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

Lori A. Weaver
Commissioner

Katja S. Fox
Director

129 PLEASANT STREET, CONCORD, NH 03301
603-271-9544 1-800-852-3345 Ext. 9544
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December 5, 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 for Behavioral Health, to enter into a contract with Human Services Research Institute (VC#170337), Cambridge, MA, in the amount of $276,467 to conduct a behavioral health system crosswalk and gaps analysis in order to identify opportunities for New Hampshire to enhance services, reduce duplication and identify potential programmatic, funding, and policy opportunities that lead to improved integration within the behavioral health system and other healthcare and social systems to promote whole person health, with the option to renew for up to two (2) additional years, effective upon Governor and Council approval through November 30, 2024. 100% Federal Funds.

Funds are available in the following account for State Fiscal Years 2024 and 2025, 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.

05-95-94-940010-24650000 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: NEW HAMPSHIRE HOSPITAL, NEW HAMPSHIRE HOSPITAL, ARPA DHHS FISCAL RECOVERY FUNDS

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2024	102-500731	Contracts for Opr Svc	00FRF602PH9510A	$243,895
2025	102-500731	Contracts for Opr Svc	00FRF602PH9510A	$32,572
			Total	**$276,467**

EXPLANATION

The purpose of this request is for the Contractor to conduct a behavioral health system crosswalk and gaps analysis in order to identify opportunities for New Hampshire to enhance services, reduce duplication and identify potential programmatic, funding, and policy opportunities that lead to improved integration within the behavioral health system and other healthcare and social systems to promote whole-person health.

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The Contractor will identify and map current behavioral health programs, practices, and policies across the continuum of care, including prevention, intervention, treatment, recovery and harm reduction services; assess shared goals and gaps; conduct a crosswalk of the shared goals and gaps; facilitate work teams to improve integration, enhance services and identify programmatic, funding, and policy opportunities; and design sustainable assessment and management tools for the Department. The agreement prohibits the Contractor from having or acquiring any interest, direct or indirect, that would conflict in any manner or degree with the performance of these services and is required to immediately notify the Department of any potential conflicts of interest.

The Department will monitor services by reviewing the monthly progress, interim and final reports submitted by the Contractor, and through regularly scheduled meetings with the Contractor.

The Department selected the Contractor through a competitive bid process using a Request for Proposals (RFP) that was posted on the Department's website from September 11, 2023 through October 4, 2023. The Department received six (6) responses that were reviewed and scored by a team of qualified individuals. This was not a low-cost award; the Contractor received the overall highest combined technical and cost score. The Scoring Sheet is attached.

As referenced in Exhibit A, Revisions to Standard Agreement Provisions, 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 ability of the Department to move towards an integrated system of care focused on whole-person health will be diminished. Without an independent evaluation of the current systems' capacities, capabilities, and levels of integration necessary across systems, service delivery will remain fractured and siloed, and opportunities for braided funding, shared workforces and other collaboration of resources to make the most impact on NH's behavioral health system across the lifespan will remain limited; impacting access to and quality of the care received by individuals experiencing mental health conditions including substance use disorder.

Source of Federal Funds: Assistance Listing Number #93.958, FAIN #1B09SM08537-01.

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

Respectfully submitted,

Lori A. Weaver
Commissioner

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

Project ID # RFP-2024-DBH-04-BEHAV

Project Title Behavioral Health System Crosswalk and Gaps Analysis

	Maximum Points Available	Behavioral Health Improvement Institute at Keene State	Human Services Research Institute	Initium Health	Milliman, Inc	Public Consulting Group LLC	Third Horizon Strategies
Technical							
Experience (Q1)	50	45	45	35	46	40	38
Analysis Recommendations (Q2)	100	90	80	65	90	70	75
Health Equity Lens (Q3)	80	55	75	55	70	75	65
Systems Assessment (Q4)	80	70	68	40	73	65	55
Expertise (Q5)	100	80	82	85	85	85	75
Systems Integration (Q6)	110	92	85	85	95	85	65
Tool Design (Q7)	60	45	57	40	50	45	45
Recommendations (Q8)	60	55	55	45	51	47	45
Research (Q9)	60	55	50	30	50	40	45
Subtotal - Technical	**700**	**587**	**597**	**480**	**610**	**552**	**508**
If a Vendor fail to achieve 350 minimum points in the preliminary scoring, it will receive no further consideration from the evaluation team and the Vendor's Cost Proposal will remain unopened.							
Cost							
Vendor Cost	150	134	128	150	123	122	121
Vendor Budget Evaluation	150	125	140	100	50	90	80
Subtotal - Cost	**300**	**259**	**268**	**250**	**173**	**212**	**201**
TOTAL POINTS	**1000**	**846**	**865**	**730**	**783**	**764**	**709**
TOTAL PROPOSED VENDOR COST		$264,991.56	$276,466.50	$236,650.00	$288,640.00	$291,375.00	$293,500.00

	Reviewer Name	Title
1	Jennifer O'Higgins	Senior Policy Analyst
2	Reuben Hampton	Director, Office of Health Equity
3	Lauren Holden	Pediatric Mental Health Care Access Coordinator
4	Kyra Leonard	Finance Director
5	Susan Drown	Director, Bureau of Program Quality

Subject: Behavioral Health Systems Crosswalk and Gaps Analysis (RFP-2024-DBH-04-BEHAV-01)

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

AGREEMENT

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

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name New Hampshire Department of Health and Human Services		1.2 State Agency Address 129 Pleasant Street Concord, NH 03301-3857	
1.3 Contractor Name Human Services Research Institute		1.4 Contractor Address 2336 Massachusetts Avenue Cambridge, MA 02140	
1.5 Contractor Phone Number 617-876-0426	1.6 Account Unit and Class 05-95-94-940010-24650000-102-500731	1.7 Completion Date November 30, 2024	1.8 Price Limitation $276,467
1.9 Contracting Officer for State Agency Robert W. Moore, Director		1.10 State Agency Telephone Number (603) 271-9631	
1.11 Contractor Signature DocuSigned by: David Hughes 512ABBBD4A3F495... Date: 12/5/2023		1.12 Name and Title of Contractor Signatory David Hughes President	
1.13 State Agency Signature DocuSigned by: Katja S. Fox ED9D05B04C63442... Date: 12/5/2023		1.14 Name and Title of State Agency Signatory Katja S. Fox Director	
1.15 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)* By: Director, On:			
1.16 Approval by the Attorney General (Form, Substance and Execution) *(if applicable)* By: DocuSigned by: Robyn Guarino 74873484941460... On: 12/5/2023			
1.17 Approval by the Governor and Executive Council *(if applicable)* G&C Item number: G&C Meeting Date:			

Contractor Initials DS DH
Date 12/5/2023

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, 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.

3.3 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. 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 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, 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 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. 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.

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 The State's liability under this Agreement shall be limited to monetary damages not to exceed the total fees paid. The Contractor agrees that it has an adequate remedy at law for any breach of this Agreement by the State and hereby waives any right to specific performance or other equitable remedies against the State.

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 and the Governor's order on Respect and Civility in the Workplace, Executive order 2020-01. 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 age, sex, sexual orientation, race, color, marital status, physical or mental disability, religious creed, national origin, gender identity, or gender expression, and will take affirmative action to prevent such discrimination, unless exempt by state or federal law. The Contractor shall ensure any subcontractors comply with these nondiscrimination requirements.

6.3 No payments or transfers of value by Contractor or its representatives in connection with this Agreement have or shall be made which have the purpose or effect of public or commercial bribery, or acceptance of or acquiescence in extortion, kickbacks, or other unlawful or improper means of obtaining business.

6.4. 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 this Agreement and all rules, regulations and orders pertaining to 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 The Contracting Officer specified in block 1.9, or any successor, shall be the State's point of contact pertaining to this Agreement.

DS

Contractor Initials DH

Date 12/5/2023

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) calendar days from the date of the notice; and if the Event of Default is not timely cured, terminate this Agreement, effective two (2) calendar 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.

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) calendar 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) calendar 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. In addition, at the State's discretion, the Contractor shall, within fifteen (15) calendar days of notice of early termination, develop and submit to the State a transition plan for Services under the Agreement.

10. PROPERTY OWNERSHIP/DISCLOSURE.

10.1 As used in this Agreement, the word "Property" shall mean all data, 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 Disclosure of data, information and other records shall be governed by N.H. RSA chapter 91-A and/or other applicable law. Disclosure 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 Contractor shall provide the State written notice at least fifteen (15) calendar days before any proposed assignment, delegation, or other transfer of any interest in this Agreement. No such assignment, delegation, or other transfer shall be effective without the written consent of the State.

12.2 For purposes of paragraph 12, 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.

12.3 None of the Services shall be subcontracted by the Contractor without prior written notice and consent of the State.

12.4 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. The Contractor shall indemnify, defend, and hold harmless the State, its officers, and employees from and against all actions, claims, damages, demands, judgments, fines, liabilities, losses, and other expenses, including, without limitation, reasonable attorneys' fees, arising out of or relating to this Agreement directly or indirectly arising from death, personal injury, property damage, intellectual property infringement, or other claims asserted against the State, its officers, or employees caused by the acts or omissions of negligence, reckless or willful misconduct, or fraud by the Contractor, its employees, agents, or subcontractors. 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 State's sovereign immunity, which immunity is hereby reserved to the State. This covenant in paragraph 13 shall survive the termination of this Agreement.

DS

Contractor Initials DH

Date 12/5/2023

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 any successor, a certificate(s) of insurance for all insurance required under this Agreement. At the request of the Contracting Officer, or any successor, the Contractor shall provide certificate(s) of insurance for all renewal(s) of insurance required under this Agreement. 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 any successor, proof of Workers' Compensation in the manner described in N.H. RSA chapter 281-A and any applicable renewal(s) thereof, which shall be attached and are incorporated herein by reference. The State shall not be responsible for payment of any Workers' Compensation premiums or for any other claim or benefit for Contractor, or any subcontractor or employee of Contractor, which might arise under applicable State of New Hampshire Workers' Compensation laws in connection with the performance of the Services under this Agreement.

16. WAIVER OF BREACH. A State's failure to enforce its rights with respect to any single or continuing breach of this Agreement shall not act as a waiver of the right of the State to later enforce any such rights or to enforce any other or any subsequent breach.

17. NOTICE. Any notice by a party hereto to the other party shall be deemed to have been duly delivered or given at the time of mailing by certified mail, postage prepaid, in a United States Post Office addressed to the parties at the addresses given in blocks 1.2 and 1.4, herein.

18. AMENDMENT. This Agreement may be amended, waived or discharged only by an instrument in writing signed by the parties hereto and only after approval of such amendment, waiver or discharge by the Governor and Executive Council of the State of New Hampshire unless no such approval is required under the circumstances pursuant to State law, rule or policy.

19. CHOICE OF LAW AND FORUM.
19.1 This Agreement shall be governed, interpreted and construed in accordance with the laws of the State of New Hampshire except where the Federal supremacy clause requires otherwise. 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.
19.2 Any actions arising out of this Agreement, including the breach or alleged breach thereof, may not be submitted to binding arbitration, but must, instead, be brought and maintained in the Merrimack County Superior Court of New Hampshire which shall have exclusive jurisdiction thereof.

20. CONFLICTING TERMS. In the event of a conflict between the terms of this P-37 form (as modified in EXHIBIT A) and any other portion of this Agreement including any attachments thereto, the terms of the P-37 (as modified in EXHIBIT A) shall control.

21. THIRD PARTIES. This Agreement is being entered into for the sole benefit of the parties hereto, and nothing herein, express or implied, is intended to or will confer any legal or equitable right, benefit, or remedy of any nature upon any other person.

22. 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.

23. SPECIAL PROVISIONS. Additional or modifying provisions set forth in the attached EXHIBIT A are incorporated herein by reference.

24. FURTHER ASSURANCES. The Contractor, along with its agents and affiliates, shall, at its own cost and expense, execute any additional documents and take such further actions as may be reasonably required to carry out the provisions of this Agreement and give effect to the transactions contemplated hereby.

25. 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.

26. 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.

DS
DH
Contractor Initials
Date 12/5/2023

New Hampshire Department of Health and Human Services
Behavioral Health Systems Crosswalk and Gaps Analysis
EXHIBIT A

Revisions to Standard Agreement Provisions

1. Revisions to Form P-37, General Provisions

   1.1. Paragraph 3, Effective Date/Completion of Services, is amended by deleting subparagraph 3.3 in its entirety and replacing it as follows:

   3.3. Contractor must complete all Services by the Completion Date specified in block 1.7. 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.

   1.2. Paragraph 12, Assignment/Delegation/Subcontracts, is amended by adding subparagraph 12.5 as follows:

   12.5. 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 if applicable, a Business Associate Agreement in accordance with the Health Insurance Portability and Accountability Act. Written agreements shall specify how corrective action shall be managed. 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.

EXHIBIT B

Scope of Services

1. Statement of Work

1.1. The Contractor must conduct a Behavioral Health System Crosswalk and Gaps Analysis, as described in this Agreement.

1.2. For the purposes of this Agreement, all references to business hours mean Monday through Friday from 8:00 AM to 4:00 PM, Eastern Standard Time.

1.3. The Contractor must ensure project management includes, but is not limited to:

1.3.1. Scheduling a kick-off meeting with the Department within two (2) weeks of the contract effective date, or as otherwise mutually agreed upon between the Contractor and the Department.

1.3.2. Developing a work plan for Department approval within 30 days of the contract effective date. The Contractor must ensure the work plan includes, but is not limited to:

1.3.2.1. A detailed communications plan for Department approval, within the first month of the project, that describes:

1.3.2.1.1. The target audiences;

1.3.2.1.2. Distribution strategies for recruitment materials;

1.3.2.1.3. Dissemination of findings; and

1.3.2.1.4. Accessibility and translation needs for all information, reports and data.

1.4. The Contractor must conduct a review and analysis of the behavioral health system of care, which includes, but is not limited to:

1.4.1. The Ten-Year Mental Health Plan.

1.4.2. The Children's System of Care.

1.4.3. Other behavioral health strategic plans, needs assessments and existing data sources, both internal and external to the Department.

1.5. The Contractor must identify and map current behavioral health programs, practices, and policies across the continuum of care as outlined by the Department to include:

1.5.1. A comprehensive accounting of what currently exists across multiple domains, including, but not limited to:

1.5.1.1. Prevalence.

1.5.1.2. Utilization.

1.5.1.3. System components.

1.5.1.4. Capacity.

1.5.1.5. Community assets, gaps, and characteristics.

1.5.1.6. Social Determinants of Health.

1.6. The Contractor must work with the Department to identify and receive relevant information and data for review and analysis, including, but not limited to:

1.6.1. 10-Year Mental Health Plan.

1.6.2. Governor's Commission on Alcohol and Other Drugs Strategic Plan.

1.6.3. Children's System of Care.

1.6.4. Council on Housing Stability Strategic Plan and annual updates.

1.6.5. Housing and Urban Development (HUD) Continuums of Care.

1.6.6. State of NH Consolidated Plan and the Consolidated Annual Performance Evaluation Report for HUD.

1.6.7. NH Suicide Prevention Strategic Plan.

1.6.8. Integrated Delivery Networks (IDN) Promising Practices.

1.6.9. Regional Public Health Network (RPHN) Community Health Improvement Plans.

1.6.10. Local Hospitals' Community Needs Assessments.

1.6.11. State Opioid Response reports and data including Doorway summary reporting and SOR GPRA data, CORBI (Opioid Crisis) Dashboard.

1.6.12. Department of Public Health Services (DPHS) State Health Assessment and DPHS State Health Improvement Plan.

1.6.13. PEER Workforce Advancement Plan.

1.6.14. External programs and organizations as identified by the Department.

1.6.15. Other reports, data and plans as determined by the Department.

1.7. The Contractor must assess shared goals and gaps across the Behavioral Health system of care, including, but not limited to:

1.7.1. The Division for Behavioral Health (DBH), including:

1.7.1.1. The Bureau of Mental Health Services (BMHS);

1.7.1.2. The Bureau for Children's Behavioral Health (BCBH);

1.7.1.3. The Bureau of Drug and Alcohol Services (BDAS);

1.7.1.4. The Bureau of Homeless Services (BHS); and

1.7.1.5. The DBH Policy Unit.

1.7.2. Division of Public Health, including relevant work in behavioral health, which may include, but not be limited to:

1.7.2.1. Overdose prevention.

1.7.2.2. Opioid Data 2 Action (OD2A).

1.7.2.3. Regional Public Health Networks.

1.7.3. Other State agencies.

1.8. The Contractor must conduct a crosswalk of the shared goals and gaps across the behavioral health system of care. The Contractor must ensure inclusion of:

1.8.1. A comparison model of what exists and what should exist; and

1.8.2. A conceptual model of an ideal behavioral health system informed by up-to-date theoretical approaches and empirical evidence.

1.9. The Contractor must complete an assessment of the information obtained from the activities described in Sections 1.3. through 1.8. in order to:

1.9.1. Inform behavioral health programs, policies and practices;

1.9.2. Develop a health equity foundation for all assessments and recommendations, and highlight opportunities for the Department to better promote equity in strategy, policy and programming, including, but not limited to:

1.9.2.1. Using estimates of the relationship between prevalence and utilization in the form of penetration rates that identify:

1.9.2.1.1. The appropriateness of services and system imbalances; and

1.9.2.1.2. Groups for whom need is greatest, thereby helping policymakers and system planners target interventions and prioritize the allocation of limited resources.

1.9.2.2. Employing participatory action research approaches that engage key informants early and often.

1.9.3. Identify innovations or practices that should be implemented.

1.9.4. Measure, both quantitatively and qualitatively, the discrepancy between the current state and the desired future state, which defines the need; and

1.9.5. Make actionable recommendations for addressing the discrepancy, accompanied by:

1.9.5.1. Prioritization and strategies for action;

1.9.5.2. Strategic planning; and

1.9.5.3. Support for implementation, based on implementation research science.

1.10. The Contractor must ensure community engagement, as approved by the Department, may include, but is not limited to:

1.10.1. Development of a key informant guide, and a focus group protocol and guide;

1.10.2. A minimum of 25 key informant interviews, 4 focus groups and 4 public community listening sessions;

1.10.3. Collection of demographic characteristics, with participant consent, of all persons interviewed individually or through focus groups or listening sessions to ensure interviewees are representative of the target population for the assessment; and

1.10.4. Incentives, not to exceed $25, offered to people with lived experience, or their loved ones, who participate in interviews or focus groups not as part of their paid job.

1.11. The Contractor must work with mental health, substance use and homeless service providers across the state to conduct focus groups and collaborative planning to determine how systems could integrate in order to aid future programming and financing strategy. At a minimum, the Contractor must:

1.11.1. Apply a theoretical framework of cross-sector alignment that outlines three (3) pathways to integration between agencies in different sectors, including:

1.11.1.1. Shared data that is meaningful to all partners and that enables sectors to effectively coordinate activities and measure shared progress;

1.11.1.2. Long-term financing that supports partnerships with incentives and accountability; and

1.11.1.3. Robust governance structures that include local representation and voice.

1.12. The Contractor must employ a mixed-methods approach to ensure that the data collected through quantitative, qualitative, and document review methods inform each other.

1.13. The Contractor must facilitate work teams, as approved by the Department, to identify opportunities to:

1.13.1. Identify shared risk and protective factors across the continuum of care; and

1.13.2. Improve integration within the behavioral health system and other healthcare and social systems in order to promote whole person health;

1.13.3. Maximize use of funding, resources, and workforce across the behavioral health system of care;

1.13.4. Enhance services;

1.13.5. Reduce duplication;

1.13.6. Identify other potential programmatic, funding, and policy opportunities;

1.13.7. Develop specific recommendations for tracking system performance that aligns metrics across sectors; and

1.13.8. Develop a list of metrics and recommendations for enhancement of data systems across sectors to improve the Department's ongoing ability to measure need, capacity, and client outcomes, including feasibility and cost estimates.

1.14. The Contractor must design sustainable assessment and management tools that determine where the system is achieving defined goals and where the system needs improvement to achieve defined goals across the behavioral health system of care, including, but not limited to:

1.14.1. Multi-system logic models.

1.14.2. Multi-system alignment of metrics across various programs.

1.15. The Contractor must maintain quality assurance and quality control through:

1.15.1. Comprehensive communication by meeting at least weekly to review deliverables, issues, and status;

1.15.2. Monitoring progress of the comprehensive Work Plan approved by the Department that encompasses each major task/deliverable, and breaks them down in subtasks;

1.15.3. Quality control and data integrity, including but not limited to:

1.15.3.1. Data validation at intake of survey data and/or data submissions.

1.15.3.2. Regular analytic checks of incoming data including inter-interviewer/inter-rater reliability checks.

1.15.3.3. Monitoring incoming data for completeness and outliers.

1.15.3.4. Performing multi-level reviews at all stages of the project, with associated change tracking and sign-offs at each step, and reviews by senior subject matter experts;

1.15.4. Contingency planning; and

1.15.5. Targeted reporting that at a minimum, builds in at least two (2) weeks for client review and feedback of all major deliverables before preparing the final version.

1.16. The Contractor must ensure the assessment and management tools are dynamic, and not static, in order for the Department and its stakeholders to continue to identify:

1.16.1. Opportunities for ongoing system improvement; and

1.16.2. The need for further evolution to achieve a more robust and effective continuum of care as population needs, practices and resources emerge over time.

1.17. The Contractor must identify and acquire all research data from internal and external sources, and obtain Department approval prior to utilizing this data. At a minimum, the Contractor must ensure:

1.17.1. A mixed-methods approach in which quantitative and qualitative data are analyzed iteratively as they are being collected;

1.17.2. Quantitative data analysis involving appropriate statistical and/or methodological techniques; and

1.17.3. Qualitative data analysis involving thematic organization of key informant interview and focus group data using rapid qualitative techniques.

1.18. The Contractor must identify potential limitations, constraints, or other factors that might assist in the interpretation of the data or affect the reliability or sensitivity of the data, and develop a plan for the Department's approval, to mitigate such limitations, constraints, or other factors as necessary to ensure the Department's confidence that the selected data sufficiently supports the Contractor's fair and impartial recommendations.

1.19. The Contractor must participate in meetings with the Department on a biweekly basis, or as otherwise requested by the Department.

1.20. The Contractor must ensure it has no interest and will not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services under this contract, and must immediately notify the Department of any potential conflicts of interest.

1.21. Reporting

1.21.1. The Contractor must submit monthly progress reports detailing the status of activities described in Sections 1.4. through 1.20.

1.21.2. On or before April 30, 2024, the Contractor must prepare and submit a report entitled, "Substance Misuse Continuum of Care Gaps

Analysis," to the Department that includes findings and recommendations relative to gaps in care.

1.21.3. On or before April 30, 2024, the Contractor must prepare and submit a report entitled, "Homeless Services Continuum of Care Gaps Analysis," to the Department that includes findings and recommendations relative to gaps in care.

1.21.4. On or before June 30, 2024, the Contractor must prepare and submit a report entitled, "Interim Behavioral Health System Crosswalk" to the Department that includes findings and recommendations to-date relative to the activities described in this Scope of Work.

1.21.5. On or before October 31, 2024, the Contractor must prepare, and submit a report entitled, "Behavioral Health System Crosswalk" to the Department that:

1.21.5.1. Details the completed initial review;

1.21.5.2. Includes findings and recommendations relative to the completed initial review, including, but not limited to:

1.21.5.2.1. Overlapping goals and work.

1.21.5.2.2. Opportunities for efficiencies, including, but not limited to:

1.21.5.2.2.1. Policy changes.

1.21.5.2.2.2. Shared, and cross-trained workforce.

1.21.5.2.2.3. Braided funding.

1.21.5.2.2.4. More robust, sustainable and integrated services.

1.21.5.2.3. Opportunities for collaboration.

1.21.5.2.4. Overview of financial investments across the Division for Behavioral Health and recommendations for reduction of duplication and recommendations for the future.

1.21.5.2.5. Gaps in care.

1.21.5.2.6. Equity recommendations.

1.21.5.3. Includes designed management tools for the Department to use and update as needed over time, including, but not limited to:

1.21.5.3.1. Logic models of current programming and/or other sustainable tools.

1.21.5.3.2. Templates for future program use.

1.21.5.3.3. Cross-sector data crosswalk, as approved by the Department, which incorporates necessary data on program findings.

1.21.5.4. Includes findings and recommendations relevant to staffing and financial mapping, including, but not limited to:

1.21.5.4.1. Number of clinicians across the mental health and substance use systems of care relative to the level of need.

1.21.5.4.2. Number of peer support and certified recovery support professionals across the mental health and substance use system of care relative to the level of need.

1.21.5.4.3. Number of certified prevention specialists, student assistance professionals and other prevention/intervention positions relative to the level of need.

1.21.5.4.4. Mapping where clinicians, prevention workers and peer workers are working in order to inform decisions about how the workforce can better meet needs.

1.21.5.4.5. Mapping where financial investments are being made and recommendations for prioritization of future financial investments to best support an integrated system in line with best practices for better participant outcomes.

1.21.6. The Contractor may be required to provide other data and metrics to the Department in a format specified by the Department.

2. Exhibits Incorporated

2.1. The Contractor must comply with all Exhibit D Federal Requirements, which are attached hereto and incorporated by reference herein.

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

3. Additional Terms

3.1. Impacts Resulting from Court Orders or Legislative Changes

3.1.1. 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.

3.2. Credits and Copyright Ownership

3.2.1. 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."

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

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

3.2.3.1. Brochures.

3.2.3.2. Resource directories.

3.2.3.3. Protocols or guidelines.

3.2.3.4. Posters.

3.2.3.5. Reports.

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

4. Records

4.1. The Contractor must keep records that include, but are not limited to:

4.1.1. 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.

4.1.2. 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.

4.2. During the term of this Agreement and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives must have access to all reports and records maintained pursuant to the Agreement for purposes of audit, examination, excerpts and transcripts.

4.3. 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
Behavioral Health Systems Crosswalk and Gaps Analysis
EXHIBIT C

Payment Terms

1. This Agreement is funded by:
   1.1. 100% Federal Funds (ARPA).
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 for services provided in the fulfillment of this Agreement, as specified in Exhibit B Scope of Work, and in accordance with Deliverables Table A – SFY24 and Table B – SFY25 below:

Table A – SFY24

Item	Due Date*	Deliverable Payment Upon Completion
Map: Identification and map of current behavioral health programs, practices, and policies across the continuum of care as outlined by the Department.	On or before February 29, 2024	$28,401
Analysis: Identification, collection, review and analysis of information and data.	On or before April 30, 2024	$66,519
Focus Groups: Delivery of a minimum of 25 key informant interviews, 4 focus groups, and 4 public community listening sessions with mental health, substance use and homeless service providers across the state and plan collaboratively to determine how systems could integrate in order to aid future programming and financing strategy.	On or before April 30, 2024	$28,112
Assessment and Management Tools: Design of sustainable assessment and management tools that determine where the system is achieving defined goals and where the system needs improvement to achieve defined goals across the behavioral health system of care.	On or before April 30, 2024	$30,746
"Substance Misuse Continuum of Care Gaps Analysis" Report: Submission of a report entitled, "Substance Misuse Continuum of Care Gaps Analysis," to the Department that includes findings and recommendations relative to gaps in care.	On or before May 31, 2024	$30,039
"Homeless Services Continuum of Care Gaps Analysis" Report: Submission of a report entitled, "Homeless Services Continuum of Care Gaps	On or before May 31, 2024	$30,039

Analysis," to the Department that includes findings and recommendations relative to gaps in care.		
"Interim Behavioral Health System Crosswalk" Report: Submission of a report entitled, "Interim Behavioral Health System Crosswalk" to the Department that includes findings and recommendations to-date relative to the activities described in Exhibit B, Scope of Work.	On or before July 31, 2024	$30,039
*Due dates subject to change upon approval by the Department	**Total**	**$243,895**

Table B – SFY25

Item	Due Date*	Deliverable Payment Upon Completion
"Behavioral Health System Crosswalk" Report: Submission of a report entitled, "Behavioral Health System Crosswalk" to the Department that addresses the items described in Subsection 1.21. Reporting, Subparagraphs 1.21.5.1. through 1.21.5.4.	On or before October 31, 2024	$32,572
*Due dates subject to change upon approval by the Department	**Total**	**$32,572**

4. Payment for said services shall be made as follows:
   - 4.1. The Contractor shall submit invoices within twenty (20) days from the dates in Table A – SFY24 and Table B – SFY25 above for payment of accepted Deliverables according to the tables.
   - 4.2. The Contractor shall ensure invoices are in a format specified by the Department and include detailed information, as follows:
     - 4.2.1. Identification of the completed Deliverable(s);
     - 4.2.2. The Deliverable(s) due date(s);
     - 4.2.3. The Deliverable(s) completion date(s); and
     - 4.2.4. The Deliverable(s) acceptance date(s).
   - 4.3. Is assigned an electronic signature, includes supporting documentation, and is emailed to dhhs.dbhinvoicesmhs@dhhs.nh.gov or mailed to:

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 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.

      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 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.

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.

New Hampshire Department of Health and Human Services

Exhibit D

DHHS Information Security Requirements

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" or "Confidential Data" 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, 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 an explicit or implied security policy, which includes attempts (either failed or successful) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent. Incidents include the loss of data through theft or device misplacement, loss

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or misplacement of hardcopy documents, and misrouting of physical or electronic mail, all of which may have the potential to put the data at risk of unauthorized access, use, disclosure, modification or destruction.

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

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

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

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

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

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

I. RESPONSIBILITIES OF DHHS AND THE CONTRACTOR

A. Business Use and Disclosure of Confidential Information.

1. The Contractor must not use, disclose, maintain or transmit Confidential Information except as reasonably necessary as outlined under this Contract. 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. If DHHS notifies the Contractor that DHHS 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 Contractor must be bound by such additional restrictions and must not disclose PHI in violation of such additional restrictions and must abide by any additional security safeguards.
4. 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.
5. The Contractor agrees DHHS Data obtained under this Contract may not be used for any other purposes that are not indicated in this Contract.
6. The Contractor agrees to grant access to the data to the authorized representatives of DHHS for the purpose of inspecting to confirm compliance with the terms of this Contract.

II. METHODS OF SECURE TRANSMISSION OF DATA

1. Application Encryption. If End User 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. End User may not use computer disks or portable storage devices, such as a thumb drive, as a method of transmitting DHHS data.
3. Encrypted Email. End User 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 End User 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. End User may not use file hosting services, such as Dropbox or Google Cloud Storage, to transmit Confidential Data.
6. Ground Mail Service. End User 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 End User is employing portable devices to transmit Confidential Data said devices must be encrypted and password-protected.

8. Open Wireless Networks. End User 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 End User is employing remote communication to access or transmit Confidential Data, a virtual private network (VPN) must be installed on the End User's mobile device(s) or laptop from which information will be transmitted or accessed.
10. SSH File Transfer Protocol (SFTP), also known as Secure File Transfer Protocol. If End User 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 End User 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 the data and any derivative of the data for the duration of this Contract. After such time, the Contractor will have 30 days to destroy the data and any derivative in whatever form it may exist, unless, otherwise required by law or permitted under this Contract. 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.
3. The Contractor agrees to provide security awareness and education for its End Users in support of protecting Department 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, the latest anti-viral, antihacker, anti-spam, anti-spyware, and anti-malware 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

1. If the Contractor will maintain any Confidential Information on its systems (or its sub-contractor systems), the Contractor will maintain a documented process for securely disposing of such data upon request or contract termination; and will obtain written certification for any State of New Hampshire data destroyed by the Contractor or any subcontractors as a part of ongoing, emergency, and or disaster recovery operations. When no longer in use, electronic media containing State of New Hampshire data shall be rendered unrecoverable via a secure wipe program in accordance with industry-accepted standards for secure deletion and media sanitization, or otherwise physically destroying the media (for example, degaussing) as described in NIST Special Publication 800-88, Rev 1, Guidelines for Media Sanitization, National Institute of Standards and Technology, U. S. Department of Commerce. The Contractor will document and certify in writing at time of the data destruction, and will provide written certification to the Department upon request. The written certification will include all details necessary to demonstrate data has been properly destroyed and validated. Where applicable, regulatory and professional standards for retention requirements will be jointly evaluated by the State and Contractor prior to destruction.
2. 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.
3. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to completely destroy all electronic Confidential Data by means of data erasure, also known as secure data wiping.

IV. PROCEDURES FOR SECURITY

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

1. The Contractor will maintain proper security controls to protect Department confidential information collected, processed, managed, and/or stored in the delivery of contracted services.

2. The Contractor will maintain policies and procedures to protect Department confidential information throughout the information lifecycle, where applicable, (from creation, transformation, use, storage and secure destruction) regardless of the media used to store the data (i.e., tape, disk, paper, etc.).

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

4. The Contractor will 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.

5. The Contractor will provide regular security awareness and education for its End Users in support of protecting Department confidential information.

6. If the Contractor will be sub-contracting any core functions of the engagement supporting the services for State of New Hampshire, the Contractor will maintain a program of 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.

7. 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.

8. 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.

9. The Contractor will work with the Department at its request to complete a System Management Survey. The purpose of the survey is to enable the Department and Contractor to monitor for any changes in risks, threats, and vulnerabilities that may occur over the life of the Contractor engagement. The survey will be completed annually, or an alternate time frame at the Departments discretion with agreement by the Contractor, or the Department may request the survey be completed when the scope of the engagement between the Department and the Contractor changes.

10. The Contractor will not store, knowingly or unknowingly, 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.

11. Data Security Breach Liability. In the event of any security 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.

12. 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 requirements applicable to federal agencies, including, but not limited to, provisions of the Privacy Act of 1974 (5 U.S.C. § 552a), DHHS Privacy Act Regulations (45 C.F.R. §5b), HIPAA Privacy and Security Rules (45 C.F.R. Parts 160 and 164) that govern protections for individually identifiable health information and as applicable under State law.

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

14. Contractor agrees to maintain a documented breach notification and incident response process. The Contractor will notify the State's Privacy Officer and the State's Security Officer of any security breach immediately, at the email addresses provided in Section VI. 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.

15. 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.

16. The Contractor must ensure that all End Users:

    a. comply with such safeguards as referenced in Section IV A. above, implemented to protect Confidential Information that is furnished by DHHS under this Contract from loss, theft or inadvertent disclosure.

    b. safeguard this information at all times.

    c. ensure that laptops and other electronic devices/media containing PHI, PI, or PFI are encrypted and password-protected.

d. send emails containing Confidential Information only if encrypted and being sent to and being received by email addresses of persons authorized to receive such information.

e. limit disclosure of the Confidential Information to the extent permitted by law.

f. Confidential Information received under this Contract and individually identifiable data derived from DHHS Data, must be stored in an area that is physically and technologically secure from access by unauthorized persons during duty hours as well as non-duty hours (e.g., door locks, card keys, biometric identifiers, etc.).

g. only authorized End Users may transmit the Confidential Data, including any derivative files containing personally identifiable information, and in all cases, such data must be encrypted at all times when in transit, at rest, or when stored on portable media as required in section IV above.

h. in all other instances Confidential Data must be maintained, used and disclosed using appropriate safeguards, as determined by a risk-based assessment of the circumstances involved.

i. understand that their user credentials (user name and password) must not be shared with anyone. End Users will keep their credential information secure. This applies to credentials used to access the site directly or indirectly through a third party application.

Contractor is responsible for oversight and compliance of their End Users. DHHS reserves the right to conduct onsite inspections to monitor compliance with this Contract, including the privacy and security requirements provided in herein, HIPAA, and other applicable laws and Federal regulations until such time the Confidential Data is disposed of in accordance with this Contract.

V. LOSS REPORTING

The Contractor must notify the State's Privacy Officer and Security Officer of any Security Incidents and Breaches immediately, at the email addresses provided in Section VI.

The Contractor must further handle and report Incidents and Breaches involving PHI in accordance with the agency's documented Incident Handling and Breach Notification procedures and in accordance with 42 C.F.R. §§ 431.300 - 306. In addition to, and notwithstanding, Contractor's compliance with all applicable obligations and procedures, Contractor's procedures must also address how the Contractor will:

1. Identify Incidents;
2. Determine if personally identifiable information is involved in Incidents;
3. Report suspected or confirmed Incidents as required in this Exhibit or P-37;

4. Identify and convene a core response group to determine the risk level of Incidents and determine risk-based responses to Incidents; and
5. Determine whether Breach notification is required, and, if so, identify appropriate Breach notification methods, timing, source, and contents from among different options, and bear costs associated with the Breach notice as well as any mitigation measures.

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

VI. PERSONS TO CONTACT

A. DHHS Privacy Officer:

DHHSPrivacyOfficer@dhhs.nh.gov B.

DHHS Security Officer:

DHHSInformationSecurityOffice@dhhs.nh.gov

BUSINESS ASSOCIATE AGREEMENT

The Contractor identified in Section 1.3 of the General Provisions of the Agreement (Form P-37) ("Agreement"), and any of its agents who receive use or have access to protected health information (PHI), as defined herein, shall be referred to as the "Business Associate." The State of New Hampshire, Department of Health and Human Services, "Department" shall be referred to as the "Covered Entity," The Contractor and the Department are collectively referred to as "the parties."

The parties agree, to comply with the Health Insurance Portability and Accountability Act, Public Law 104-191, the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160, 162, and 164 (HIPAA), provisions of the HITECH Act, Title XIII, Subtitle D, Parts 1&2 of the American Recovery and Reinvestment Act of 2009, 42 USC 17934, et sec., applicable to business associates, and as applicable, to be bound by the provisions of the Confidentiality of Substance Use Disorder Patient Records, 42 USC s. 290 dd-2, 42 CFR Part 2, (Part 2), as any of these laws and regulations may be amended from time to time.

(1) Definitions

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

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

b. Business Associate Agreement, (BAA) means the Business Associate Agreement that includes privacy and confidentiality requirements of the Business Associate working with PHI and as applicable, Part 2 record(s) on behalf of the Covered Entity under the Agreement.

c. "Constructively Identifiable," means there is a reasonable basis to believe that the information could be used, alone or in combination with other reasonably available information, by an anticipated recipient to identify an individual who is a subject of the information.

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

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

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

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

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

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

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

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

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

III. According to the HIPAA minimum necessary standard;

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

V. Data that is de-identified or aggregated and remains constructively identifiable may not be used for any purpose outside the performance of the Agreement.

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

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

(3) <u>Obligations and Activities of Business Associate</u>

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

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

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

d. The Business Associate shall perform a risk assessment, based on the information available at the time it becomes aware of any known or suspected privacy or

security breach as described above and communicate the risk assessment to the Covered Entity. The risk assessment shall include, but not be limited to:

I. The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;

II. The unauthorized person who accessed, used, disclosed, or received the protected health information;

III. Whether the protected health information was actually acquired or viewed; and

IV. How the risk of loss of confidentiality to the protected health information has been mitigated.

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

f. Business Associate shall make available all of its internal policies and procedures, books and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of Covered Entity to the US Secretary of Health and Human Services for purposes of determining the Business Associate's and the Covered Entity's compliance with HIPAA and the Privacy and Security Rule, and Part 2, if applicable.

g. Business Associate shall require all of its business associates that receive, use or have access to PHI under the BAA to agree in writing to adhere to the same restrictions and conditions on the use and disclosure of PHI contained herein.

h. Within ten (10) business days of receipt of a written request from Covered Entity, Business Associate shall make available during normal business hours at its offices all records, books, agreements, policies and procedures relating to the use and disclosure of PHI to the Covered Entity, for purposes of enabling Covered Entity to determine Business Associate's compliance with the terms of the BAA and the Agreement.

i. Within ten (10) business days of receiving a written request from Covered Entity, Business Associate shall provide access to PHI in a Designated Record Set to the Covered Entity, or as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR Section 164.524.

j. Within ten (10) business days of receiving a written request from Covered Entity for an amendment of PHI or a record about an individual contained in a Designated Record Set, the Business Associate shall make such PHI available to Covered Entity for amendment and incorporate any such amendment to enable Covered Entity to fulfill its obligations under 45 CFR Section 164.526.

k. Business Associate shall document any disclosures of PHI and information related to any disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.

l. Within ten (10) business days of receiving a written request from Covered Entity for a request for an accounting of disclosures of PHI, Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill its obligations to provide an accounting of disclosures with respect to PHI in

accordance with 45 CFR Section 164.528.

m. In the event any individual requests access to, amendment of, or accounting of PHI directly from the Business Associate, the Business Associate shall within five (5) business days forward such request to Covered Entity. Covered Entity shall have the responsibility of responding to forwarded requests. However, if forwarding the individual's request to Covered Entity would cause Covered Entity or the Business Associate to violate HIPAA and the Privacy and Security Rule, the Business Associate shall instead respond to the individual's request as required by such law and notify Covered Entity of such response as soon as practicable.

n. Within thirty (30) business days of termination of the Agreement, for any reason, the Business Associate shall return or destroy, as specified by Covered Entity, all PHI received from or created or received by the Business Associate in connection with the Agreement, and shall not retain any copies or back-ups of such PHI in any form or platform.

VI. If return or destruction is not feasible, or the disposition of the PHI has been otherwise agreed to in the Agreement, or if retention is governed by state or federal law, Business Associate shall continue to extend the protections of the Agreement, to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible for as long as the Business Associate maintains such PHI. If Covered Entity, in its sole discretion, requires that the Business Associate destroy any or all PHI, the Business Associate shall certify to Covered Entity that the PHI has been destroyed.

(4) Obligations of Covered Entity

a. Covered Entity shall post a current version of the Notice of the Privacy Practices on the Covered Entity's website:

https://www.dhhs.nh.gov/oos/hipaa/publications.htm in accordance with 45 CFR Section 164.520.

b. Covered Entity shall promptly notify Business Associate of any changes in, or revocation of permission provided to Covered Entity by individuals whose PHI may be used or disclosed by Business Associate under this BAA, pursuant to 45 CFR Section 164.506 or 45 CFR Section 164.508.

c. Covered entity shall promptly notify Business Associate of any restrictions on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

(5) Termination of Agreement for Cause

a. In addition to the General Provisions (P-37) of the Agreement, the Covered Entity may immediately terminate the Agreement upon Covered Entity's knowledge of a material breach by Business Associate of the Business Associate Agreement. The Covered Entity may either immediately terminate the Agreement or provide an opportunity for Business Associate to cure the alleged breach within a timeframe specified by Covered Entity.

(6) Miscellaneous

a. Definitions, Laws, and Regulatory References. All laws and regulations used,

herein, shall refer to those laws and regulations as amended from time to time. A reference in the Agreement, as amended to include this Business Associate Agreement, to a Section in HIPAA or 42 Part 2, means the Section as in effect or as amended.

b. **Change in law** - Covered Entity and Business Associate agree to take such action as is necessary from time to time for the Covered Entity and/or Business Associate to comply with the changes in the requirements of HIPAA, 42 CFR Part 2 other applicable federal and state law.

c. **Data Ownership** - The Business Associate acknowledges that it has no ownership rights with respect to the PHI provided by or created on behalf of Covered Entity.

d. **Interpretation** - The parties agree that any ambiguity in the BAA and the Agreement shall be resolved to permit Covered Entity and the Business Associate to comply with HIPAA and 42 CFR Part 2.

e. **Segregation** - If any term or condition of this BAA or the application thereof to any person(s) or circumstance is held invalid, such invalidity shall not affect other terms or conditions which can be given effect without the invalid term or condition; to this end the terms and conditions of this BAA are declared severable.

f. **Survival** - Provisions in this BAA regarding the use and disclosure of PHI, return or destruction of PHI, extensions of the protections of the BAA in section (3) g. and (3) n.l., and the defense and indemnification provisions of the General Provisions (P-37) of the Agreement, shall survive the termination of the BAA.

IN WITNESS WHEREOF, the parties hereto have duly executed this Business Associate Agreement.

Department of Health and Human Services	HSRI
The State	Name of the Contractor
DocuSigned by: Katja S. Fox ED9D05B64C63442...	DocuSigned by: David Hughes 512ABBBD4A3F495...
Signature of Authorized Representative	Signature of Authorized Representative
Katja S. Fox	David Hughes
Name of Authorized Representative	Name of Authorized Representative
Director	President
Title of Authorized Representative	Title of Authorized Representative
12/5/2023	12/5/2023
Date	Date

Contractor Initials DS DH

Date 12/5/2023

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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 HUMAN SERVICES RESEARCH INSTITUTE is a District Of Columbia Nonprofit Corporation registered to transact business in New Hampshire on February 04, 2016. 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: **738451**

Certificate Number: **0006351818**

IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 1st day of December A.D. 2023.

David M. Scanlan
Secretary of State

CERTIFICATE OF AUTHORITY

I, Roy Gabriel, hereby certify that:
(Name of the elected Officer of the Corporation/LLC; cannot be contract signatory)

1. I am a duly elected Clerk/Secretary/Officer of Human Services Research Institute.
(Corporation/LLC Name)

2. The following is a true copy of a vote taken at a meeting of the Board of Directors/shareholders, duly called and held on August 3, 2023, at which a quorum of the Directors/shareholders were present and voting.
(Date)

VOTED: That David Hughes, President (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of Human Services Research Institute to enter into contracts or agreements with the State
(Name of Corporation/ LLC)

of New Hampshire and any of its agencies or departments and further is authorized to execute any and all documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, which may in his/her judgment be desirable or necessary to effect the purpose of this vote.

3. I hereby certify that said vote has not been amended or repealed and remains in full force and effect as of the date of the contract/contract amendment to which this certificate is attached. This authority was **valid thirty (30) days prior to and remains valid for thirty (30)** days from the date of this Certificate of Authority. I further certify that it is understood that the State of New Hampshire will rely on this certificate as evidence that the person(s) listed above currently occupy the position(s) indicated and that they have full authority to bind the corporation. To the extent that there are any limits on the authority of any listed individual to bind the corporation in contracts with the State of New Hampshire, all such limitations are expressly stated herein.

Dated: 12/4/2023

Roy N. Gabriel
Signature of Elected Officer
Name: Roy Gabriel
Title: Chair

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ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 9/19/2023

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

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

PRODUCER
Marsh & McLennan Agency LLC - New England
100 Front St, Ste 800
Worcester MA 01608

CONTACT NAME:
PHONE (A/C, No, Ext): 888-850-9400 FAX (A/C, No): 866-795-8016
E-MAIL ADDRESS: MMA.NewEngland.Cert@marshmc.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Philadelphia Indemnity Insurance Co.	18058
INSURER B : State National Insurance Company, Inc	12831
INSURER C : Phoenix Insurance Company	25623
INSURER D :	
INSURER E :	
INSURER F :	

INSURED HUMANSERVI
Human Services Research Institute
2336 Massachusetts Avenue
Cambridge MA 02140

COVERAGES **CERTIFICATE NUMBER:** 67676234 **REVISION NUMBER:**

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

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY			PHPK2588579	9/30/2023	9/30/2024	EACH OCCURRENCE	$ 2,000,000
	CLAIMS-MADE X OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 100,000
							MED EXP (Any one person)	$ 5,000
							PERSONAL & ADV INJURY	$ 2,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 4,000,000
	POLICY PRO-JECT X LOC						PRODUCTS - COMP/OP AGG	$ 4,000,000
	OTHER:							$
A	AUTOMOBILE LIABILITY			PHPK2588579	9/30/2023	9/30/2024	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
	ANY AUTO						BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	X HIRED AUTOS ONLY / X NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
A	X UMBRELLA LIAB / OCCUR			PHUB876848	9/30/2023	9/30/2024	EACH OCCURRENCE	$ 2,000,000
	EXCESS LIAB / CLAIMS-MADE						AGGREGATE	$ 2,000,000
	DED X RETENTION $ 10,000							$
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			UB4L04750A	9/29/2023	9/29/2024	X PER STATUTE / OTH-ER	
	ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N (Mandatory in NH)	N / A					E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000
B	Cyber Liability			EHJADM01741445	9/30/2023	9/30/2024	Limit	2,000,000
A	D&O/EPL/Fiduciary Liability			PHSD1819231	9/30/2023	9/30/2024	Limit	1,000,000
A	E&O/ Professional Liability			PHPK2588579	9/30/2023	9/30/2024	Limit	2,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

State of NH
Department of Health and Human Services
129 Pleasant Street
Concord NH 03301-3857

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

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Mission Statement

The Human Services Research Institute (HSRI) is a 501(c)(3) nonprofit research organization established in 1976. For nearly 50 years, we've assisted federal and state agencies and local communities improve the health, wellbeing, and economic and housing stability of populations our partners serve.

Our mission is to improve systems that improve lives. We achieve this through collaborative, inclusive, participatory research, and working to identify sustainable solutions to complex health and social challenges. With decades of experience, we understand the complexity of the human services landscape, including the interrelated physical, social, behavioral, and environmental factors that affect the wellbeing of individuals and communities.

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HUMAN SERVICES RESEARCH INSTITUTE, INC.

FINANCIAL STATEMENTS

with

INDEPENDENT AUDITORS' REPORT

YEARS ENDED SEPTEMBER 30, 2022 AND 2021

Smith Sullivan
& Brown PC
CERTIFIED PUBLIC ACCOUNTANTS

80 Flanders Road, Suite 200 Westborough, Massachusetts 01581
Tel: 508.871.7178 Fax: 508.871.7179 www.ssbcpa.com

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HUMAN SERVICES RESEARCH INSTITUTE, INC.

REPORT ON FINANCIAL STATEMENTS

YEARS ENDED SEPTEMBER 30, 2022 AND 2021

Mission Statement

In the fields of intellectual and developmental disabilities, population health, substance use and prevention, mental health and child and family services, HSRI works to:

- Assist public managers and human service organizations to develop services and supports that work for children, adults, and families;
- Enhance the involvement of individuals and their families in shaping policy, priorities and practice;
- Improve the capacity of systems, organizations, and individuals to cope with changes in fiscal, administrative, and political realities;
- Expand the use of research, performance measurement and evaluation to improve and enrich lives.

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HUMAN SERVICES RESEARCH INSTITUTE, INC.

REPORT ON FINANCIAL STATEMENTS

YEARS ENDED SEPTEMBER 30, 2022 AND 2021

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Statements of Financial Position as of September 30, 2022 and 2021	3
Statements of Activities for the Years Ended September 30, 2022 and 2021	4
Statement of Functional Expenses for the Year Ended September 30, 2022 *(With Summarized Comparative Totals for 2021)*	5
Statement of Functional Expenses for the Year Ended September 30, 2021	6
Statements of Cash Flows for the Years Ended September 30, 2022 and 2021	7
Notes to Financial Statements	8 - 21

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Smith Sullivan
& Brown PC
CERTIFIED PUBLIC ACCOUNTANTS

80 Flanders Road, Suite 200 Westborough, Massachusetts 01581
Tel: 508.871.7178 Fax: 508.871.7179 www.ssbcpa.com

INDEPENDENT AUDITORS' REPORT

To the Board of Directors
Human Services Research Institute, Inc.
Cambridge, Massachusetts

Opinion

We have audited the accompanying financial statements of Human Services Research Institute, Inc. (a Massachusetts nonprofit organization), which comprise the statements of financial position as of September 30, 2022 and 2021, and the related statements of activities, functional expenses and cash flows for the years then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Human Services Research Institute, Inc. as of September 30, 2022 and 2021, and the 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 audits in accordance with auditing standards generally accepted in the United States of America ("GAAS"). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Human Services Research Institute, Inc. 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 Financial Statements

Management is responsible for the preparation and fair presentation of the 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 financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Human Services Research Institute, Inc.'s ability to continue as a going concern within one year after the date that the financial statements are available to be issued.

Auditors' Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's 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 generally accepted auditing standards 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 financial statements.
America.

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To the Board of Directors
Human Services Research Institute, Inc.

In performing an audit in accordance with generally accepted auditing standards, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the 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 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 Human Services Research Institute, Inc.'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 financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Human Services Research Institute, Inc.'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.

Smith, Sullivan & Brown, PC

Westborough, Massachusetts
February 2, 2023

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HUMAN SERVICES RESEARCH INSTITUTE, INC.

STATEMENTS OF FINANCIAL POSITION AS OF SEPTEMBER 30, 2022 AND 2021

ASSETS

	2022	2021
CURRENT ASSETS:		
Cash	$ 448,236	$ 1,941,868
Accounts Receivable	3,153,490	2,162,593
Accrued Receivables	298,748	88,146
Employee Advances	14,211	13,001
Prepaid Expenses	36,873	18,657
Total Current Assets	3,951,558	4,224,265
PROPERTY AND EQUIPMENT:		
Net of Accumulated Depreciation	1,332,392	1,357,502
OTHER ASSETS:		
Deposits	5,580	7,680
Board Designated Operating Reserve Fund	1,372,868	1,709,600
Total Other Assets	1,378,448	1,717,280
TOTAL ASSETS	$ 6,662,398	$ 7,299,047

LIABILITIES AND NET ASSETS

CURRENT LIABILITIES:		
Current Portion of Long-Term Debt	$ 91,932	$ 94,739
Subcontracts Payable	494,195	407,856
Accounts Payable and Accrued Expenses	186,161	194,719
Accrued Payroll and Related Costs	366,337	271,248
Advance Billings	1,502,220	2,298,760
Total Current Liabilities	2,640,845	3,267,322
LONG-TERM LIABILITIES:		
Long-Term Debt, Net of Current Portion	429,082	521,211
Total Long-Term Liabilities	429,082	521,211
TOTAL LIABILITIES	3,069,927	3,788,533
NET ASSETS:		
Net Assets Without Donor Restrictions:		
Available for Operations	1,408,225	1,059,362
Invested in Property and Equipment	811,378	741,552
Board Designated Operating Reserve	1,372,868	1,709,600
Total Net Assets Without Donor Restrictions	3,592,471	3,510,514
TOTAL LIABILITIES AND NET ASSETS	$ 6,662,398	$ 7,299,047

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HUMAN SERVICES RESEARCH INSTITUTE, INC.

STATEMENTS OF ACTIVITIES
FOR THE YEARS ENDED SEPTEMBER 30, 2022 AND 2021

	2022	2021
SUPPORT AND REVENUES:		
Contract and Grant Funded Research	$11,876,235	$ 9,687,900
Paycheck Protection Program Grant	-	986,900
Investment Return (Loss) and Interest	(336,428)	273,326
TOTAL SUPPORT AND REVENUES	**11,539,807**	**10,948,126**
FUNCTIONAL EXPENSES:		
Program Services:		
Applied Research and Consulting Services:		
Intellectual and Developmental Disabilities	2,916,671	3,173,966
Behavioral Health	2,546,047	1,822,731
Child, Youth and Families	726,330	562,012
Population Health	3,803,314	3,155,872
Verity Analytics	760,763	577,371
Total Program Services	10,753,125	9,291,952
Supporting Services:		
Administrative	704,725	853,401
TOTAL FUNCTIONAL EXPENSES	**11,457,850**	**10,145,353**
CHANGE IN NET ASSETS WITHOUT DONOR RESTRICTIONS	**81,957**	**802,773**
NET ASSETS WITHOUT DONOR RESTRICTIONS - BEGINNING OF YEAR	**3,510,514**	**2,707,741**
NET ASSETS WITHOUT DONOR RESTRICTIONS - END OF YEAR	**$ 3,592,471**	**$ 3,510,514**

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HUMAN SERVICES RESEARCH INSTITUTE, INC.

STATEMENT OF FUNCTIONAL EXPENSES
FOR THE YEAR ENDED SEPTEMBER 30, 2022
(With Summarized Comparative Totals for 2021)

	PROGRAM SERVICES								
	APPLIED RESEARCH AND CONSULTING SERVICES					TOTAL		TOTAL	
	IDD	BEHAVIORAL HEALTH	CYF	POPULATION HEALTH	VERITY ANALYTICS	PROGRAM SERVICES	ADMINI-STRATIVE	FUNCTIONAL EXPENSES 2022	2021
Salaries and Wages	$ 1,540,400	$ 1,144,148	$ 457,783	$ 1,532,613	$ 377,489	$ 5,052,433	$ 129,188	$ 5,181,621	$ 4,103,508
Payroll Taxes and Benefits	647,126	480,660	192,316	643,855	158,584	2,122,541	54,272	2,176,813	1,931,669
Subcontractors and Consultants	501,467	719,727	14,375	1,399,894	161,684	2,797,147	166,630	2,963,777	3,172,357
Professional Services	-	-	-	-	-	-	91,639	91,639	92,264
Travel	22,700	36,192	6,400	2,897	-	68,189	42,560	110,749	3,935
Occupancy	26,856	19,947	7,981	26,720	6,581	88,085	6,396	94,481	113,772
Repairs and Maintenance	25,297	18,790	7,518	25,169	6,199	82,973	6,024	88,997	78,804
Office Supplies and Expense	9,410	9,341	2,865	12,016	1,137	34,769	16,035	50,804	30,571
Telephone and Communications	17,735	16,763	5,646	23,020	2,236	65,400	13,896	79,296	68,146
Technology Expenses	61,790	57,558	19,151	83,763	42,753	265,015	25,936	290,951	321,305
Conferences	47,002	15,785	-	218	-	63,005	38,920	101,925	19,562
Depreciation Expense	7,137	5,301	2,121	7,101	1,748	23,408	1,702	25,110	25,111
Staff Development and Enrichment	-	-	-	-	-	-	50,221	50,221	33,833
Dues and Subscriptions	-	-	8	36,500	-	36,508	21,361	57,869	64,877
Equipment Rental	9,596	7,128	2,852	9,548	2,352	31,476	2,285	33,761	37,692
Insurance	-	-	-	-	-	-	18,182	18,182	16,987
Miscellaneous Expense	155	14,707	7,314	-	-	22,176	19,478	41,654	30,960
Total Functional Expenses	**$ 2,916,671**	**$ 2,546,047**	**$ 726,330**	**$ 3,803,314**	**$ 760,763**	**$10,753,125**	**$ 704,725**	**$11,457,850**	**$10,145,353**

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HUMAN SERVICES RESEARCH INSTITUTE, INC.

STATEMENT OF FUNCTIONAL EXPENSES
FOR THE YEAR ENDED SEPTEMBER 30, 2021

	PROGRAM SERVICES							
	APPLIED RESEARCH AND CONSULTING SERVICES					TOTAL		TOTAL
	IDD	BEHAVIORAL HEALTH	CYF	POPULATION HEALTH	VERITY ANALYTICS	PROGRAM SERVICES	ADMINI-STRATIVE	FUNCTIONAL EXPENSES
Salaries and Wages	$ 1,646,069	$ 670,049	$ 344,592	$ 1,034,012	$ 220,359	$ 3,915,081	$ 188,427	$ 4,103,508
Payroll Taxes and Benefits	774,864	315,416	162,212	486,747	103,731	1,842,970	88,699	1,931,669
Subcontractors and Consultants	576,495	704,590	8,267	1,387,656	192,235	2,869,243	303,114	3,172,357
Professional Services	-	-	-	-	-	-	92,264	92,264
Travel	-	-	-	-	-	-	3,935	3,935
Occupancy	44,597	18,154	9,336	28,014	5,970	106,071	7,701	113,772
Repairs and Maintenance	30,890	12,574	6,467	19,404	4,135	73,470	5,334	78,804
Office Supplies and Expense	4,333	4,042	1,455	6,535	444	16,809	13,762	30,571
Telephone and Communications	14,384	13,518	4,994	21,679	1,580	56,155	11,991	68,146
Technology Expenses	55,029	55,877	19,536	122,861	45,621	298,924	22,381	321,305
Conferences	2,282	2,639	-	1,000	-	5,921	13,641	19,562
Depreciation Expense	9,843	4,007	2,060	6,183	1,318	23,411	1,700	25,111
Staff Development and Enrichment	-	-	-	-	-	-	33,833	33,833
Dues and Subscriptions	-	-	-	32,500	-	32,500	32,377	64,877
Equipment Rental	14,775	6,014	3,093	9,281	1,978	35,141	2,551	37,692
Insurance	-	-	-	-	-	-	16,987	16,987
Miscellaneous Expense	405	15,851	-	-	-	16,256	14,704	30,960
Total Functional Expenses	**$ 3,173,966**	**$ 1,822,731**	**$ 562,012**	**$ 3,155,872**	**$ 577,371**	**$ 9,291,952**	**$ 853,401**	**$10,145,353**

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HUMAN SERVICES RESEARCH INSTITUTE, INC.

STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED SEPTEMBER 30, 2022 AND 2021

	2022	2021
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in Net Assets	$ 81,957	$ 802,773
Adjustments to Reconcile the Above to Net Cash Provided (Used) by Operating Activities:		
Depreciation Expense	25,110	25,111
Investment Return	336,732	(272,036)
(Increase) Decrease in Current Assets:		
Accounts Receivable	(990,897)	(146,926)
Accrued Receivables	(210,602)	572,616
Employee Advances	(1,210)	127
Prepaid Expenses	(18,216)	(7,178)
Increase (Decrease) in Current Liabilities:		
Subcontracts Payable	86,339	230,117
Accounts Payable and Accrued Expenses	(8,558)	52,462
Accrued Payroll and Related Costs	95,089	8,003
Advance Billings	(796,540)	65,424
Conditional Grant Advance	-	(986,900)
(Increase) Decrease in Other Assets:		
Deposits	2,100	8,044
Net Adjustment	(1,480,653)	(451,136)
NET CASH PROVIDED (USED) BY OPERATING ACTIVITIES	**(1,398,696)**	**351,637**
CASH FLOWS FROM FINANCING ACTIVITIES:		
Principal Payments on Long-Term Debt	(94,936)	(92,595)
Net Cash Flows from Financing Activities	(94,936)	(92,595)
NET INCREASE (DECREASE) IN CASH BALANCES	**(1,493,632)**	**259,042**
CASH - BEGINNING OF YEAR	**1,941,868**	**1,682,826**
CASH - END OF YEAR	**$ 448,236**	**$ 1,941,868**
Supplemental Disclosure:		
Interest Paid	*$ 14,316*	*$ 16,658*

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HUMAN SERVICES RESEARCH INSTITUTE, INC.

NOTES TO FINANCIAL STATEMENTS

SEPTEMBER 30, 2022 AND 2021

NOTE 1 ORGANIZATION

Human Services Research Institute, Inc. ("HSRI", the "Institute" or the "Organization") was incorporated in 1976 pursuant to the District of Columbia Nonprofit Corporation Act and qualifies as a tax-exempt nonprofit corporation under Section 501(c)(3) of the Internal Revenue Code ("IRC"). The Organization has been classified as an organization which is not a private foundation under IRC Section 509(a); accordingly, contributions made to this Organization qualify for the maximum charitable deduction for federal income tax purposes.

NOTE 2 PROGRAM SERVICES

Since 1976, we've been helping to craft community-based, person-driven service and support systems. We're passionate about supporting leaders and policymakers, and the people they serve, because we share the same goal: to see all people living healthy, fulfilling lives as empowered, respected members of society.

Our team of dedicated professionals provides research, support and guidance to clients looking to develop more efficient and responsive service systems. Combining rigorous quantitative research with community-based participatory research and system design, we strive for more-impactful results and more specific roadmaps to improvement.

We work across all sectors and program areas in health and human services, addressing the needs of people with intellectual and developmental disabilities; people experiencing behavioral health disorders; children, youth and families; seniors and people with physical disabilities; people experiencing housing instability or homelessness; and states and communities looking to promote population health.

Intellectual and Developmental Disabilities, Aging, and Disability:

Since 1976, we've been working with self-advocates and families to research and shape effective community-based services and supports for people with intellectual and developmental disabilities ("IDD"). We've been honored to assist agencies in moving consistently in the direction of higher-quality, more person-driven, self-directed services:

- Building policy and practice in support of self-directed models of service delivery
- Supporting the expansion of integrated community living options as people with IDD move from public institutions
- Applying Medicaid waiver funds efficiently and effectively to achieve person-centered policy objectives in community based settings
- Working with stakeholders to build capacity for person centered practice
- Growing the availability of practices to support families
- Enhancing quality assurance and improvement systems including the development of nationally recognized quality measures
- Supporting the self-advocacy movement including grassroots work to build an expectation of person-centered practice
- Reviewing and modifying service planning and delivery in order to provide culturally and linguistically competent services
- Teaming with government agencies and national organizations to promote the well-being of older individuals and people with physical disabilities by improving the services and programs designed to help them live independently in their homes and communities

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NOTE 2 *(Continued)*

We collaborate with national organizations in these efforts, including the National Association of State Directors of Developmental Disabilities Services to support the National Core Indicators - an outcome measurement system that spans nearly all 50 states. We also have longstanding partnerships with the Institute on Community Inclusion at the University of Massachusetts and the Research and Training Center on Community Integration at the University of Minnesota.

We also assist IDD agencies around the country to allocate resources more efficiently, effectively, and equitably. This process often involves systems changes to alter the services available, rebase reimbursement rates, assess individual support needs, and assign personal supports budgets to each individual.

In addition to HSRI's 20-year commitment to National Core Indicators, the Organization has teamed with the National Association of State Units on Aging and Disability to launch the National Core Indicators for Aging and Disability ("NCI-AD"). NCI-AD entails a survey of adult participants in Aging and Disability Home and Community-Based Services waivers, Older Americans programs, and state plan Medicaid services.

Child, Youth and Family:

We provide program evaluation, consultation, training and technical assistance to child-serving agencies to promote best practices. We also support cross-agency approaches to address the whole needs of child welfare-involved families, including children and families with developmental disabilities and families living with mental health or substance use issues.

Our approach hinges on strong communication and collaboration, making sure our work is grounded in the reality of the current service environment as experienced by children and families. We also find value in sharing findings as a project progresses, so everyone involved can see the value of the effort and make ongoing adjustments as needed.

Behavioral Health:

We work with government agencies, community-based organizations, and other partners to identify sustainable ways to promote wellness and advance the quality of life for people and communities. Our projects include program evaluation, intervention research, needs assessment, systems planning, and technical assistance. The methods we employ range from community-based participatory research to advanced data analysis, and we frequently use mixed methods approaches that integrate qualitative and quantitative data to inform our findings and recommendations.

Our values are front and center in all that we do: People with lived experience of receiving mental health and substance use services should drive change, as external partners (e.g. advisors, advocates) and internal leaders (e.g. service providers, executive leadership). We embrace and promote person-centered, trauma-informed, culturally responsive practices, and we hold that good and modern behavioral health systems should emphasize equity, self-determination, and inclusion.

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NOTE 2 *(Continued)*

The behavioral health team has: conducted needs assessment to identify service needs at the national, state and local levels; identified, implemented and evaluated evidence-based practices and promising practices in the areas of housing, employment, case management, integrated services, peer-operated services, etc.; evaluated the cultural competency of services; developed computerized budget simulation and resource allocation models for projecting the costs and potential cost offsets of implementing jail or prison diversion programs for offenders with mental illness; and have conducted synthetic estimations and other techniques to assist states and counties prepare for health care reform. The Behavioral Health team also works with health data in building data warehouses and working with states on using this data to track utilization, cost and monitoring quality.

Population Health:

The population health team builds data systems to collect, analyze, and report health care data to improve the quality of health information available for research, policy, and practice. Our data helps health policy makers improve population health and health care delivery and aids consumers in choosing where they receive care. For 20 years, we've analyzed health claims data to generate high-quality insights into population health. Combining that experience with our expertise working with stakeholder groups to collaboratively develop and define quality measures and data metrics (including consumer outcome measures), we now help agencies develop non-proprietary data collection and reporting systems. With our deep understanding of models and systems across the health and human services sectors, we help leverage and enhance existing health claims and other datasets wherever possible.

HSRI works closely with a variety of federal, state and private entities to design, implement, and evaluate health data systems with the goal of providing high-quality data for both system management and research functions. HSRI prides itself on creating health data systems that are responsive to the needs of all stakeholders: funders, data submitters, data users, and the general public. Based on this principle, our health data systems are designed so provider organizations and states can manage their information assets; to facilitate retrieval of relevant information quickly and efficiently; to ensure the reliability of data submitted; to meet the needs of multiple data users related to program oversight, cost monitoring, quality assurance and program evaluation; and to quickly provide those data back to stakeholders in a user-friendly fashion.

We are promoting more effective use of healthcare data to inform and transform public and population health, improve the effectiveness of healthcare markets, and address persistent inequities and disparities in healthcare. To advance equitable solutions, we are working towards health data systems that can disaggregate data by race. When we disaggregate health data by race, our goal is to show the effects of policies and practices that have been shaped by structural racism and other forms of discrimination - and to envision solutions that can create an equitable future for all communities.

Verity Analytics:

Verity Analytics helps policy makers and others improve workflows and make informed policy decisions to drive person-centered outcomes - all while staying compliant with data security requirements. Verity Analytics is a cloud-based business intelligence software that enables users to work more efficiently to monitor system performance and improve workflows. Built to be easily consumed and shared, Verity Analytics provides the foundation to answer big predictive questions, examine policy implications, and coordinate strategies across agencies.

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NOTE 2 *(Continued)*

Whether interacting with the data from your own dashboards, publishing point-in-time extracts, or providing a live interactive demonstration with key stakeholders, these data can help you make data-driven decisions that best serve people.

NOTE 3 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting:

The financial statements of the Human Services Research Institute, Inc. have been prepared on the accrual basis of accounting and accordingly, reflect all significant receivables, payables and other liabilities.

Estimates:

The preparation of financial statements in conformity with generally accepted accounting principles ("GAAP") 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 date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates; however, adherence to generally accepted accounting principles, has in management's opinion, resulted in reliable and consistent financial reporting by the Organization.

Fair Value of Financial Instruments:

The Organization reports its fair value measures by using a three-level hierarchy that prioritizes the inputs used to measure fair value. This hierarchy, established by generally accepted accounting principles, requires that entities maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value.

The three levels of inputs used to measure fair value are as follows:

Level 1 - Quoted prices for identical assets or liabilities in active markets to which the Organization has access at the measurement date.

Level 2 - Inputs other than quoted prices included in Level 1 that are observable for the asset or liability, either directly or indirectly. Level 2 inputs include quoted prices for similar assets or liabilities in active markets; quoted prices for identical or similar assets in markets that are not active; observable inputs other than quoted prices for the asset or liability (for example, interest rate and yield curves); and inputs derived principally from, or corroborated by, observable market data by correlation or by other means.

Level 3 - Unobservable inputs for the asset or liability. Unobservable inputs should be used to measure the fair value to the extent that observable inputs are not available.

The primary use of fair value measures in the Organization's financial statements is the recurring measurement of its investments. There have been no changes to this valuation methodology.

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NOTE 3 *(Continued)*

Financial Statement Presentation:

The Organization reports information regarding its financial position and activities according to two classes of net assets: net assets without donor restrictions and net assets with donor restrictions. These classifications are related to the existence or absence of donor-imposed restrictions as defined below.

Net Assets Without Donor Restrictions - Net assets without donor restrictions are resources available to support operations and not subject to donor restrictions. In addition, net assets within this classification include funds which represent resources designated by the Board of Directors for specific purposes.

Net Assets With Donor Restrictions - Some restrictions are temporary in nature, such as those that are restricted by a donor for use for a particular purpose or in a particular future period. Other restrictions may be perpetual in nature; such as those that are restricted by a donor that the resources be maintained in perpetuity. As of September 30, 2022 and 2021, the Organization has no net assets that are required to be maintained in perpetuity. The Organization's unspent contributions are reported in net assets with donor restrictions if the donor limited their use, as are promised contributions that are not yet due. Contributions of property and equipment or cash restricted to acquisition of property and equipment are reported as net assets with donor restrictions if the donor has restricted the use of the property or equipment to a particular program. These restrictions expire when the assets are placed in service.

Accounts Receivable:

Accounts Receivable represents amounts due from grant and contract revenues earned. HSRI carries its accounts receivable at net realizable value. Management periodically reviews specific receivables to determine if any balances are uncollectible. HSRI does not accrue interest on its receivables. A receivable is considered past due if payment has not been received within the stated terms. HSRI will then exhaust all methods to collect the receivable. As of September 30, 2022, and 2021, all receivables were considered fully collectible; accordingly, there is no provision for uncollectible receivables and there was no bad debt expense for the years then ended.

Accrued Receivables:

Accrued Receivables represents amounts due for services provided but not yet invoiced under the terms of the grant or contract.

Property and Equipment:

Property, equipment, furnishing and improvement purchases in excess of $5,000 are capitalized at cost, if purchased, or if donated, at fair value at the date of receipt. Expenditures for maintenance, repairs and renewals are charged to expense as incurred, whereas major betterments are capitalized as additions to property and equipment. Depreciation of property and equipment is computed on a straight-line basis over the following estimated useful lives of the assets, as expressed in terms of years.

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NOTE 3 *(Continued)*

Asset Category	Useful Life
Land	-
Building	40
Furniture and Fixtures	5
Equipment	5

The Organization reviews its investment in real estate for impairment whenever events or changes in circumstances indicate that the carrying value may not be recoverable. Recoverability is measured by a comparison of the carrying amount of the real estate to the future net undiscounted cash flow expected to be generated by the property and any estimated proceeds from the eventual disposition of the real estate. If the real estate is considered to be impaired, the impairment to be recognized is measured at the amount by which the carrying amount of the real estate exceeds the fair value of the property. There were no impairment losses recognized in the years presented.

Investments:

The Organization maintains an investment portfolio which consists of cash, mutual funds and exchange traded products. Investment purchases are recorded at cost, or if donated at fair value on the date of donation. Thereafter, investments are reported at their fair values in the Statements of Financial Position. Net investment return (loss) is reported in the Statements of Activities and consists of interest and dividend income, realized and unrealized capital gains and losses, less external and direct internal investment expenses. Cash held in brokerage accounts is reported as investments for purposes of these financial statements. Investments are classified as either short-term or long-term, depending upon the underlying intentions. For the years presented, investments comprise the *Board Designed Operating Reserve Fund.*

Revenue Recognition:

Revenue from grants and contracts is recognized as eligible expenditures are incurred or as deliverable services are provided under the terms of the grant or contract. Under the provisions of certain grants and contracts, HSRI may receive payments in advance and scheduled monthly and quarterly payments which may also be in advance of services rendered and/or costs incurred. Funds received in excess of amounts earned, are recorded as *Advance Billings,* a contract liability in the accompanying Statements of Financial Position.

HSRI follows the below five-step process for revenue recognition for its *Contract and Grant Funded Research:*

1. Identify the contract with the customer
2. Identify the performance obligations within the contract
3. Determine the overall transaction price for the contract
4. Allocate the transaction price to the performance obligations
5. Recognize revenue when performance obligations are satisfied

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NOTE 3 *(Continued)*

Performance obligations are determined based on the nature of the services provided by the Organization in accordance with the contract. Revenue for performance obligations satisfied over time is recognized ratably over the period based on time elapsed. The Organization believes this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Revenues from consulting are recognized as the services are performed. Revenue for performance obligations satisfied at a point in time is generally recognized when goods or services are provided to customers at a single point in time and the Organization does not believe it is required to provide additional services related to that agreement or portion thereof. The Organization determines the transaction price based on standard charges for services provided. The Organization's revenue streams do not have significant financing components or contract costs.

Gifts, Grants and Contributions:

The Organization is the beneficiary of contributions in the form of grants from other organizations, governmental agencies, donations of cash and financial assets from individuals and contributions of nonfinancial assets. Contributions, including promises to give, without donor conditions are recognized as revenue at their estimated fair value at the date of donation and classified as either with or without donor restrictions depending on the donor's stipulations or lack thereof. Unconditional, multi-year commitments are recognized in the year during which the initial commitment is made at the amount that the Organization reasonably expects to collect. Contributions to be received after one year are discounted at an appropriate discount rate commensurate with the risk involved when such amounts are considered material. Amounts receivable from donors are evaluated yearly for collectability and an allowance for uncollectible pledges is recorded as necessary.

Support that is restricted by the donor is reported as an increase in net assets with donor restrictions depending on the nature of the restriction until the restriction expires, at which time these amounts are reclassified to net assets without donor restrictions. Donor restricted contributions are classified as net assets without donor restrictions if the restrictions are met in the same reporting period in which the contributions are received.

Conditional donations are those that have a measurable performance or other barrier and include a right of return of the assets or right of release of the donor from further obligation if the conditions are not met. Conditional donations are not recognized until the associated barriers are met. Any cash received before the conditions or barriers are met is reported as a refundable grant advance. When the conditions are met the revenue is reported as contributions without donor restrictions unless there are further restrictions over and above those associated with the donor conditions. In such cases, when the conditions and restrictions are met within the same reporting period, the support is recognized as contributions or grants without donor restrictions.

Donations of Nonfinancial Assets:

Donated services are recognized as contributions if the services (a) create or enhance nonfinancial assets or (b) require specialized skills, are performed by people with those skills, and would otherwise be purchased by the Organization. For the years presented, there were no contributions of goods or services which met the recognition criteria.

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NOTE 3 *(Continued)*

Functional Expenses:

The Organization allocates its expenses on a functional basis among its various programs and support services. Expenses which can be identified with a specific program and support service are allocated directly according to their natural expense classification. For the years presented, *Salaries and Wages* and *Payroll Taxes and Benefits* are allocated based on employee time and effort. *Occupancy, Repairs and Maintenance, Depreciation Expense, Equipment Rental* and *Insurance* are allocated based on square footage weighted by employee time and effort. Supporting services are those related to operating and managing the Human Services Research Institute, Inc. and its programs on a day-to-day basis.

Supporting services have been sub-classified as follows:

Administrative - includes all activities related to Human Services Research Institute, Inc.'s internal management and accounting for program services.

Fund Raising - includes all activities related to maintaining contributor information, membership development, distribution of materials and other similar projects related to the procurement of funds for the Organization's programs. For the years presented, there were no fund raising activities or costs.

NOTE 4 PROPERTY AND EQUIPMENT

The following is a summary of *Property and Equipment* as of September 30, 2022 and 2021:

Asset Category	2022	2021
Land	$ 453,540	$ 453,540
Building	1,004,402	1,004,402
Subtotal	1,457,942	1,457,942
Less: Accum. Depreciation and Amortization	(125,550)	(100,440)
Net Property and Equipment	$1,332,392	$1,357,502

Depreciation expense was $25,110 and $25,111 for the years ended September 30, 2022 and 2021, respectively, and is included in *Depreciation Expense* on the Statement of Functional Expenses.

NOTE 5 INVESTMENTS

As of September 30, 2022 and 2021, all investments represent the *Board Designated Operating Reserve Fund* and are classified as long-term in the accompanying Statements of Financial Position. Investments consisted of the following components:

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NOTE 5 *(Continued)*

Investment Type	September 30, 2022 Fair Value (Level 1)	Total Investments
Equity Mutual Funds	$ 251,474	$ 251,474
Bond Mutual Funds	270,719	270,719
Exchange-Traded Equity Funds	799,948	799,948
Exchange-Traded Bonds Funds	34,292	34,292
Cash and Cash Equivalents	-	16,435
Total	$1,356,433	$1,372,868

Investment Type	September 30, 2021 Fair Value (Level 1)	Total Investments
Equity Mutual Funds	$ 605,485	$ 605,485
Bond Mutual Funds	620,394	620,394
Exchange-Traded Equity Funds	422,748	422,748
Exchange-Traded Bonds Funds	42,330	42,330
Cash and Cash Equivalents	-	18,643
Total	$1,690,957	$1,709,600

HSRI uses the following ways to determine the fair value of its investments:

Mutual Funds and Exchange-Traded Products: Determined by the published closing price on the last business day of the fiscal year.

NOTE 6 DEBT

Seller-Financed Debt:

In connection with the acquisition of real estate, HSRI issued a mortgage note and a promissory note to the sellers of the property with the following terms and conditions. The Organization's Founder and President Emeritus, together with her spouse, hold a promissory note dated October 12, 2017 in the original amount of $965,771. The promissory note is secured by a first priority mortgage on the underlying property, subject to interest at the annual rate of 2.5%, and payable in monthly installments of $9,104 over a ten-year term, maturing October 12, 2027. As of September 30, 2022, the outstanding balance on the mortgage note was $521,014 and interest paid during FY 2022 and FY 2021 amounted to $14,316 and $16,658, respectively, which is included in *Occupancy* in the accompanying Statements of Functional Expenses.

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NOTE 6 *(Continued)*

The current portion of the debt due in FY 2023 is $91,932, while the subsequent maturities of the long-term portion are scheduled below.

Fiscal Year Ending	Amount
September 30, 2024	$ 99,384
September 30, 2025	101,897
September 30, 2026	104,474
September 30, 2027	107,116
September 30, 2028	16,211
Total	$429,082

Working Capital Line-of-Credit:

HSRI maintains a $500,000 revolving line-of-credit with Century Bank (the "Bank"). Borrowings on the line-of-credit bear interest at a floating rate per annum equal to the Bank's prime lending rate plus 0.5%, which was 6.75% and 3.75% as of September 30, 2022 and 2021, respectively. The note is collateralized by a first priority security interest in all business assets and requires HSRI to maintain its operating cash accounts at the Bank. The line-of-credit is subject to an annual renewal review, and unless renewed, expires on January 31, 2023. There were no borrowings on the line-of-credit during either year presented.

NOTE 7 REVENUE FROM CONTRACTS WITH CUSTOMERS

Future performance obligations under contract agreements are as follows:

Fiscal Year Ending	Amount
September 30, 2023	$12,166,449
September 30, 2024	3,812,868
September 30, 2025	1,521,510
Total	$17,500,827

The change in contract liabilities for future performance obligations arising from contracts with customers, reported as *Advance Billings,* is scheduled below.

Advance Billings	Amount
Advance Billings, October 1, 2020	$ 2,233,336
Revenue Recognized FY 2021	(1,731,073)
Increase in Advance Billings	1,796,497
Advance Billings, September 30, 2021	2,298,760
Revenue Recognized FY 2022	(1,548,773)
Increase in Advance Billings	752,233
Advance Billings, September 30, 2022	$ 1,502,220

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NOTE 8 RETIREMENT PLAN

HSRI sponsors a defined contribution plan (the "Plan") available to all employees meeting certain eligibility requirements. The Plan allows employees to defer a percentage of their salaries. HSRI may contribute up to 5% of the employee's salary. Employer contributions were $254,020 and $236,963 for the years ended September 30, 2022 and 2021, respectively, representing 5% of eligible compensation in each year and is included in *Payroll Taxes and Benefits* in the accompanying Statements of Functional Expenses.

NOTE 9 LEASE OBLIGATIONS

Facilities:

During the years ended September 30, 2022 and 2021, HSRI leased office and program space in Oregon that amounted to $8,044 and $5,700, respectively. The Organization's lease commitments in Oregon ended in March 2022.

HSRI leases additional space in Cambridge, Massachusetts under a lease that expired in July 2021. Thereafter, HSRI has continued to occupy this space on a tenancy-at-will basis. Rent paid under this lease amounted to $60,840 and $63,148 for the years ended September 30, 2022 and 2021, respectively, and HSRI paid a $5,580 security deposit as part of the agreement.

Occupancy, as reported on the Statement of Functional Expenses, includes mortgage interest expense, rent expense, utility costs and common area maintenance costs.

Equipment:

HSRI also leases office equipment under operating leases that expire at various dates through December 2022. The total equipment lease expense was $33,761 and $37,693 for the years ended September 30, 2022 and 2021, respectively, and the remaining obligation of $300 is due in FY 2023.

NOTE 10 COMMITMENTS

Long-Term Contract Commitments:

Contract Revenue

HSRI has been providing contracted technical support and analytic services to build and support a data warehouse under a long-term contract with the State of Maine, Maine Health Data Organization ("MHDO") that initiated in March 2013. The contract, as amended, provided for annual renewals of $1 million through November 30, 2022, subject to MHDO approval, for HSRI to provide ongoing technical support and project management to MHDO. Effective May 1, 2018, HSRI and MDHO executed a contract for HSRI to continue its services for the period of July 1, 2018 through November 30, 2022, with an initial maximum compensation amount of $4,637,000. The contract was amended several times to add additional services, increasing the maximum compensation to $10,113,844 and $6,211,844 as of September 30, 2022 and 2021, respectively. For the years ended September 30, 2022 and 2021, total billings under this contract amounted to $1,915,873 and $1,234,192, respectively. As of September 30, 2022 and 2021, *Advance Billings* in connection with the MHDO contracts amounted to $238,705 and $40,716, for each respective year.

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NOTE 10 *(Continued)*

The balance remaining on the contract was $3,850,599 and $1,632,319 as of September 30, 2022 and 2021, of which amount HSRI anticipates that it will recognize approximately $1,472,724 in FY 2023, $1,678,500 in FY 2024 and $699,375 by the contract termination date of November 30, 2024.

HSRI is also party to a Master Service Agreement with the Center for Improving Value in Health Care ("CIVHC"), a Colorado nonprofit organization. The original agreement for services was for a two-year term expiring on June 30, 2019, at which time the agreement provided for an extension for up to two successive two-year periods. CIVHC and HSRI agreed to extend the term of the agreement through June 30, 2023, for which HSRI is compensated a fixed monthly amount of $100,846 through June 30, 2022 and $104,640 thereafter through June 30, 2023. Total revenue recognized under agreements with CIVHC for the years ended September 30, 2022 and 2021 amounted to $1,318,502 and $1,309,332, respectively. As of September 30, 2022 and 2021, *Advance Billings* in connection with the CIVHC contracts amounted to $62,910 and $20,769, respectively.

Subcontracted Research

In connection with the MHDO contract, HSRI has subcontracted NORC at the University of Chicago ("NORC") to collaborate in the development and ongoing technical support of the data warehouse project. HSRI and NORC entered into a subcontractor agreement effective for the period July 1, 2018 through November 30, 2022, in line with the MHDO project. Under the subcontract agreement, HSRI will compensate NORC for services in the aggregate amount of $1,854,000, payable in specific monthly installments pursuant to a statement of work as defined in the agreement. For the fiscal years ended September 30, 2022 and 2021, payments to NORC in connection with this subcontract agreement amounted to $399,733 and $400,000, respectively, while the balance of the contract is expected to be paid in monthly installments of $33,200 through November 30, 2022.

In connection with the CIVHC contract, HSRI has entered into an additional subcontract agreement with NORC for the four-year period expiring June 30, 2023, with a maximum compensation limit of $1,429,824 payable in monthly installments ranging from $23,246 to $34,650 for the duration of the agreement.

NOTE 11 IMPACT OF COVID-19 AND CARES ACT FUNDING

Impact of COVID-19:

The COVID-19 outbreak in the United States has caused business disruption through mandated and voluntary closings of many organizations. While the disruption is currently expected to be temporary, there is considerable uncertainty around the duration of the closings. However, the related financial impact and duration cannot be reasonably estimated at this time. Due to no cost extensions and other temporary suspension of activities in some limited cases, certain current liabilities may be realized more than twelve months from the balance sheet date.

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NOTE 11 *(Continued)*

Paycheck Protection Program:

The Organization received a loan in the amount of $986,900 from Century Bank through the Paycheck Protection Program established by the U.S. CARES Act (the "PPP Loan") on April 30, 2020. The Organization has elected to account for the expected forgivable portion of this loan as a conditional grant commitment as permitted by the AICPA. The Organization applied for and received forgiveness in full of the PPP Loan on August 17, 2021 and recognized $986,900 of grant income for the year ended September 30, 2021.

NOTE 12 CONCENTRATIONS

Cash:

The Organization maintains its depository balances in two financial institutions. Cash balances are insured up to $250,000 per institution by the Federal Deposit Insurance Corporation ("FDIC"). As of September 30, 2022 and 2021, cash balances in excess of the FDIC coverage were $211,224 and $1,727,412, respectively; however, the Organization has not experienced any losses on uninsured cash balances and management considers credit risk on cash to be low.

Investments:

The Organization invests in professionally managed funds that contain various types of marketable securities. The Organization's investments are exposed to various risks, such as fluctuations in market value, and credit risk. Thus, it is at least reasonably possible that changes in the near term could materially affect investment balances. The Organization's investment performance is reviewed by the Board of Directors on a periodic basis.

Advance Billings:

One project represents 43% and 49% of the *Advance Billings* as of September 30, 2022 and 2021, respectively.

Expenses and Payables:

A significant portion of total expenses consists of subcontracted services. Of these services, amounts attributed to one subcontractor represented 48% and 43% of total *Subcontractors and Consultants* expense for the years ended September 30, 2022 and 2021, respectively, and 73% and 74% of *Subcontracts Payable* as of September 30, 2022 and 2021, respectively.

NOTE 13 RELATED PARTY TRANSACTION

Debt:

As further discussed in Note 6, HSRI purchased a facility from an entity which was controlled by former senior HSRI staff members with debt held by one current member of HSRI's staff.

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NOTE 14 LIQUIDITY AND AVAILABILITY OF FINANCIAL ASSETS

The following table reflects the Organization's financial assets, reduced by amounts not available for general expenditure within one year. Financial assets are considered unavailable when illiquid or not convertible to cash within one year or because the governing board has set aside the funds for a specific contingency reserve or a long-term investments.

As part of the Organization's liquidity management, it has a policy to structure its financial assets to be available as its general expenditures, liabilities, and other obligations come due. To help manage unanticipated liquidity needs the Organization has a working capital line-of-credit of $500,000, which it could draw upon. See Note 6 for information about the Organization's line-of-credit. Additionally, the Organization has Board-Designated investment funds that, while the Organization does not intend to spend these for general operating purposes within the next year, these amounts could be made available for current operations, if necessary.

For purposes of analyzing resources available to meet general expenditures over a twelve-month period, HSRI considers all expenditures related to its ongoing activities of research programs as well as the conduct of services undertaken to support those activities to be general expenditures.

	2022	2021
Financial Assets:		
Cash	$ 448,236	$ 1,941,868
Accounts Receivable	3,153,490	2,162,593
Accrued Receivables	298,748	88,146
Investments	1,372,868	1,709,600
Total Financial Assets as of September 30,	5,273,342	5,902,207
Less Amounts Not Available to be Used Within One Year:		
Board-Designated Operating Reserve Fund	(1,372,868)	(1,709,600)
Financial Assets Available to Meet General Expenditures Within One Year	$ 3,900,474	$ 4,192,607

NOTE 15 SUBSEQUENT EVENTS

Management is required to consider events subsequent to the financial statement date for potential adjustment to or disclosure in the financial statements. Therefore, Management has evaluated subsequent events through February 2, 2023, the date which the financial statements were available for issue, and noted the below event which met the disclosure criteria:

Subcontract Research Commitment:

Subsequent to year end, effective December 1, 2022, HSRI extended its existing agreement with NORC on the MHDO long-term contract. The extended subcontract agreement is for 12 months with fixed monthly subcontract payments of $38,551, totaling $462,608 through November 30, 2023.

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Board of Directors

Roy Gabriel, Chair
Joseph Ray, Vice Chair
Eric Washington, Secretary-Treasurer
Sheryl White-Scott
Finn Gardiner
Ray Campbell
Ruth Luckasson

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Benjamin Cichocki, ScD, CRC, CPRP

Research Associate
[redacted] | www.hsri.org

Profile

Dr. Cichocki has over 24 years of experience in behavioral health, 17 years of which have been spent conducting systems and program evaluation and research. He has led and been a key member of numerous national and smaller-scale evaluations of mental health programs and systems, employing a mix of qualitative and quantitative approaches.

Project Experience

Research Associate, *North Dakota Behavioral Health Needs Assessment and North Dakota Behavioral Health Strategic Planning*

Funder: **ND Department of Human Services Behavioral Health Division** | Dates: **2017 – Present**

Contribution: In 2017 and 2018, HSRI conducted an in-depth review of North Dakota's behavioral health system and produced recommendations and strategies for implementing changes to address the needs of the community. Beginning in 2018, HSRI is working with the State's Behavioral Health Planning Council to facilitate an in-depth strategic planning process to implement the recommendations for behavioral health systems transformation. Populations of focus include individuals with mental health conditions, substance use disorders, and brain injury. Ben contributes to all aspects of the study, including recruiting key informants for interviews, conducting interviews, and analyzing interview and other qualitative data. He also assists with reports.

Project Director, *Decoded Evaluation*

Funder: **The Social Changery** | Dates: **2022 – Present**

Contribution: In collaboration with The Social Changery, its client Sonoma County, San Mateo County, and other project partners, HSRI will develop, plan, and implement strategy and efforts to evaluate the (Cannabis) Decoded campaign's messaging and media asset content targeting youth and young adults ages 13-25 in preparation for a larger public education campaign planned for Spring of 2023. Ben developed the evaluation plan, has overseen development of the data collection tools, and has recruited the participant pool. He will oversee data collection, analysis, and reporting as those phases of the project are completed.

Research Associate, *Wake County Behavioral Health Crisis System Assessment*

Funder: **Wake County, North Carolina** | Dates: **2022 – 2023**

Contribution: Wake County contracted HSRI to assess the county's behavioral health crisis service system. This included an assessment of services across the crisis continuum in comparison to national best practices for crisis care. Using

Education

ScD
Boston University
Boston, MA
(Rehabilitation Sciences/Psychiatric Rehabilitation)

MS
Boston University
Boston, MA
(Rehabilitation Counseling/ Psychiatric Rehabilitation)

BS
Boston University
Boston, MA
(Rehabilitation and Human Services)

Professional Experience

Research Associate
(2014 – Present)
Senior Policy/Research Analyst
(2013 – 2014)
Policy Analyst
(2007 – 2013)
Research Assistant
(2006 – 2007)
Human Services Research Institute
Cambridge, MA

Oversight Committee Member, CPS Program
(2014 – Present)
The Transformation Center
Roxbury, MA

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qualitative and quantitative methods, the team identified strengths and gaps in the county's crisis system and made recommendations for improvements. Ben participated in project meetings and assisted with development of project materials, conducted focus groups with individuals with lived experience, and summarized focus group findings for the final report.

Research Associate, *Comprehensive Statewide Assessment of the Vocational Rehabilitation Needs of Individuals with Disability in New Hampshire*
Funder: **NH Department of Education, Division of Workforce Innovation, Bureau of Vocational Rehabilitation** | Dates: **2019**
Contribution: HSRI designed and implemented a CSNA for the New Hampshire Department VR. The work involved data collection and analysis in order to inform the 2019 CSNA which (1) assured that the Agency is in compliance with 34 CFR 361.29, and (2) yielded information on the known participant levels and the unknown possible participants, both of which will impact program outreach and operation. Ben helped develop data collection materials.

Research Associate, *Evaluation of Implementation to Fidelity of Evidence-Based Services*
Funder: **University of South Florida** | Dates: **2022 – Present**
Contribution: As sub-contractor to the University of South Florida, HSRI is leading the fidelity evaluation of nine evidence-based programs, rated under the Title IV-E Prevention Services Clearinghouse, and assisting with both the process and outcomes components of the state-wide study. Ben is a member of the process evaluation team. He participated in key informant interviews and conducted qualitative analysis of them, and will be assisting with the EBP fidelity component of the evaluation.

Project Manager/Research Associate, *Traumatic Brain Injury Technical Assistance and Resource Center (TBI TARC)*
Funder: Administration for Community Living (ACL) | Dates: 2019 – Present
Contribution: HSRI is operating a Technical Assistance and Resource Center for ACL's TBI State Partnership Program (SPP) grantees and its stakeholders. Ben developed the Center's TA protocols and procedures, and is currently supporting the delivery of TA and materials, providing project management, and actively delivering TA to TBI SPP grantee workgroups.

Project Director, *Gap Analysis of Group, Residential, and Psychiatric Treatment in South Dakota*
Funder: **SD Department of Social Services, Division of Child Protection** | Dates: **2021 – 2022**
Contribution: HSRI explored the needs in services either provided or not currently offered to youth in South Dakota by conducting an assessment and evaluation of current stakeholders at multiple levels of service in order to determine services needed and the feasibility of providing those services in the state. As lead staff person for the work, Ben was fully responsible for all activities and performance on this project and served as the primary point of contact. He was responsible for monitoring deliverables and the budget.

Project Director, *Study of the Baltimore Law Enforcement Assisted Diversion (LEAD) Program*
Funder: **Alliance for Open Society International, Inc.** | Dates: **2021 – 2022**
Contribution: HSRI evaluated the Baltimore LEAD program to provide more in-depth information about the structure and processes of the current system with recommendations about opportunities for improvement. LEAD is an evidence-based program of the Baltimore Police Department, developed in partnership with a variety of other agencies, that aims to reduce harm and criminal behavior related to

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minor drug offenses and prostitution. Ben was responsible for reviewing LEAD policies, overseeing the literature review, conducting key interviews of important stakeholders, performing qualitative analysis, and writing the final report.

Project Manager, *AllyNetwork Evaluation*
Funder: **Alameda County, CA** | Dates: **2020 – 2022**
Contribution: HSRI evaluated the AllyNetwork App, a web-based application designed to increase access and use of the mental health services for the 500,000 immigrants, refugees, and asylees in Alameda County. The evaluation involved an observational, longitudinal, pre-post study design using a mix of qualitative and quantitative methods with both survey and interview components. Ben was responsible for obtaining IRB approval, conducting interviews, overseeing data collection and analysis, and authored the final report.

Project Manager, *South Dakota Behavioral Health Service System Needs Assessment/Gap Analysis*
Funder: **SD Department of Social Services** | Dates: **2020 – 2021**
Contribution: HSRI conducted a comprehensive assessment of South Dakota's public behavioral health system and provided recommendations to the state for addressing gaps in services. Ben was involved in all aspects of the study, including recruiting key informants for interviews, conducting interviews, analyzing interview and other qualitative data, and drafting the final report.

Research Associate, *Developing the Framework for a Large-Scale National Demonstration of Self-Direction in Behavioral Health*
Funder: **Robert Wood Johnson Foundation** | Dates: **2016 – 2021**
Contribution: Funded by the Robert Wood Johnson Foundation and the New York State Health Foundation with support from Substance Abuse and Mental Health Services Administration (SAMHSA), HSRI led an evaluation of mental health self-direction in six states, charting best practices and exploring its impacts at the individual and system level. As part of the project, HSRI developed mentalhealthselfdirection.org, a resource that features participant stories and serves as a clearinghouse for all things mental health self-direction. Ben conducted qualitative analysis, and co-presented early process findings via a NASMHPD webinar. He also co-authored the draft evaluation plan and data collection materials.

Project Manager, *North Central Health Care (NCHC) Behavioral Health System Planning Project*
Funder: **NCHC** | Dates: **2019 – 2020**
Contribution: HSRI conducted a systems needs and gaps analysis and assisted with the development of a system-wide strategic plan for the public behavioral health system for 3 counties in Central Wisconsin. HSRI examined services available and the access, utilization, workforce capacity, use of best practices, quality, and outcomes of the services provided within the public behavioral health system. Ben developed data collection materials, recruited and conducted key informant interviews and focus groups, worked to obtain claims and other data from the NCHC system for analysis, oversaw quantitative analysis, performed qualitative analysis, and developed the draft of the final report.

Research Associate, *Maine Homeless Initiatives Gaps and Needs Analysis*
Funder: **Maine State Housing Authority** | Dates: **2019 – 2020**
Contribution: HSRI conducted a gap and needs analysis of the services, resources, and housing available to, and needed by, individuals and families experiencing homelessness in Maine. HSRI produced a set of actionable, measurable, prioritized recommendations for addressing gaps and needs that can be used to inform homeless project and services planning in the Maine Continuum of Care

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(MCoC) and 2020-2024 Consolidated Plan. Ben helped develop data collection materials; recruited, scheduled and conducted interviews and focus groups with key stakeholders; and contributed to the final report.

Project Director, *Public Behavioral Health Gap Analysis*
Funder: **Behavioral Health System Baltimore (BHSB)** | Dates: **2018 – 2020**
Contribution: HSRI conducted a gap analysis of BHSB, examining services available and the access, utilization, workforce capacity, use of best practices, quality, and outcomes of the services provided. Ben developed data collection materials; recruited and conducted key informant interviews and focus groups and led analysis; and oversaw analysis of existing documents and reports, claims, and other quantitative data from the State and other agencies. He authored the final report and was also responsible for all IRB-related activities.

Research Associate, *Milwaukee County Behavioral Health Crisis System Planning*
Funder: **Milwaukee County, Wisconsin Services** | Dates: **2018 – 2019**
Contribution: HSRI helped to facilitate a decision-making process and the development of an implementation strategy for the behavioral health crisis service system in Milwaukee County. Ben developed the project work plan, conducted key informant interviews with stakeholders for the environmental scan, led efforts to collect and analyze quantitative data from health systems to inform the planning process, and co-authored the environmental scan report. He also provided support to implementation efforts.

Evaluation Consultant, *National Empowerment Center (NEC)*
Funder: **NEC** | Dates: **2016 – 2019**
Contribution: HSRI assisted in meeting program evaluation requirements. Ben provided ongoing ad hoc consultation related to evaluation activities, such as helping enhance TA delivery tracking processes to capture core data elements for evaluation.

Project Manager, *Independent Evaluation of the Capacity of the Current Health System*
Funder: **New Hampshire Department of Health and Human Services (NH DHHS)** | Dates: **2017 – 2018**
Contribution: HSRI conducted an evaluation of the capacity of the health system in New Hampshire to respond to the inpatient, acute care psychiatric needs of patients, including but not limited to those patients who require involuntary emergency admissions. The work included developing a comprehensive system map, reporting on hospital and emergency department admission data, conducting a system of care gap analysis, and developing a written report and presentation. Ben was responsible for leading the project team and overseeing deliverables. He managed the collection and analysis of qualitative and quantitative data, conducted key informant interviews and qualitative analysis, and managed production of, co-authored, and presented the final report.

Research Associate, *North Carolina Olmstead Evaluation Project*
Funder: **Independent Reviewer, U.S. DOJ Settlement with North Carolina** | Dates: **2017 – 2018**
Contribution: HSRI was contracted to conduct an analysis of the services provided to the covered target population in the Olmstead Settlement Agreement, informing the court monitor's determination of compliance with the agreement. Ben helped lead the quantitative analysis of service utilization data.

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Research Associate, *Evaluation of Cooperative Agreements to Benefit Homeless Individuals for States and Communities (CABHI-States and Communities)*
Funder: **SAMHSA-CMHS-CSAT** | Dates: **2016 – 2018**
Contribution: HSRI received a subcontract through RTI International to evaluate two programs: The Cooperative Agreements to Benefit Homeless Individuals (CABHI) and the Programs for Assistance in Transition from Homelessness (PATH). HSRI had the lead for the multi-site evaluation of the PATH program, which was a task under the cross-site CABHI evaluation. Ben was responsible for a variety of cross-site evaluation tasks such as data collection, data analysis, providing evaluation technical assistance, and reporting for 5 programs serving homeless individuals in Los Angeles, CA, and the state of Michigan.

Evaluation TA Team Co-Manager, *Project LAUNCH (Linking Actions for Unmet Needs of Children's Health)*
Funder: **Substance Abuse and Mental Health Services Administration - Administration on Children, Youth and Families (SAMHSA-ACF)** | Dates: **2013 – 2018**
Contribution: HSRI assisted in evaluating and providing technical assistance to 35 grantees implementing interventions to improve community health for children and families through the implementation of evidence-based practices and the integration of behavioral health and primary care. Ben played an integral role in the development of evaluation TA processes and protocols and the evaluability assessment tool. In addition to managing the Evaluation TA team, he provided technical assistance to over 10 grantees around the design of their local evaluations, including qualitative and quantitative data collection and analysis efforts. He also reviewed and provided feedback to grantees and SAMHSA Project Officers on grantee strategic plans, evaluation plans, and evaluation reports. Overall, Ben provided Evaluation TA for over 20 LAUNCH local evaluations focused on children ages 0-8.

Research Associate, *National Process Evaluation of the Long-Term Care Ombudsman Program*
Funder: **Administration for Community Living (ACL)** | Dates: **2016 – 2017**
Contribution: HSRI assisted with a process evaluation project of the long-term care ombudsman program. Ben assisted with the development of data collection tools, conducted key informant interviews and qualitative analysis, and drafted sections of the final report.

Research Associate, *Comprehensive Behavioral Health System Analysis and Study for Pierce County*
Funder: **Pierce County, Washington** | Dates: **2016 – 2017**
Contribution: HSRI conducted a comprehensive analysis to identify and understand gaps in service access. The study identified the prevalence of behavioral health issues and the extent of services available to address behavioral health-related needs, and provided recommendations for services, policies, and practices the county should pursue to address system gaps. HSRI also supported the implementation of the recommendations. Ben helped develop key informant interview guides.

Research Associate, *Evaluation of Programs That Provide Services to Persons Who Are Homeless with Mental and/or Substance Use Disorders*
Funder: **SAMHSA-CMHS-CSAT** | Dates: **2013 – 2016**
Contribution: HSRI evaluated four programs: CABHI, the Grants for the Benefit of Homeless Individuals (GBHI), Services in Supportive Housing (SSH), and PATH. HSRI led the multi-site evaluation of the PATH program. Ben assisted with refinement of cross-site data extraction tools, performed data extraction from key documents, and developed stakeholder survey protocols. He also

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conducted site visits, co-authored site visit reports and associated materials, and served as a member of the analysis and dissemination teams, where he helped lead quantitative analyses of services data and led qualitative analyses of key program barriers and facilitators.

Policy Analyst, *Environmental Scan of Self-Direction in Behavioral Health Services and Supports*
Funder: **Robert Wood Johnson Foundation** | Dates: **2012 – 2016**
Contribution: This environmental scan was designed to 1) understand barriers and facilitators to self-direction in the mental health and substance use fields; 2) ascertain interest among stakeholders; 3) adapt the model and outcome measures to better fit the needs of behavioral health consumers; and 4) develop recommendations to inform next steps. The scan was a joint effort of researchers from the National Center for Participant-Directed Services, HSRI, and others. Ben assisted with the qualitative analysis of key informant interviews.

Research Associate, *Milwaukee County Mental Health System Redesign*
Funder: **Milwaukee County** | Dates: **2009 – 2016**
Contribution: HSRI addressed systemic issues with access to service delivery within the adult mental health system. Ben designed and oversaw the implementation of "Secret Shopper" campaign with randomly selected behavioral health providers serving Milwaukee County residents to assess availability of services, average time to appointment, and acceptance of Medicaid as a funding option. He trained and oversaw research assistants, compiled the dataset, and performed analyses.

Evaluation Consultant, *Maine Medical Center Service Utilization Analysis*
Funder: **Maine Medical Center** | Dates: **2014**
Contribution: Ben designed a small study examining the impact of achieving stable employment on utilization of case management services for the Department of Vocational Services. He performed all analyses and delivered presentations to client and ME DHHS Commissioner Mayhew and her leadership team on the findings.

Research Associate, *Defining and Measuring the Quality of Home and Community Services Report*
Funder: **National Council on Disability** | Dates: **2013 – 2014**
Contribution: Ben served as the mental health home and community services expert. He conducted the mental health literature review and authored final report content related to mental health.

Project Manager, *Community Inclusion Program Cost Project*
Funder: **Temple University** | Dates: **2012 – 2014**
Contribution: HSRI conducted a survey related to costs of programs focused on the community inclusion of individuals with psychiatric disabilities. Ben assisted with the development of the survey and online interface, oversaw sampling and recruitment, assisted with analysis, and co-authored the final report and disseminated findings.

Policy Analyst, *Mental Health Transformation Grant (MHTG) National Evaluation*
Funder: **Substance Abuse and Mental Health Services Administration - Center for Mental Health Services (SAMHSA-CMHS)** | Dates: **2011 – 2012**
Contribution: HSRI evaluated the overall effectiveness of the SAMSHA-funded MHTG program. Ben was involved in all facets of the evaluation. He drafted the technical proposal, and co-authored the cross-site evaluation plan, final report, and other deliverables.

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Subcontract Co-Manager, *Mental Health Transformation State Incentive Grant (MHT-SIG) Evaluation*

Funder: **Substance Abuse and Mental Health Services Administration - Center for Mental Health Services (SAMHSA-CMHS)** | Dates: **2006 – 2011**

Contribution: HSRI evaluated the overall effectiveness of the SAMSHA-funded MHT-SIG program. The objectives of the cross-site evaluation centered around determining the extent to which the mental health systems became recovery-focused, how these transformations impacted mental health consumer recovery, how the transformations resulted in changes in client outcomes, and to identify factors that contributed to successful transformation of the systems and difficulties encountered along the way. Ben was involved in all facets of the evaluation. He co-authored the cross-site evaluation plan, final report, and other deliverables. He helped lead the development of and managed GPRA data collection efforts, which strongly influenced the development of CMHS' TRAC system.

Research Assistant, *Evaluation Technical Assistance Center for Adult Mental Health System Change*

Funder: **Substance Abuse and Mental Health Services Administration - Center for Mental Health Services (SAMHSA-CMHS)** | Dates: **2006 – 2008**

Contribution: HSRI provided technical assistance related to the evaluation of adult mental health system change, specifically related to improving the planning, development, and operation of adult mental health services carried out as part of the Community Mental Health Services Block Grant program. HSRI assisted states and political subdivisions of states and other stakeholders to conduct evaluations, provided direct and indirect technical assistance activities, and developed and disseminated materials. Ben co-authored and edited products such as "Addendum to Measuring the Promise: A Compendium of Recovery Measures" and "Evidence Based Workforce Development Strategies for Evidence Based Practices in Mental Health."

Project Manager, *Massachusetts Psychiatric Rehabilitation Association (MassPRA) Course Evaluation*

Funder: **MassPRA** | Dates: **2006 – 2007**

Contribution: HSRI conducted an evaluation of a Massachusetts Psychiatric Rehabilitation Association workforce development training course for incumbent workers. Ben was responsible for the design of the course evaluation, conducting data collection and analysis, and authored a summary report of findings and recommendations.

Publications and Presentations

Articles

Croft, B., Wang, K., **Cichocki, B.**, Weaver, A., & Mahoney, K. J. (2017). The emergence of self-direction in behavioral health: An international learning exchange, *Psychiatric Services, 68*(1), 88-91. doi: 10.1176/appi.ps.201600014

Leff, H.S., **Cichocki, B.**, Chow, C., Salzer, M.S., & Wieman, D. (2016). A menu with prices: Annual per person costs of programs addressing community integration, *Evaluation and Program Planning, 54*, 112-120.

Chow, C.M. & **Cichocki, B.** (2016). Predictors of job accommodations for individuals with psychiatric disability. *Rehabilitation Counseling Bulletin, 59*(3), 172-184. doi: 10.1177/0034355215583057

Cichocki, B. (2015). The alliance in psychiatric rehabilitation: Client characteristics associated with the initial alliance in a supported employment program. *Work: A Journal of Prevention, Assessment, & Rehabilitation*. doi: 10.3233/WOR-152107

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Chow, C.M., Croft, B., & **Cichocki, B.** (2015). Evaluating the potential cost-savings of job accommodations among individuals with psychiatric disability. *Journal of Vocational Rehabilitation, 43*(2), 67-74. doi: 10.3233/JVR-150755

Chow, C.M., **Cichocki, B.**, & Croft, B. (2014). The impact of job accommodations on employment outcomes among individuals with psychiatric disability. *Psychiatric Services, 65*(9), 1126-1132.

Leff, S., **Cichocki, B.**, Chow, C. M., & Lupton, C. (2014). Infrastructure change is not enough: Outside evaluation of the Mental Health Transformation State Incentive Grants. *Psychiatric Services, 65*(7), 947-950.

Chow, C.M., Wieman, D., **Cichocki, B.**, Qvicklund, H., & Hiersteiner, D. (2013). Mission impossible: Treating serious mental illness and substance use co-occurring disorder with integrated treatment: A meta-analysis. *Mental Health and Substance Use, 6*(2), 150-168. doi: 10.1080/17523281.2012.693130

Chow, C. & **Cichocki, B.** (2009). The need for evidence-based training strategies. *Psychiatric Rehabilitation Journal, 33*(1), 62-65.

Chow, C., **Cichocki, B.**, & Leff, H. S. (2009). The support for evidence-based training strategies. *Psychiatric Rehabilitation Journal, 33*(2), 156-159.

Evaluation Center @HSRI (2007). *Addendum to measuring the promise: A compendium of recovery measures, (Vol. II).* Human Services Research Institute, Cambridge, MA.

Leff, H. S., Chow, C., Pepin, R., Ostrow, L., Conley, J., Jameson, M., & **Cichocki, B.** (2007). *A new hope: The evidence on housing for persons with severe mental illness and its implications.* Human Services Research Institute, Cambridge, MA.

Leff, H. S., Leff, J., Chow, C., **Cichocki, B.**, Phillips, D., & Joseph, T. (2007). *Evidence based workforce development strategies for evidence based practices in mental health.* Human Services Research Institute, Cambridge, MA.

Presentations

Cichocki, B., Barbone, M., & Schnepp, J. (2018). "Mental Health Self-Direction: Lessons Learned and Future Directions." Psychiatric Rehabilitation Association (PRA) 41st Annual Conference. Denver, CO.

Cichocki, B., Seguine, B., & Tilton, M. (2018). "Implementing Evidence into Practice for Occupational Therapy Assistants." American Occupational Therapy Association (AOTA) 2018 Annual Conference and Expo, Salt Lake City, UT.

Croft, B., **Cichocki, B.**, & Mahoney, K. (2016). "Barriers and Facilitators for Self-Directed Care: Early Process Evaluation Findings from the Demonstration and Evaluation of Self-Direction in Behavioral Health." A National Association of State Mental Health Program Directors (NASMHPD) TA Coalition Webinar.

Cichocki, B., Wieman, D., & Hughes, D. (2013). "Using Local Evaluations and Implementation Studies to Enhance Cross-Site Studies." American Evaluation Association (AEA) 27th Annual Conference. Washington, D.C. (Lead author of presentation; Hughes, D. in-person presenter.)

Cichocki, B., Sullivan-Soydan, A., & Barrett, N. (2008). "Evidence Based Staff Training." A seminar at United States Psychiatric Rehabilitation Association (USPRA) 33rd Annual Conference, Lombard, IL.

Chow, C. & **Cichocki, B.** (2007). "Evidence Based Teaching." Consortium of Psychiatric Rehabilitation Educators (CPRE) 2007 Symposium, Manchester, NH.

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Rachael Gerber, MPH

Director of Operations
[redacted] | www.hsri.org

Profile

Ms. Gerber has over 14 years of experience in behavioral health program evaluation, needs assessment, and system planning. Her expertise is in collection and analysis of data to assist policymakers in system transformation efforts. She is experienced working with Medicaid and other administrative claims data as well as data from national and state surveys and surveillance systems. In her role as director of operations for HSRI's behavioral health team, she develops and oversee standard operating procedures for quality assurance and production of high-quality deliverables. She also serves on HSRI's Equity Review Board.

Project Experience

Data Analyst, *Behavioral Health System Analysis for Nashville and Davidson County*

Funder: **The Metropolitan Government of Nashville and Davidson County** | Dates: **2022 – Present**

Contribution: HSRI is providing a comprehensive behavioral health system assessment for the Metropolitan Government of Nashville and Davidson County, Tennessee. The findings from the assessment and resulting recommendations will be used to direct policy and action and support long-term strategic planning. Rachael is contributing to the study design, development of data collection tools, conducting interviews with key informants, collecting and analyzing data, and report writing.

Data Analyst, *Evaluation of Implementation to Fidelity of Evidence-Based Services*

Funder: **University of South Florida** | Dates: **2022 – Present**

Contribution: As sub-contractor to the University of South Florida, HSRI is leading the fidelity evaluation of nine evidence-based programs, rated under the Title IV-E Prevention Services Clearinghouse, and assisting with both the process and outcomes components of the state-wide study. In her role as data analyst, Rachael contributes to the design of the outcomes evaluation, analyzes child welfare data, and creates data summaries and visualizations.

Project Manager, *New Hampshire State Youth Treatment – Planning and Implementation Evaluation (SYT-P/I)*

Funder: **NH DHHS** | Dates: **2017 – Present**

Contribution: HSRI is evaluating New Hampshire's initiative to develop and pilot a continuum of care model for adolescents and transitional aged youth with substance use disorders and co-occurring substance use and mental health disorders, integrating evidence-based screening, assessment, treatment, recovery, and peer support services. During the planning phase of the initiative, HSRI developed an evaluation plan, designed tools to track the planning process, attended all planning meetings, administered surveys to

Education

MPH
Yale School of Public Health
New Haven, CT
(Social and Behavioral Science)

BA
Boston University
Boston, MA
(History)

Professional Experience

Director of Operations for Behavioral Health Team
(2022 – Present)
Research Associate
(2013 – Present)
Human Services Research Institute
Cambridge, MA

Sr. Research Associate
(2012 – 2013)
New England Research Institutes, Inc.
Watertown, MA

Research Analyst
(2009 – 2012)
Human Services Research Institute
Cambridge, MA

Research Assistant
(2007 – 2009)
Center for Interdisciplinary Research on AIDS
New Haven, CT

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Interagency Council members, supported the state in fulfilling its federal reporting requirements, and developed annual evaluation reports. HSRI continues to evaluate the initiative, now in its implementation phase. During the planning phase of the initiative, Rachael contributed to development of the evaluation plan and data collection instruments and served as project manager. She attended Interagency Council meetings and managed the workplan and other deliverables during the planning grant.

Data Analyst, *North Dakota Behavioral Health Needs Assessment and North Dakota Behavioral Health Strategic Planning*
Funder: **ND Department of Human Services Behavioral Health** | Dates: **2017 – Present**
Contribution: In 2017 and 2018, HSRI conducted an in-depth review of North Dakota's behavioral health system and produced recommendations and strategies for implementing changes to address the needs of the community. Beginning in 2018, HSRI is working with the State's Behavioral Health Planning Council to facilitate an in-depth strategic planning process to implement the recommendations for behavioral health systems transformation. Populations of focus include individuals with mental health conditions, substance use disorders, and brain injury. Rachael coordinates data transfers and analyzes data from Medicaid and other secondary sources.

Data Analyst, *Home and Community-Based Services (HCBS) Technical Assistance*
Funder: **Centers for Medicare & Medicaid Services (CMS)** | Dates: **2015 – Present**
Contribution: HSRI is providing technical assistance to over a dozen states in response to individual TA requests as well as through the development and presentation of issue papers and webinars. Rachael participates in providing technical assistance to states around waiver application requirements and conducts environmental scans to summarize how states are using 1915(c) and 1915(i) waivers to fund and implement behavioral health services.

Project Manager and Data Lead, *Wake County Behavioral Health Crisis System Assessment*
Funder: **Wake County, North Carolina** | Dates: **2022 – 2023**
Contribution: Wake County contracted HSRI to assess the county's behavioral health crisis service system. This included an assessment of services across the crisis continuum in comparison to national best practices for crisis care. Using qualitative and quantitative methods, the team identified strengths and gaps in the county's crisis system and made recommendations for improvements. In her role as project manager and data lead, Rachael developed and oversaw the work plan and timeline, collected and analyzed quantitative and qualitative data, conducted key informant interviews, drafted reports and recommendations, and presented key findings to County leadership and community partners.

Data Analyst, *Louisiana Olmstead Evaluation Project*
Funder: **Louisiana Department of Justice** | Dates: **2022 – 2023**
Contribution: HSRI assisted Louisiana in successfully meeting the requirements of Olmstead-related settlement agreements and court decisions. HSRI provided data analysis for utilization of case management for the at-risk population and of claims data for review of service utilization. Rachael developed analytics methods and conducted analysis of Medicaid claims and data from the state's case management system.

Project Manager, *Walla Walla County Needs Assessment and Gaps Analysis of Behavioral Health Services*
Funder: **Walla Walla County** | Dates: **2021 – 2023**
Contribution: HSRI conducted a needs assessment/gap analysis of behavioral health services as a guide for strategic planning to help the County achieve improved outcomes through a comprehensive,

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evidence-based continuum of care. The project capitalized on the use of existing readily available data and summary reports, supplemented by stakeholder and focus group interviews, and incorporated an extensive implementation component. In her role as lead data analyst, Rachael was responsible for overseeing the collection and analysis of data to inform the system assessment and development of recommendations, and conducted interviews with key informants.

Data Analyst, *Gap Analysis of Group, Residential and Psychiatric Treatment in South Dakota*

Funder: **SD Department of Social Services, Division of Child Protection** | Dates: **2020 – 2022**

Contribution: HSRI explored the needs in services either provided or not currently offered to youth in South Dakota by conducting an assessment and evaluation of current stakeholders at multiple levels of service in order to determine services needed and the feasibility of providing those services in the state. Rachael was responsible for gathering and analyzing quantitative data, synthesizing quantitative and qualitative data, and collaborating in the development of recommendations and the final report.

Data Analyst, *South Dakota Behavioral Health Service System Needs Assessment/Gap Analysis*

Funder: **SD Department of Social Services** | Dates: **2020 – 2021**

Contribution: HSRI conducted a comprehensive assessment of South Dakota's public behavioral health system and provided recommendations to the state for addressing gaps in services. Rachael served as the lead data analyst, analyzing data from Medicaid- and state-funded services and other secondary sources to identify service use patterns and gaps to inform recommendations for systems improvement.

Data Analyst, *North Carolina Olmstead Planning*

Funder: **North Carolina Department of Health and Human Services (NC DHHS)** | Dates: **2020 – 2021**

Contribution: NC DHHS contracted the Technical Assistance Collaborative (TAC), in partnership with HSRI, to conduct a comprehensive system analysis and provide recommendations to assist NC in developing its Olmstead Plan. Rachael served as lead data analyst, analyzing data from Medicaid, State Operated Healthcare Facilities, and other state agencies to inform development of recommendations.

Data Analyst, *Louisiana Department of Justice*

Funder: **Technical Assistance Collaborative (TAC)** | Dates: **2019 – 2021**

Contribution: HSRI worked with TAC to help the state of Louisiana to develop a Population Health Strategic Plan aligned with the Louisiana Medicaid Managed Care Quality Strategy. Rachael analyzed data from Medicaid, transition assessments, and other survey instruments, collaborating in drafting the final report, and presented findings to the state, DOJ, and other stakeholders.

Research Analyst and Project Manager, *River Valley Rising (RVR) DFC Grant Evaluation*

Funder: **River Valley Rising Substance Use Coalition** | Dates: **2019 – 2021**

Contribution: RVR is a prevention coalition located in Rumford, ME that was in its fourth year of a 5-year Drug Free Communities (DFC) grant, funded through the Office of National Drug Control Policy (ONDCP) and Substance Abuse and Mental Health Services Administration (SAMHSA). The goals of the DFC program are to strengthen collaboration among community entities and reduce substance use among youth. As the evaluation partner, HSRI assessed the Coalition's progress toward meeting its goals and objectives over the course of the grant. Rachael's responsibilities included evaluation design and reporting activities, data analysis, project coordination, and assisting RVR in their application for a grant renewal.

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Research Analyst, *Evaluation of the Community Resource Navigator Program*
Funder: **Provincetown, MA, Health Department** | Dates: **2019 – 2020**
Contribution: HSRI assessed the current data reporting procedures and helped to streamline those processes for Department of Health in Provincetown, to facilitate the evaluation of the Community Navigator program serving individuals with behavioral health concerns. HSRI worked with the town to provide evaluation and consulting services regarding the Mental Health and Substance Abuse Case Management Services grant implementation. Rachael collaborated in developing data collection tools and report writing.

Data Analyst, *Multnomah County Mental Health System Analysis*
Funder: **Multnomah County Department of County Management** | Dates: **2019 – 2020**
Contribution: HSRI was awarded a contract to conduct a detailed review and analysis of the mental health system within Multnomah County. The review and analysis resulted in a comprehensive report which included an inventory of mental health services provided by the county, how the services interfaced with one another, gaps in services, and key funding and reimbursement mechanisms for services. Rachael gathered information on financing for mental health services from the leadership of county health and human services agencies. She compiled and analyzed data, developed data visualizations, and drafted the report.

Data Analyst, *Maine Homeless Initiatives Gaps and Needs Analysis*
Funder: **Maine State Housing Authority** | Dates: **2019 – 2020**
Contribution: HSRI conducted a gap and needs analysis of the services, resources, and housing available to, and needed by, individuals and families experiencing homelessness in Maine. HSRI produced a set of actionable, measurable, prioritized recommendations for addressing gaps and needs that can be used to inform homeless project and services planning in the Maine Continuum of Care (MCoC) and 2020-2024 Consolidated Plan. Rachael was responsible for cleaning and analyzing state-wide data from the point-in-time Youth Addendum Survey, programming online surveys disseminated to homeless shelters and schools, and producing data analysis results.

Senior Data Analyst, *Public Behavioral Health Gap Analysis*
Funder: **Behavioral Health System Baltimore (BHSB)** | Dates: **2018 – 2020**
Contribution: HSRI conducted a gap analysis of the Baltimore public behavioral health system, examining services available and the access, utilization, workforce capacity, use of best practices, quality, and outcomes of the services provided. Rachael was responsible for management and analysis of data from Medicaid, the state psychiatric hospital, and the Baltimore Police dispatch call system. She also participated in key informant interviews with stakeholders.

Research Analyst, *Consumer Survey for the Massachusetts Commission for the Blind (MCB)*
Funder: MCB | Dates: 2019
Contribution: HSRI developed survey tools for the Commission to identify the social and vocational service needs of its consumers. HSRI also worked with the Commission to optimize their use of available data sources, including their current case management data system and data from national sources such as the American Community Survey, Current Population Surveys, the Behavioral Risk Factor Surveillance System, and the Survey of Income and Program Participation. Rachael conducted an environmental scan of national surveys, assessed data availability, and contributed to the development of survey tools and survey methodology

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Research Analyst and Project Manager, *Substance Abuse Disorder Providers and Insurance Reimbursement*

Funder: **Assistant Secretary for Planning and Evaluation (ASPE)** | Dates: **2017 – 2019**

Contribution: HSRI documented state licensing and credentialing requirements for substance use disorder (SUD) treatment providers in each state and the District of Columbia. HSRI reviewed state reimbursement policies for SUD services for Medicaid, Medicare, and a sample of private insurers. HSRI also conducted case studies of states that had implemented innovative strategies to incentivize SUD providers to join provider networks and accept insurance reimbursement. Rachael was responsible for reviewing, compiling, and analyzing data on policies across all 50 states, as well as drafting reports, workplans, and presentations, and producing progress reports and meeting materials.

Research Analyst, *Analysis of HMIS data for Lane County, Oregon*

Funder: **Lane County Department of Health and Human Services** | Dates: **2018**

Contribution: HSRI analyzed Homeless Management Information Systems (HMIS) data for Lane County, Oregon. HSRI calculated the cumulative length of time in housing and the number of discrete visits to emergency shelters in FY2016 to help develop a system map and to identify demographic characteristics of high-utilizers. Rachael analyzed HMIS data to determine length of time in emergency shelters and other client-level characteristics.

Data Analyst, *Independent Evaluation of the Capacity of the Current Health System*

Funder: **New Hampshire Department of Health and Human Services (NH DHHS)** | Dates: **2017 – 2018**

Contribution: HSRI conducted an evaluation of the capacity of the health system in New Hampshire to respond to the inpatient, acute care psychiatric needs of patients, including but not limited to those patients who require involuntary emergency admissions. The work included developing a comprehensive system map, reporting on hospital and emergency department admission data, conducting a system of care gap analysis, and developing a written report and presentation. Rachael was responsible for coordinating with state agencies to obtain data; analyzing data and producing data visualizations; and conducting key informant interviews with stakeholders.

Senior Data Analyst, *North Carolina Olmstead Evaluation Project*

Funder: **Independent Reviewer, US DOJ Settlement with North Carolina** | Dates: **2017 – 2018**

Contribution: HSRI was contracted to conduct an analysis of the services provided to the covered target population in the Olmstead Settlement Agreement, informing the court monitor's determination of compliance with the agreement. Rachael coordinated with state agencies to obtain data from numerous sources, cleaned and linked data on individuals' housing status with claims data from Medicaid and state-funded behavioral health services, analyzed data, drafted reports, and produced data summaries to facilitate stakeholder discussions.

Analyst, *Evaluation of Cooperative Agreements to Benefit Homeless Individuals for States and Communities (CABHI-States and Communities)*

Funder: **SAMHSA-CMHS-CSAT** | Dates: **2016 – 2018**

Contribution: HSRI received a subcontract through RTI International to evaluate two programs: The Cooperative Agreements to Benefit Homeless Individuals (CABHI) and the Programs for Assistance in Transition from Homelessness (PATH). HSRI had the lead for the multi-site evaluation of the PATH program, which was a task under the cross-site CABHI evaluation. Rachael was involved in data management and analysis of program data.

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Lead Analyst, *Program Evaluation for Prevention Contract (PEP-C)*
Funder: **Substance Abuse and Mental Health Services Administration - Center for Substance Abuse Prevention (SAMHSA-CSAP)** | Dates: **2013 – 2018**
Contribution: HSRI worked on the PEP-C project, which included a national cross-site evaluation of CSAP's Minority AIDS Initiative (MAI). MAI awards grants to community-based organizations and minority-serving academic institutions to prevent substance abuse and the spread of HIV, viral hepatitis, and other STDs among high-risk minority communities. Rachael was responsible for managing large and complex datasets, developing data collection protocols and instruments, designing data validation and cleaning rules, analyzing process- and participant-level outcomes, producing data for Government Performance and Results Act (GPRA) measures, writing reports and dissemination materials, and creating materials for training and technical assistance to grantees and federal staff.

Data Analyst, *Comprehensive Behavioral Health System Analysis and Study for Pierce County*
Funder: **Pierce County, Washington** | Dates: **2016 – 2017**
Contribution: HSRI conducted a comprehensive analysis to identify and understand gaps in service access. The study identified the prevalence of behavioral health issues and the extent of services available to address behavioral health-related needs, and provided recommendations for services, policies, and practices the county should pursue to address system gaps. HSRI also supported the implementation of the recommendations. Rachael was responsible for identifying sources of behavioral health prevalence and service utilization data, developing and analyzing results of an online survey for case managers and service users on the adequacy of services to meet consumers' needs, and analyzing behavioral health claims data from Washington's Comprehensive Hospital Abstract Reporting Systems (CHARS).

Data Analyst and Project Manager, *Bridging the Gaps: The Rochester Community Coalition for Alcohol and Drug Prevention*
Funder: **City of Rochester, NH** | Dates: **2016**
Contribution: HSRI provided evaluation services to Bridging the Gaps, the Drug and Alcohol Prevention Coalition of Rochester, New Hampshire in support of its Drug Free Communities (DCF) grant. The DFC grant is administered by the Office of National Drug Control Policy (ONDCP) and supported by SAMHSA to build community coalitions to prevention substance use among youth. In addition to project management responsibilities, Rachael contributed to the development of the evaluation design, created and disseminated an online survey, analyzed trend data on youth substance use in New Hampshire, and contributed to writing the final evaluation report.

Senior Analyst, *Training Materials for Aging and Disability Resource Centers (ADRC) on Mental Health Promotion and Suicide Prevention*
Funder: **Administration for Community Living (ACL)** | Dates: **2015 – 2016**
Contribution: HSRI helped to develop training materials on behavioral health promotion and suicide prevention for the eight states with ADRC Part A: Enhanced Options Counseling grants. Rachael was responsible for coordinating and participating in key informant interviews with state agency directors, drafting a needs assessment report, developing an online survey for person-centered counseling professionals and analyzing results, and collaborating in the development of a training webinar and resource guide.

Analyst, *Milwaukee County Mental Health System Redesign*
Funder: **Milwaukee County** | Dates: **2009 – 2016**

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Contribution: HSRI addressed systemic issues with access to service delivery within the adult mental health system. Rachael was responsible for data management and analysis of data from numerous sources, including county- and state-level Medicaid claims and hospital admissions data.

Research Analyst, *Data Analysis Coordination and Consolidation Center (DACCC)*
Funder: **Substance Abuse and Mental Health Services Administration - Center for Substance Abuse Prevention (SAMHSA-CSAP)** | Dates: **2007 – 2012**
Contribution: CSAP funded the DACCC as a means to centralize and elevate its data collection and analysis efforts, producing data that would help it provide appropriate guidance to grantees and to the prevention field in general. Rachael was responsible for managing, cleaning, and analyzing data across programs including the Minority AIDS Initiative (MAI), the Strategic Prevention Framework-State Incentive Grant (SPF SIG), and the Substance Abuse Prevention and Treatment 20% Set-Aside Block Grant. She contributed to technical reports, policy briefs, and guidance documents, led trainings and technical assistance during in-person and webinar trainings to grantees and federal Project Officers, and presented findings at professional conferences.

Associations

College of Behavioral Health Leadership

Publications and Presentations

Articles

Gerber, R., Vita, J.A., Ganz, P., Wager, C.G., Araujo, A.B., Rosen, R.C., & Kupelian, V. (2014). Microvascular endothelial function and lower urinary tract symptoms. Manuscript accepted for publication by European Urology.

Kershaw, T., **Gerber, R.**, Divney, A., Albritton, T., Sipsma, H., Magriples, U., & Gordon, D. (2012). Bringing your baggage to bed: Associations of previous relationship experiences with sexual risk among young couples. AIDS Behav.

Technical Reports

Co-Author: Wake County Crisis System Assessment Report. (2023). Wake County, North Carolina.

Co Author: Walla Walla Behavioral Health Assessment. (2022). Walla Walla County Board of County Commissioners

Co-Author: Credentialing, Licensing, and Reimbursement of the SUD Workforce: A Review of Policies & Practices Across the Nation. (2019). U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

Co-Author: North Dakota Behavioral Health System Study. (2018). North Dakota Department of Health and Human Services.

Co-Author: HIV Cross-Site Evaluation Report. (2016). Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention, Rockville, MD.

Co-Author: HIV Cross-Site Evaluation Report. (2015). Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention, Rockville, MD.

Co-Author: National Outcome Measures: State-Level Trends, Volume V: 2002-2009. (2011). Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention, Rockville, MD.

Co-Author: Accountability Report, Volume IX: FY 2010 (2011). Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention, Rockville, MD.

Presentations

Isvan, N., **Gerber, R.**, Hughes, D., Battis, K., Dey, J.G., West, K.D., & Anderson, E. (2019). Credentialing, Licensing, and Reimbursement of the SUD Counseling Workforce: Review of Policies and Practices Across the Nation. Paper presented at the Academy Health Research Conference, Washington, D.C.

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Isvan, N., Lundquist, L., **Gerber, R.**, Battis, K., Burnett, M., & Brown, D.C. (2017). The Effects of Service Type and Dosage on HIV Risk Factors Among Participants of Minority AIDS Initiative Programs. Paper presented at the Annual Meeting of the Society for Prevention Research, Washington, D.C.

Isvan, N.A., **Gerber, R.**, Battis, K., Burnett, M., Lundquist, L., Brown, D.C., Graham, P.G., & Youngman, L. (2016). HIV and Substance Abuse Prevention Needs of Transgender Individuals: An Analysis of Program Evaluation Data from SAMHSA's Minority AIDS Initiative. Presented at the 144th Annual Meeting & Expo of the American Public Health Association, Denver, CO.

Isvan, N.A., Brown, D.C., **Gerber, R.**, Battis, K., Lundquist, L., Burnett, M., Graham, P.W., Blake, S., & Clarke, T. (2016). The Success Case Method: Integrating Qualitative and Quantitative Data to Evaluate Behavioral Health Interventions. Presented at the 30th Annual Conference of the American Evaluation Association, Atlanta, GA.

Isvan, N.A., Lundquist, L., Burnett, M., **Gerber, R.**, Brown, D.C., Youngman, L., & Pinnock, W. (2016). The Role of SAMHSA/CSAP's Minority AIDS Initiative in Addressing Health Disparities. Presented at the 24th Annual Conference of the Society for Prevention Research, San Francisco, CA.

Gerber, R., Vita, J.A., Ganz, P., Wager, C.G., Araujo, A.B., Rosen, R.C., & Kupelian, V. (June). Association of peripheral microvascular dysfunction and erectile dysfunction. Poster presented at the annual meeting of the Society for Epidemiologic Research, Boston, MA.

Gerber, R., Howard, K., McInerney, K., Oliver, N.M., & Auerbach, K. (November). Reentry populations: Examining group differences in knowledge, attitudes and behaviors. Presented orally at the Annual Meeting of the American Public Health Association, Washington, DC.

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David Hughes, PhD

President
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Profile

Dr. Hughes is a nationally recognized expert in behavioral health services research, multi-site evaluations, self-direction, evidence-based practices, permanent supported housing, quality measurement, behavioral health and health cost simulation models, and the intersection of the behavioral health and criminal justice systems. He has directed and served in senior roles on dozens of HHS-sponsored projects and has worked on more than 15 projects for SAMHSA, ACL, ACF, and ASPE. He received the SAMHSA Leadership Award for his work on the behavioral health managed care multi-site study.

Project Experience

Project Director, *Reclaiming Employment*
Funder: **National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILLR)** | Dates: **2021 – Present**
Contribution: HSRI is assisting with the evaluation design and selection of data collection tools for Reclaiming Employment, an online curriculum intended to help individuals with psychiatric disabilities explore and develop self-employment opportunities. David advises and provides guidance to the project team.

Senior Advisor, *South Dakota Behavioral Health Needs Assessment & Gap Analysis*
Funder: **SD Department of Social Services** | Dates: **2020 – Present**
Contribution: HSRI is working with South Dakota to develop a complete picture of its entire behavioral health system to help guide improvement efforts. David provides guidance to the project team and is helping with the final report.

Senior Advisor, *Project Management for the National Center on Advancing Person-Centered Practices and Systems (NCAPPS)*
Funder: **ND Department of Human Services** | Dates: **2020 – Present**
Contribution: HSRI is working with the state of North Dakota to provide content expertise and project management as part of the state's continuing implementation of a systemwide change effort which includes NCAPPS. David provides overall guidance to the team.

Senior Advisor, *Traumatic Brain Injury Technical Assistance and Resource Center*
Funder: **ACL** | Dates: **2019 – Present**
Contribution: HSRI is operating a Technical Assistance and Resource Center for ACL's Traumatic Brain Injury (TBI) State Partnership Program grantees

Education

PhD
Brandeis University
Waltham, MA
(Social Policy)

MA
Brandeis University
Waltham, MA
(Social Policy)

MA
University of Massachusetts
Boston, MA
(Applied Sociology)

BA Honors
Trent University
Ontario, Canada
(Honors Sociology)

BA
Trent University
Ontario, Canada
(Psychology / Sociology)

Professional Experience

President
(2017 – Present)
Executive Vice President
(2015 – 2017)
Vice President
(2008 – 2015)
Senior Research Specialist
(2007 – 2008)
Project Director
(1997 – 2007)
Project Manager
(1996 – 1997)
Research Analyst
(1995 – 1996)
Research Assistant
(1993 – 1995)
Human Services Research Institute
Cambridge, MA

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and its stakeholders. David is responsible for providing oversight and guidance to the project director.

Senior Research Associate, *Louisiana Department of Justice*
Funder: **Technical Assistance Collaborative (TAC)** | Dates: **2019 – Present**
Contribution: HSRI is working with TAC to help the state of Louisiana to develop a Population Health Strategic Plan aligned with the Louisiana Medicaid Managed Care Quality Strategy. David is helping with the needs assessment which will help form the plan.

Senior Advisor, *National Center on Advancing Person-Centered Practices and Systems (NCAPPS)*
Funder: **ACL** | Dates: **2019 – Present**
Contribution: HSRI is leading a Center that provides actionable technical assistance to assist states, tribes, and territories in transforming their LTSS systems by implementing U.S. Department of Health and Human Services policy on person-centered thinking, planning, and practice. David provides guidance to the co-project directors.

Senior Research Associate, *Support Services Navigation & Housing Services for Individuals with Opioid Use Disorder*
Funder: **Pennsylvania DHS** | Dates: **2019 – Present**
Contribution: HSRI is working with TAC to provide technical assistance (TA) to direct and monitor effective housing strategies to support Pennsylvania's pilot projects under the Substance Abuse and Mental Health Administration's (SAMHSA) State Opioid Response Grant. David is helping with the development and implementation of interim reporting tools, as well as establishing protocols and mechanisms for the pilot projects to report data. He is also assisting DHS in designing and collecting additional measures to demonstrate progress in achieving DHS's goals for the pilot projects.

Project Director, *North Central Health Care Behavioral Health System Planning Project*
Funder: **North Central Health Care (NCHC)** | Dates: **2019 – Present**
Contribution: HSRI is conducting a systems needs and gaps analysis and assisting with the development of a systemwide strategic plan for the public behavioral health system for 3 counties in central Wisconsin. HSRI is examining services available and the access, utilization, workforce capacity, use of best practices, quality and outcomes of the services provided within the public behavioral health system. David is responsible for overseeing the project. He is also conducting key informant interviews and focus groups and drafting the final report.

Senior Advisor, *New Hampshire State Youth Treatment – Planning and Implementation Evaluation*
Funder: **NH DHHS** | Dates: **2017 – present**
Contribution: HSRI is evaluating New Hampshire's initiative to develop and pilot a continuum of care model for adolescents and transitional-aged youth with substance use disorders and co-occurring substance use and mental health disorders, integrating evidence-based screening, assessment, treatment, recovery, and peer support services. During the planning phase of the initiative, HSRI developed an evaluation plan, designed tools to track the planning process, attended all planning meetings, administered surveys to Interagency Council members, supported the state in fulfilling its federal reporting requirements, and developed annual evaluation reports. HSRI continues to evaluate the initiative, now in its implementation phase. The team also provides training and technical assistance to pilot sites in collecting and submitting their data, frequently reports evaluation updates to program managers, and makes recommendations for continuous quality improvement. David provides guidance to the project director.

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Project Director, ***North Dakota Behavioral Health Needs Assessment and North Dakota Behavioral Health Vision 20/20 Strategic Planning***

Funder: **ND Department of Human Services Behavioral Health Division** | Dates: **2017 – Present**

Contribution: In 2017 and 2018, HSRI conducted an in-depth review of North Dakota's behavioral health system and produced recommendations and strategies for implementing changes to address the needs of the community. Beginning in 2018, HSRI is working with the State's Behavioral Health Planning Council to facilitate an in-depth strategic planning process to implement the recommendations for behavioral health systems transformation. Populations of focus include individuals with mental health conditions, substance use disorders, and brain injury. David is responsible for carrying out all aspects of the study, including recruiting key informants for interviews, conducting interviews, and analyzing interview and service utilization data.

Senior Advisor, ***Reconfiguring Disability Waiver Programs and Developing an Individual Budgeting Model for HCBS Service Recipients in Minnesota***

Funder: **MN Disabilities Service Division** | Dates: **2017 – Present**

Contribution: HSRI has been contracted by the State of Minnesota to study the reconfiguration of the disability waiver programs and developing an individual budgeting model for Home and Community Based Services (HCBS). David provides HCBS content expertise.

Co-Project Director, ***Rethinking Supports for People with Disabilities***

Funder: **Prince Edward Island Dept. of Family and Human Services** | Dates: **2017 – Present**

Contribution: HSRI received a contract to help the department conduct a gap analysis to improve services offered to individuals with intellectual and developmental disabilities (IDD) and physical disabilities; and establish means for supporting individuals with mental health needs. David is responsible for overseeing the project and providing leadership with document reviews, data analysis, and writing reports.

Senior Research Advisor, ***Multnomah County Mental Health System Analysis and Strategic Plan***

Funder: **Multnomah County Department of County Management** | Dates: **2017 – Present**

Contribution: HSRI conducted a detailed review and analysis of the mental health system in Multnomah County. HSRI developed a comprehensive report that included an inventory of mental health services provided by the county, the ways the services interface with one another, gaps in services, and key funding and reimbursement mechanisms for services. David advises the project on relevant national developments with his work on projects with SAMHSA, CMS and the National Association of County Behavioral Health and Developmental Disability Directors.

Project Director, ***Home and Community-Based Services (HCBS) Technical Assistance***

Funder: **CMS** | Dates: **2015 – Present**

Contribution: HSRI is providing technical assistance to over a dozen states in response to individual TA requests as well as through the development and presentation of issue papers and webinars. David is responsible for drafting TA plans, cost estimates, and working with states on self-direction and HCBS research.

Senior Advisor, ***Evaluation of Colorado's Implementation of the IV-E Waiver***

Funder: **CO DHS** | Dates: **2013 – Present**

Contribution: HSRI is conducting a process, outcomes, and cost evaluation of Colorado's Title IV-E Waiver. Colorado's waiver seeks to improve child and family outcomes through three primary

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interventions: family engagement, trauma-informed child assessment, and trauma-focused behavioral health treatments. David helps lead the project in order to examine how the availability of flexible funds enables the state to make changes in service delivery and to alter expenditure patterns, ultimately improving safety, permanency, and wellbeing outcomes for children.

Senior Advisor, *Developing the Framework for a Large-Scale National Demonstration of Self-Direction in Behavioral Health*
Funder: **Robert Wood Johnson Foundation** | Dates: **2016 – 2021**
Contribution: Funded by the Robert Wood Johnson Foundation and the New York State Health Foundation with support from SAMHSA, HSRI led an evaluation of mental health self-direction in six states, charting best practices and exploring its impacts at the individual and system level. As part of the project, HSRI developed mentalhealthselfdirection.org, a resource that features participant stories and serves as a clearinghouse for all things mental health self-direction. David served as a senior advisor to the team and helps with the evaluation plan and design.

Project Director, *Comprehensive Statewide Assessment of the Vocational Rehabilitation Needs of Individuals with Disability in New Hampshire*
Funder: **NH Department of Education, Division of Workforce Innovation, Bureau of Vocational Rehabilitation** | Dates: **2019 – 2020**
Contribution: HSRI designed and implemented a CSNA for the New Hampshire Department VR. The work involved data collection, and analysis in order to inform the 2019 CSNA which (1) assured that the Agency was in compliance with 34 CFR 361.29, and (2) yielded information on the known participant levels and the unknown possible participants, both of which impacted program outreach and operation. David oversaw the project; and was responsible for conducting interviews and drafting the final report.

Project Director, *Public Behavioral Health System Gap Analysis*
Funder: **Behavioral Health System Baltimore (BHSB)** | Dates: **2018 – 2020**
Contribution: HSRI conducted a gap analysis of the Baltimore public behavioral health system. HSRI examined services available and the access, utilization, workforce capacity, use of best practices, quality and outcomes of the services provided within the public behavioral health system. David oversaw the entire project and is involved in all reporting tasks.

Co-Project Director, *Milwaukee County Behavioral Health Crisis System Planning*
Funder: **Milwaukee County, Wisconsin Services** | Dates: **2018 – 2019**
Contribution: HSRI helped to facilitate a decision-making process and the development of an implementation strategy for the behavioral health crisis service system in Milwaukee County. David was responsible for conducting the environmental scan, developing and conducting interviews, and developing the implementation plan.

Project Director, *Substance Abuse Disorder Providers and Insurance Reimbursement*
Funder: **ASPE** | Dates: **2017 – 2019**
Contribution: HSRI documented state licensing and credentialing requirements for substance use disorder (SUD) treatment providers in each state and the District of Columbia. HSRI reviewed state reimbursement policies for SUD services for Medicaid, Medicare, and a sample of private insurers. HSRI also conducted case studies of states that had implemented innovative strategies to incentivize SUD providers to join provider networks and accept insurance reimbursement. David was responsible for overseeing all work on the project and led the key informant interview process.

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Project Director, *North Carolina Olmstead Evaluation Project*
Funder: **Independent Reviewer, US DOJ Settlement with North Carolina** | Dates: **2017 – 2018**
Contribution: HSRI was contracted to conduct an analysis of the services provided to the covered target population in the Olmstead Settlement Agreement, informing the court monitor's determination of compliance with the agreement. David was responsible for overseeing the project and reporting findings to the Court Monitor and the Department of Justice.

Project Director, *Independent Evaluation of the Capacity of the Current Health System*
Funder: **NH DHHS** | Dates: **2017 – 2018**
Contribution: HSRI conducted an evaluation of the capacity of the health system in New Hampshire to respond to the inpatient, acute care psychiatric needs of patients, including but not limited to those patients who require involuntary emergency admissions. The work included developing a comprehensive system map, reporting on hospital and emergency department admission data, conducting a system of care gap analysis, and developing a written report and presentation. David led the project team, monitoring the technical, budget, and schedule performance.

Co-Project Director, *Network Capacity for Substance Use Disorder Treatment*
Funder: **ASPE** | Dates: **2017 – 2018**
Contribution: HSRI conducted an environmental scan on needs assessment methodologies for substance use disorder treatment capacity and provided a summary of alternative data sources and methods. David was responsible for overseeing all tasks on the project. He led the work with the technical advisory group, the writing of the final report, and the briefing for HHS officials.

Senior Research Specialist, *Evaluation of Cooperative Agreements to Benefit Homeless Individuals for States and Communities (CABHI-States and Communities)*
Funder: **SAMHSA-CMHS-CSAT** | Dates: **2016 – 2018**
Contribution: HSRI evaluated two programs: The Cooperative Agreements to Benefit Homeless Individuals (CABHI) and the Programs for Assistance in Transition from Homelessness (PATH). HSRI led the multi-site evaluation of the PATH program, which was a task under the cross-site CABHI evaluation, and also collaborated on the CABHI evaluation. David was involved with developing the evaluation plan, data collection and data reporting.

Project Director, *Project LAUNCH (Linking Actions for Unmet Needs of Children's Health)*
Funder: **SAMSHA-ACF** | Dates: **2013 – 2018**
Contribution: HSRI evaluated and provided technical assistance to 35 grantees implementing interventions to improve community health for children and families through the implementation of evidence-based practices and the integration of behavioral health and primary care. David was responsible for developing mechanisms for the delivery of TA, monitoring TA accomplishments, and coordinating TA for both local site evaluations and the project's multi-site evaluation.

Project Director, *Comprehensive Behavioral Health System Analysis and Study for Pierce County*
Funder: **Pierce County, Washington** | Dates: **2016 – 2017**
Contribution: HSRI conducted a comprehensive analysis to identify and understand gaps in service access. The study identified the prevalence of behavioral health issues, extent of services available to address behavioral health-related needs, and provided recommendations for services, policies, and practices the county should pursue to address system gaps. HSRI also supported the implementation of the recommendations. David was responsible for overseeing the project and the final report which

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included key recommendations to ensure a comprehensive, cost-effective, and recovery-oriented behavioral health treatment system that meets the needs of the Pierce County community.

Project Director, ***Training Materials for Aging and Disability Resource Centers (ADRC) on Mental Health Promotion and Suicide Prevention***
Funder: **ACL** | Dates: **2015 – 2017**
Contribution: HSRI helped to develop training materials on behavioral health promotion and suicide prevention for the eight states with (ADRC) Part A: Enhanced Options Counseling grants. David oversaw the needs assessment, which included interviews, an environmental scan, and an online survey. David was responsible for using the results to develop a training webinar and resource guide designed to be adapted as needed for the diverse workforce of those who perform access functions for ADRCs.

Project Director, ***Evaluation of Programs That Provide Services to Persons Who Are Homeless with Mental and/or Substance Use Disorders***
Funder: **SAMHSA-CMHS-CSAT** | Dates: **2011 – 2016**
Contribution: HSRI evaluated four programs: CABHI, the Grants for the Benefit of Homeless Individuals (GBHI), Services in Supportive Housing (SSH), and PATH. HSRI led the multi-site evaluation of the PATH program. David was responsible for overseeing HSRI's work on this project and working with RTI and SAMHSA staff to coordinate the multiple tasks included in this evaluation. David was involved with developing the evaluation plan, data collection, and data reporting.

Project Director, ***Milwaukee County Mental Health System Redesign***
Funder: **Milwaukee County** | Dates: **2009 – 2016**
Contribution: HSRI addressed systemic issues with access to service delivery within the adult mental health system. David worked closely with stakeholders to design a rigorous redesign plan. David was responsible for conducting informant interviews, analyzing service utilization and assessment data, and identifying national best practices in order to develop and draft recommendations for system improvements.

Project Director, ***Minnesota Preferred Integrated Network (PIN) Evaluation***
Funder: **MN DHS** | Dates: **2013 – 2015**
Contribution: HSRI conducted an evaluation of the Minnesota PIN, an initiative that integrates physical and mental health services in a prepaid health plan and coordinates these with social services. David oversaw the evaluation in order to address access, quality, accountability, and cost issues associated with integrating physical and behavioral health for the target population of adults with serious mental illness and children with serious emotional disturbance.

Project Director, ***California 1115 Mental Health and Substance Use Services Needs Assessment and Service Plan Project***
Funder: **CA Department of Health Care Services** | Dates: **2011 – 2014**
Contribution: HSRI examined how the federal health reform initiative would impact the behavioral health system in California. David oversaw the examination of 5 years' worth of Medicaid data to develop cost and beneficiary utilization projections. He also provided policy assistance regarding the types of benefits and delivery systems needed to serve the Medicaid expansion population.

Mental Health Technical Assistance Provider, ***National Quality Enterprise***
Funder: **CMS** | Dates: **2001 – 2013**
Contribution: For over 10 years, HSRI provided technical assistance to state waiver program staff as part of the National Quality Contractor and as part of the National Quality Enterprise. The TA included working with operating agencies and Medicaid agencies to collaborate on the development of

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performance indicators. David assisted states with waiver renewals, development of evidence packages, preparation of performance measures, and monographs on topics such as sampling and risk management.

Mental Health Technical Assistant Provider, *Money Follows the Person (MFP)*
Funder: **CMS** | Dates: **2007 – 2012**
Contribution: HSRI received a subcontract through the Ascellon Corporation to assist the Centers for Medicaid and State Operations (CMSO) in providing technical assistance to MFP Grantees. David provided technical assistance regarding quality assurance, improvement strategies, interventions, and data collection strategies as mandated by the MPP statute.

Project Director, *Implementing Permanent Supportive Housing for People with Disabilities in Louisiana*
Funder: **Louisiana Department of Health and Hospitals (DHH) and the Louisiana Housing Corporation (LHC)** | Dates: **2008 – 2011**
Contribution: HSRI received a contract to evaluate permanent supported housing programs based in Louisiana. As project Director, David designed the evaluation component, engaged all stakeholders, and supervised data collection efforts, including data already collected at the state level. David also developed a management plan for multisite database, including data security and confidentiality and prepared site specific IRB submission. He also directed efforts at responding to a variety of requests for information with quick turn-around time on issues surrounding housing and homelessness.

Senior Research Specialist, *Mental Health Transformation State Incentive Grant (MHT-SIG) Evaluation*
Funder: **SAMHSA-CMHS** | Dates: **2006 – 2011**
Contribution: HSRI evaluated the overall effectiveness of the SAMSHA-funded MHT-SIG program. The objectives of the cross-site evaluation centered around determining the extent to which the mental health systems became recovery focused, how these transformations impacted mental health consumer recovery, how the transformations resulted in changes in client outcomes, and to identify factors that contributed to successful transformation of the systems and difficulties encountered along the way. David was involved in the design of the evaluation and in data collection and data reporting.

Project Director, *Study of the Cost Efficiency of the Mental Health Block Grant Program*
Funder: **SAMHSA** | Dates: **2008 – 2010**
Contribution: HSRI studied the cost-efficiency of implementing evidence-based practices in three states (Arizona, Oregon, and West Virginia). David coordinated all efforts of data collection, including the development of a data layout plan for administrative data and all pertinent cross-walk designs. He also directed efforts at integrating SAMHSA URS (Uniform Reporting System) and NOM measures into the data analytic design and oversaw all response to requests by senior SAMHSA Block Grant program staff.

Developer, *Mental Health Jail Diversion Resource Allocation and Planning Model*
Funder: **SAMHSA** | Dates: **2006 – 2009**
Contribution: This project was funded by SAMHSA to develop a computerized budget simulation and resource allocation model for projecting the costs and potential cost offsets of implementing jail or prison diversion programs for offenders with mental illness. David oversaw all relevant aspects of model implementation, including convening expert panels that included consumers as well as providers, administrators, and federal SAMHSA policymakers, and drafting the data collection plan. He also supervised all analysis involving the model and designed several implementations targeting at trauma-informed care for mental health consumers involved in the criminal justice system.

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Project Director, *2004 Real Choice Systems Change Mental Health Transformation Grantee Technical Assistance*

Funder: **CMS** | Dates: **2005 – 2009**

Contribution: HSRI provided technical assistance to the 2004 Real Choice grantees funded by CMS. David provided ongoing technical assistance and training opportunities to 10 states awarded grants in the mental health area, including veterans and military families. They included designing intervention for supported employment and housing. David also managed technical assistance efforts focused on the implementation of peer provided services, evidence-based practices, policy briefs to help with local implementation, and regional trainings on implementation, workforce and self-determination. He also prepared rapid turnaround response to request by CMS on various aspects of the technical assistance.

Project Lead, *Coordinating Center for Managed Care and Vulnerable Populations Project*

Funder: **SAMHSA** | Dates: **1997 – 2004**

Contribution: This project facilitated common data collection approaches and analyses across 21 managed care evaluation sites. David oversaw the development of a multisite dataset and managed all aspects of data collection from documentation to ensure timeliness of data submission. David conducted multivariate statistical analyses and qualitative data documenting the nature of managed care provided by each site.

Honors, Awards and Memberships

Board Member – Foundation for Excellence in Mental Health Care (FEMHC)
National Quality Form, Measure Applications Partnership (MAP) Committee Member (2017 – Present)
SAMHSA Leadership Award (2011)

Publications and Presentations

Articles

Hughes, D., Wieman, D., Gerber, R., & Burnett, M. (2016). Resource Guide for Aging and Disability Resource Centers. Prepared by the Human Services Research Institute and Mission Analytics Group under contract with the Substance Abuse and Mental Health Services Administration in collaboration with the Administration for Community Living.

Hughes, D., Wieman, D., Gerber, R., & Burnett, M. (2016). Training Materials for Aging and Disability Resource Centers. Prepared by the Human Services Research Institute and Mission Analytics Group under contract with the Substance Abuse and Mental Health Services Administration in collaboration with the Administration for Community Living.

Hughes, D. (2016). A Simulation Modeling Approach for Planning and Costing Jail Diversion Programs for Persons with Mental Illness. In F. Taxman & A. Pattavina (Eds.), Simulation Strategies to Reduce Recidivism (pp. 223-265). Springer, NY.

Mark, T. & **Hughes, D.** (2013). Behavioral Health Treatment Needs Assessment Toolkit for State (HHS Publication No. SMA13-4757). Substance Abuse and Mental Health Services Administration, Rockville, MD.

Hughes, D., Steadman, H., Case, B., Griffin, P., & Leff, H.S. (2012). A Simulation Modeling Approach for Planning and Costing Jail Diversion Programs for Persons with Mental Illness. Criminal Justice and Behavior, 39(4), 434-446.

Hughes D., Mulkern V., & Witham S. (2010). Medicaid Managed Care for Adolescent Substance Abuse Treatment Clients. In: McFarland, B.H., McCarty, D., & Kovas, A.E. (Eds.), Medicaid and Treatment for People with Substance Abuse Problems. Nova Science Publishers, Inc., Hauppauge, NY.

Leff, H.S., **Hughes, D.R.**, Chow, C.M., Noyes, S., & Ostrow, L. "A Mental Health Allocation and Planning Simulation: A Mental Health Planner's Perspective." In Handbook for Healthcare Delivery Systems. Edited by Y. Yih. In press.

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Leff, H.S., **Hughes, D.R.**, & Chow, C.A. (2007). CMHS Decision Support Simulation Pilot Cost-Efficiency Study. Human Services Research Institute, Cambridge, MA.

Hughes, D.R. (2004). Forensic Diversion and Diversion Simulation Model: Chester County, PA. Human Services Research Institute, Cambridge, MA.

Hughes, D.R. (2004). Evaluation Report for the Forensic Access to Community Services (FACS) Program. Human Services Research Institute, Cambridge, MA.

Hughes, D.R. and Leff, H.S. (1996). Analyzing the Validity and Reliability of Cost Data in the Special Care Initiative. Human Services Research Institute, Cambridge MA.

Hughes, D. (editor) (1995). Evaluating Models of Medicaid Managed Mental Health Care: Program Evaluations and Evaluation Materials from States. The Evaluation Center@Human Services Research Institute, Cambridge, MA.

Hughes, D.R. and Leff, H.S. (1995). Getting Started: Implementation of the Special Care Initiative. Human Services Research Institute, Cambridge MA.

Hughes, D.R. and Leff, H.S. (1995). Enrollment Patterns in the Special Care Initiative. Human Services Research Institute, Cambridge MA.

Leff, H.S., **Hughes, D.**, Fisher, W., & Warren, R. (1993). Consumer comparisons of hospital and community care resulting from Department of Mental Health facility consolidation: Results of a follow-up of Danvers State Hospital consumes transferred to Tewksbury State Hospital. Proceedings of the Fourth Annual Conference on State Mental Health Agency Services Research (pp. 22-23). National Association of State Mental Health Program Directors Research Institute, Alexandria, VA.

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Nilufer Isvan, PhD

Senior Research Associate and Chief Methodologist

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Profile

Dr. Isvan has over 20 years of research and evaluation experience in the behavioral health field. Her areas of interest include substance misuse prevention interventions, complex care needs, social determinants of health, health disparities, community integration, and the integration of physical and mental health. Nilufer has extensive experience applying her qualitative and quantitative methodological skills and program evaluation experience to performance measure development, study design, and complex statistical analysis, and providing technical assistance in measure development, data collection, and program evaluation.

Project Experience

Outcome Evaluation Methodologist, *Evaluation of Implementation to Fidelity of Evidence-Based Services*

Funder: **University of South Florida** | Dates: **2022 – Present**

Contribution: As sub-contractor to the University of South Florida, HSRI is leading the fidelity evaluation of nine evidence-based programs, rated under the Title IV-E Prevention Services Clearinghouse, and assisting with both the process and outcomes components of the state-wide study. Nilufer works with the outcome evaluation workgroup to develop outcome measures, identify data elements, provide guidance on data collection, analyze data, and report results to evaluate program outcomes and support continuous quality improvement.

Methodologist, *Person-Reported and Health Care Utilization Outcomes of Home and Community Based Care Recipients With and Without Alzheimer's Disease and its Related Dementias*

Funder: **National Institutes of Health (NIH)** | Dates: **2021 – Present**

Contribution: HSRI is subcontracting with the University of Minnesota (UMN) to secure and de-identify National Core Indicators – Aging and Disabilities (NCI-AD) data to help the UMN team link NCI-AD data to other datasets. Nilufer provides guidance on analyses and interpretation of findings for all aims.

Project Director, *New Hampshire State Youth Treatment – Planning and Implementation Evaluation (SYT-P/I)*

Funder: **NH DHHS** | Dates: **2017 – Present**

Contribution: HSRI is evaluating New Hampshire's initiative to develop and pilot a continuum of care model for adolescents and transitional aged youth with substance use disorders and co-occurring substance use and mental health disorders, integrating evidence-based screening, assessment, treatment, recovery, and peer support services. During the planning phase of the

Education

PhD
University of Michigan
Ann Arbor, MI
(Sociology)

MS
Boğaziçi University
Istanbul, Turkey
(Computer Science and Systems Analysis)

BS
University of London
London, UK
(Computer Science and Statistics)

Professional Experience

Chief Methodologist
(2021 – Present)
Co-Director, Behavioral Health
(2017 – 2021)
Senior Research Fellow
(2006 – 2017)
Human Services Research Institute
Cambridge, MA

Sr. Research Scientist
(2003 – 2005)
Survey Research Group
Channing Bete Company
South Deerfield, MA

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initiative, HSRI developed an evaluation plan, designed tools to track the planning process, attended all planning meetings, administered surveys to Interagency Council members, supported the state in fulfilling its federal reporting requirements, and developed annual evaluation reports. HSRI continues to evaluate the initiative, now in its implementation phase. Nilufer is the project director for the evaluation, leading the effort to collect data from service users, manage and analyze the data, and develop annual evaluation reports. The team also provides training and technical assistance to pilot sites in collecting and submitting their data, frequently reports evaluation updates to program managers, and makes recommendations for continuous quality improvement.

Senior Methodologist and Statistician, *Technical Assistance to the Administration for Community Living (ACL)*

Funder: **ACL** | Dates: **2020 – Present**

Contribution: HSRI is providing technical assistance to the Administration for Community Living (ACL) and its federal partners, national associations, states, and community-based organizations around issues related to mental and behavioral health. Nilufer worked on designing and analyzing the data from a technical assistance (TA) needs assessment survey administered to ACL's grantees, contributed to the development of a TA workplan, and designed multiple behavioral health-related guidance documents and toolkits for community-based organizations.

Senior Methodologist and Statistician, *Traumatic Brain Injury Technical Assistance and Resource Center (TBI TARC)*

Funder: **Administration for Community Living (ACL)** | Dates: **2019 – Present**

Contribution: HSRI is operating a Technical Assistance and Resource Center for ACL's TBI State Partnership Program (SPP) grantees and its stakeholders. Nilufer is involved in designing an impact evaluation of the TBI SPP and the performance of the technical assistance and resource center. She also provides expertise and information related to evaluation, sustainability, quality improvement, performance measurement, and other areas identified by ACL and/or the grantees.

Senior Methodologist, *National Core Indicators – Aging and Disabilities (NCI-AD)*

Funder: **State Medicaid, Aging, and Disability Agencies** | Dates: **2015 – Present**

Contribution: HSRI partners with the ADvancing States on the NCI-AD project. An extension of the National Core Indicators (NCI) project, NCI-AD works to assess, compare, and improve programs that provide long-term services and supports to older adults and people with physical disabilities. Currently, 25 states participate in NCI-AD, collecting data on a standard set of performance and outcome measures. States use this data to assess the performance of their programs and delivery systems in order to improve services for older adults and individuals with physical disabilities. Nilufer provides methodological guidance on survey and sample design, psychometric testing, and data analysis.

Senior Methodologist, *National Core Indicators --Intellectual and Developmental Disabilities (NCI-IDD)*

Funder: **State Developmental Disability Agencies**| Dates: **2012 – Present**

Contribution: NCI is a data collection effort designed to assist state Developmental Disability (DD) agencies to collect data on a standard set of performance and outcome measures. States use this data to assess satisfaction and experience with supports, track key outcomes across multiple years, compare outcomes to other states and the average across states, and improve state human service system performance. Nilufer provides methodological guidance on survey design, psychometric testing, and data analysis.

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Senior Analyst, *Home and Community-Based Services (HCBS) Technical Assistance*
Funder: **Centers for Medicare & Medicaid Services (CMS)** | Dates: **2015 – Present**
Contribution: HSRI is providing technical assistance to over a dozen states in response to individual TA requests as well as through the development and presentation of issue papers and webinars. Nilufer is responsible for drafting TA plans, cost estimates, and working with states regarding Self-Direction and HCBS research.

Senior Methodologist, *Walla Walla County Needs Assessment and Gaps Analysis of Behavioral Health Services*
Funder: **Walla Walla County** | Dates: **2021 – 2023**
Contribution: HSRI conducted a needs assessment/gap analysis of behavioral health services as a guide for strategic planning to help the County achieve improved outcomes through a comprehensive, evidence-based continuum of care. The project capitalized on the use of existing readily available data and summary reports, supplemented by stakeholder and focus group interviews, and incorporated an extensive implementation component. Nilufer assisted with the evaluation plan, data analysis, and report development.

Project Director, *Massachusetts Commission for the Blind (MCB) Assistive Technology Survey*
Funder: **MCB** | Dates: **2022**
Contribution: HRSI designed and conducted a random sample survey of MCB's consumer population to gain insight regarding assistive technology usage and need for support in this area. Participants were given the option to respond online, via a large-print survey instrument mailed to them, or a phone interview. Nilufer's role was to oversee survey and sample design, data collection, analysis, quality control, and report development for the project.

Project Director, *River Valley Rising (RVR) DFC Grant Evaluation*
Funder: **River Valley Rising Substance Use Coalition** | Dates: **2019 – 2021**
Contribution: RVR is a prevention coalition located in Rumford, ME, that was in its fourth year of a 5-year Drug Free Communities (DFC) grant, funded through the Office of National Drug Control Policy (ONDCP) and Substance Abuse and Mental Health Services Administration (SAMHSA). The goals of the DFC program are to strengthen collaboration among community entities and reduce substance use among youth. As the evaluation partner, HSRI assessed the Coalition's progress toward meeting its goals and objectives over the course of the grant. Nilufer was responsible for designing the evaluation and overseeing all evaluation activities.

Senior Analyst, *Developing the Framework for a Large-Scale National Demonstration of Self-Direction in Behavioral Health*
Funder: **Robert Wood Johnson Foundation** | Dates: **2016 – 2021**
Contribution: Funded by the Robert Wood Johnson Foundation and the New York State Health Foundation with support from Substance Abuse and Mental Health Services Administration (SAMHSA), HSRI led an evaluation of mental health self-direction in six states, charting best practices and exploring its impacts at the individual and system level. As part of the project, HSRI developed mentalhealthselfdirection.org, a resource that features participant stories and serves as a clearinghouse for all things mental health self-direction. Nilufer was responsible for developing analysis plans and providing consultation on complex quantitative methods.

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Project Director, *Massachusetts Commission for the Blind (MCB) Consumer Survey*
Funder: **MCB** | Dates: **2020**
Contribution: HSRI provided consultation support to MCB for the implementation of a consumer survey, as well as training for the administration of the survey. Nilufer was responsible for overseeing the project, including study design, statistical analysis, deliverables, and overall quality assurance.

Senior Methodologist, *Support Services Navigation & Housing Services for Individuals with Opioid Use Disorder*
Funder: **Pennsylvania DHS** | Dates: **2019 – 2020**
Contribution: HSRI worked with TAC to provide technical assistance (TA) to direct and monitor effective housing strategies to support Pennsylvania's pilot projects under the Substance Abuse and Mental Health Administration's (SAMHSA) State Opioid Response Grant. Nilufer was responsible for providing technical support to grantees in using a data portal; and with providing data analysis and reporting.

Project Director, *Evaluation of the Community Resource Navigator Program*
Funder: **Provincetown, MA, Health Department** | Dates: **2019 – 2020**
Contribution: HSRI assessed the current data reporting procedures and helped to streamline those processes for the Department of Health in Provincetown, to facilitate the evaluation of the Community Navigator program serving individuals with behavioral health concerns. HSRI worked with the town to provide evaluation and consulting services regarding the Mental Health and Substance Abuse Case Management Services grant implementation. Nilufer assisted with improving the program logic model to better communicate the grant program goals and processes, 2) ensured the program implementation occurred in line with the program logic model and 3) provided data collection and evaluation training and technical assistance for the program.

Project Director, *Consumer Survey for the Massachusetts Commission for the Blind (MCB)*
Funder: MCB | Dates: 2019
Contribution: HSRI developed survey tools for the Commission to identify the social and vocational service needs of its consumers. HSRI also worked with the Commission to optimize their use of available data sources, including their current case management data system and data from national sources such as the American Community Survey, Current Population Surveys, the Behavioral Risk Factor Surveillance System, and the Survey of Income and Program Participation. Nilufer oversaw all project activities including directing the project methodology.

Senior Methodologist, *Comprehensive Statewide Assessment of the Vocational Rehabilitation Needs of Individuals with Disability in New Hampshire*
Funder: **NH Department of Education, Division of Workforce Innovation, Bureau of Vocational Rehabilitation** | Dates: **2019**
Contribution: HSRI designed and implemented a CSNA for the New Hampshire Department VR. The work involved data collection, and analysis in order to inform the 2019 CSNA which (1) assured that the Agency is in compliance with 34 CFR 361.29, and (2) yielded information on the known participant levels and the unknown possible participants, both of which will impact program outreach and operation. Nilufer led the project team and provided data analysis and methodological guidance.

Senior Methodologist, *Substance Abuse Disorder Providers and Insurance Reimbursement*
Funder: **Assistant Secretary for Planning and Evaluation (ASPE)** | Dates: **2017 – 2019**

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Contribution: HSRI documented state licensing and credentialing requirements for substance use disorder (SUD) treatment providers in each state and the District of Columbia. HSRI reviewed state reimbursement policies for SUD services for Medicaid, Medicare, and a sample of private insurers. HSRI also conducted case studies of states that had implemented innovative strategies to incentivize SUD providers to join provider networks and accept insurance reimbursement. Nilufer helped lead the team on numerous tasks such as: producing work plans, conducting the environmental scan, reviewing licensing and credentials of SUD providers, reviewing billing eligibility, conducting case studies, and writing reports and issue briefs.

Statistician, *Independent Evaluation of the Capacity of the Current Health System*
Funder: **New Hampshire Department of Health and Human Services (NH DHHS)** | Dates: **2017 – 2018**
Contribution: HSRI conducted an evaluation of the capacity of the health system in New Hampshire to respond to the inpatient, acute care psychiatric needs of patients, including but not limited to those patients who require involuntary emergency admissions. The work included developing a comprehensive system map, reporting on hospital and emergency department admission data, conducting a system of care gap analysis, and developing a written report and presentation. Nilufer was responsible for leading the analysis of qualitative and quantitative data. She is also assisted with identifying and obtaining existing data and writing reports.

Cross-Site Evaluation Co-Lead, *Program Evaluation for Prevention Contract (PEP-C)*
Funder: **Substance Abuse and Mental Health Services Administration - Center for Substance Abuse Prevention (SAMHSA-CSAP)** | Dates: **2013 – 2018**
Contribution: HSRI worked on the PEP-C project, which included a national cross-site evaluation of CSAP's Minority AIDS Initiative (MAI). MAI awards grants to community-based organizations and minority-serving academic institutions to prevent substance abuse and the spread of HIV, viral hepatitis, and other STDs among high-risk minority communities. Nilufer was responsible for overseeing the project team's data processing, analysis and reporting activities. She was also responsible for developing the cross-site evaluation and analysis plans, reviewing grantees' evaluation plans, conducting trainings for grantees and SAMHSA project officers, overseeing the team's responses to technical assistance requests from grantees, designing the annual reports, and developing conference presentations and scholarly publications based on evaluation findings. As part of this project, she led the effort to review and revise the MAI outcome measures and to redesign the participant-level data collection instruments and protocols.

Senior Analyst, *Evaluation of Programs Providing Services to Persons who are Homeless with Mental and/or Substance Use Disorders*
Funder: **SAMHSA-CMHS-CSAT** | Dates: **2011 – 2016**
Contribution: HSRI evaluated four programs: CABHI, the Grants for the Benefit of Homeless Individuals (GBHI), Services in Supportive Housing (SSH), and PATH. HSRI led the multi-site evaluation of the PATH program. Nilufer served as a Senior Analyst and led the planning, analysis and interpretation of the data, and development of scholarly articles.

Data Analysis Team Lead, *Data Analysis Coordination and Consolidation Center (DACCC)*
Funder: **Substance Abuse and Mental Health Services Administration - Center for Substance Abuse Prevention (SAMHSA-CSAP)** | Dates: **2007 – 2012**
Contribution: CSAP funded the DACCC as a means to centralize and elevate its data collection and analysis efforts, producing data that would help it provide appropriate guidance to grantees and to the prevention field in general. Nilufer led a team of 15 research analysts in consolidating data from multiple sources into reports that summarize the performance of CSAP programs and contracts. She

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also interacted with the client to obtain requirements for deliverables, conducted original research to inform the field, presented findings at national conferences, and offered trainings in data and evaluation methods to CSAP staff and grantees.

Associations

The College for Behavioral Health Leadership
American Evaluation Association
American Public Health Association
Society for Prevention Research
AcademyHealth

Publications and Presentations

Articles

Isvan, N., Bonardi, A., & Hiersteiner, D. (2023). Effects of person-centered planning and practices on the health and well-being of adults with intellectual and developmental disabilities: a multilevel analysis of linked administrative and survey data. *Journal of Intellectual Disability Research*, doi: 10.1111/jir. 13015.

Giordano, S. & **Isvan, N.** (2022). Socioeconomic factors, long-term support services and aging or disabled populations. Presented at the National Association of Health Data Organizations Spotlight Series on Health Equity and Disparities.

Croft, B., Battis, K., **Isvan, N.**, & Mahoney, K. (2019). Service Utilization Before and After Self-Direction: A Quasi-experimental Difference-in-Differences Analysis of Utah's Mental Health Access to Recovery Program. *Administration and Policy in Mental Health and Mental Health Services Research.* http://dx.doi.org/10.1007/s10488-019-00969-4

Croft, B. & **Isvan, N.** (2015). Impact of the 2nd story peer respite program on use of inpatient and emergency services. *Psychiatric Services*, 66, 632 – 637.

Croft, B., **Isvan, N.**, Parish, S. & Mahoney, K. (2018). Housing and employment outcomes for mental health self-direction participants. *Psychiatric Services*, 69, 819-825.

Technical Reports

Co-Author: New Hampshire State Youth Treatment Implementation Grant Annual Evaluation Report (2021).

Co-Author: Comprehensive Statewide Needs Assessment of New Hampshire's Vocational Rehabilitation System. New Hampshire Department of Education, Bureau of Vocational Rehabilitation (2020).

Co-Author: Credentialing, Licensing, and Reimbursement of the SUD Workforce: A Review of Policies & Practices Across the Nation. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (2019).

Co-Author: The Minority AIDS Initiative (MAI) Cross-Site Evaluation Report, FY 2015, Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration (2016).

Co-Author: Accountability Report, Volume X: FY 2011, Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration (2012).

Co-Author: National Outcome Measures: State-Level Trends, Volume VI: 2002-2010. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration (2012).

Co-Author: Trends and Directions in Substance Abuse Prevention, Volume IX: 2002-2010, Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration (2011).

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Co-Author: HIV Cross-Site Evaluation Report, Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration (2012).

Co-Author: STOP Act Annual Report, Volume III: FY 2011, Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration (2012).

Presentations

Isvan, N., Hiersteiner, D., & Bonardi, A. (2023). Impact of Person-Centered Practices on Choice Making and Wellbeing Among Adults with IDD Receiving Long-Term Services and Supports. Paper presented at the AcademyHealth Annual Research Meeting, Seattle, WA.

Isvan, N., Bauman, A., Malloy, J., Battis, K., & Solomon, V. (2022). Pilot Study Of a Novel Model Of Care For Youth With Substance Use Or Co-Occurring Mental Health & Substance Use Disorders. Paper presented at the European Association for Research on Adolescence. Dublin, Ireland.

Li, H., **Isvan, N.**, & Bonardi, A. (2021). Measuring Satisfaction with Community Inclusion Of People with Intellectual & Developmental Disabilities Who Receive Long-Term Services and Supports. Poster presented at the Academy Health Virtual Annual Research Meeting.

Isvan, N., Gerber, R., Hughes, D., Battis, K., Dey, J.G., West, K.D., & Anderson, E. (2019). Credentialing, Licensing, and Reimbursement of the SUD Counseling Workforce: Review of Policies and Practices Across the Nation. Paper presented at the Academy Health Research Conference, Washington, D.C.

Isvan, N., Lundquist, L., Gerber, R., Battis, K., Burnett, M., & Brown, D.C. (2017). The Effects of Service Type and Dosage on HIV Risk Factors Among Participants of Minority AIDS Initiative Programs. Paper presented at the Annual Meeting of the Society for Prevention Research, Washington, D.C.

Isvan, N., Gerber, R., Battis, K., Burnett, M., Lundquist, L., Brown, D.C., Graham, P.W., & Youngman, L. (2016). HIV and Substance Abuse Prevention Needs of Transgender Individuals: An Analysis of Program Evaluation Data from SAMHSA's Minority AIDS Initiative. Poster presented at the American Public Health Association Annual Conference, Denver, CO.

Isvan, N., Brown, D.C., Gerber, R., Battis, K., Lundquist, L., Burnett, M., Graham, P.W., Blake, S., & Clarke, T. (2016). The Success Case Method: Integrating Qualitative and Quantitative Data to Evaluate Behavioral Health Interventions. Paper presented at the American Evaluation Association Annual Conference, Atlanta, GA.

Isvan, N., Lundquist, L., Burnett, M., Gerber, R., Brown, D.C., Youngman, L., & Pinnock, W. (2016). The Role of SAMHSA/CSAP's Minority AIDS Initiative (MAI) in Addressing Health Disparities. Paper presented at the Annual Conference of the Society for Prevention Research, San Francisco, CA.

Croft, B. & **Isvan, N.** (2013). Impact of the 2nd Story Peer Respite Program on Inpatient and Emergency Service Use. Poster presented at the American Public Health Association Annual Conference, Boston, MA.

Isvan, N. & Roddy, P. (2012). Characteristics of Successful Substance Abuse/HIV Prevention Interventions. Paper presented at the National Prevention Network Annual Research Conference. Pittsburgh, PA.

Fallik, B. & **Isvan, N.** (2011). Recent National Trends in Substance Abuse Indicators and Implications for Prevention Policy. Paper presented at the National Prevention Network Research Conference, Atlanta, GA.

Isvan, N. & Smith LeBeau, L. (2010). Adolescent Risk and Protective Factors Predicting Young Adult Substance Use. Paper presented at the annual meeting of the American Psychological Association, San Diego, CA.

Fallik, B. & **Isvan, N.** (2009). An Analysis Examining Longitudinal Data of Early Teenage Factors Associated with Substance Use Among Young Adults. Paper presented at the National Prevention Network Research Conference, Anaheim, CA.

Rogers, K., **Isvan, N.**, & Bailey, D. (2009). Predicting Participant Retention in Direct Service Prevention Programs: The Case of CSAP's Methamphetamine Prevention Grant Initiative. Paper presented at the Annual Meeting of the Society for Prevention Research, Washington, D.C.

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Contractor Name
Key Personnel

Name	Job Title	Salary Amount Paid from this Contract
Benjamin Cichocki	Project Director	$60,405
Rachael Gerber	Project Manager	$64,935
David Hughes	Senior Advisor	$39,902
Nilufer Isvan	Methodologist	$44,282