Assistance Program.

**Dartmouth-Hitchcock Medical Center:**

- 1994-1995 Committee Member, Infection Control Committee of Dartmouth-Hitchcock Medical Center
- 1995-1997 Ad hoc member of the Antimicrobial Subcommittee, with responsibility to develop a comprehensive antimicrobial policy, of the Pharmacy and Therapeutics Committee of Dartmouth-Hitchcock Medical Center, Lebanon NH.
- 7/99-2/00 Acting chair, Infections Committee, Dartmouth-Hitchcock Medical Center, Lebanon NH.
- 7/99-2/00 Acting co-chair, Antimicrobial Subcommittee of the Pharmacy and Therapeutics Committee of Dartmouth-Hitchcock Medical Center, Lebanon NH.
- 1997-present Committee member, Antimicrobial Subcommittee of the Pharmacy and Therapeutics Committee of Dartmouth-Hitchcock Medical Center, Lebanon NH.
- 1998-2004 Committee member, Internship Selection Committee, Department of Medicine, Dartmouth-Hitchcock Medical Center, Lebanon NH.
- 1999-2011 Coordinator, Infectious Disease Section weekly clinical conference, Dartmouth-Hitchcock Medical Center, Lebanon NH.
- 2001-2010 Committee member, CIS Steering Group (advisory to the Board of Governors), Dartmouth-Hitchcock Medical Center, Lebanon NH.

2004 Dermatology Residency internal review committee.  
3/10-present Blood Borne Pathogen Committee, Dartmouth-Hitchcock Medical Center, Lebanon NH.

**Professional Societies:**

1993-present Member, Northern New England Infectious Disease Society.  
1997-2010 Member, Vermont Medical Society.  
1996-present Member, American Society for Microbiology.  
1993-1997 Member-in-training, Infectious Disease Society of America.  
1997-present Member, Infectious Disease Society of America.  
1998-present Member, American College of Physicians.  
2000-2010 Member of the American Academy of HIV Medicine.  
2000-present Member, International AIDS Society.  
2001-present Member, HIV Medicine Association of the Infectious Disease Society of America.

**Community Service Related to Professional Work:**

2004 Outside senior thesis examiner, Marlboro College

**Editorial Boards:**

Ad hoc reviewer: *AIDS, Clinical Infectious Diseases, The Journal of Infectious Diseases, Clinical Therapeutics*

**Awards and Honors:**

1980 Cum Laude, Dartmouth College.  
1980 With Distinction in Biology, Dartmouth College.  
1983 Roy Albert Prize for "outstanding work in the field of anthropology."  
1996 Red Ribbon Physician Award of the Granite State AIDS Consortium "In recognition of Outstanding Medical Care to People Living with HIV/AIDS."

**Report of Teaching:**

1. Narrative report.

My interest in teaching is a reflection of my clinical focus – the care of people living with HIV/AIDS (PLWHA). The dramatic reduction in morbidity and mortality from HIV/AIDS in the U.S. in the last 10 years has been the result of a remarkable synergy between clinical and basic research, translated through the practice of expert clinicians. I thus hope not only to contribute to the development of expert clinicians but also to stimulate an awareness and understanding of the process of medical science that has led to the benefits now open to PLWHA in resource-rich settings.

HIV care is now truly a specialty of its own, so I consider my most important audience those who are actively involved in the care of PLWHA. To further this within the DHMC ID Section I have initiated two programs for the ID fellows. First, I established and run a biweekly one hour teaching session with the ID fellows, during which time we discuss sophisticated issues in the management of HIV infection. And second, I established an HIV teaching clinic at the Manchester Hitchcock Clinic, during which time I mentor the senior DHMC ID fellows in the care of a significant number of HIV patients. I believe that the combination of these two teaching venues has significantly improved the competence in HIV care of the ID fellows who graduate from our program.

I also provide training to established HIV experts both locally and regionally. At DHMC I am the most up-to-date and informed of the HIV providers and act as a resource to the other members of the section. Within the region I accept any and all opportunities to provide HIV training to other HIV treaters, most consistently by providing twice annual updates for the HIV providers in the southern region of the state and in Portland, Maine.

Finally, I have now provided significant training and education in HIV medicine to lead HIV physicians from Kosovo, Tanzania, and Guyana.

In addition to working with clinicians who are expert in HIV care I do feel a commitment to providing appropriate education to non-experts. The HIV mini-elective for DHMC medicine residents is the only structured exposure the residents have to HIV medicine, and I commit several hours per week to this activity.

2. Local contributions.

Dartmouth-Hitchcock Medical Center and Dartmouth Medical School

- June, 2008      Primer on "The Diagnosis, Prevention, and Management of Tuberculosis" for the staff of the Dartmouth College Health Service  
Lecturer  
12 physicians and other clinicians
- 5, 2005      "An introduction to HIV" in Anthropology 17 (The Anthropology of Health and Illness)  
Instructor  
Large undergraduate class at Dartmouth College  
One 1 hour didactic presentation
- 2004-present      Infectious Disease Section fellow didactic training in HIV/AIDS  
Instructor and discussion leader  
3 ID fellows  
Two 1 hour didactic and discussion sessions/month
- 2002-present      Infectious Disease Section fellow clinical training in HIV/AIDS  
Clinical instructor  
2 senior ID fellows  
One 3-4 hour intensive HIV clinic/month at the Manchester outreach clinic
- 2002      Medical Grand Rounds (HIV Update), DHMC
- 2000-present      Infectious Disease Updates for the staff of the Dartmouth College Health Service  
Lecturer  
8-12 physicians and other clinicians  
One session/year, one hour of contact time, 3 hours of preparation
- 1998      Medical Grand Rounds (HIV Update), DHMC
- 1997-2010      HIV for the primary care provider  
Lecturer and panel discussant in an annual program presented by the DHMC ID Section  
10-30 audience members  
One hour of contact time, 5 hours of preparation
- 1997- present      Infectious Disease Block, Scientific Basis of Medicine, DMS  
Lecturer and small group leader  
70 DMS2 students for lectures, 20 for small groups  
5 hours of contact time, 10 hours of preparation
- 1997- present      HIV mini-elective at DHMC  
Director and instructor  
12-18 PGY-2/3 medicine residents/year  
3 hours/week
- 1997- present      Infectious Disease Service, Department of Medicine  
Instructor.  
1-3 DMS-4 and DOM residents rotating on the ID inpatient consult service  
8 weeks/year, 1-2 hours/day of clinical teaching

3. Regional, national, or international contributions.

- June, 2008      Grand Rounds at Valley Regional Hospital: "Updates in HIV Testing Guidelines."  
Lecturer  
17 physicians
- April, 2008      "CROI Conference Update" for southern NH HIV physicians  
Lecturer  
12 physicians and other clinicians

- April, 2008 "HIV Update" for Society of NH Pharmacists  
Lecturer  
80 pharmacists
- September, 2005 HIV/AIDS training for many Guyanese physicians  
Principal instructor in a national training course in Guyana  
5-8 hours/day for 1 week
- June, 2005 HIV/AIDS training for many Tanzanian physicians and students  
Director and instructor (didactic and clinical) in Tanzania  
5-8 hours/day for 2 weeks
- May, 2005 HIV/AIDS training for many Guyanese physicians and students  
Director and instructor (didactic and clinical) in Guyana  
5-8 hours/day for 1 week
- 2003 HIV/AIDS training for two Infectious Disease physicians from Kosovo  
Director and instructor  
2 hours/day for 2 weeks
- 2003 HIV/AIDS training for one Infectious Disease physician from Tanzania  
Director and instructor  
2 hours/day for 2 weeks
- 2001-present HIV updates for HIV specialists affiliated with the Hitchcock Clinic HIV Program  
Lecturer  
4-8 physicians and other clinicians  
Twice per year  
2 hours of contact time, 5 hours preparation/session
- 2000 Dartmouth Community Medical School, Fall series  
Lecturer in an evening program on HIV/AIDS  
Approximately 50 audience members  
Two evening sessions, 10 hours preparation
- 1997-present Grand Rounds at regional hospitals on various subjects (e.g. HIV, HCV, Community acquired pneumonia).  
Lecturer  
20-50 physicians  
1-3 times/year  
1 hour contact time/lecture, 5-10 hours of preparation
4. Teaching awards received.
5. Major curriculum offerings, teaching cases or innovative educational programs developed.
- 2005 Formalization of an annual curriculum for the ID fellowship bimonthly HIV training course first established in 2004
- 2004 I developed the first series of scheduled didactics/case based discussions within the ID Section for the ID fellows. We meet twice per month to discuss sophisticated aspects of the care of people living with HIV/AIDS.
- 2002 I developed a new training experience in the clinical management of HIV/AIDS for the DHMC ID fellows. This consists of an intensive 3-4 hour HIV clinic once per month, during which I provide teaching in the medical care of people living with HIV and training in the development of coordinated care plans with affiliated care providers and community based organizations.
6. Education funding.

- 1998-present I have received a small amount of funding (variable but always <0.05 FTE) from the New England AIDS Education and Training Grant
- 1997-present The DHMC DOM committed to 0.10 FTE salary support for HIV teaching for the DOM residents, but I have never drawn on this support.

**Report of Research Activities:**

1. Current research projects

- 2005-present Co-investigator for *STIRR Intervention for Dually Diagnosed Clients*.
- 2005-2006 PI for GlaxoSmithKline phase 3 trial of a new class of HIV antiviral (CCR5 blocker).
- 2004-2005 PI for Bristol Myers Squibb IMPACT trial, an observational trial of HIV resistance to antiviral therapy.
- 2004-2005 PI for GlaxoSmithKline ALOHA trial, a phase 4 trial of antiviral therapy.

2. Research funding information

- 2005-2008 Co-investigator. The STIRR Intervention for Dually Diagnosed Clients. NIMH, \$10,412/year, 4/05-present; PI Stanley Rosenberg.
- 2000-2002 Co-investigator. Treatment of Chronic Viral Infections in Patients with Severe Mental Illness. New Hampshire State Hospital, \$32,000 one time grant.
- 1998-2000 PI. A pilot Study of Dual Skin Testing with *M. avium* Sensitin and PPD in Health Care Workers with a 10-14 mm PPD Reaction. Department of Medicine, Dartmouth-Hitchcock Medical Center, \$10,568.
- 1997-2001 Co-investigator. A survey of Tuberculosis and Sexually Transmitted Diseases. CDC, \$62,112/year, 9/97-9/01; PI C. Robert Horsburgh.

**Non-research grant funding information:**

- 2002-present PI and Medical Director. Southern NH Integrated Care, an HIV/AIDS Early Intervention Services Program. DHHS, Ryan White Title III EIS Program, \$340,000/year total.
- 2000-present Co-investigator. New England AIDS Education and Training Center. DHHS, \$66,500/year total; \$800/year salary support; sub-contract PI Richard Waddell.

**Report of Clinical Activities:**

I have two main clinical activities.

1. My major clinical focus is on the management of people living with HIV/AIDS (PLWHA). As such I have developed true expertise in this area and am confident that my knowledge and clinical skills are comparable to those of regional and national experts. I see HIV-infected patients both at DHMC and at the Hitchcock Clinic in Manchester, NH, and I now care for more PLWHA than does any other provider in northern New England.

My interest in HIV has also been evidenced in my role as the Medical Director for the Hitchcock Clinic HIV Program, which I took on in 2002. As the Medical Director I have been committed to a process of integration and expansion and have helped steward the development of what is now a large regional program which receives close to 1 million dollars in grant funding annually to support patient care, HIV education, and other services. This program is about to undergo another significant expansion in the coming year with the addition of three new physicians within the ID Section, all of whom will be, amongst other responsibilities, providing HIV clinical care.

2. In addition to my focus on HIV I remain committed to being an expert general Infectious Disease clinician. I continue to spend eight to twelve weeks per year on the Infectious Disease inpatient service, during which time I care for patients with the entire range of infectious diseases seen in the population served by DHMC; and I care for patients with general infectious diseases in my outpatient clinic at DHMC.

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## Original Articles:

1. von Reyn CF, Green PA, McCormick D, Huitt GA, Marsh BJ, Magnusson M, Barber TW. Dual Skin Testing with *Mycobacterium avium* Sensitin and Purified Protein Derivative: An Open Study of Patients with *M. avium* Complex Infection or Tuberculosis. *Clinical Infectious Diseases* 1994; 19:15-20.
2. Pinto-Powell R, Olivier KN, Marsh BJ, Donaldson S, Parker HW, Boyle W, Knowles M, Magnusson M, von Reyn CF. Skin testing with *Mycobacterium avium* Sensitin to Identify Infection with *M. avium* Complex in Cystic Fibrosis. *Clinical Infectious Diseases* 1996; 22(3):560-562.
3. von Reyn CF, Arbeit RD, Yeaman G, Waddell RD, Marsh BJ, Morin P, Modlin JF, Remold HG. Immunization of healthy adult subjects in the United States with a three dose series of inactivated *Mycobacterium vaccae*. *Clinical Infectious Diseases*. *Clinical Infectious Diseases* 1997; 24(5): 843-848.
4. Marsh BJ, von Reyn CF, Edwards J, Tosteson A, Arbeit RD, International MAC Study Group. The risks and benefits of childhood BCG immunization among adults with AIDS. *AIDS*. *AIDS* 1997; 11(5): 669-672.
5. Marsh BJ, von Reyn CF, Arbeit RD, Morin P. Immunization of HIV-infected adults with a 3 dose schedule of inactivated *Mycobacterium vaccae*. *The American Journal of Medical Sciences* 1997; 313 (6):377-383.
6. von Reyn CF, Marsh BJ, Waddell R, Lein AD, Tvaroha S, Morin P, Modlin JF. Cellular immune responses to mycobacteria after a five dose schedule of *Mycobacterium vaccae* among healthy and HIV-positive subjects in the United States. *Clinical Infectious Diseases* 1998; 27: 1517-1520.
7. von Reyn CF, Williams D, Horsburgh CR, Jaeger AS, Marsh BJ, Haslov K, Magnusson M. Dual skin testing with *Mycobacterium avium* sensitin and purified protein derivative to discriminate pulmonary disease due to *M. avium* complex from pulmonary disease due to *Mycobacterium tuberculosis*. *Journal of Infectious Diseases* 1998; 177:730-736.
8. Brunette MF, Drake RE, Marsh BJ, Torrey WC, Rosenberg SD, and the Five-Site Health and Risk Study Research Committee. Responding to blood-borne infections among persons with severe mental illness. *Psychiatric Services* 2003; 54 (6):860-865.
9. Rosenberg SD, Swanson JW, Wolford GL, Osher FC, Swartz MS, Essock SM, Butterfield MI, Marsh BJ, and the Five-Site Health and Risk Study Research Committee. The Five-Site Health and Risk Study of blood-borne infections among persons with severe mental illness. *Psychiatric Services* 2003; 54 (6):827-835.
10. Marsh BJ, San Vicente J, von Reyn CF. Utility of dual skin tests to evaluate tuberculin skin test reactions of 10-14 mm in healthcare workers. *Infection Control and Hospital Epidemiology* 2003;24:821-824.
11. Rosenberg S, Brunette M, Oxman T, Marsh B, Dietrich A, Mueser K, Drake R, Torrey W, Vidaver R. The STIRR Model of Best Practices for Blood-Borne Diseases Among Clients with Serious Mental Illness. *Psychiatric Services* 2004; 55 (6):660-664.
12. Rosenberg SD, Drake RE, Brunette MF, Wolford GL, Marsh BJ. Hepatitis C virus and HIV co-infection in people with severe mental illness and substance use disorders. *AIDS* 2005; 19 (suppl 3):S26-S33.
13. Reed C, von Reyn CF, Chamblee S, Ellerbrock TV, Johnson JW, Marsh BJ, Johnson LS, Trenchel RJ, Horsburgh CR. Environmental risk factors for infection with *Mycobacterium avium* complex. *American Journal of Epidemiology* 2006;1 64(1):32-40.
14. Lahey T, Lin M, Marsh B, Curtin J, Wood K, Eccles B, von Reyn CF. Increased Mortality in Rural Patients with HIV Patients in New England. *AIDS Research and Human Retroviruses* 2007; 23 (5): 693-98.
15. O'Donnell M, Chamblee S, von Reyn CF, Ellerbrock TV, Johnson J, Marsh BJ, Moreland JD, Narita M, Pedrosa M, Johnson LS, Horsburgh CR. Racial Disparities in Primary and Reactivation Tuberculosis in a Rural Community in the Southeastern U.S.. *International Journal of Tuberculosis and Lung Disease* 2010; 14(6): 733-40.

16. Horsburgh CR Jr, O'Donnell M, Chamblee S, Moreland JL, Johnson J, Marsh BJ, Narita M, Johnson LS, von Reyn CF. Revisiting Rates of Reactivation Tuberculosis: a Population-Based approach. *American Journal of Respiratory and Critical Care Medicine* 2010; 182 (3): 420-5
17. Larson EM, O'Donnell M, Chamblee S, Horsburgh CR, Marsh BJ, Moreland JD, Johnson LS, von Reyn CF. Dual skin tests with *M. avium* sensitin and PPD to detect misdiagnosis of latent tuberculosis infection. *International Journal of Tuberculosis and Lung Disease* 2011; 15(11): 1504-9.
18. O'Donnell MR, Chamblee S, von Reyn CF, Marsh BJ, Moreland JD, Narita M, Johnson LS, Horsburgh Jr CR. Sustained reduction in Tuberculosis Incidence Following a Community-Based Participatory Intervention. *Public Health Action* 2012 in press.

**Proceedings of Meetings:**

**Clinical Communication:**

1. Lewis F, Marsh BJ, von Reyn CF. Fish Tank Exposure and Cutaneous Infections Due to *Mycobacterium marinum*: Tuberculin Skin Testing, Treatment, and Prevention. *Clinical Infectious Diseases* 2003; 37:390-397.

**Reviews, Chapters, and Editorials:**

1. Marsh BJ. Infectious Complications of HTLV-I Infection. *Clinical Infectious Diseases* 1996; 23(1):138-145.
2. Marsh BJ. A life-threatening adverse reaction during trimethoprim-sulfamethoxazole desensitization in a previously hypersensitive patient infected with human immunodeficiency virus. *Clinical Infectious Diseases* 1997; 25:754-755 [correspondence].
3. Marsh BJ. Human T-cell lymphotropic virus type I does not increase human immunodeficiency virus viral load in vivo. *Journal of Infectious Diseases*, *Journal of Infectious Diseases* 1997; 176:543-544 [correspondence].
4. Zegans M, Marsh B, Walton RC. Cytomegalovirus Retinitis in the Era of Highly Active Antiretroviral Therapy. *International Ophthalmology Clinics* 2000;40(2):127-135.
5. Kinlaw WB, Marsh B. Adiponectin and HIV-Lipodystrophy: Taking HAART. *Endocrinology* 2004, 145:484-486 [News & Views].
6. Mistler LA, Brunette MF, Marsh BJ, Vidaver RM, Luckoor R, Rosenberg SD. Hepatitis C Treatment for People with Severe Mental Illness. *Psychosomatics* 2006;47(2):1-15.

**Books, Monographs and Textbooks:**

1. Marsh BJ. A Critique of Optimal Foraging Theory in Anthropology. M.A. Thesis, University of Chicago, May, 1983.
2. Marsh BJ, et al.. Institutional Protocols for Decisions about Life-Sustaining Treatments - Special Report OTA-BA-389. U.S. Congress Office of Technology Assessment, Washington, D.C.: U.S. Government Printing Office, July, 1988.

**Abstracts:**

1. Marsh BJ, von Reyn CF, Edwards J, Tosteson A, Arbeit RD, International MAC Study Group. The risks and benefits of childhood BCG immunization among adults with AIDS. *Infectious Disease Society of America 34th Annual Meeting*. New Orleans, Louisiana. September 18-20, 1996.
2. Marsh BJ, von Reyn CF, Waddell R, Morin P, Remold HG, Arbeit RD. Immunization of HIV-infected adults with a 3 dose schedule of inactivated *Mycobacterium vaccae*. *4th Conference on Retroviruses and Opportunistic Infections*. Washington, DC. January 22-26, 1997.

3. von Reyn CF, Williams DE, Horsburgh CR, Jaeger AS, Marsh BJ, Haslov K, Magnusson M. Dual skin testing with *Mycobacterium avium* sensitin and purified protein derivative to discriminate pulmonary disease due to *M. avium* complex from pulmonary disease due to *Mycobacterium tuberculosis*. Infectious Disease Society of America 35th Annual Meeting. San Francisco, CA. September 13-16, 1997.
4. Siegel CA, Bensen SP, Marsh BJ, Robertson DJ, Waddell R, et al. Skin testing to evaluate the association between Crohn's disease and mycobacterial infection. American College of Gastroenterology Annual Meeting. Seattle, WA October 18-23, 2002.
5. Rosenberg S, Marsh BJ, et al. Obstacles to the diagnosis and treatment of Hepatitis C among patients with severe mental illness. 14<sup>th</sup> International AIDS Conference. Barcelona, Spain. July 7-12, 2002
6. Ellerbrock TV, Chamblee S, Bush TJ, Johnson J, Marsh BJ, Lowell P, von Reyn CF, Scoles L, Horsburgh CR. Decreased HIV Prevalence in a Rural U.S. Community between 1986 and 2000. 10<sup>th</sup> Conference on Retroviruses and Opportunistic Infections. Boston, MA. February 10-14, 2003.

**Other Published Material:**

## Curriculum Vitae

**DATE PREPARED:** December 2022

**NAME:** Elizabeth A. Talbot, MD

### I. EDUCATION

<u>DATE</u>	<u>INSTITUTION</u>	<u>DEGREE</u>
Sept 1988 – May 1992	The Robert Wood Johnson Medical School, University of Medicine and Dentistry of New Jersey, Piscataway NJ	MD
Sept 1984 – May 1988	Mount Holyoke College, South Hadley MA, <i>Magna Cum Laude</i> – Thesis: “Latent <i>Chlamydia trachomatis</i> infections in cultured McCoy cells”	Bachelor of Arts
Sept 1980 – June 1984	Point Pleasant Borough High School, Point Pleasant NJ	High School Diploma

### II. POSTDOCTORAL TRAINING

<u>DATE</u>	<u>SPECIALTY</u>	<u>INSTITUTION</u>
July 1998 – June 2000	Epidemic Intelligence Service Officer, International Activities, Division of TB Elimination	U.S. Centers for Disease Control and Prevention (CDC), Atlanta GA
July 1995 – June 1998	Infectious Disease Fellowship, Laboratory of Mycobacterial Genetics	Duke University Medical Center, Durham NC
Oct 1996	Hospital Epidemiology Training Course	SHEA/CDC, San Antonio TX
Feb 1996	Clinical Management and Control of TB	National Jewish Center for Immunology and Respiratory Medicine, Denver CO
July 1993 – June 1995	Internal Medicine Residency	Duke University Medical Center, Durham NC
July 1992 – June 1993	Medicine-Psychiatry Internship	University of Iowa Hospitals and Clinics, Iowa City IA

### III. PROFESSIONAL DEVELOPMENT ACTIVITIES

<u>DATES</u>	<u>TITLE</u>	<u>INSTITUTION</u>
June 2019	Humanitarian Action: Challenges in 21 <sup>st</sup> Century	Summer Institute, McGill University, Montreal CA

May 2022

Page 2

Winter 2019	Climate Change	United Nations online training
Nov 2018	High Threat Infectious Disease Response Training	National Ebola Training and Education Center, Boston MA
Dec 2018	Nontuberculous Mycobacterial Clinical Training	National Institutes of Health, Bethesda MD
May 2017	Wilderness Medicine Course	Wilderness Medicine Institute, Santa Fe NM
Sept 2016	Tropical Medicine Update Course	American Society of Tropical Medicine and Hygiene, Houston TX
Oct 2014	Ebola Deployment Preparedness Training	Center for Domestic Preparedness, CDC, Aniston Alabama
Feb 2014	Treatment of Nontuberculous Mycobacteria mini-fellowship	National Jewish Center for Immunology and Respiratory Medicine, Denver CO
Feb 2012	National Incident Management System training 100, 200 and 300	NH DHHS, Concord NH
Oct 1996	Hospital Epidemiology Training Course	SHEA/CDC, San Antonio TX
Feb 1996	Clinical Management and Control of TB	National Jewish Center for Immunology and Respiratory Medicine, Denver CO
Mar - July 1994	International Clinical Research Training Program	Duke University Medical Center, Vitoria Brazil
Mar - April 1992	Medical Student Clerkship	London School of Hygiene and Tropical Medicine, London UK

#### IV. ACADEMIC APPOINTMENTS

<u>DATE</u>	<u>TITLE</u>	<u>INSTITUTION</u>
Nov 2020 - present	Professor	Dartmouth Medical School, Department of Medicine, Lebanon NH
July 2009 - Nov 2019	Associate Professor	Dartmouth Medical School, Department of Medicine, Lebanon NH
July 2003 - July 2009	Assistant Professor	Dartmouth Medical School, Department of Medicine, Lebanon NH
July 2000 - July 2003	Associate Director, TB/HIV Research	BOTUSA Project, CDC, Botswana

May 2022

Page 3

**V. INSTITUTIONAL LEADERSHIP ROLES**

<u>DATES</u>	<u>INSTITUTION</u>	<u>TITLE</u>
Jan 2019 - Present	Dartmouth Global Health Leadership	Member
Aug 2016 - Present	Dartmouth Center for Healthcare Equity	Associate Director for Research
July 2004 - Present	DHMC International Health Clinic	Medical Director
2004 - 2021	Co-chair of Readiness and Response to Epidemic Infectious Disease Threats Subcommittee	DHMC
July 2007 – July 2016	Associate Medical Director for Infection Prevention and Control	DHMC, Lebanon NH
Fall 2010 - Present	Medical Committee for Medical Exemption from Mandatory Influenza and COVID-19 Vaccination	DHMC, Lebanon NH

**VI. LICENSURE AND CERTIFICATION**

May 2018	Buprenorphine Waiver for medication-assisted treatment for substance use disorder
Oct 2010	Civil Surgeon for US Citizenship and Immigration Services
Nov 2006	Diplomate, Tropical Medicine and Hygiene (ASTMH)
April 2006	Commissioned Officer, US DHHS, FDA
July 2005	Travel Medicine Certification, International Society of Travel Medicine
July 2003	New Hampshire, Medical License 12111
Nov 1998	Diplomate, Infectious Disease
July 1995 – July 2004	North Carolina, Medical License
1995 - 2015	Diplomate, American Board of Internal Medicine
1992	Diplomate, National Board of Medical Examiners

**VII. HOSPITAL APPOINTMENTS**

<u>DATE</u>	<u>POSITION/TITLE</u>	<u>INSTITUTION</u>
July 2003 – Present	Staff Physician, Infectious Disease and International Health Section	DHMC, Lebanon NH

May 2022

Page 4

**VIII. OTHER PROFESSIONAL POSITIONS (NON-DARTMOUTH)**

<u>DATE</u>	<u>POSITION/TITLE</u>	<u>INSTITUTION/ORGANIZATION</u>
Aug 2022 - Present	Member	TB Interest Group, Regional, Hosted by Boston Medical Center
Sept 2020 - 2022	Branch Chief	Vaccine Allocation Strategy Branch, COVID-19 Response Team, State of New Hampshire
2020- Present	Course Director	International Society of Travel Medicine, Virtual Review Course and Updates
April 2021	Member	NTM Research Consortium, Chair Kevin Winthrop MD, OHSU
Nov 2021 - Present	COVID-19 Scientific Advisory Board	ResApp Health
March 2020 - 2022	Member	<u>State Disaster Medical Advisory Committee</u> , a Governor-appointed advisory committee for allocation of limited resources in the COVID public health emergency
Jan 2020 - Present	Subject Matter Expert	Incident Command, COVID-19 Response Team, State of New Hampshire
Jan 2020 - Present	Consultant, TB Biomarker Team	Gates Medical Research Institute, Cambridge MA
Sep 2021 - Present	Member, Safety Review Team	First-In-Human RSV Monoclonal Antibody Trial, Gates Medical Research Institute, Cambridge MA
Jan - Aug 2019	Medical Advisor, Region 1	CDC Crimson Contagion (pandemic influenza) National Functional Exercise Planning Committee, August 12-16 2019
2019 - Present	Medical Review Committee	National TB Controllers Association Annual Conference Planning Committee
2018 - 2022	Member	Clinical Advisory Committee, Insmad Inc, for amikacin liposomal inhalation Solution (ALIS or Arikayce)
Jan 2018-current	Member	Advisory Council, CDC Center of Excellence, Global Tuberculosis Institute, Newark NJ
April 2017 - current	Editorial Board	Rwandan Medical Journal
June - Dec 2016	Expert Witness	Oxford Immunotec v Qiagen (patent infringement case involving TB diagnostic)
Dec 2016	Member	TB Latent Infection Surveillance System Workgroup, CDC

May 2022

Page 5

2015 and 2016	Member	Planning Committee for Integrated STD/HIV/HCV/TB Conference, Division of Public Health Services (DPHS), NH DHHS, Concord NH
2016	Member	Planning Committee for High Threat Pathogens Conference, DPHS, NH DHHS
2016 - Present	Clinical Advisor	Antimicrobial Resistance Advisory Workgroup, DPHS, NH DHHS
2015-2018	Member	Zika Planning Committee, DPHS, NH DHHS
2014 – 2016	Training Coordinator	Ebola Technical Unit, International Medical Corps, Washington DC, and two deployments to Sierra Leone
2014-5	Member	CDC Infection Control and Response (ICAR, US Ebola Readiness) Team, DPHS, NH DHHS
2013 – Present	Member	Hospital Acquired Infections Technical Advisory Workgroup, DPHS, NH DHHS
2011 - 2015	Consultant	Foundation for Innovative New Diagnostics (FIND), Geneva Switzerland
July 2007 – 2011	Medical Scientist	FIND, Geneva Switzerland
Aug 2009 - Present	TB Medical Director	DPHS, NH DHHS
Aug 2009 - 2011	Medical Advisor	NH DHHS
2003 – 9 and 2011 – Present	Deputy State Epidemiologist	NH DHHS
July 2007 – 2020	Member, New Diagnostics Working Group	STOP TB Partnership, Geneva
2003 – Present	Subject Matter Expert	DPHS, NH DHHS Incident Management Team. Example events include COVID-19, nosocomial HCV, anthrax exposure/case, Ebola, Zika, Eastern Equine Encephalitis Outbreak, nosocomial CJD exposure, widespread perfluorchemical contamination, nosocomial fungal infection of corneal transplants, legionella
July 2004 – 2007	Research Director	DPHS, NH DHHS

May 2022

Page 6

July 2000 – Commander with US Commissioned Corps  
2003 Top Secret Security Clearance

July 2000 – Team Leader for Division of TB Elimination, CDC, Atlanta GA  
July 2003 TB/HIV, International Activities

## IX. TEACHING ACTIVITIES

### A. UNDERGRADUATE (NON-MEDICAL) EDUCATION

Date	Institution	Course Title	Role	Hours
Apr 11, 2022	Dartmouth College	Women in Medicine	Panelist	3
Feb 6, 2020	Dartmouth College	Global Health Scholars Program Conference Series	Guest Lecturer on Impact of Climate Change on Emerging Infectious Diseases	2
April 5, 2019	Dartmouth College	National Public Health Week Lecture Series	Climate Change panelist, representing role of climate change on infectious diseases and human health	2
2015-2021, 2013, 2011, 2009, 2006, 2005	Dartmouth College	Global Health Elective	Lectures in Ebola, global pandemics, influenza pandemics, malaria, MDR TB, COVID-19	1/year
2001-3, 2022	Dartmouth College	Human Biology 46	Guest Lecturer: Response to Humanitarian Disasters; Emerging Infections	1/year
Oct 17 2016	Dartmouth College	Approaching uncertainty and failure in the practice of medicine: Patients, Policy and the International Health	Cholera in Haiti	1

May 2022

Page 7

2021, 2019, 2016, 2017	Dartmouth College	BIOL 46: Microbiology BIOL 11 VIROLOGY	Guest lectures for emerging infections such as Ebola, Zika and COVID-19	1
April 11 2016	Dartmouth College	Global Health Scholars Program Conference Series	The Zika Outbreak	2

**B. GRADUATE (NON-MEDICAL) EDUCATION**

Date	Institution	Course Title	Role	Hours
Apr 27, 2022	Dartmouth	Virology	Public Health Perspectives on Emerging Viral Diseases	2
Sept 4 2018	The Dartmouth Institute (TDI)	Epidemiology and Biostatistics	Teach ID Epidemiology	2
Mar 3 2016	TDI		Public Health Preparedness: The Ebola and Zika examples	3
2016-2021	Dartmouth, including Geisel, Tuck, TDI and undergraduates	Global Health Case Studies (elective)	Presented case studies of Ebola Virus Outbreak Response and Zika Virus	3/year
May 20 2015	Thayer	Medical Diagnostics and Monitoring	Created lecture Development of Diagnostics for Poverty-Related Disease	2

**C. UNDERGRADUATE MEDICAL EDUCATION****CLASSROOM TEACHING**

Date	Institution	Course Title	Role	Hours
2005- 2007, 2010, 2012- 2021	Geisel School of Medicine at Dartmouth (Geisel)	Scientific Basis of Medicine (SBM)	I teach the didactic lectures focused on international health, travel medicine and parasitology, as well as serving as a small group leader for the infectious diseases portions of the course.	6-8/year

May 2022

Page 8

2009, 2010, 2013- 2018	Geisel	Medical Microbiology	I teach the lectures on TB, Leprosy and Nontuberculous Mycobacteria	2/year
2007	Geisel	Infectious and Tropical Disease Elective	Filariasis: A Case Study of the Poverty Cycle	1

**CLERKSHIP TEACHING**

Since 2003, I have clinically supervised medical students in inpatient and outpatient settings of the Section of Infectious Disease and International Health.

**D. GRADUATE MEDICAL EDUCATION**

Date	Institution	Course Title	Role	Hours
Feb 14 2018	Dartmouth Hitchcock Medical Center (DHMC)	Medical Grand Rounds	Speaker: Outbreaks in the Anthropocene	1
Dec 6 2017	DHMC	AIDS Seminar	Co-lecturer with Dr. Lisa Adams on Global TB-HIV Update	1
Once monthly since 2005	DHMC webinar for statewide clinicians	Trip and Tropical Topics	Organizer, director, speaker for 50%	1/month, exclusive of administration
Sept 10 2015	DHMC	Pulmonary Fellow Didactic Series, Dartmouth Hitchcock	Nontuberculous Mycobacterial Infection Diagnosis and Treatment	1
2003-current	DHMC	ID fellows conference	Lectures focused on outbreak investigation, mycobacterial diseases, international health, travel medicine and parasitology	1/quarter
July 23 2004	DHMC	Medical Grand Rounds	Outbreaks and Public Health Preparedness, New Hampshire 2003- 2004	

May 2022

Page 9

May 7 2009	DHMC	HIV Translational Research Conference	Urine Lipoarabinomannin Detection for TB Diagnosis in Tanzania	1
2008, 2009	DHMC	ICU lecture series	I lecture in sepsis	1/year
2005, 2009, 2015	DHMC	Primary Care Residents Lecture series	Travel medicine	1/year
2005-current	DHMC	Internal Medicine Residents conference	Lecture in travel medicine; zoonotic, parasitic, bioterrorism, mycobacterial diseases	3-4/year
Sept 13 2013	Elliot Hospital, Manchester NH	Medical Grand Rounds	Tuberculosis Updates: New Drugs, New Diagnostics, New Hope	1
Dec 20 2013	DHMC	Medical Grand Rounds	Dartmouth's Impact in Rwanda: Developing Human Capital for Sustainable Health	1
Dec 13, 2013	DHMC	Medical Grand Rounds	Outbreaks in 2013: Relevance to DHMC Clinicians	1
Aug 30 2013	The Dartmouth Institute	Lecturer	Crash Course in Travel Medicine	3
2013	CHUB, Butare Rwanda	Medical residents infectious disease lectures	Through Clinton Foundation, HRH,	2/week for 3 months
2014-2017	Hopital Universitaire Mirebalais, Haiti	Medical residents infectious disease lectures	Partners in Health	1/week

#### E. OTHER CLINICAL EDUCATION

- Beginning ~January 2020, I lead standing statewide educational opportunities COVID-19 pandemic including
  - Weekly long term care facility partners' webinar
  - Weekly (16 months) then QOW school partner call
  - Weekly (18 months) then QOW clinical partners' science review
  - 7 Project Echo series, including as course director for 3 series dedicated to vaccine hesitancy
  - Many ad hoc lectures

May 2022

Page 10

- During Zika epidemic in Americas, provided multiple educational outreaches to regional and DHMC clinicians. For example, I presented in multiple conference calls to review testing algorithms for pregnant women and provided formal didactic at the NNEPQIN meeting in April 2017.
- During the Ebola epidemic in West Africa, I participated in the development of clinical training curriculum and established "Ebola University" with International Medical Corps for incoming clinicians to take care of patients in the Ebola Treatment Units and provided on-site teaching during two deployments to Sierra Leone.
- Alice Werbel RN and I applied and were successful to apply for Dartmouth Haiti Earthquake Relief Fund (Rose M. Murphy and John Butterly administrators) in order to provide on-site mannequin-based 'train the trainers' clinical education to Hopital Universite Mirabelais, Haiti, during 2014 and 2015.
- Since 2003, I have clinically supervised infectious disease fellows and internal medicine residents in inpatient and outpatient settings of the Section of Infectious Disease and International Health
- Inclusive of instruction of residents and fellows during clinical practice.
- I have also initiated education initiatives in Haiti (through PEPFAR and DOMACE funding, see below)
- For 3 months on site (May 20-July 30 2013), I served as infectious diseases subspecialist providing didactic and clinical teaching on infectious and tropical diseases as part of the Rwandan national medical curriculum redesign in Butare Rwanda through the Clinton Foundation Human Resources for Health.

## X. ADVISING/MENTORING (NonResearch)

### A. UNDERGRADUATE STUDENTS

<u>DATES</u>	<u>STUDENT'S NAME</u>	<u>PROGRAM</u>
2019-Present	Christophe T. Courtine	Emergency COVID-19 Intern, NH DHHS
2008-10	Katherine E. Ferguson	Presidential Scholar
2015	Tara Kedia	Rodis Fellow

### B. GRADUATE STUDENTS

<u>DATES</u>	<u>STUDENT'S NAME</u>	<u>PROGRAM NAME</u>
2019-Present	Taylor Selembo	CDC Public Health Associate at NH DHHS
2017	Hannah Leeman MPH	CDC Public Health Associate at NH DHHS

### C. MEDICAL STUDENTS

<u>DATES</u>	<u>STUDENT'S NAME</u>	<u>PROGRAM NAME</u>
2017	Tolulope O. Kehinde	Global health career advice
2012-4	Kristen M Jogerst	PEPFAR funded work in Haiti

July 2000 – June 2003: Direct primary supervisor to 8 U.S. medical school students (each on 6 month on-site elective), Botswana, US CDC

May 2022

Page 11

**D. RESIDENTS/FELLOWS**

<u>DATES</u>	<u>MENTEE'S NAME</u>	<u>SPECIALTY</u>
2014-15	Leway Kailani (ID Fellow)	Ebola DEVOTE team
2014-201	Laura Shevy (ID Fellow)	Ebola DEVOTE team
2014-2015	Jessie Leyse (ID Fellow)	Ebola DEVOTE team
2015-2017	Merly Robert (ID Program Director)	Partners in Health, Haiti
2015-2016	Nessa Meshkaty (ID fellow, U Mass)	Partners in Health, Haiti
2017-Present	Suthanya Sornprom (ID Fellow)	Fellowship Mentor

**XI. RESEARCH TEACHING/MENTORING****A. UNDERGRADUATE STUDENTS**

<u>DATES</u>	<u>STUDENT'S NAME</u>	<u>PROGRAM</u>
2019-Present	Christophe Courtine	Emergency COVID-19 Intern at NH DHHS
2012	Katherine Ferguson	Presidential Scholar

**B. GRADUATE STUDENTS**

<u>DATES</u>	<u>STUDENT'S NAME</u>	<u>PROGRAM NAME</u>	<u>DEGREE</u>
2021 -Present	Rattanaorn Mahatanan	The Dartmouth Institute	MPH
2019- Present	Taylor Selembo	CDC Public Health Associate	BS
2019	Ritika Zijoo	The Dartmouth Institute	MPH
2019	Varahi Travedi	The Dartmouth Institute	MPH
2017-2021	Hannah Leeman	CDC Public Health Associate	BS
2016-2018	Hannah Bowman	NH DHHS	MPH
2016-2018	Christiaan A. Rees	Thayer	PhD
2016-2018	Theodore R. Mellors	Thayer	PhD

**C. MEDICAL STUDENTS**

<u>DATES</u>	<u>STUDENT'S NAME</u>	<u>PROGRAM NAME</u>
June -July 2016	Kara Abarcar	CHE-Dickey International Health Fellowship

**D. RESIDENTS/FELLOWS/RESEARCH ASSOCIATES**

<u>DATES</u>	<u>STUDENT'S NAME</u>	<u>SPECIALTY</u>
2021-Present	Rattanaorn Mahatanan (ID Fellow)	ID: Nontuberculous mycobacteremia
2021-2022	Anais Ovalle (ID Fellow)	ID: Nontuberculous mycobacteremia
2019-2020	Mark Abel (ID Fellow)	ID: Tropical medicine
2016-2019	Martha Desbiens (ID Fellow)	ID: TB; ID complications of substance use
2015-2019	David DeGijssel (ID Fellow)	ID: TB; ID complications of substance use
2014-2017	Laura Shevy MD (ID Fellow)	ID: multiple
2012-2014	Scott Crabtree MD (ID Fellow)	ID: IGRA research
2014-2019	Jessie Leyse MD (ID Fellow)	ID: Travel medicine
2006-8	David Blaney MD	Epidemic Intelligence Service, CDC
2004-8	Rachel Plotinsky MD	Epidemic Intelligence Service, then ID

May 2022

Page 12

2000-2

Lisa J Nelson, MD, MPH

Epidemic Intelligence Service, CDC

**E. FACULTY****DATES**

2015-2020

2014-15

**MENTEE'S NAME**

Benjamin Chan MD, MPH

Anne Mathew MD

**SPECIALTY**

NH DHHS State Epidemiologist

ID, DHMC then Nashua NH

**XII. COMMUNITY SERVICE, EDUCATION, AND ENGAGEMENT**

<b>Date</b>	<b>Conference, Institution</b>	<b>Title</b>	<b>H/yr</b>
<b><u>Regional:</u></b>			
Nov 18, 2022	New Hampshire Infection Control and Epidemiology Professionals Annual Conference, Manchester NH	Emerging Infectious Diseases: The What's and the Why's	2
Apr 28, 2022	New England Association for Professionals in Infection Control and Epidemiology Annual Conference	Beyond the COVID-19 Pandemic: Anticipating the Massive Enduring Impacts to Global Health	2
Apr 19, 2022	Granite State Healthcare Coalition Annual Meeting	The Tale of Two Locations: Addressing Vaccine Hesitancy and Ensuring Equitable Access in NYC & NH During the COVID-19 Pandemic	2
Apr 12, 2022	TB Clinicians' Intensive, Global TB Institute, Rutgers	TB Diagnosis	2
Jan 21, 2022	New Hampshire Infection Control and Epidemiology Professionals Annual Conference, Virtual	The Other, Older Cough Illness: Tuberculosis	2
March 30, 2020	Upper Valley Long Term Care Association	COVID-19 Guidance for Long Term Care Facilities	1
Weekly since March 27, 2020 - 2022	Statewide LTCF Clinician Webinar	Long-term Care Facility Clinicians COVID-19 Updates	1h/w
March 25, 2020	NH Laboratory Reference Network monthly meeting	COVID-19 Diagnostics	1
March 24, 2020	NH Hospitals' Chief Medical Officer Webinar	COVID-19 NH Update	1
Weekly since March 20, 2020 - Present	Statewide Clinician Webinar	COVID-19: The Latest Science for Clinicians	1h/w

May 2022

Page 13

March 13, 2020	Medical Grand Rounds, Elliot Hospital	COVID-19: An Update on a Dynamic Situation for Busy Clinicians	1
March 6, 2020	Manchester and Nashua Health Department staff	COVID-19 Emergency Briefing	2
March 2, 2020	State of NH	COVID-19 Briefing for State Officials including Senators Shaheen and Hassan	2
Feb 27, 2020	Public Lecture sponsored by Dartmouth Center for Global Health Equity	US Emergency Legal Response to Novel Coronavirus	2
June 21, 2019	Global TB Institute Monthly TB Grand Rounds, Webinar	Mycobacteri-o-rama: TB and NTM Clinical Considerations	1
June 14, 2019	Emergency Preparedness Conference	Emerging Infections Relevant to New Hampshire	1.5
April 1, 2019	New England TB Clinicians Conference, Global TB Institute	Top 10 Updates in TB Diagnosis, Prevention, and Treatment	1.5
March 20 2019	NH Antimicrobial Stewardship Symposium	Culturing Stewardship Together/Animal and Human Case Studies (Session Moderator)	1.5
Jan 31 2019	The Exchange, NH Public Radio (call-in show), NPR	Winter Infections	1
June 1 2018	TB: Beyond the Basics	Two lectures: Latent TB Infection Updates and The TB Diagnostics, Treatment and Vaccine Pipeline	3
May 23 2018	NH Antimicrobial Stewardship Symposium	Global Perspectives on Antimicrobial Resistance and Antimicrobial Stewardship	1
April 19 2016	Global TB Institute Monthly TB Grand Rounds, Webinar	TB Tenosynovitis: Case and Review of the Literature	1
Mar 31 2016	Institute for Local Public Health Practice, Manchester NH	3 lectures: Emerging Infections, Vaccine Preventable Diseases and TB	3
Mar 24 2016	Nashua City Health Department, Dartmouth Hitchcock-Nashua	Most Important TB Breakthroughs: World TB Day	2
Mar 24 2016	High Threat Pathogens Conference, DPHS, NH DHHS, Concord NH	Opening remarks, then lecture on Update on Emerging Infections	1.5

May 2022

Page 14

Mar 23 2016	NH Immunization Conference, Manchester NH	Emerging Infectious Diseases	2
Mar 22 2016	Oxford Immunotec, Marlborough MA	Top Ten Tuberculosis Updates	1
Mar 16 2016	The Science Café, Nashua NH	The Zika Epidemic	3
Feb 19 2016	NH Laboratory Network Meeting	Zika Soup to Nuts	0.5
Sept 21 2016	Ohler Speaker Series, New London Hospital, New London H	Emerging Infections	2
Mar 31 2015	26th Mason Library Lecture, Keene State College	Primer to Conduct Outbreak Investigations	2
2012, 2011, 2009, 2008	Dartmouth College Advanced Medical School	Several lectures: Extensively drug resistant TB, Superbugs and Antibiotic use, TB Diagnostics	2
2015 and 2016	DPHS, NH DHHS Integrated STD/HIV/HCV/TB Conference, Concord NH	Top 10 TB Breakthroughs (2015) and TB plenary lecture and LTBI testing and treatment workshop (2016)	3
Nov 3, 2015	Northeast Ambulatory Nurses' Network Quarterly Meeting, Manchester NH	Plenary: Global Health Security and lecture: What's New in Infectious Diseases	1
Nov 6 2015	New Hampshire Infection Control and Epidemiology Professionals Annual Conference, Concord NH	Biosecurity and the Importance of Infectious Disease Preparedness at All Levels – Even in New Hampshire	1
Oct 9 2015	Public Health Symposium, St. Anselm	Hepatitis C: Epidemiology, Testing and Treatment	1.5
Oct 15 2015	Infection Control Day, New Hampshire Healthcare Association Annual Conference, Concord NH	What's Trending in Infectious Diseases	1
May 21 2015	Connecticut Department of Corrections Webinar	TB Updates for Correctional Facilities	1
May 20 2015	New England TB Clinicians Conference, Clark University, Worcester MA	TB: An Annual Review	1
Aug 27 2014	DPHS NH DHHS Webinar	Ebola Update	1
Aug 20 2014	DPHS NH DHHS Webinar	Case Discussion: MERS Co-V	1
Aug 13 2014	DPHS NH DHHS Webinar	MERS Co-V Update	1

May 2022

Page 15

Nov 2 2013	New Hampshire Assistant Deputy Medical Examiner Meeting	Outbreak Investigations for Medical Examiners	1
Oct 18 2013	Vermont Infectious Diseases Conference, Vermont Department of Health, Burlington VT	Emerging Global Threats	1
Oct 18 2013	Latebreaker Session of the Northeast Epidemiologists Conference, Burlington VT	Creutzfeld Jacob Disease Investigation, NH	1
Oct 14 2013	NH Society of Health System Pharmacists, Manchester NH	Rational Control of Respiratory Viruses	1
Sept 13 2013	Elliot Hospital Medical Grand Rounds, Manchester NH	Tuberculosis Updates: New Drugs, New Diagnostics, New Hope	1
Sept 11 2013	Maine Annual TB Conference, Center for Disease Control, Lewiston ME	TB Global and Local Trends	1
Sept 11 2013	Maine Annual TB Conference, Center for Disease Control, Lewiston ME	Managing Challenging TB Cases	1
Aug 23 2013	Elliot Hospital Medical Grand Rounds, Manchester NH	Respiratory Viruses with Pandemic Potential	1
April 29 2013	Clinical Care of Refugees Conference, DPHS, NH DHHS, Manchester NH	Top TB Issues for Refugee Care	1
April 29 2013	Clinical Care of Refugees Conference, DPHS, NH DHHS, Manchester NH	Case-based Parasite Review	1
March 27 2013	New England Immunization Conference, NH DHHS, Manchester NH "	Global Outbreaks: Just a Plane Ride Away	1
March 22 2013	Annual Occupational Medicine Conference, Frisbie Hospital, Rochester NH	National Nosocomial Outbreaks: New Hampshire's Role	1
March 13 2013	Cheshire Medical Center Medical Grand Rounds, Kean NH	National Nosocomial Outbreaks: New Hampshire's Role	1
Feb 13 2013	NH Ambulatory Surgery Association Annual Meeting, Concord NH	Two Ambulatory Surgery Center Outbreaks: HCV and Fungal Meningitis	1

May 2022

Page 16

Feb 7 2013	NH Public Health Institute, Manchester NH	Communicable Disease Transmission by Air, Droplet and Droplet Nuclei	1
Sept 25 2013	New London Hospital Medical Grand Rounds, New London NH	Travel Medicine for Primary Care	1
March 2012	"Update on Immunizations"	New England Immunization Conference, NH DHHS, Manchester NH	1
Nov 18 2011	TB 101 course, sponsored by NH DHHS, Concord NH	TB Epidemiology: Powerful Hypnotic or Useful to Your Clinical Practice?	1
Oct 26, 2011	Annual Meeting of Northeast American Society of Microbiology, Waltham MA	The Pipeline of TB Diagnostics	1
June 10, 2011	TB: Beyond the Basics, NH DHHS and NJMS Global TB Center, Manchester NH	Myth Busters! TB Infection Control	1
June 10, 2011	TB: Beyond the Basics, NH DHHS and NJMS Global TB Center, Manchester NH	What's New in TB Diagnosis?"	1
March 23, 2011	TB Control Program NH DHHS, Concord NH	Xpert MTB/RIF: Evidence, WHO Policy Recommendations and Roadmap	1
Jan 26, 2011	TB Control Program NH DHHS, Concord NH	TB Diagnostics Update	1
March 25, 2010	Grand Rounds, Massachusetts General Hospital, Boston MA	CPC Case 25-2010 discussant	1
May 11, 2009	Managing Medical Emergencies Conference, Lebanon NH	Travel Medicine Emergencies	1
April 1, 2009	NH Laboratory Managers, Lebanon NH	IGRA Update	1
March 27, 2009	TB Clinical Conference for Physicians, New England Regional Training & Medical Consultation Consortium, York ME	The Most Important TB Publications: A Power Review	1
Jan 12, 2009	Colby Sawyer College, New London NH	Top Ten Tropical Medicine Issues for US Clinicians	1

May 2022

Page 17

March 29, 2008	TB Clinical Conference for Physicians, NE Regional Training & Medical Consultation Consortium, Waltham MA	Tuberculosis Diagnostics: New Developments	1
Oct 29, 2007	TB 2007: Recent Advances for an Ancient Disease, Nashua NH	Top Ten Differential TB Diagnoses	1
Oct 29, 2007	TB 2007: Recent Advances for an Ancient Disease, Nashua NH	Frontiers in TB Diagnosis	1
Jan 24, 2007	Eliminating TB Case by Case Series of Northeast TB Control Programs, Regional TB Webinar	Managing Hepatitis During TB Treatment	1
Nov 9, 2006	Managing Medical Emergencies Conference, Concord NH	What if the Chicken Crosses the Road? Scientific Update of H5N1 in Humans	1
Oct 26, 2006	Northeast Epidemiology Conference, Saratoga Springs NY	Eastern Equine Encephalitis Control in NH.	1
Sept 29, 2006	TB 2006: Recent Advances for an Ancient Disease, Rochester NH	Top Ten Differential TB Diagnoses	1
Sept 29, 2006	TB 2006: Recent Advances for an Ancient Disease, Rochester NH	Blood-Based Testing for Latent Tuberculosis Infection	1
Sept 25, 2006	Pandemic Influenza Summit, Concord NH	How Recent Science Informs Pandemic Influenza Planning	1
Aug 17, 2006	Medical Grand Rounds, Androscoggin Valley Hospital, Berlin NH	The Changing Epidemiology of <i>C. difficile</i>	1
July 12, 2006	Medical Grand Rounds, Littleton Regional Hospital, Littleton NH	<i>C. (more) difficile</i> : Changing Epidemiology of <i>C. difficile</i>	1
June 21, 2006	Clinical Care of Refugees Conference, Manchester NH	Top Ten Infectious Disease Issues for Newly-Arrived Refugees	1
Jan 11, 2006	Workshop sponsored by NH Hospital Association, Concord NH	Controlling Multi-drug Resistant Microorganisms in Acute and Long-term Care Facilities	1
Jan 6, 2006	Medical Grand Rounds, Littleton Regional Hospital, Littleton NH	Pandemic Influenza Preparedness	1
Dec 15, 2006	Medical Grand Rounds, Cottage Hospital, Woodsville NH	Pandemic Respiratory Infection in the Healthcare Setting	1

May 2022

Page 18

Oct 6, 2005	Medical Grand Rounds, Alice Peck Day Hospital, Lebanon NH	Arbovirus Update: Eastern Equine Encephalitis in New Hampshire	1
Sept 30, 2005	Medical Grand Rounds, Memorial Hospital, North Conway NH	Community-Acquired MRSA	1
Sept 14, 2005	Medical Grand Rounds, Lakes Region General Hospital, Laconia, NH	Update on Avian Influenza	1
Aug 10, 2005	Medical Grand Rounds, Littleton Regional Hospital, Littleton NH	Public Health Preparedness	1
July 2005	Medical Grand Rounds, Androscoggin Valley Hospital, Berlin NH	Outbreak Investigations 101	1
June 2005	Workshop sponsored by NH Hospital Association, Concord NH	Controlling Multi-drug Resistant Microorganisms in Acute and Long-term Care Facilities	1
May 2005	Medical Grand Rounds, Cheshire Medical Center, Keene NH	Bacterial Meningitis in New Hampshire	1
Jan 11, 2005	Medical Grand Rounds, Exeter Hospital, Exeter NH	Your Friendly Neighborhood Health Department: A Year in Review	1
Nov 18, 2004	Managing Medical Emergencies Conference, Rochester NH	Public Health Emergencies, 2004	1
Oct 14, 2004	Northeast Epidemiology Conference, Meredith NH	New Hampshire Takes on Multidrug Resistant Organisms	1
Feb 11, 2004	DHHS Forensic Epidemiology Course, Concord NH	New Hampshire Response to SARS...and Beyond	1
Dec 2003	Tufts University, Boston MA	Public Health and Emergency Response in Africa	1
Aug 28, 2003	NH DHHS, Concord NH	Lessons from an African Field Site	1
Oct 2, 2003	St. Joseph Hospital CME Program, Nashua NH	Meningitis Update	1
Feb 1995	Duke University Medical Center, Durham NC	The Interaction of HIV and Tropical Diseases	1

**National:**

May 2022

Page 19

March 11, 2020	Gates Medical Research Institute	COVID19: The latest science and state and federal perspectives on transition from containment to mitigation strategies	1
June 26, 2019	National Webinar, Oxford Immunotec	LTBI Surveillance or TB Elimination? A Rational Approach to Healthcare Personnel Screening	2
Feb 14 2018	National Webinar, Oxford Immunotec	Diagnosing TB in the US: Your Vital Role	3
Oct 2 2013	Annual TB Medical Consultants Meeting, Global Tuberculosis Institute, Newark NJ	Great News for Mycobacteriophiles	1
Dec 5 2011	2011 American Society of Tropical Medicine and Hygiene, Philadelphia PA	Symposium Chair, Symposium #60: Clinical Update: What's New in the Literature?	2
Oct 20 2011	TB Update Session, 2011 Infectious Disease Society Annual Meeting, Boston MA	Molecular TB Diagnostics	1
Oct 6 2010	New Tools Roundtable at the Regional Training and Consultation Meeting in Newark NJ	TB Diagnostics: What's New?	2
<b><u>International:</u></b>			
Feb 2-5 2022 - Present	North American Regional Meeting of the International Union of TB and Lung Disease, Vancouver CA	Multiple roles: Abstract committee, poster facilitator, clinical subcommittee	5
Dec 14 2018	International Webinar: TB CARE2 (USAID)	A Toolkit for Delivery Models to Improve IPT for Children and People Living with HIV: Results and Next Steps (with Lisa V. Adams, David DeGijssel, Samson Haumba)	1
Dec 3 2015	Sponsored Symposium at the International Union of TB and Lung Disease, Cape Town, RSA	Global IGRA and LTBI Guidelines: Practical Implications for Resource-Constrained Settings	2
May 27 2015	Workshop, International Travel Medicine Society Annual Conference, Quebec Canada	The Most Important Travel Medicine Papers in 2015	1

May 2022

Page 20

Nov 12 2012	American Society for Tropical Medicine and Hygiene Annual Conference Atlanta GA	Tuberculosis Update for Tropical Medicine Practitioners	1
March 23 2011	CoreTB Educational Series, Webinar	Xpert MTB/RIF: Evidence, WHO Policy Recommendations and Roadmap	1
Nov 2 2010	FHI Malaria Consultation Conference, Research Triangle Park, NC	Updates and Imperatives for Malaria Diagnosis	2
May 17 2010	American Thoracic Society International Conference, New Orleans, LA	TB Diagnostics: A New Era	1
Nov 5 2007	Fogarty Conference on Reducing Mortality from HIV-TB, Dar es Salaam Tanzania	Update on New TB Diagnostics	1
May 30, 2006	Global Health Council Annual Conference, Washington DC	The TB Diagnostic Pipeline	1
Feb 19, 2002	International TB/HIV Conference, WHO/CDC/USAID, Nairobi Kenya	International Research Ethics: The Botswana Experience	1
July 23-26, 2002	Workshop on the Ethical Review Complex Protocols, U.S. CDC, Francistown Botswana	Key Elements in the Ethical Review of Research" and "Research Confidentiality	1
July 19, 2000	International Conference on Emerging Infectious Diseases, Atlanta GA	A Tale of Three Studies: Behavioral Research to Improve Health Communications for HIV Control in Botswana	1
June 17, 1997	Chiang Mai University, Chiang Mai Thailand	The Search for New Life Forms Using the 16S rDNA PCR Target	1
May 30, 1997	Chiang Mai University, Chiang Mai Thailand	Molecular Epidemiology of <i>Mycobacterium tuberculosis</i>	1

**Other Teaching Activities:**

April 3-4 2013. Organized and spoke at "Radiology and New Diagnostics for TB Diagnosis in Haiti" Workshop funded by PEPFAR, Les Cayes Haiti

May 2010: Clinical response team to Haiti for laboratory and clinical technical assistance after the January 12, 2010 earthquake.

2003 - 2010: Participated in children's education programs at local parish, Our Lady of Fatima, including assisting 1<sup>st</sup> - 4<sup>th</sup> grade Sunday school and leading the Christmas pageant.

May 2022

Page 21

April – July 1997: Taught scientific English writing and conversation to Thai scientists, Chiang Mai University, Chiang Mai Thailand

February – March 1993: Development project volunteer. Conducted disease and nutrition survey in rural Ethiopian villages. World Vision, Ethiopia

February 1992: Medical clerkship. Assisted in primary care of Qunnault Indian Nation through the Public Health Service. Taholah Indian Reservation, Taholah WA

Summer 1989: Medical intern. Provided medical services in a mobile medical mission. Medical Group Missions, Azua Dominican Republic

Summer 1987: Medical intern. Participated in first aid, education and nutrition projects among rural Ifugua people. Batad Medical Mission, Banaue Philippines

Summer 1986: Research intern. Studied potential angiogenesis factors using rat and cell culture models. National Institutes for Health, Bethesda MD

### XIII. PAST RESEARCH FUNDING

Dates	Project title and award number	Role	% effort	Sponsoring agency
Oct 2010 – Nov 2017	TB Care II to USAID: five-year cooperative agreement	Researcher toward Isoniazid Preventive Therapy Implementation in Swaziland	0.08	PI: University Research Co., LCC ( <a href="http://tbcare.net/content/who-we-are-introduction">http://tbcare.net/content/who-we-are-introduction</a> )
Aug 2011 – Aug 2015	CDC-RFA-GH11-1191, "Improvement of Integrated HIV Clinical-based Services (Counseling and Testing, Prevention of Mother to Child Transmission, TB/HIV, Care and Treatment) Through Financial and Technical Assistance to Centers of Excellence in Haiti under the President's Emergency Plan for AIDS Relief (PEPFAR)"	TB-HIV technical advisor	0.1	PI: GHESKIO, Haiti
April 2010 through Jan 2013	USAID TB IQC Task Order 01, Contract No. GHN-I-00-09-00006	Technical assistance to revise Tanzania and Democratic Republic of Congo pediatric TB treatment	0.05 - .20 FTE	PI: PATH

May 2022

Page 22

		guidelines, train, implement and conduct monitoring and evaluation of implementation		
Oct 2014-2015	Dartmouth Haiti Earthquake Relief Fund	Co- PI with Alice Werbel RN: Providing a model of mannequin-based train the trainers clinical education to Hopital Universite Mirabelais, Haiti	\$10,000	Rose M. Murphy and John Butterly administrators
July 2008	Oxford Immunotec	"Specificity of T SPOT® TB in Low TB Risk Populations at Dartmouth College"	\$19,767	PI
July 2009	Oxford Immunotec	"Evaluation of T SPOT® TB Xtend in a High TB Incidence Setting, Dar es Salaam Tanzania"	\$70,000	PI
May 2007	Dartmouth Department of Medicine Research Grant funding	"Blood cultures and urinary LAM antigen detection for the diagnosis of tuberculosis among HIV-infected inpatients in Tanzania"	\$25,000	PI
2007	Dartmouth International Health Group and Infectious Disease Society Association	"Effects of highly active antiretroviral therapy on employment and social integration, Accra Ghana"	\$10,000	Principle Investigator: Isaac Howley (I served as his supervisor)
May 2006	Oxford Immunotec	"Evaluation of T SPOT® TB and QuantiFERON®-Gold Among Refugees and Healthcare Workers in New Hampshire"	\$41,987	

May 2022

Page 23

**XIV. PROGRAM DEVELOPMENT**

In the summer of 2019, I conceived and organized on behalf of DHMC a national monthly webinar series on management of challenging cases of nontuberculous mycobacterial infection. We have ~300 clinicians on our listserv, which I am co-managing with Keira Cohen MD at Johns Hopkins University

In fall 2019, I conceived, organized and emceed the DHMC Northern New England Travel Medicine Symposium for regional travel medicine practitioners. The first was in Meredith NH, and we are poised to repeat in November 2021, COVID-allowing.

I have led NH's participation in Sanofi Pasteur's Expanded Access Program for Stamaril, the nonFDA-approved yellow fever vaccine to be used during national shortage of YFVax

In 2017, I began a multidisciplinary nontuberculous mycobacterial (NTM) clinic, engaging Pulmonary Medicine, Outpatient Antibiotic Therapy (OPAT), Respiratory Therapy, Specialty Pharmacy, ENT, and others ad hoc, in order to provide the necessary comprehensive care for NTM patients. We have created protocols, clinical templates, and plan regional advertisement for patient recruitment. We will add translational and operational research within the year.

I began and continue to lead a monthly meeting called "Trip and Tropical Topics", which is a CME/CEU seminar to advance institutional educational opportunities within the subspecialty of travel and tropical infectious diseases. Medical students, residents, nurses and physicians attend this meeting, which is delivered in an in-person didactic format, plus available regionally through webinar format.

**XV. MAJOR COMMITTEE ASSIGNMENTS AND CONSULTATIONS****National/International:**

<b><u>DATES</u></b>	<b><u>COMMITTEE</u></b>	<b><u>ROLE</u></b>	<b><u>INSTITUTION</u></b>
Jan – Feb 2021	Clinical Committee	Member	North American Region of the International Union Against Tuberculosis and Lung Disease
Nov 2018 – current	Abstract Scientific Committee	Member	North American Region of the International Union Against Tuberculosis and Lung Disease
Jan 2018 – current	Advisory Council	Member	Global Tuberculosis Institute, Newark NJ
Oct 2014 - May 2015	Ebola Technical Unit	Training Coordinator	International Medical Corps
Nov 2011 - Jan 2014	TB Scientific Committee	Member	IMPAACT: International Maternal, Pediatric, Adolescent AIDS Clinical Trial Group, NIH-funded research consortium

May 2022

Page 24

Oct 2010 – 2015	Pediatric TB	Consultant	TB CARE II
Jan 2009 - June 2014	TB PANNET	Partner for FIND	TB PANNET is a translational research consortium funded by the European Commission's Seventh Framework Programme for Research (FP7). TB PAN-NET conducts basic and clinical research related to MDR-TB, TB control and molecular epidemiology Republic of Tanzania Ministry of Health
Dec 2009 – 2013	Working Group for Pediatric TB Guideline Revision and Implementation	Consultant through Program for Appropriate Technology for Health (PATH)	
Nov 2007 - Present	Working Group on New Diagnostics	Member	Stop TB Partnership, World Health Organization, Geneva Switzerland
Jan 2006 – July 2007	Critical Backup Team	Field consultant for investigation and pandemic influenza control	Council of State and Territorial Epidemiologists and CDC
March 2005 – June 2007	Control of Multidrug-resistant <i>Salmonella</i> in Ground Beef	Committee Member	Hosted by NH DHHS and Tufts University, Boston MA
Feb – May 2003	Antimicrobial Resistance Containment and Surveillance	Consultant to develop guidelines	World Health Organization, Geneva Switzerland
Feb – May 2003	Global Fund for AIDS, TB and Malaria	Consultant to develop guidelines for countries to prevent antimicrobial drug resistance	World Health Organization, Geneva Switzerland
Aug. 2002 – July 2003	Consortium to Respond Effectively to the AIDS-TB Epidemic	Member and Editorial Board Member	Johns Hopkins University, Baltimore MD
May 2000 – July 2003	STOP TB's TB/HIV Working Group	Member, with role to assist development of	World Health Organization, Geneva Switzerland

May 2022

Page 25

consensus on  
research priorities**Regional:**

<b><u>DATES</u></b>	<b><u>COMMITTEE</u></b>	<b><u>ROLE</u></b>	<b><u>INSTITUTION</u></b>
Oct 2013 - Present	Healthcare Quality Commission	Member of this Governor- appointed taskforce	State of NH
2003- Present	Refugee Health Committee	Co-organized and moderated conference, "Clinical Care of Refugees" 2005, 2006, 2013	NH DHHS/ Dartmouth College
Apr 2009 - Present	Novel H1N1 Clinical Guidance Committee	Member	NH DHHS, Concord NH
Mar 27 2009	Planning Committee	Co-organized "Tuberculosis: Power Update for Busy Clinicians"	Regional Training and Medical Consultation Center and MA Dept. of Public Health
Oct 11-12 2005	NH Assessment of National Public Health Performance Standards	Technical expert	NH DHHS
Jan 2004 - Present	NH Immunization Advisory Board	Member	NH DHHS
Nov 2003 - Present	NH Communicable Epidemic Control Committee	Founder, Chairman	NH DHHS
Oct 2003 - Oct 2004	Council of State and Territorial Epidemiologist Chapter (CSTE)	Co-organized and co- moderated "2004 Northeast Epidemiologist Annual Meeting" - Oct. 13-15, 2004	NH DHHS and CSTE
July 2003 - Present	NH TB Advisory Board	Member	NH DHHS

May 2022

Page 26

**Institutional:**

<b><u>DATES</u></b>	<b><u>COMMITTEE</u></b>	<b><u>ROLE</u></b>	<b><u>INSTITUTION</u></b>
Nov 3-6 2021	Planning Committee for Northern New England Travel Medicine Conference: Navigating Global Travel in the Pandemic Era	Lead	DHMC
Nov 22-24 2019	Planning Committee for Northern New England Travel Medicine Conference: Over the River and Through the Woods Safely,	Lead	DHMC
Fall 2017 - Present	Global Health Colloquium	Member	Dartmouth College
Jan 2013 - Present	Readiness and Response to Epidemic Respiratory Infections	Chair	DHMC
March 2011 - Present	Mandatory Influenza Vaccine Technical Committee	Member	DHMC
January 2010 - Present	Global Health Steering Committee	Member	Dartmouth College
July 2007 - Present	Hospital Infections Committee	Member	DHMC
May 2006 - May 2007	NH Medical Surge Planning Committee	Chairman	NH DHHS
July 2005 - Feb 2006	NH Pandemic Influenza Drill Planning Committee	Epidemiology and Clinical Consultant	NH DHHS
June 2005 - Present	Pandemic Influenza Preparedness Ethics Subcommittee	Member	NH DHHS
May 2005 - Feb 2006	Strategic Prevention Framework Epidemiology Working Group	Chairman	NH DHHS
March 2005 - June 2006	NH Bioterrorism Strategic Team	Member	NH DHHS
Jan 2005 - Present	TB Interest Group for those at Dartmouth engaged in TB research	Founder and Chairman	DHMC
April 2005 - Present	Traveler's Health Group (monthly meeting for those who practice travel medicine)	Founder and Chairman	DHMC
Oct 2003 - Present	Epidemic Readiness Committee (epidemic respiratory infection preparation)	Member, Chairman since July 2007	DHMC

May 2022

Page 27

July 2003 – Present	Public Information Office (media communications)	Designated Contact	NH DHHS
July 2003 – Present	Emergency Physician on-call duty (Approximately bimonthly)	Member	NH DHHS
July 2003 – June 2007	Outbreak Investigation Weekly Rounds	Founder, Team Leader through June 2007	NH DHHS
July 2003 – Nov 2003	SARS Surveillance and Clinical Response for the State of NH	Working Group Chairman	NH DHHS

#### **XVI. MEMBERSHIPS, OFFICE & COMMITTEE ASSIGNMENTS IN PROFESSIONAL SOCIETIES**

<u>DATES</u>	<u>SOCIETY</u>	<u>ROLE</u>
2016 - 2020	National TB Controllers Association, working group on TB Latent Infection Surveillance (TBLISS)	Member
2005 – Present	International Society for Travel Medicine	Member
2003 – 2018	Northern New England Infectious Diseases Society	Member
1998 – Present	International Union Against TB and Lung Disease	Member
1996 – Present	American Society of Tropical Medicine and Hygiene	Member
1996 – 2000	American Society for Microbiology	Member
1995 – Present	Infectious Diseases Society of America	Member
1990 – Present	Alpha Omega Alpha	Member
1988 – 1999	Christian Medical and Dental Society	Member
1988 – 1999	American Medical Association	Member

#### **XVII. EDITORIAL BOARDS**

<u>DATES</u>	<u>ROLE</u>	<u>BOARD NAME</u>
May 2008	Reviewer	2009 Red Book Review Board – 28 <sup>th</sup> Edition, Chapter assignment Needlestick Injuries and Hansen's Disease (Leprosy). Editors Drs Pickering, Baker, Kimberlin and Long
Nov 2007	Reviewer, Scientific Panel	Global Health Council, Infectious Disease Track, for 2008 Annual Meeting

May 2022

Page 28

March 21- 23 2005	Member, Special Emphasis Panel	International Research in Infectious Disease (IRID) Program, National Institute of Allergy and Infectious Diseases (NIAID), NIH
June 2006	Member, Special Emphasis Panel	Tuberculosis Research Unit Contract Review, Division of Microbiology and Infectious Diseases, National Institute of Allergy and Infectious Diseases (NIAID), NIH
Aug 2002 – Present	Editorial Board Member	Consortium to Respond Effectively to the AIDS-TB Epidemic (CREATE)
Nov 2004 – Present	Editor	New Hampshire Communicable Disease Bulletin, a quarterly publication for US state epidemiologists and NH clinicians and partners

### XVIII. JOURNAL REFEREE ACTIVITY

Ad hoc reviewer for: Clinical Infectious Diseases, Tuberculosis, Pediatric Infectious Diseases; PLoS, Bone Marrow Transplantation; The International Journal of TB and Lung Disease; International Journal of Epidemiology; American Journal of Tropical Medicine and Hygiene

### XIX. AWARDS AND HONORS

<u>DATE</u>	<u>AWARD</u>
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2021	Bi-State Primary Care Association Award
2020	Long term Care Facility Award, sponsored by ARC and NHH
2016	United States Centers for Disease Control and Prevention TB Elimination Champion
2012	Nomination to CDC's Charles C. Shepard Science Award ( <a href="http://www.cdc.gov/niosh/awards/shepard/">http://www.cdc.gov/niosh/awards/shepard/</a> ) for Research: Samandari T, Agizew TB, Nyirenda S, Tedla Z, Sibanda T, Shang N, Mosimaneotsile B, Motsamai OI, Bozeman L, Davis MK, Talbot EA, Moeti TL, Moffat HJ, Kilmarx PH, Castro KG, Wells CD. Continuous isoniazid therapy is superior to six months to prevent tuberculosis in tuberculin-skin-test-positive HIV-infected adults in Botswana. <i>Lancet</i> 2011; 377: 1588-1598
2009	Nomination to CDC's Charles C. Shepard Science Award for Manuscript: Greene SK, Daly ER, Talbot EA, Demma LJ, Holzbauer S, Patel NJ, Hill TA, Walderhaug MO, Hoekstra RM, Lynch MF, Painter JA. Recurrent multistate outbreak of <i>Salmonella</i> Newport associated with tomatoes from contaminated fields, 2005. <i>Epidemiol Infect.</i> 2008;136(2):157-65
2007	Dartmouth College Department of Medicine Teaching Award for Excellence in Teaching
2006	Nomination to CDC's Charles C. Shepard Science Award for Assessment and Epidemiology

May 2022

Page 29

- 2005 Nomination to CDC's Charles C. Shepard Science Award for Assessment and Epidemiology
- 2004 Nomination to CDC's Charles C. Shepard Science Award for Assessment and Epidemiology
- 2002 Achievement Medal, U.S. Public Health Service
- 2002 Exemplary Service Award, NCHSTP, US CDC
- 2001 Foreign Service Medal, US Public Health Service
- 1999 Mary Lyon Award, Mount Holyoke College
- 1998 Dade MicroScan Young Investigator Award, American Society of Microbiology
- 1992 Association of Women Psychiatrists Dickstein Award
- 1992 Janet M. Glasgow Memorial Achievement Citation
- 1992 Elected to Housestaff Affairs Committee, University of Iowa
- 1991 Alpha Omega Alpha, Robert Wood Johnson Medical School
- 1989 National Institutes of Health Research Scholar (NIAID)
- 1988 - Mary P. Dole Medical Fellowship, Mount Holyoke College  
91
- 1988 Magna Cum Laude, High Honors, Mount Holyoke College
- 1987 Phi Beta Kappa, Mount Holyoke College
- 1987 Student Leadership Award, Mount Holyoke College
- 1986 Charles A. Dana Intern for Summer Research, National Institutes for Health

**XX. INVITED PRESENTATIONS:**

- (\*) I was extended an invitation to present  
 (#) I presented a poster/talk, but not following a personalized invitation  
 (^) if the talk/presentation was CME activity.

**International:**

<u>DATE</u>	<u>TOPIC/TITLE</u>	<u>ORGANIZATION</u>	<u>LOCATION</u>
#^Oct 21 2022	Matters of the Heart: A Scoping Review Toward Better Management of Nontuberculous Mycobacterial Infections of Cardiac Devices	ID Week (Infectious Disease Society of America Annual Conference)	Washington DC

May 2022

Page 30

*^Feb 2020	The social implications of participant choice on adherence to Isoniazid Preventive Therapy (IPT): A follow-up study to high completion rates in Eswatini	Latebreaker program of the North American Regional Meeting of the International Union of Tuberculosis and Lung Disease	Chicago IL
*^Oct 1, 2019	Better tracking of deadly complications of substance use – Report of a collaborative analysis between public health and an academic medical center to assess substance use-associated infective endocarditis	ID Week (Infectious Disease Society of America Annual Conference)	Washington DC
*^Oct 24, 2018	Integrated care and patient choice enable treatment completion of IPT in Swaziland	International Union Against TB and Lung Disease	The Hague, The Netherlands
*Sept 22 2016	Ethical Issues in the Zika Epidemic Response	Dartmouth Ethics Interest Group	Hanover NH
*^Sept 29 2016	Practical Aspects of Treatment of TB Infection	NH TB Conference	Manchester NH
*^Sept 29 2016	Case Based Approach to MDR TB Diagnosis and Treatment	NH TB Conference	Manchester NH
*Sept 30, 2016	Zika Updates Relevant to NH Clinicians	NH DHHS	NH Webinar
#July 12 2016	“Completion of Isoniazid Preventive Therapy among HIV Infected Patients in Swaziland”	Swaziland National Emergency Response Council on HIV and AIDS (NERCHA)	Mbane Swaziland
*July 3 2016	“Pediatric TB Treatment: Confirming the Basics and Preparing for Innovations”	Liangjiang International Pediatric Forum	Chongqing China
#^Nov 13, 2006	“Rapid implementation of a comprehensive control strategy including vaccination with Tdap in a hospital pertussis outbreak, New Hampshire 2006”	Infectious Disease Society of America Annual Conference Latebreaker Program	Toronto Canada
#^Aug 13-18 2006	“Characteristics of people living with HIV-1 screened for isoniazid preventive therapy - Botswana, 2004-6”	XVI International AIDS Conference	Toronto Canada

May 2022

Page 31

July 11-6 2004	“Diagnosing HIV and tuberculosis in children in Botswana”	XV International AIDS Conference	Bangkok Thailand
June 2003	“TB-HIV Research Priorities” (presenting author)	WHO TB-HIV Working Group Annual Meeting ;	Montreux Switzerland
Dec 1999	“Estimating the Impact of Different Treatment Strategies in Settings with High Rates of Multi-drug Resistant TB”	Tuberculosis Surveillance and Response Unit Conference	Tokyo Japan

**National:**

<b><u>DATE</u></b>	<b><u>TOPIC</u></b>	<b><u>ORGANIZATION</u></b>	<b><u>LOCATION</u></b>
*^June 2021	Focus on the Most Vulnerable: COVID-19 Outbreaks within New Hampshire Residential Facilities	Council of State and Territorial Epidemiologist	Virtual
*^Nov 17, 2021	Value of Whole Genome Sequencing during a Vancomycin Resistant Enterococci Cluster Investigation at an Acute Care Hospital, New Hampshire, 2019	Council of State and Territorial Epidemiologist, Healthcare Associated Infection/Antimicrobial Resistance Subcommittee Meeting	Virtual
*^April 8, 2019	Global TB Updates Relevant to US Microbiologists	Northeast Branch of the American Society for Microbiology and Northeast Assoc for Clin Microbiol and Infect Diseases	Portsmouth, NH
^April 23 2019	A Chronic Cluster of TB in a Low Incidence State: What Can be Done?	National TB Controllers Association Conference	Atlanta, GA
*^April 9, 2019	Trends in Infective Endocarditis: A Methodological Riddle	Northeast Branch of the American Society for Microbiology and Northeast Assoc for Clin Microbiol and Infect Diseases	Portsmouth, NH
*^June 4 2019	Trends of Infective Endocarditis at a Northern New England Academic Medical Center, from 2011 to 2017 - a Case for Improved Methods to Reliably Identify Associated Substance Use (abstract 11586)	Council of State and Territorial Epidemiologist Annual Meeting	Durham NC
*^June 10 2018	Small State, Big Collaboration: Creation of New Hampshire’s First Statewide Antibigram Guides Stewardship Efforts (abstract 9578)	Council of State and Territorial Epidemiologist Annual Meeting	West Palm Beach FL

May 2022

Page 32

*^May 21 2018	Novel TB Diagnostics: Urine, Breath, and Stool, Oh My!	National TB Controllers Association Annual Meeting	Palm Springs CA
#June 4 2017	A Cluster of Group A Streptococcus (GAS) Infection Among Persons Who Inject Drugs (PWID)	Council of State and Territorial Epidemiologist Annual Meeting, June 4-8, 2017	Boise, ID
#^June 20 2016	Workplace Safety Concerns Among Co-Workers of a Traveler Returning from an Ebola-Affected Country. Abstract 6139	Council of State and Territorial Epidemiologist Annual Meeting, June 19-23 2013,	Anchorage AK
June 12 2013	"National Nosocomial Hepatitis C Outbreak Investigation"	Council of State and Territorial Epidemiologists Annual Meeting	Pasadena CA
June 12 2013	"Hepatitis C Outbreak Investigation: Relevance of Controlled Medication Use Patterns"	Council of State and Territorial Epidemiologists Annual Meeting	Pasadena CA
Feb 20 2008	"Multistate Outbreak of <i>Salmonella</i> Typhimurium Associated with Consumption of Tomatoes in Restaurants", September–October 2006	Prevention Medicine Annual Meeting	Austin TX
June 26 2007	"Failure of the CSTE Case Definition to Exclude Pertussis During a Large Hospital Outbreak of a Cough Illness"	Council of State and Territorial Epidemiologists Annual Meeting	Atlantic City NJ
June 23 2007	"A Multistate Outbreak of <i>Salmonella</i> Oranienburg Infections Associated with Fruit Salad Served in Healthcare Settings - Northeastern United States and Canada, 2006"	Council of State and Territorial Epidemiologists Annual Meeting	Atlantic City, NJ
Apr 20, 2007	"Large Outbreak of Pertussis Like Illness at a Medical Center, New Hampshire, 2007"	Epidemic Intelligence Service Conference	Atlanta GA
Mar 5-8 2007	"Evidence for the ACIP Recommendations on Intervals and Administrative Sequence of Diphtheria Toxoid-Containing Vaccines"	National Immunization Conference	Kansas City MO
Mar 5-8 2007	"Safety of Tdap During a Mass Immunization of Healthcare Personnel"	National Immunization Conference	Kansas City MO
Nov 6, 2006	'Response to an Outbreak of Hepatitis A Among Illegal-Drug Users"	American Public Health Association	Boston MA

May 2022

Page 33

Nov. 6, 2006	"Pandemic Influenza Functional Exercise" – New Hampshire 2005	American Public Health Association	Boston MA
Nov 8, 2006	"An Evaluation of New Hampshire's Innovative Syndromic Tracking Encounter Management System (STEMS)"	American Public Health Association	Boston MA
Dec 14, 2005	"Lead Poisoning Among Refugee Children, New Hampshire"	American Public Health Association	Philadelphia PA
Apr 10, 2000	"Control of Drug Resistant TB, Botswana, 1999"	Epidemic Intelligence Service Conference	Atlanta GA
Apr 23, 1999	"TB in Foreign-born Persons, United States, 1993-1997"	Epidemic Intelligence Service Conference	Atlanta GA
Apr 25, 1999	"TB in Foreign-born Persons, United States, 1993-1997"	American Lung Association/American Thoracic Society International Conference	San Diego CA
Dec 2, 1996	Molecular Methods for the Identification of <i>Mycobacterium bovis</i> BCG	American Society of Tropical Medicine and Hygiene	Baltimore MD

**Regional/Local:**

<u>DATE</u>	<u>TOPIC</u>	<u>ORGANIZATION</u>	<u>LOCATION</u>
*^Nov 14, 2017	"Tuberculosis Primer"	Maine Centers for Disease Control Infectious Diseases Conference	Augusta ME
*^Oct 18 2017	MDR TB: A Primer for New England Clinical and Public Health Practioners	Northeast Regional Antimicrobial Resistance Conference "A Spectrum of Threat"	Northampton MA
Oct 25, 2012	"National Hepatitis C Outbreak: The Role of Public Health"	Annual Meeting of Northeast Epidemiologists	Meredith NH
Oct 26, 2006	"Safety of Tdap During a Mass Vaccination Campaign"	Annual Meeting of Northeast Epidemiologists	Saratoga Springs NY
Oct 27, 2006	"A Multistate Outbreak of <i>Salmonella</i> Oranienburg Infections Associated with Fruit Salad Served in Healthcare Settings—Northeastern United States, June – July 2006"	Late breaker program of Annual Meeting of Northeast Epidemiologists	Saratoga Springs NY

May 2022

Page 34

Nov 4, 2005	“Use of Intradermal Influenza Vaccine for Healthcare Workers During a Severe Vaccine Shortage”	Annual Meeting of Northeast Epidemiologists	Chatham MA
Sept 27, 2005	“TB Elimination in New Hampshire”	Northeast TB Controllers Meeting	Albany NY

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May 2022

Page 40

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May 2022

Page 41

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### **Guidelines and Other Scholarly Work**

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  - a. Medical Surge Guidelines
  - b. SARS Epidemic Preparedness Plan
  - c. SARS Surveillance and Clinical Response Guidelines
  - d. Recommendations for the Use of Antiviral Agents for Influenza
  - e. Recommendations for Prevention and Control of Multidrug-Resistant Organisms

May 2022

Page 42

## f. Refugee Health Provider Guideline

**Letters to the Editor:**

1. Blaney D, Daly ER, Kirkland KB, Tongren JE, Tassler Kelso P, **Talbot EA**, Use of Alcohol-Based Hand Sanitizers as a Risk Factor for Norovirus Outbreaks in Long-term Care Facilities in Northern New England, December 2006-March 2007. Response to Letter to Editor. *Am J Infect Control* 2012; 40: 191-2.
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**C. Abstracts:** oral and poster presentations.**Presented at National Meetings:**

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May 2022

Page 43

4. DesBiens M, Morse D, **Talbot EA**. Rethinking the contagion of laryngeal tuberculosis: Two case reports and literature review. Abstract. North American Regional Meeting of the International Union Against Tuberculosis and Lung Disease. Feb 2018, Chicago, IL.
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7. Abarcar K, **Talbot EA**. Improving Healthcare Provider Counseling of Pediatric Patients with TB and their Parents Using the Teach-Back Method. Abstract. Consortium of Universities for Global Health. April 2017, Washington DC.
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May 2022

Page 44

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May 2022

Page 46

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2. Leeman H, Hansen K, Chan BP, **Talbot EA**, Zimmermann C, Calderwood M, Dave A, Santos P. Small State, Big Collaboration: New Hampshire's Statewide Antibiograms Guide Stewardship Efforts. Abstract 72810. ID Week, Oct 3-7, 2018, San Francisco CA.
3. Gitzus JF, White JA, Caine L, Kansen K, Daly ER, Chan BP, Bowen H, Metcalf E, Pierce L, Kusch R, Benton C, Gao F, **Talbot EA**, Noble JT. An Outbreak of Invasive Group A Streptococcal Infections in Injection Drug Users. Abstract. Infectious Disease Society of America Annual Meeting, Oct 4-8 2017, San Diego CA.
4. Adams LV, **Talbot EA**, Mahlalela N, Ginindza S, Pasipamire M, Calnan M, Mazibuko S, Haumba S. Urgent Interventions to Improve Isoniazid Preventive Therapy Delivery in Swaziland Annual Meeting of the International Union Against Tuberculosis and Lung Disease, Oct 2016, Liverpool UK.
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9. **Talbot EA**, Blaney D, Taylor TH, Adams LV, Wieland-Alter W, von Reyn CF. Latent Class Analysis to Compare the Tuberculin Skin Test and Two Interferon-gamma Release Assays. International Union Against TB and Lung Disease, Berlin Germany, Nov 11-15, 2010.
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15. Kirkland KB, Ptak J, Smith R, Taylor E, **Talbot EA**. The Holy Grail: Successful Reduction of Healthcare-Associated Infection Rates through Improved Hospital Wide Hand Hygiene (abstract 4269). Infectious Disease Society of America Annual Meeting, Oct 25-28 2008, Washington DC.
16. Howley IW, Lartey M, Machan JT, Obo-Akwa A, Flanigan TP, **Talbot EA**, Kiwara A. Highly Active Antiretroviral Therapy and Effects on Employment, Accra, Ghana (abstract 2977). Infectious Disease Society of America Annual Meeting, Oct 25-28 2008, Washington DC.
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27. Nelson LJ, Davis A, McCrann CH, Sugo C, Sonoto R, Notha M, Bakgethis C, Wells CD, **Talbot EA**. Tuberculosis screening at a refugee camp in Botswana, 2003-2003. International Union Against TB and Lung Disease, Paris France, October 29-31 2003.
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41. **Talbot EA**, Kenyon TA, Halabi S, Moeti TL, More K, Binkin NJ. Knowledge, attitudes and beliefs regarding TB preventive therapy for HIV-infected persons living in Botswana, 1999. 11th International Conference on AIDS and STDs in Africa, Lusaka Zambia, September 12 - 16 1999.
42. Lishimpi K, Waddell RD, von Reyn CF, Chileshe R, Baboo KS, Zumla A, Chintu C, [Acknowledged]. Disseminated mycobacterial infections in HIV-positive children in Lusaka, Zambia [abstract 14PT55-24] in 11<sup>th</sup> International Conference in AIDS and STDs in Africa, Lusaka Zambia, September 12-16 1999.
43. Waddell RD, von Reyn CF, Boboo KS, et al. [Acknowledged]. Childhood BCG immunization and the subsequent risk of adult disseminated mycobacterial disease among AIDS patients in Lusaka, Zambia [abstract 737] in 5<sup>th</sup> Conference of Retroviruses and Opportunistic Infections, Chicago II, February 1-5 1998.
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#### MAJOR RESEARCH INTERESTS:

- Diagnosis of TB and latent TB infection in adults and children
- Impact assessment of tuberculosis diagnostic implementation
- Epidemic response and preparedness

#### Active Projects include:

- PI IND (IRBD19060) for use of clofazimine for NTM infections
- PI for DHMC participation in PTK 0796 phase 2bc study of omadacycline in patients with *M. abscessus*
- PI for DHMC participation in phase 3 EBO301 MACrO2 Study of eptraborole in refractory MAC patients
- Coinvestigator in Prospective Evaluation of a Standardized Approach to Diagnosis (PREDICT) and Treatment (PATIENCE) of Nontuberculous Mycobacteria Disease in Cystic Fibrosis
- PI for SPR720-202 for DHMC participation in phase 2 study of SPR720: A Randomized, Double-Blinded, Placebo-Controlled, Multicenter, Phase 2, Dose-Ranging Study to Evaluate the Efficacy, Safety, Tolerability, and Pharmacokinetics of SPR720 as Compared with Placebo for the Treatment of Patients with *Mycobacterium avium* Complex (MAC) Pulmonary Disease

#### MANUSCRIPTS IN PREPARATION:

1. AlSalman A, Mathewson A, Martin I, Rattanaporn M, **Talbot EA**. Confirmed Case of Locally Acquired Cystic Echinococcosis in New Hampshire. Submitted, Emerg Infect Dis J Dec 2022.
2. Nability SA, Marks SM, Goswami ND, et al for the NTCA/CDC TB-COVID-19 Collaboration. Characteristics and Mortality of 333 Patients with Tuberculosis and COVID-19 before COVID-19 Vaccine Availability in a Cross-sectional Sample from 26 U.S. Jurisdictions. Submitted to Emerg Infect Dis J Dec 2022.

May 2022

Page 52

3. Trivedi T, Talbot EA, McLellan R, Boyle P, Dube M. Engaging Healthcare Personnel in a Latent Tuberculosis Infection Surveillance System: Enacting New U.S. Guidelines. Planned for Fast Track Submission July to the Journal of Occupational and Environmental Medicine.

**Updated by: Dr Elizabeth A. Talbot**  
**This CV was last revised on Tuesday, March 21, 2023**

Contractor Name  
Key Personnel

Name	Job Title	Salary Amount Paid from this Contract
Bryan Marsh, MD	Program Director	\$331,641
Elizabeth Talbot, MD	Deputy State Epidemiologist	\$289,722