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

129 PLEASANT STREET, CONCORD, NH 03301
603-271-9544 1-800-852-3345 Ext. 9544
Fax: 603-271-4332 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

Lori A. Weaver
Commissioner

Katja S. Fox
Director

March 26, 2024

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 **Sole Source** amendment to an existing contract with Mary Hitchcock Memorial Hospital (VC#177160), Lebanon, NH, to outline additional subject matter experts and information needed for the evaluation of integrated primary care, community behavioral health care and wellness services for young people with serious emotional disturbance, serious mental illness, serious and persistent mental illness, with no change to the price limitation of $770,249 and no change to the contract completion date of September 29, 2024, effective upon Governor and Council approval.

The original contract was approved by Governor and Council on November 22, 2021, item #22 and most recently amended with Governor and Council approval on December 20, 2023, item #32.

EXPLANATION

This request is **Sole Source** because MOP 150 requires all amendments to agreements previously approved as sole source to be identified as sole source. The Contractor was identified in the original federal ProHealth NH grant application submitted to the Substance Abuse and Mental Health Services Administration (SAMHSA). ProHealth NH is an innovative model of integrated care intended to improve health and wellness for young people with serious emotional disturbance and serious mental illness. ProHeath NH, funded by a 5-year federal grant, embedded primary care services delivered by Federally Qualified Healthcare Centers within Community Mental Health Center facilities via contract with the Department. On September 20, 2023, SAMHSA notified the Department of the approval of continued ProHealth NH grant funds. The use of federal funding is contingent upon the Department continuing to contract with the current Contractor, therefore the Contractor is the only authorized contractor able to perform the services.

The purpose of this request is to add scope, at no additional cost, that details the subject matter experts the Contractor will provide, and their role to assist the Department with program evaluation. These content experts will conduct a final analysis of information gathered as part of the federal grant program. Additionally, the scope outlines the de-identified information required for the program evaluation. This evaluation is a critical part of understanding how significant the positive health outcomes youth and young adults with complex co-occurring mental and physical health conditions achieved through their participation in the ProHealth NH Partnership Grant. The Contractor will continue to finalize evaluation of the program and provide orderly close-out to SAMHSA on behalf of the Department.

The Department will continue monitoring services by reviewing the final evaluation reports provided by the Contractor.

Should the Governor and Council not authorize this request, the Department will not have access to the overall program evaluation of community-based treatment and recovery options achieved through this grant program and will be limited in its ability to close out the ProHealth NH Partnership Grant.

Area served: Greater Manchester, Greater Nashua, and Strafford County.

Respectfully submitted,

Lori A. Weaver
Commissioner

State of New Hampshire
Department of Health and Human Services
Amendment #2

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

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on November 22, 2021 (Item #22), as amended on December 20, 2023 (Item #32), the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended and in consideration of certain sums specified; and

WHEREAS, pursuant to Form P-37, General Provisions, the Contract may be amended upon written agreement of the parties and approval from the Governor and Executive Council; and

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

1. Modify Exhibit B, Scope of Services, by adding Section 2.4, to read:

   2.4. The Contractor shall collaborate with the Department by providing a team of statistical, analytic and content experts to conduct analyses of NH Medicaid claims to complete the evaluation of the ProHealth Integrated Care Program, including, but not limited to:

      2.4.1. Receipt and safe storage of de-identified NH Medicaid service encounter claims.

      2.4.2. Claims without direct identifiers for all community mental health and all hospital services including emergency services among adults age 18-40 in 2018-2023, and associated files with diagnoses and demographics along with a flag to indicate whether the beneficiary participated in the ProHealth program.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be effective upon Governor and Council approval.

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

State of New Hampshire
Department of Health and Human Services

3/14/2024
Date

DocuSigned by:
Katja S. Fox
ED9B05B81C63142...
Name: Katja S. Fox
Title: Director

Mary Hitchcock Memorial Hospital

3/14/2024
Date

DocuSigned by:
Edward J. Merrens, MD
8ACA3CF1A0CC43B...
Name: Edward J. Merrens, MD
Title: Chief Clinical Officer

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

OFFICE OF THE ATTORNEY GENERAL

3/15/2024
Date

DocuSigned by:
Robyn Guarino
7487348440A1480...
Name: Robyn Guarino
Title: Attorney

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

OFFICE OF THE SECRETARY OF STATE

Date

Name:
Title:

State of New Hampshire

Department of State

CERTIFICATE

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

Business ID: **68517**

Certificate Number: **0005760740**

IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 18th day of April A.D. 2022.

David M. Scanlan

Secretary of State

CERTIFICATE OF VOTE/AUTHORITY

I, Roberta L. Hines, MD, do hereby certify that:

1. I am the duly elected Chair of the Boards of Trustees of Mary Hitchcock Memorial Hospital and Dartmouth-Hitchcock Clinic (together, "Dartmouth-Hitchcock").
2. The following is a true and accurate excerpt from the Amended, Restated and Integrated Bylaws of the Dartmouth-Hitchcock Corporations:
    a. **"ARTICLE II – Section A. Fiduciary Duty. Stewardship over Corporate Assets.** As responsible stewards of tax-exempt, charitable Corporations, members of the Corporations' Boards have the fiduciary duty to oversee, with due care and loyalty, the stewardship of the Corporations' assets and operations in order to create a sustainable health system that is population focused and value-based, and to advance their respective corporate purposes. In exercising this duty, the Boards may, consistent with the respective Corporation's Articles of Agreement and these Bylaws, delegate authority to Board Committees and other bodies, or to various officers, to provide input with respect to issues and strategies, incur indebtedness, make expenditures, enter into contracts and agreements and take such other binding actions on behalf of the Corporations as may be necessary or desirable in furtherance of their charitable purposes."
3. Pursuant to policy approved and adopted by the Boards of Trustees consistent with the above Bylaws provision, the Chief Clinical Officer, Edward Merrens, MD, has subdelegated signature authority to enter into contracts and agreements on behalf of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital.
4. The foregoing authority shall remain in full force and effect as of the date of the agreement executed or action taken in reliance upon this Certificate. This authority shall remain valid for thirty (30) days from the date of this Certificate and the State of New Hampshire shall be entitled to rely upon same, until written notice of modification, rescission or revocation of same, in whole or in part, has been received by the State of New Hampshire.

IN WITNESS WHEREOF, I have hereunto set my hand as the Chair of the Boards of Trustees of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital this 7th day of March, 2024.

Roberta L. Hines, MD, Board Chair

CERTIFICATE OF INSURANCE

DATE: June 29, 2023

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

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

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

COVERAGES

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

TYPE OF INSURANCE		POLICY NUMBER	POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	LIMITS	
GENERAL LIABILITY		0002023-A	7/1/2023	7/1/2024	EACH OCCURRENCE	$1,000,000
					DAMAGE TO RENTED PREMISES	$1,000,000
X	CLAIMS MADE				MEDICAL EXPENSES	N/A
					PERSONAL & ADV INJURY	$1,000,000
	OCCURRENCE				GENERAL AGGREGATE	$3,000,000
OTHER					PRODUCTS-COMP/OP AGG	$1,000,000
PROFESSIONAL LIABILITY		0002023-A	7/1/2023	7/1/2024	EACH CLAIM	$1,000,000
X	CLAIMS MADE				ANNUAL AGGREGATE	$3,000,000
	OCCURENCE					
OTHER						

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

CERTIFICATE HOLDER

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

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

AUTHORIZED REPRESENTATIVES

DARTHIT-01 LSTILES

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 7/10/2023

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

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

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

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	☐ OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						X PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y / N ☐	N / A		AGC4066562	7/1/2023	7/1/2024	E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

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

Cheshire Medical Center
Dartmouth-Hitchcock Health
Mary Hitchcock Memorial Hospital
Alice Peck Day Memorial Hospital
New London Hospital Association
SEE ATTACHED ACORD 101

CERTIFICATE HOLDER

NH DHHS
129 Pleasant Street
Concord, NH 03301

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

Brenda J. Keaney

AGENCY CUSTOMER ID: DARTHIT-01 LSTILES

LOC #: 1

ACORD

ADDITIONAL REMARKS SCHEDULE

AGENCY	License # 1780862	NAMED INSURED
HUB International New England		Dartmouth-Hitchcock Health 1 Medical Center Dr. Lebanon, NH 03756
POLICY NUMBER		
SEE PAGE 1		
CARRIER	NAIC CODE	EFFECTIVE DATE: SEE PAGE 1
SEE PAGE 1	SEE P 1	

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,

FORM NUMBER: ACORD 25 FORM TITLE: Certificate of Liability Insurance

Description of Operations/Locations/Vehicles:
Mt. Ascutney Hospital and Health Center
Visiting Nurse Associates and Hospice of Vermont and New Hampshire

About Dartmouth Hitchcock Medical Center and Clinics

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

Our physicians and researchers collaborate with Geisel School of Medicine scientists and faculty as well as other leading health care organizations to develop new treatments at the cutting edge of medical practice bringing the latest medical discoveries to the patient.

Who are Dartmouth Hitchcock Medical Center and Clinics?

Dartmouth Hitchcock Medical Center

Dartmouth Hitchcock Medical Center is the state's only academic medical center, and the only Level I Adult and Level II Pediatric Trauma Center in New Hampshire. The Dartmouth-Hitchcock Advanced Response Team (DHART), based in Lebanon and Manchester, provides ground and air medical transportation to communities throughout northern New England. In 2021, Dartmouth Hitchcock Medical Center was named the #1 hospital in New Hampshire by U.S. News & World Report (https://health.usnews.com/best-hospitals/area/nh), and recognized for high performance in 11 clinical specialties, procedures, and conditions.

Dartmouth Hitchcock Clinics

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

Children's Hospital at Dartmouth Hitchcock Medical Center

Children's Hospital at Dartmouth Hitchcock Medical Center is New Hampshire's only children's hospital and a member of the Children's Hospital Association, providing advanced pediatric inpatient, outpatient and surgical services at Dartmouth Hitchcock Medical Center.

Norris Cotton Cancer Care Pavilion Lebanon

Norris Cotton Cancer Care Pavilion Lebanon (https://cancer.dartmouth.edu/), one of only 51 NCI-designated Comprehensive Cancer Centers in the nation, is one of the premier facilities for cancer treatment, research, prevention, and education.

Our mission, vision, and values

Our mission

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

Our vision

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

Our values

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

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

Dartmouth-Hitchcock Health and Subsidiaries

Consolidated Financial Statements
June 30, 2021 and 2020

Dartmouth-Hitchcock Health and Subsidiaries
Index
June 30, 2021 and 2020

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Report of Independent Auditors

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

We have audited the accompanying consolidated financial statements of Dartmouth-Hitchcock Health and its subsidiaries (the "Health System"), which comprise the consolidated balance sheets as of June 30, 2021 and 2020, and the related consolidated statements of operations and changes in net assets and of cash flows for the years then ended.

Management's Responsibility for the Consolidated Financial Statements

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

Auditors' Responsibility

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

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

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Dartmouth-Hitchcock Health and its subsidiaries as of June 30, 2021 and 2020, and the results of their operations, changes in net assets and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

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

pwc

Other Matter

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

PricewaterhouseCoopers LLP

Boston, Massachusetts
November 18, 2021

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Balance Sheets
June 30, 2021 and 2020

(in thousands of dollars)	2021	2020
Assets		
Current assets		
Cash and cash equivalents	$ 374,928	$ 453,223
Patient accounts receivable (Note 4)	232,161	183,819
Prepaid expenses and other current assets	157,318	161,906
Total current assets	764,407	798,948
Assets limited as to use (Notes 5 and 7)	1,378,479	1,134,526
Other investments for restricted activities (Notes 5 and 7)	168,035	140,580
Property, plant, and equipment, net (Note 6)	680,433	643,586
Right of use assets, net (Note 16)	58,410	57,585
Other assets	177,098	137,338
Total assets	$ 3,226,862	$ 2,912,563
Liabilities and Net Assets		
Current liabilities		
Current portion of long-term debt (Note 10)	$ 9,407	$ 9,467
Current portion of right of use obligations (Note 16)	11,289	11,775
Current portion of liability for pension and other postretirement plan benefits (Note 11 and 14)	3,468	3,468
Accounts payable and accrued expenses	131,224	129,016
Accrued compensation and related benefits	182,070	142,991
Estimated third-party settlements (Note 3 and 4)	252,543	302,525
Total current liabilities	590,001	599,242
Long-term debt, excluding current portion (Note 10)	1,126,357	1,138,530
Long-term right of use obligations, excluding current portion (Note 16)	48,167	46,456
Insurance deposits and related liabilities (Note 12)	79,974	77,146
Liability for pension and other postretirement plan benefits, excluding current portion (Note 11 and 14)	224,752	324,257
Other liabilities	214,714	143,678
Total liabilities	2,283,965	2,329,309
Commitments and contingencies (Notes 3, 4, 6, 7, 10, 13, and 16)		
Net assets		
Net assets without donor restrictions (Note 9)	758,627	431,026
Net assets with donor restrictions (Notes 8 and 9)	184,270	152,228
Total net assets	942,897	583,254
Total liabilities and net assets	$ 3,226,862	$ 2,912,563

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

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Statements of Operations and Changes in Net Assets
Years Ended June 30, 2021 and 2020

(in thousands of dollars)	2021	2020
Operating revenue and other support		
Net patient service revenue (Note 4)	$ 2,138,287	$ 1,880,025
Contracted revenue	85,263	74,028
Other operating revenue (Note 5)	424,958	374,622
Net assets released from restrictions	15,201	16,260
Total operating revenue and other support	2,663,709	2,344,935
Operating expenses		
Salaries	1,185,910	1,144,823
Employee benefits	302,142	272,872
Medications and medical supplies	545,523	455,381
Purchased services and other	383,949	360,496
Medicaid enhancement tax (Note 4)	72,941	76,010
Depreciation and amortization	88,921	92,164
Interest (Note 10)	30,787	27,322
Total operating expenses	2,610,173	2,429,068
Operating income (loss)	53,536	(84,133)
Non-operating gains (losses)		
Investment income, net (Note 5)	203,776	27,047
Other components of net periodic pension and post retirement benefit income (Note 11 and 14)	13,559	10,810
Other losses, net (Note 10)	(4,233)	(2,707)
Total non-operating gains, net	213,102	35,150
Excess (deficiency) of revenue over expenses	$ 266,638	$ (48,983)

Consolidated Statements of Operations and Changes in Net Assets – continues on next page

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

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Statements of Operations and Changes in Net Assets - Continued
Years Ended June 30, 2021 and 2020

(in thousands of dollars)	2021	2020
Net assets without donor restrictions		
Excess (deficiency) of revenue over expenses	$ 266,638	$ (48,983)
Net assets released from restrictions for capital	2,017	1,414
Change in funded status of pension and other postretirement benefits (Note 11)	59,132	(79,022)
Other changes in net assets	(186)	(2,316)
Increase (decrease) in net assets without donor restrictions	327,601	(128,907)
Net assets with donor restrictions		
Gifts, bequests, sponsored activities	30,107	26,312
Investment income, net	19,153	1,130
Net assets released from restrictions	(17,218)	(17,674)
Increase in net assets with donor restrictions	32,042	9,768
Change in net assets	359,643	(119,139)
Net assets		
Beginning of year	583,254	702,393
End of year	$ 942,897	$ 583,254

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

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Statements of Cash Flows
Years Ended June 30, 2021 and 2020

(in thousands of dollars)	2021	2020
Cash flows from operating activities		
Change in net assets	$ 359,643	$ (119,139)
Adjustments to reconcile change in net assets to net cash provided by operating and non-operating activities		
Depreciation and amortization	88,904	93,704
Amortization of bond premium, discount, and issuance cost, net	(2,820)	153
Amortization of right of use asset	10,034	8,218
Payments on right of use lease obligations - operating	(9,844)	(7,941)
Change in funded status of pension and other postretirement benefits	(59,132)	79,022
Loss (gain) on disposal of fixed assets	592	(39)
Net realized gains and change in net unrealized gains on investments	(228,489)	(14,060)
Restricted contributions and investment earnings	(3,445)	(3,605)
Changes in assets and liabilities		
Patient accounts receivable	(48,342)	37,306
Prepaid expenses and other current assets	4,588	(78,907)
Other assets, net	(39,760)	(13,385)
Accounts payable and accrued expenses	1,223	9,772
Accrued compensation and related benefits	39,079	14,583
Estimated third-party settlements	9,787	260,955
Insurance deposits and related liabilities	2,828	18,739
Liability for pension and other postretirement benefits	(40,373)	(35,774)
Other liabilities	11,267	19,542
Net cash provided by operating and non-operating activities	95,740	269,144
Cash flows from investing activities		
Purchase of property, plant, and equipment	(122,347)	(128,019)
Proceeds from sale of property, plant, and equipment	316	2,987
Purchases of investments	(95,943)	(321,152)
Proceeds from maturities and sales of investments	75,071	82,986
Net cash used in investing activities	(142,903)	(363,198)
Cash flows from financing activities		
Proceeds from line of credit	-	35,000
Payments on line of credit	-	(35,000)
Repayment of long-term debt	(9,183)	(10,665)
Proceeds from issuance of debt	-	415,336
Repayment of finance lease	(3,117)	(2,429)
Payment of debt issuance costs	(230)	(2,157)
Restricted contributions and investment earnings	3,445	3,605
Net cash (used in) provided by financing activities	(9,085)	403,690
(Decrease) increase in cash and cash equivalents	(56,248)	309,636
Cash and cash equivalents		
Beginning of year	453,223	143,587
End of year	$ 396,975	$ 453,223
Supplemental cash flow information		
Interest paid	$ 41,819	$ 22,562
Construction in progress included in accounts payable and accrued expenses	16,192	17,177

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

	2021	2020
Cash and cash equivalents	$ 374,928	$ 453,223
Cash and cash equivalents included in assets limited as to use	18,500	-
Restricted cash and cash equivalents included in Other investments for restricted activities	3,547	-
Total of cash, cash equivalents and restricted cash shown in the consolidated statements of cash flows	$ 396,975	$ 453,223

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

1. Organization and Community Benefit Commitments

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

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

D-HH, DHC, MHMH, NLH, Cheshire, and APD are NH not-for-profit corporations exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code (IRC). MAHHC and VNH are VT not-for-profit corporations exempt from federal income taxes under Section 501(c)(3) of the IRC.

On September 30, 2019, D-HH and GraniteOne Health (GOH) entered into an agreement (The Combination Agreement) to combine their respective healthcare systems. The GOH system is comprised of Catholic Medical Center (CMC), an acute care community hospital in Manchester, New Hampshire, Huggins Hospital (HH) located in Wolfeboro, NH and Monadnock Community Hospital, (MCH) located in Peterborough, NH. Both HH and MCH are designated as Critical Access Hospitals (CAH). The three member hospitals of GOH have a combined licensed bed count of 380 beds. GOH is a non-profit, community based health care system. The overarching rationale for the proposed combination is to improve access to high quality primary and specialty care in the most convenient, cost-effective sites of service for patients and the communities served by D-HH and GOH. Other stated benefits of the combination include reinforcing the rural health network, investing in needed capacity to accommodate unmet and anticipated demand, and drawing on our combined strengths to attract the necessary health care workforce. The parties have submitted regulatory filings with the Federal Trade Commission and the New Hampshire Attorney General's office seeking approval of the proposed transaction. As of June 30, 2021, the proposed combination remains under regulatory review.

Community Benefits

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

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

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

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

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

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

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

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

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

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

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

- *The Uncompensated Cost of Care for Medicaid* patients reported in the unaudited Community Benefits Reports for 2020 was approximately $182,209,000. The 2021 Community Benefits Reports are expected to be filed in February 2022.

The following table summarizes the value of the community benefit initiatives outlined in the Health System's most recently filed Community Benefit Reports for the year ended June 30, 2021:

(in thousands of dollars)

Government-sponsored healthcare services	$	309,203
Health professional education		38,978
Charity care		17,441
Subsidized health services		17,341
Community health services		13,866
Research		7,064
Community building activities		4,391
Financial contributions		3,276
Community benefit operations		57
Total community benefit value	$	411,617

In fiscal years 2021 and 2020, funds received to offset or subsidize charity care costs provided were $848,000 and $1,224,000, respectively.

2. Summary of Significant Accounting Policies

Basis of Presentation

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

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

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

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

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

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

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

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

Other Revenue
The Health System recognizes other revenue which is not related to patient medical care but is central to the day-to-day operations of the Health System. Other revenue primarily consists of revenue from retail pharmacy, which the Health System records as customer revenues in the amounts that reflect the consideration to which it expects to be entitled in exchange for the prescription. Other revenue also includes the Department of Health and Human Services ("HHS") Coronavirus Aid, Relief, and Economic Securities Act ("CARES Act" Provider Relief Funds ("Provider Relief Funds") operating agreements, grant revenue, cafeteria sales and other support service revenue (Note 3).

Cash Equivalents
Cash and cash equivalents include amounts on deposit with financial institutions; short-term investments with maturities of three months or less at the time of purchase and other highly liquid investments, primarily cash management funds, which would be considered level 1 investments under the fair value hierarchy. All short-term, highly liquid investments, otherwise qualifying as cash equivalents, included within the Health System's endowment and similar investment pools are classified as investments, at fair value and therefore are excluded from Cash and cash equivalents in the Statements of Cash Flows.

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

Investments in pooled/commingled investment funds, private equity funds and hedge funds that represent investments where the Health System owns shares or units of funds rather than the underlying securities in that fund are valued using the equity method of accounting with changes in value recorded in the excess (deficiency) of revenue over expenses.

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

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

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

Level 1	Unadjusted quoted prices in active markets that are accessible at the measurement date for assets or liabilities.
Level 2	Prices other than quoted prices in active markets that are either directly or indirectly observable as of the date of measurement.
Level 3	Prices or valuation techniques that are both significant to the fair value measurement and unobservable.

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

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

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

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

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

Intangible Assets and Goodwill
The Health System records within other assets on the consolidated balance sheets goodwill and intangible assets such as trade names and leases-in-place. The Health System considers trade names and goodwill to be indefinite-lived assets, assesses them at least annually for impairment or more frequently if certain events or circumstances warrant and recognizes impairment charges for amounts by which the carrying values exceed their fair values. The Health System has recorded $9,403,000 and $10,007,000 as intangible assets associated with its affiliations as of June 30, 2021 and 2020, respectively.

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

Recently Issued Accounting Pronouncements
In August 2018, FASB issued *ASU No. 2018-15, Intangibles – Goodwill and Other – Internal-Use Software (Subtopic 350-40): Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That is a Service Contract.* This ASU aligns the requirements for capitalizing implementation costs incurred in a hosting arrangement that is a service contract with the requirements for capitalizing implementation costs incurred to develop or obtain internal-use software or software licenses. The ASU is effective for fiscal year 2022 and the Health System is evaluating the impact of the new guidance on the consolidated financial statements.

3. COVID – 19's Impact on Dartmouth-Hitchcock Health

Throughout the 18 months since New Hampshire's first COVID-19 patient presented at Dartmouth-Hitchcock Health's academic medical center campus in Lebanon, New Hampshire, the organization has responded to meet the needs of our patients, community and staff, transforming as necessary to resume operations. Personal Protective Equipment (PPE), which was critically short at the outset of the pandemic, is now readily available. D-HH'S academic medical center campus continues to serve as the referral site for the state's and region's most complex COVID cases.

There have been three primary points of clinical emphasis in responding to COVID-19: telehealth, laboratory medicine, and clinical trials throughout the past year and a half. The pace and volume of COVID-19 response lessened in this past quarter, as vaccination efforts and declining case counts in D-HH's service area have made a significant difference in the necessary clinical response. While demand for telehealth has seen an expected drop in utilization from the daily virtual encounters seen early in the pandemic, in December 2020, D-HH's Center for Telehealth launched a virtual Urgent Care service for beneficiaries of the D-H health plan. In April, it was expanded as a general consumer offering and we continue to provide telehealth services to, and create partnerships with, an expanding number of hospitals and health systems around the region.

The learned and lived experiences of the past 18 months have positioned D-HH well to continue its economic recovery as we have found the clinical balance between caring for COVID-19 patients while continuing to care for non-COVID cases.

Health and Human Services ("HHS") Provider Relief Funds

D-HH received $65,600,000 and $88,700,000 from the Provider Relief funds for the years ended June 30, 2021 and 2020, respectively. We will continue to pursue Provider Relief funds as available and required to provide support to D-HH.

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

D-HH received a total of $272,600,000 of temporary funds received from the Cares Act in the form of CMS prepayment advances of $239,500,000 and accumulated payroll tax deferrals of $33,100,000. In October 2020, new regulations were issued to revise the recoupment start date from August 2020 to April 2021.

HHS Reporting Requirements for the CARES Act

In June 2021, HHS issued new reporting requirements for the CARES Act Provider Relief Funding. The new requirements first require Hospitals to identify healthcare-related expenses attributable to the COVID-19 pandemic that remain unreimbursed by another source. If those expenses do not exceed the Provider Relief funding received, Hospitals will need to demonstrate that the remaining Provider Relief funds were used to compensate for a negative variance in patient service revenue. HHS is entitled to recoup Provider Relief Funding in excess of the sum of expenses attributable to the COVID-19 pandemic that remain unreimbursed by another source and the decline in patient care revenue. Due to these new reporting requirements there is at least a reasonable possibility that amounts recorded under the CARES Act Provider Relief fund by the Health System may change in future periods.

4. Net Patient Service Revenue and Accounts Receivable

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Vermont imposes a provider tax on home health agencies in the amount of 4.25% of annual net patient revenue. In fiscal years 2021 and 2020, home health provider taxes paid were $623,000 and $624,000, respectively.

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

During the years ended June 30, 2021 and 2020, the Health System received DSH payments of approximately, $67,940,000 and $71,133,000 respectively. DSH payments are subject to audit and therefore, for the years ended June 30, 2021 and 2020, the Health System recognized as revenue DSH receipts of approximately $61,602,000 and approximately $67,500,000, respectively.

During the years ended June 30, 2021 and 2020, the Health System recorded State of NH MET and State of VT Provider taxes of $72,941,000 and $76,010,000, respectively. The taxes are calculated at 5.4% for NH and 6% for VT of certain patient service revenues. The Provider taxes are included in operating expenses in the consolidated statements of operations and changes in net assets.

Implicit Price Concessions

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

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

Settlements with third-party payers for retroactive revenue adjustments due to audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care using the most likely amount. These settlements are estimated based on the terms of the payment agreement with the payer, correspondence from the payer and historical settlement activity, including assessments to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known, or as years are settled or are no longer subject to such audits, reviews or investigations. As of June 30, 2021 and 2020, the Health System had reserves of $252,543,000 and $302,525,000, respectively, recorded in Estimated third-party settlements. As of June 30, 2021 and 2020, Estimated third-party settlements includes $179,382,000 and $239,500,000, respectively, of Medicare accelerated and advanced payments, received as working capital support during COVID-19 outbreak. As of June 30, 2021 and 2020, Other liabilities include $43,612,000 and $10,900,000, respectively.

For the years ended June 30, 2021 and 2020, additional increases in revenue of $4,287,000 and $2,314,000, respectively, were recognized due to changes in estimates of implicit price concessions for performance obligations satisfied in prior years.

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

The table below shows the Health System's sources of total operating revenue and other support presented at the net transaction price for the years ended June 30, 2021 and 2020.

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

	2020		
(in thousands of dollars)	**PPS**	**CAH**	**Total**
Hospital			
Medicare	$ 461,990	$ 64,087	$ 526,077
Medicaid	130,901	10,636	141,537
Commercial	718,576	60,715	779,291
Self Pay	2,962	2,501	5,463
Subtotal	1,314,429	137,939	1,452,368
Professional	383,503	22,848	406,351
Subtotal	1,697,932	160,787	1,858,719
VNA			21,306
Subtotal			1,880,025
Other Revenue			376,185
Provider Relief Fund			88,725
Total operating revenue and other support			$ 2,344,935

Accounts Receivable

The following table categorizes payors into four groups based on their respective percentages of patient accounts receivable as of June 30, 2021 and 2020:

	2021	2020
Medicare	34%	36%
Medicaid	13%	13%
Commercial	41%	39%
Self Pay	12%	12%
Total	100%	100%

5. Investments

The composition of investments at June 30, 2021 and 2020 is set forth in the following table:

(in thousands of dollars)	2021	2020
Assets limited as to use		
Internally designated by board		
Cash and short-term investments	$ 24,692	$ 9,646
U.S. government securities	157,373	103,977
Domestic corporate debt securities	322,616	199,462
Global debt securities	74,292	70,145
Domestic equities	247,486	203,010
International equities	81,060	123,205
Emerging markets equities	52,636	22,879
Global equities	79,296	-
Real Estate Investment Trust	422	313
Private equity funds	110,968	74,131
Hedge funds	-	36,964
	1,150,841	843,732
Investments held by captive insurance companies (Note 11)		
U.S. government securities	26,759	15,402
Domestic corporate debt securities	5,979	8,651
Global debt securities	6,617	8,166
Domestic equities	11,396	15,150
International equities	6,488	7,227
	57,239	54,596
Held by trustee under indenture agreement (Note 9)		
Cash and short-term investments	170,399	236,198
Total assets limited as to use	1,378,479	1,134,526
Other investments for restricted activities		
Cash and short-term investments	13,400	7,186
U.S. government securities	28,330	28,055
Domestic corporate debt securities	40,676	35,440
Global debt securities	8,953	11,476
Domestic equities	33,634	26,723
International equities	9,497	15,402
Emerging markets equities	5,917	2,766
Global equities	8,755	-
Real Estate Investment Trust	21	-
Private equity funds	12,251	9,483
Hedge funds	6,557	4,013
Other	44	36
Total other investments for restricted activities	168,035	140,580
Total investments	$ 1,546,514	$ 1,275,106

Investments are accounted for using either the fair value method or equity method of accounting, as appropriate on a case by case basis. The fair value method is used for all debt securities and equity securities that are traded on active markets and are valued at prices that are readily available in those markets. The equity method is used when investments are made in pooled/commingled investment funds that represent investments where shares or units are owned of pooled funds rather than the underlying securities in that fund. These pooled/commingled funds make underlying investments in securities from the asset classes listed above.

The following tables summarize the investments by the accounting method utilized, as of June 30, 2021 and 2020. Accounting standards require disclosure of additional information for those securities accounted for using the fair value method, as shown in Note 7.

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

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

For the years ended June 30, 2021 and 2020 investment income is reflected in the accompanying consolidated statements of operations and changes in net assets as other operating revenue of approximately $930,000 and $936,000 and as non-operating gains of approximately $203,776,000 and $27,047,000, respectively.

Private equity limited partnership shares are not eligible for redemption from the fund or general partner. It is the intent of the Health System to hold these investments until the fund has fully distributed all proceeds to the limited partners and the term of the partnership agreement expires. Under the terms of these agreements, the Health System has committed to contribute a specified level of capital over a defined period of time. Through June 30, 2021 and 2020, the Health System has outstanding commitments of $47,419,000 and $53,677,000, respectively.

6. Property, Plant, and Equipment

Property, plant, and equipment are summarized as follows at June 30, 2021 and 2020:

(in thousands of dollars)	2021	2020
Land	$ 40,749	$ 40,749
Land improvements	43,927	39,820
Buildings and improvements	955,094	893,081
Equipment	993,899	927,233
	2,033,669	1,900,883
Less: Accumulated depreciation	1,433,467	1,356,521
Total depreciable assets, net	600,202	544,362
Construction in progress	80,231	99,224
	$ 680,433	$ 643,586

As of June 30, 2021, construction in progress primarily consists of two projects. The Manchester Ambulatory Surgical Center (ASC) and the in-patient tower located in Lebanon, NH. The ASC partially opened in April 2021. The estimated cost to complete the ASC is $4,300,000. The anticipated completion date is the second quarter of fiscal 2022. The in-patient tower project is estimated to cost $82,000,000 to complete. The anticipated completion date is the fourth quarter of fiscal 2023.

Capitalized interest of $5,127,000 and $2,297,000 is included in construction in progress as of June 30, 2021 and 2020, respectively.

Depreciation and amortization expense included in operating and non-operating activities was approximately $86,011,000 and $89,762,000 for 2021 and 2020, respectively.

7. Fair Value Measurements

The following is a description of the valuation methodologies for assets and liabilities measured at fair value on a recurring basis:

Cash and Short-Term Investments
Consists of money market funds and are valued at net asset value (NAV) reported by the financial institution and cash which will be used for future investment opportunities.

Domestic, Emerging Markets and International Equities
Consists of actively traded equity securities and mutual funds which are valued at the closing price reported on an active market on which the individual securities are traded (Level 1 measurements).

U.S. Government Securities, Domestic Corporate and Global Debt Securities
Consists of U.S. government securities, domestic corporate and global debt securities, mutual funds and pooled/commingled funds that invest in U.S. government securities, domestic corporate and global debt securities. Securities are valued based on quoted market prices or dealer quotes where available (Level 1 measurement). If quoted market prices are not available, fair values are based on quoted market prices of comparable instruments or, if necessary, matrix pricing from a third party pricing vendor to determine fair value (Level 2 measurements). Matrix prices are based on quoted prices for securities with similar coupons, ratings and maturities, rather than on specific bids and offers for a designated security. Investments in mutual funds are measured based on the quoted NAV as of the close of business in the respective active market (Level 1 measurements).

Hedge Funds
Consists of publicly traded, daily-pricing mutual funds that use long/short trading strategies (Level 1 measurements).

The preceding methods may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Health System believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

Investments are classified in their entirety based on the lowest level of input that is significant to the fair value measurement. The following tables set forth the consolidated financial assets and liabilities that were accounted for at fair value on a recurring basis as of June 30, 2021 and 2020:

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

	2020			
(in thousands of dollars)	Level 1	Level 2	Level 3	Total
Assets				
Investments				
Cash and short term investments	$ 253,030	$ -	$ -	$ 253,030
U.S. government securities	147,434	-	-	147,434
Domestic corporate debt securities	17,577	180,834	-	198,411
Global debt securities	22,797	21,458	-	44,255
Domestic equities	187,354	7,660	-	195,014
International equities	77,481	-	-	77,481
Emerging market equities	1,257	-	-	1,257
Real estate investment trust	313	-	-	313
Other	2	34	-	36
Total investments	707,245	209,986	-	917,231
Deferred compensation plan assets				
Cash and short-term investments	5,754	-	-	5,754
U.S. government securities	51	-	-	51
Domestic corporate debt securities	7,194	-	-	7,194
Global debt securities	1,270	-	-	1,270
Domestic equities	24,043	-	-	24,043
International equities	3,571	-	-	3,571
Emerging market equities	27	-	-	27
Real estate	11	-	-	11
Multi strategy fund	51,904	-	-	51,904
Guaranteed contract	-	-	92	92
Total deferred compensation plan assets	93,825	-	92	93,917
Beneficial interest in trusts	-	-	9,202	9,202
Total assets	$ 801,070	$ 209,986	$ 9,294	$ 1,020,350

The following tables set forth the financial instruments classified by the Health System within Level 3 of the fair value hierarchy defined above as of June 30, 2021 and 2020.

	2021		
(in thousands of dollars)	Beneficial Interest in Perpetual Trust	Guaranteed Contract	Total
Balances at beginning of year	$ 9,202	$ 92	$ 9,294
Net realized/unrealized gains (losses)	1,594	(92)	1,502
Balances at end of year	$ 10,796	$ -	$ 10,796

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

There were no transfers into and out of Level 1 and 2 measurements due to changes in valuation methodologies during the years ended June 30, 2021 and 2020.

8. Net Assets with Donor Restrictions

Net assets with donor restrictions are available for the following purposes at June 30, 2021 and 2020:

(in thousands of dollars)	2021	2020
Investments held in perpetuity	$ 64,498	$ 59,352
Healthcare services	38,869	33,976
Health education	26,934	16,849
Research	24,464	22,116
Charity care	15,377	12,366
Other	7,215	4,488
Purchase of equipment	6,913	3,081
	$ 184,270	$ 152,228

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

9. Board Designated and Endowment Funds

Net assets include numerous funds established for a variety of purposes including both donor-restricted endowment funds and funds designated by the Board of Trustees to function as endowments. Net assets associated with endowment funds, including funds designated by the Board of Trustees to function as endowments, are classified and reported based on the existence or absence of donor-imposed restrictions.

The Board of Trustees has interpreted the NH and VT Uniform Prudent Management of Institutional Funds Acts (UPMIFA or Act) for donor-restricted endowment funds as requiring the preservation of the original value of gifts, as of the gift date, to donor-restricted endowment funds, absent explicit donor stipulations to the contrary. The Health System's net assets with donor restrictions which are to be held in perpetuity consist of (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to be held in perpetuity, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund, if any. Collectively these amounts are referred to as the historic dollar value of the fund.

Net assets without donor restrictions include funds designated by the Board of Trustees to function as endowments, the income from certain donor-restricted endowment funds, and any accumulated investment return thereon, which pursuant to donor intent may be expended based on trustee or management designation. Net assets with donor restrictions that are temporary in nature, either restricted by time or purpose, include funds appropriated for expenditure pursuant to endowment and investment spending policies, certain expendable endowment gifts from donors, and any retained income and appreciation on donor-restricted endowment funds, which are restricted by the donor to a specific purpose or by law. When the restrictions on these funds have been met, the funds are reclassified to net assets without donor restrictions.

In accordance with the Act, the Health System considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: the duration and preservation of the fund; the purposes of the donor-restricted endowment fund; general economic conditions; the possible effect of inflation and deflation; the expected total return from income and the appreciation of investments; other resources available; and investment policies.

The Health System has endowment investment and spending policies that attempt to provide a predictable stream of funding for programs supported by its endowment while ensuring that the purchasing power does not decline over time. The Health System targets a diversified asset allocation that places emphasis on investments in domestic and international equities, fixed income, private equity, and hedge fund strategies to achieve its long-term return objectives within prudent risk constraints. The Health System's Investment Committee reviews the policy portfolio asset allocations, exposures, and risk profile on an ongoing basis.

The Health System, as a policy, may appropriate for expenditure or accumulate so much of an endowment fund as the institution determines is prudent for the uses, benefits, purposes, and duration for which the endowment is established, subject to donor intent expressed in the gift instrument and the standard of prudence prescribed by the Act.

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below their original contributed value. Such market losses were not material as of June 30, 2021 and 2020.

Endowment net asset composition by type of fund consists of the following at June 30, 2021 and 2020:

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

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

Changes in endowment net assets for the years ended June 30, 2021 and 2020 are as follows:

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

(in thousands of dollars)	2020 Without Donor Restrictions	2020 With Donor Restrictions	2020 Total
Balances at beginning of year	$ 31,421	$ 78,268	$ 109,689
Net investment return	713	1,460	2,173
Contributions	890	2,990	3,880
Transfers	14	267	281
Release of appropriated funds	676	(2,946)	(2,270)
Balances at end of year	$ 33,714	$ 80,039	$ 113,753
Balances at end of year		80,039	
Beneficial interest in perpetual trusts		6,782	
Net assets with donor restrictions		$ 86,821	

10. Long-Term Debt

A summary of long-term debt at June 30, 2021 and 2020 is as follows:

(in thousands of dollars)	2021	2020
Variable rate issues		
New Hampshire Health and Education Facilities Authority (NHHEFA) Revenue Bonds		
Series 2018A, principal maturing in varying annual amounts, through August 2037 (1)	$ 83,355	$ 83,355
Fixed rate issues		
New Hampshire Health and Education Facilities Authority Revenue Bonds		
Series 2018B, principal maturing in varying annual amounts, through August 2048 (1)	303,102	303,102
Series 2020A, principal maturing in varying annual amounts, through August 2059 (2)	125,000	125,000
Series 2017A, principal maturing in varying annual amounts, through August 2040 (3)	122,435	122,435
Series 2017B, principal maturing in varying annual amounts, through August 2031 (3)	109,800	109,800
Series 2019A, principal maturing in varying annual amounts, through August 2043 (4)	99,165	99,165
Series 2018C, principal maturing in varying annual amounts, through August 2030 (5)	24,425	25,160
Series 2012, principal maturing in varying annual amounts, through July 2039 (6)	23,470	24,315
Series 2014B, principal maturing in varying annual amounts, through August 2033 (7)	14,530	14,530
Series 2014A, principal maturing in varying annual amounts, through August 2022 (7)	12,385	19,765
Series 2016B, principal maturing in varying annual amounts, through August 2045 (8)	10,970	10,970
Note payable		
Note payable to a financial institution due in monthly interest only payments through May 2035 (9)	125,000	125,000
Total obligated group debt	$ 1,053,637	$ 1,062,597

A summary of long-term debt at June 30, 2021 and 2020 is as follows (continued):

(in thousands of dollars)	2021	2020
Other		
Note payable to a financial institution payable in interest free monthly installments through December 2024; collateralized by associated equipment	$ 147	$ 287
Note payable to a financial institution with entire principal due June 2034; collateralized by land and building. The note payable is interest free	273	273
Mortgage note payable to the US Dept of Agriculture; monthly payments of $10,892 include interest of 2.375% through November 2046	2,489	2,560
Total nonobligated group debt	2,909	3,120
Total obligated group debt	1,053,637	1,062,597
Total long-term debt	1,056,546	1,065,717
Add: Original issue premium and discounts, net	86,399	89,542
Less: Current portion	9,407	9,467
Debt issuance costs, net	7,181	7,262
	$ 1,126,357	$ 1,138,530

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

(in thousands of dollars)	2021
2022	$ 9,407
2023	6,602
2024	1,841
2025	4,778
2026	4,850
Thereafter	1,029,068
	$ 1,056,546

Dartmouth-Hitchcock Obligated Group (DHOG) Debt
MHMH established the DHOG in 1993 for the original purpose of issuing bonds financed through NHHEFA or the "Authority". The members of the obligated group consist of D-HH, MHMH, DHC, Cheshire, NLH, MAHHC, and, APD. D-HH is designated as the obligated group agent.

Revenue Bonds issued by members of the DHOG are administered through notes registered in the name of the Bond Trustee and in accordance with the terms of a Master Trust Indenture. The Master Trust Indenture contains provisions permitting the addition, withdrawal, or consolidation of members of the DHOG under certain conditions. The notes constitute a joint and several obligation of the members of the DHOG (and any other future members of the DHOG) and are equally and ratably collateralized by a pledge of the members' gross receipts. The DHOG is also subject to certain annual covenants under the Master Trust Indenture, the most restrictive is the Annual Debt Service Coverage Ratio (1.10x).

(1) Series 2018A and Series 2018B Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds, Series 2018A and Series 2018B in February 2018. The Series 2018A Revenue Bonds were primarily used to refund a portion of Series 2015A and Series 2016A. The Series 2018B were primarily used to refund a portion of Series 2015A and Series 2016A, Revolving Line of Credit, Series 2012 Bank Loan and the Series 2015A and Series 2016A Swap terminations. A loss on the extinguishment of debt of approximately $578,000 was recognized in non-operating gains (losses) on the statement of operations and changes in net assets, as a result of the refinancing. The interest on the Series 2018A Revenue Bonds is variable with a current interest rate of 5.00% and matures in variable amounts through 2037. The interest on the Series 2018B Revenue Bonds is fixed with an interest rate of 4.18% and matures in variable amounts through 2048.

(2) Series 2020A Revenue Bonds

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

(3) Series 2017A and Series 2017B Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds, Series 2017A and Series 2017B in December, 2017. The Series 2017A Revenue Bonds were primarily used to refund Series 2009 and Series 2010 and the Series 2017B Revenue Bonds were used to refund Series 2012A and Series 2012B. The interest on the Series 2017A Revenue Bonds is fixed with an interest rate of 5.00% and matures in variable amounts through 2040. The interest on the Series 2017B Revenue Bonds is fixed with an interest rate of 2.54% and matures in variable amounts through 2031.

(4) Series 2019A Revenue Bonds

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

(5) Series 2018C Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds, Series 2018C in August, 2018. The Series 2018C Revenue Bonds were used primarily to refinance the Series 2010 Revenue Bonds. The interest on the series 2018C Revenue Bonds is fixed with an interest rate of 3.22% and matures in variable amounts through 2030.

(6) Series 2012 Revenue Bonds

The NHHEFA issued $29,650,000 of tax-exempt Revenue Bonds, Series 2012. The proceeds of these bonds were used to refund 1998 and 2009 Series Bonds, to finance the settlement cost of the interest rate swap, and to finance the purchase of certain equipment and renovations. The bonds have fixed interest coupon rates ranging from 2.0% to 5.0% (a net interest cost of 3.96%), and matures in variable amounts through 2039.

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

The DHOG issued NHHEFA Revenue Bonds, Series 2014A and Series 2014B in August 2014. The proceeds from the Series 2014A and 2014B Revenue Bonds were used to partially refund the Series 2009 Revenue Bonds and to cover cost of issuance. Interest on the 2014A Revenue Bonds is fixed with an interest rate of 2.63% and matures at various dates through 2022. Interest on the Series 2014B Revenue Bonds is fixed with an interest rate of 4.00% and matures at various dates through 2033.

(8) Series 2016B Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds, Series 2016B in July 2016 through a private placement with a financial institution. The Series 2016B Revenue Bonds were used to finance 2016 projects. The Series 2016B is fixed with an interest rate of 1.78% and matures at various dates through 2045.

(9) Note payable to financial institution

The DHOG issued a note payable to TD Bank in May 2020. Issued in response to the COVID-19 pandemic, the proceeds from the note will be used to fund working capital as needed. The interest on the note payable is fixed with an interest rate of 2.56% and matures at various dates through 2035.

Outstanding joint and several indebtedness of the DHOG at June 30, 2021 and 2020 approximates $1,053,637,000 and $1,062,597,000, respectively.

The Health System Indenture agreements require establishment and maintenance of debt service reserves and other trustee held funds. Trustee held funds of approximately $170,399,000 and $236,198,000 at June 30, 2021 and 2020, respectively, are classified as assets limited as to use in the accompanying consolidated balance sheets (Note 4). In addition, debt service reserves of approximately $8,035,000 and $9,286,000 at June 30, 2021 and 2020, respectively, are classified as other current assets in the accompanying consolidated balance sheets. The debt service reserves are mainly comprised of escrowed construction funds at June 30, 2021 and 2020.

For the years ended June 30, 2021 and 2020 interest expense on the Health System's long term debt is reflected in the accompanying consolidated statements of operations and changes in net assets as operating expense of approximately $30,787,000 and $27,322,000 and other non-operating losses of $3,782,000 and $3,784,000, respectively, net of amounts capitalized.

11. Employee Benefits

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

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

The Health System continued to execute the settlement of obligations due to retirees in the defined benefit plans through bulk lump sum offerings or purchases of annuity contracts. The annuity purchases follow guidelines established by the Department of Labor (DOL). The Health System anticipates continued consideration and/or implementation of additional settlements over the next several years.

Defined Benefit Plans

Net periodic pension expense included in employee benefits in the consolidated statements of operations and changes in net assets is comprised of the components listed below for the years ended June 30, 2021 and 2020:

(in thousands of dollars)	2021	2020
Service cost for benefits earned during the year	$ -	$ 170
Interest cost on projected benefit obligation	36,616	43,433
Expected return on plan assets	(63,261)	(62,436)
Net loss amortization	14,590	12,032
Total net periodic pension expense	$ (12,055)	$ (6,801)

The following assumptions were used to determine net periodic pension expense as of June 30, 2021 and 2020:

	2021	2020
Discount rate	3.00% - 3.10%	3.00% - 3.10%
Rate of increase in compensation	N/A	N/A
Expected long-term rate of return on plan assets	7.50%	7.50%

The following table sets forth the funded status and amounts recognized in the Health System's consolidated financial statements for the defined benefit pension plans at June 30, 2021 and 2020:

(in thousands of dollars)	2021	2020
Change in benefit obligation		
Benefit obligation at beginning of year	$ 1,209,100	$ 1,135,523
Service cost	-	170
Interest cost	36,616	43,433
Benefits paid	(52,134)	(70,778)
Expenses paid	-	(168)
Actuarial loss	(22,411)	139,469
Settlements	(30,950)	(38,549)
Benefit obligation at end of year	1,140,221	1,209,100
Change in plan assets		
Fair value of plan assets at beginning of year	929,453	897,717
Actual return on plan assets	87,446	121,245
Benefits paid	(52,134)	(70,778)
Expenses paid	-	(168)
Employer contributions	25,049	19,986
Settlements	(30,950)	(38,549)
Fair value of plan assets at end of year	958,864	929,453
Funded status of the plans	(181,357)	(279,647)
Less: Current portion of liability for pension	(46)	(46)
Long term portion of liability for pension	(181,311)	(279,601)
Liability for pension	$ (181,357)	$ (279,647)

As of June 30, 2021 and 2020, the liability for pension is included in the liability for pension and other postretirement plan benefits in the accompanying consolidated balance sheets.

Amounts not yet reflected in net periodic pension expense and included in the change in net assets without donor restrictions include approximately $481,073,000 and $546,818,000 of net actuarial loss as of June 30, 2021 and 2020, respectively.

The estimated amounts to be amortized from net assets without donor restrictions into net periodic pension expense in fiscal year 2021 for net actuarial losses is approximately $14,590,000.

The accumulated benefit obligation for the defined benefit pension plans was approximately $1,140,000,000 and $1,209,000,000 at June 30, 2021 and 2020, respectively.

The following table sets forth the assumptions used to determine the benefit obligation at June 30, 2021 and 2020:

	2021	2020
Discount rate	3.30%	3.00% - 3.10%
Rate of increase in compensation	N/A	N/A

The primary investment objective for the Plan's assets is to support the Pension liabilities of the Pension Plans for Employees of the Health System, by providing long-term capital appreciation and by also using a Liability Driven Investing ("LDI") strategy to partially hedge the impact fluctuating interest rates have on the value of the Plan's liabilities. As of June 30, 2021, it is expected that the LDI strategy will hedge approximately 75% of the interest rate risk associated with pension liabilities. As of June 30, 2020, the expected LDI hedge was approximately 60%. To achieve the appreciation and hedging objectives, the Plans utilize a diversified structure of asset classes designed to achieve stated performance objectives measured on a total return basis, which includes income plus realized and unrealized gains and losses.

The range of target allocation percentages and the target allocations for the various investments are as follows:

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

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

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

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

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

The following table sets forth the Health System's Plans' investments and deferred compensation plan assets that were accounted for at fair value as of June 30, 2021 and 2020:

	2021					
(in thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Investments						
Cash and short-term investments	$ -	$ 53,763	$ -	$ 53,763	Daily	1
U.S. government securities	52,945	-	-	52,945	Daily–Monthly	1–15
Domestic debt securities	140,029	296,709	-	436,738	Daily–Monthly	1–15
Global debt securities	-	40,877	-	40,877	Daily–Monthly	1–15
Domestic equities	144,484	40,925	-	185,409	Daily–Monthly	1–10
International equities	17,767	51,819	-	69,586	Daily–Monthly	1–11
Emerging market equities	-	43,460	-	43,460	Daily–Monthly	1–17
Global equities	-	57,230		57,230	Daily–Monthly	1–17
REIT funds	-	3,329		3,329	Daily–Monthly	1–17
Private equity funds	-	-	15	15	See Note 6	See Note 6
Hedge funds	-	-	15,512	15,512	Quarterly–Annual	60–96
Total investments	$ 355,225	$ 588,112	$ 15,527	$ 958,864		

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

The following tables present additional information about the changes in Level 3 assets measured at fair value for the years ended June 30, 2021 and 2020:

	2021		
(in thousands of dollars)	Hedge Funds	Private Equity Funds	Total
Balances at beginning of year	$ 47,351	$ 17	$ 47,368
Sales	(38,000)	-	(38,000)
Net unrealized gains (losses)	6,161	(2)	6,159
Balances at end of year	$ 15,512	$ 15	$ 15,527

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

The total aggregate net unrealized gains (losses) included in the fair value of the Level 3 investments as of June 30, 2021 and 2020 were approximately $7,635,000 and $18,261,000, respectively. There were no transfers into and out of Level 3 measurements during the years ended June 30, 2021 and 2020.

There were no transfers into and out of Level 1 and 2 measurements due to changes in valuation methodologies during the years ended June 30, 2021 and 2020.

The weighted average asset allocation for the Health System's Plans at June 30, 2021 and 2020 by asset category is as follows:

	2021	2020
Cash and short-term investments	6 %	1 %
U.S. government securities	5	5
Domestic debt securities	46	49
Global debt securities	4	8
Domestic equities	19	19
International equities	7	9
Emerging market equities	5	4
Global equities	6	0
Hedge funds	2	5
	100 %	100 %

The expected long-term rate of return on plan assets is reviewed annually, taking into consideration the asset allocation, historical returns on the types of assets held, and the current economic environment. Based on these factors, it is expected that the pension assets will earn an average of 7.50% per annum.

The Health System is expected to contribute approximately $25,045,000 to the Plans in 2022 however actual contributions may vary from expected amounts.

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

(in thousands of dollars)	
2022	$ 54,696
2023	57,106
2024	59,137
2025	60,930
2026	62,514
2027 – 2031	327,482

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

Defined Contribution Plans
The Health System has an employer-sponsored 401(a) plan for certain of its members, under which the employer makes base, transition and discretionary match contributions based on specified percentages of compensation and employee deferral amounts. Total employer contributions to the plan of approximately $60,268,000 and $51,222,000 in 2021 and 2020, respectively, are included in employee benefits in the accompanying consolidated statements of operations and changes in net assets.

Various 403(b) and tax- sheltered annuity plans are available to employees of the Health System. Plan specifications vary by member and plan. No employer contributions were made to any of these plans in 2021 and 2020 respectively.

Postretirement Medical and Life Benefits
The Health System has postretirement medical and life benefit plans covering certain of its active and former employees. The plans generally provide medical or medical and life insurance benefits to certain retired employees who meet eligibility requirements. The plans are not funded.

Net periodic postretirement medical and life benefit (income) cost is comprised of the components listed below for the years ended June 30, 2021 and 2020:

(in thousands of dollars)	2021	2020
Service cost	$ 533	$ 609
Interest cost	1,340	1,666
Net prior service income	(3,582)	(5,974)
Net loss amortization	738	469
	$ (971)	$ (3,230)

The following table sets forth the accumulated postretirement medical and life benefit obligation and amounts recognized in the Health System's consolidated financial statements at June 30, 2021 and 2020:

(in thousands of dollars)	2021	2020
Change in benefit obligation		
Benefit obligation at beginning of year	$ 48,078	$ 46,671
Service cost	533	609
Interest cost	1,340	1,666
Benefits paid	(3,439)	(3,422)
Actuarial loss	383	2,554
Employer contributions	(32)	-
Benefit obligation at end of year	46,863	48,078
Funded status of the plans	$ (46,863)	$ (48,078)
Current portion of liability for postretirement medical and life benefits	$ (3,422)	$ (3,422)
Long term portion of liability for postretirement medical and life benefits	(43,441)	(44,656)
Liability for postretirement medical and life benefits	$ (46,863)	$ (48,078)

As of June 30, 2021 and 2020, the liability for postretirement medical and life benefits is included in the liability for pension and other postretirement plan benefits in the accompanying consolidated balance sheets.

Amounts not yet reflected in net periodic postretirement medical and life benefit income and included in the change in net assets without donor restrictions are as follows:

(in thousands of dollars)	2021	2020
Net prior service income	$ -	$ (3,582)
Net actuarial loss	9,981	10,335
	$ 9,981	$ 6,753

The estimated amounts that will be amortized from net assets without donor restrictions into net periodic postretirement income in fiscal year 2022 for net losses is approximately $751,000.

The following future benefit payments, which reflect expected future service, as appropriate, are expected to be paid for the year ending June 30, 2021 and thereafter:

(in thousands of dollars)	
2022	$ 3,422
2023	3,602
2024	3,651
2025	3,575
2026	3,545
2027-2031	16,614

In determining the accumulated postretirement medical and life benefit obligation, the Health System used a discount rate of 3.10% in 2021 and an assumed healthcare cost trend rate of 6.50%, trending down to 5.00% in 2027 and thereafter.

12. Professional and General Liability Insurance Coverage

D-H, along with Dartmouth College, CMC, NLH, APD, MAHHC, and VNH are provided professional and general liability insurance on a claims-made basis through Hamden Assurance Risk Retention Group, Inc. (RRG), a VT captive insurance company. Effective November 1, 2018 APD is provided professional and general liability insurance coverage through RRG. RRG reinsures the majority of this risk to Hamden Assurance Company Limited (HAC), a captive insurance company domiciled in Bermuda and to a variety of commercial reinsurers. D-H and Dartmouth College have ownership interests in both HAC and RRG. The insurance program provides coverage to the covered institutions and named insureds on a modified claims-made basis which means coverage is triggered when claims are made. Premiums and related insurance deposits are actuarially determined based on asserted liability claims adjusted for future development. The reserves for outstanding losses are recorded on an undiscounted basis.

Selected financial data of HAC and RRG, taken from the latest available financial statements at June 30, 2021 and 2020, are summarized as follows:

	2021		
(in thousands of dollars)	HAC	RRG	Total
Assets	$ 71,772	$ 3,583	$ 75,355
Shareholders' equity	13,620	50	13,670

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

13. Commitments and Contingencies

Litigation
The Health System is involved in various malpractice claims and legal proceedings of a nature considered normal to its business. The claims are in various stages and some may ultimately be brought to trial. While it is not feasible to predict or determine the outcome of any of these claims, it is the opinion of management that the final outcome of these claims will not have a material effect on the consolidated financial position of the Health System.

Lines of Credit

The Health System has entered into Loan Agreements with financial institutions establishing access to revolving loans ranging from $10,000,000 up to $30,000,000. Interest is variable and determined using LIBOR or the Wall Street Journal Prime Rate. The Loan Agreements are due to expire March 30, 2022. There was no outstanding balance under the lines of credit as of June 30, 2021 and 2020. Interest expense was approximately $28,000 and $20,000, respectively, and is included in the consolidated statements of operations and changes in net assets.

14. Functional Expenses

Operating expenses are presented by functional classification in accordance with the overall service missions of the Health System. Each functional classification displays all expenses related to the underlying operations by natural classification. Salaries, employee benefits, medical supplies and medications, and purchased services and other expenses are generally considered variable and are allocated to the mission that best aligns to the type of service provided. Medicaid enhancement tax is allocated to program services. Interest expense is allocated based on usage of debt-financed space. Depreciation and amortization is allocated based on square footage and specific identification of equipment used by department.

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

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

	Program Services	Management and General	Fundraising	Total
Non-operating income				
Employee benefits	$ 9,200	$ 4,354	$ 5	$ 13,559
Total non-operating income	$ 9,200	$ 4,354	$ 5	$ 13,559

Operating expenses of the Health System by functional and natural basis are as follows for the year ended June 30, 2020:

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

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

15. Liquidity

The Health System is substantially supported by cash generated from operations. In addition, the Health System holds financial assets for specific purposes which are limited as to use. Thus, certain financial assets reported on the accompanying consolidated balance sheet may not be available for general expenditure within one year of the balance sheet date.

The Health System's financial assets available at June 30, 2021 and 2020 to meet cash needs for general expenditures within one year of June 30, 2021 and 2020, are as follows:

(in thousands of dollars)	2021	2020
Cash and cash equivalents	$ 374,928	$ 453,223
Patient accounts receivable	232,161	183,819
Assets limited as to use	1,378,479	1,134,526
Other investments for restricted activities	168,035	140,580
Total financial assets	$ 2,153,603	$ 1,912,148
Less: Those unavailable for general expenditure within one year:		
Investments held by captive insurance companies	57,239	54,596
Investments for restricted activities	168,035	140,580
Bond proceeds held for capital projects	178,434	245,484
Other investments with liquidity horizons greater than one year	111,390	111,408
Total financial assets available within one year	$ 1,638,505	$ 1,360,080

For the years ended June 30, 2021 and June 30, 2020, the Health System generated positive cash flow from operations of approximately $95,740,000 and $269,144,000, respectively. In addition, the Health System's liquidity management plan includes investing excess daily cash in intermediate or long term investments based on anticipated liquidity needs. The Health System has an available line of credit of up to $30,000,000 which it can draw upon as needed to meet its liquidity needs. See Note 13 for further details on the line of credit.

16. Lease Commitments

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

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

Certain lease agreements for real estate include payments based on actual common area maintenance expenses and/or rental payments adjusted periodically for inflation. These variable lease payments are recognized in other occupancy costs in the consolidated statements of operations and changes in net assets but are not included in the right-of-use asset or liability balances in our consolidated balance sheets. Lease agreements do not contain any material residual value guarantees, restrictions or covenants.

The components of lease expense for the year ended June 30, 2021 and 2020 are as follows:

(in thousands of dollars)	2021	2020
Operating lease cost	10,381	8,992
Variable and short term lease cost (a)	8,019	1,497
Total lease and rental expense	18,400	10,489
Finance lease cost:		
Depreciation of property under finance lease	3,408	2,454
Interest on debt of property under finance lease	533	524
Total finance lease cost	3,941	2,978

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

Supplemental cash flow information related to leases for the year ended June 30, 2021 and 2020 are as follows:

(in thousands of dollars)	2021	2020
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flows from operating leases	10,611	8,755
Operating cash flows from finance leases	533	542
Financing cash flows from finance leases	3,108	2,429
	$ 14,252	$ 11,726

Supplemental balance sheet information related to leases as of June 30, 2021 and 2020 are as follows:

(in thousands of dollars)	2021	2020
Operating Leases		
Right of use assets - operating leases	51,410	42,621
Accumulated amortization	(15,180)	(8,425)
Right of use assets - operating leases, net	**36,230**	**34,196**
Current portion of right of use obligations	8,038	9,194
Long-term right of use obligations, excluding current portion	28,686	25,308
Total operating lease liabilities	**36,724**	**34,502**
Finance Leases		
Right of use assets - finance leases	27,940	26,076
Accumulated depreciation	(5,760)	(2,687)
Right of use assets - finance leases, net	**22,180**	**23,389**
Current portion of right of use obligations	3,251	2,581
Long-term right of use obligations, excluding current portion	19,481	21,148
Total finance lease liabilities	**22,732**	**23,729**
Weighted Average remaining lease term, years		
Operating leases	6.75	4.64
Finance leases	18.73	19.39
Weighted Average discount rate		
Operating leases	2.12%	2.24%
Finance leases	2.14%	2.22%

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

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

Future maturities of lease liabilities as of June 30, 2021 are as follows:

(in thousands of dollars)	Operating Leases	Finance Leases
Year ending June 30:		
2022	8,721	3,698
2023	7,331	3,363
2024	6,336	2,265
2025	3,537	1,229
2026	2,475	850
Thereafter	11,249	16,488
Total lease payments	39,649	27,893
Less: Imputed interest	2,925	5,161
Total lease payments	$ 36,724	$ 22,732

17. Subsequent Events

The Health System has assessed the impact of subsequent events through November 18, 2021, the date the audited consolidated financial statements were issued, and has concluded that there were no such events that require adjustment to the audited consolidated financial statements or disclosure in the notes to the audited consolidated financial statements other than as noted below.

Consolidating Supplemental Information – Unaudited

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2021

(In thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	Alice Peck Day Memorial	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Assets											
Current assets											
Cash and cash equivalents	$ 1,826	$ 226,779	$ 35,146	$ 41,371	$ 26,814	$ 18,350	$ -	$ 350,286	$ 24,642	$ -	$ 374,928
Patient accounts receivable, net	-	196,350	13,238	6,779	6,699	6,522	-	229,588	2,573	-	232,161
Prepaid expenses and other current assets	23,267	151,336	20,932	2,012	4,771	1,793	(35,942)	168,169	(10,634)	(217)	157,318
Total current assets	25,093	574,465	69,316	50,162	38,284	26,665	(35,942)	748,043	16,581	(217)	784,407
Assets limited as to use	380,020	1,039,327	19,016	15,480	16,725	20,195	(169,849)	1,320,914	57,565	-	1,378,479
Notes receivable, related party	845,157	11,769	-	1,010	-	-	(856,926)	1,010	(1,010)	-	-
Other investments for restricted activities	248	111,209	12,212	1,128	4,266	7,699	-	136,762	31,273	-	168,035
Property, plant, and equipment, net	-	501,640	64,101	22,623	47,232	15,403	-	650,999	29,434	-	680,433
Right of use assets, net	1,233	32,343	2,396	16,104	360	5,819	-	58,255	155	-	58,410
Other assets	2,431	146,226	1,315	14,380	7,262	5,172	-	176,806	292	-	177,098
Total assets	$ 1,254,182	$ 2,416,979	$ 168,356	$ 120,887	$ 114,149	$ 80,953	$ (1,062,717)	$ 3,092,789	$ 134,290	$ (217)	$ 3,226,862
Liabilities and Net Assets											
Current liabilities											
Current portion of long-term debt	$ -	$ 7,575	$ 885	$ 777	$ 91	$ -	$ -	$ 9,308	$ 99	$ -	$ 9,407
Current portion of right of use obligations	354	8,369	656	1,078	197	550	-	11,204	85	-	11,289
Current portion of liability for pension and other postretirement plan benefits	-	3,468	-	-	-	-	-	3,468	-	-	3,468
Accounts payable and accrued expenses	207,566	99,374	11,911	2,455	4,968	5,858	(205,791)	126,341	5,100	(217)	131,224
Accrued compensation and related benefits	-	156,073	8,648	5,706	4,407	5,343	-	180,177	1,893	-	182,070
Estimated third-party settlements	-	160,410	31,226	27,006	26,902	6,230	-	251,774	769	-	252,543
Total current liabilities	207,920	435,269	53,306	37,022	36,565	17,981	(205,791)	582,272	7,946	(217)	590,001
Notes payable, related party	-	811,563	-	-	27,793	17,570	(856,926)	-	-	-	-
Long-term debt, excluding current portion	1,047,659	29,848	22,753	23,558	55	(115)	-	1,123,758	2,601	-	1,126,357
Right of use obligations, excluding current portion	879	24,463	1,878	15,351	172	5,357	-	48,098	69	-	48,167
Insurance deposits and related liabilities	-	78,528	475	325	388	218	-	79,934	40	-	79,974
Liability for pension and other postretirement plan benefits, excluding current portion	-	218,955	5,286	-	-	511	-	224,752	-	-	224,752
Other liabilities	-	179,497	4,224	4,534	4,142	-	-	192,397	22,317	-	214,714
Total liabilities	1,256,458	1,778,121	87,920	80,790	69,115	41,522	(1,062,717)	2,251,209	32,973	(217)	2,283,965
Commitments and contingencies											
Net assets											
Net assets without donor restrictions	(2,524)	526,153	65,224	38,969	39,557	29,838	-	697,217	61,370	40	758,627
Net assets with donor restrictions	248	112,705	15,212	1,128	5,477	9,593	-	144,363	39,947	(40)	184,270
Total net assets	(2,276)	638,858	80,436	40,097	45,034	39,431	-	841,580	101,317	-	942,897
Total liabilities and net assets	$ 1,254,182	$ 2,416,979	$ 168,356	$ 120,887	$ 114,149	$ 80,953	$ (1,062,717)	$ 3,092,789	$ 134,290	$ (217)	$ 3,226,862

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2021

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

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

(in thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	Alice Peck Day Memorial	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Assets											
Current assets											
Cash and cash equivalents	$ 108,856	$ 217,352	$ 43,940	$ 26,079	$ 22,874	$ 14,377	$ -	$ 433,478	$ 19,745	$ -	$ 453,223
Patient accounts receivable, net	-	146,886	11,413	8,634	10,200	4,367	-	181,500	2,319	-	183,819
Prepaid expenses and other current assets	25,243	179,432	37,538	3,808	6,105	1,715	(82,822)	171,019	(8,870)	(243)	161,906
Total current assets	134,099	543,670	92,891	38,521	39,179	20,459	(82,822)	785,997	13,194	(243)	798,948
Assets limited as to use	344,737	927,207	19,376	13,044	12,768	12,090	(235,568)	1,093,654	40,872	-	1,134,526
Notes receivable, related party	848,250	593	-	1,211	-	-	(848,843)	1,211	(1,211)	-	-
Other investments for restricted activities	-	98,490	6,970	97	3,077	6,266	-	114,900	25,680	-	140,580
Property, plant, and equipment, net	8	486,938	64,803	20,805	43,612	16,823	-	612,989	30,597	-	643,586
Right of use assets	1,542	32,714	1,822	17,574	621	3,221	-	57,494	91	-	57,585
Other assets	2,242	122,481	1,299	14,748	5,482	4,603	(10,971)	139,884	(2,546)	-	137,338
Total assets	$ 1,330,878	$ 2,192,093	$ 187,161	$ 106,000	$ 104,739	$ 63,462	$ (1,178,204)	$ 2,806,129	$ 106,677	$ (243)	$ 2,912,563
Liabilities and Net Assets											
Current liabilities											
Current portion of long-term debt	$ -	$ 7,380	$ 865	$ 747	$ 147	$ 232	$ -	$ 9,371	$ 96	$ -	$ 9,467
Current portion of right of use obligations	338	8,752	420	1,316	259	631	-	11,716	59	-	11,775
Current portion of liability for pension and other postretirement plan benefits	-	3,468	-	-	-	-	-	3,468	-	-	3,468
Accounts payable and accrued expenses	272,764	126,283	39,845	3,087	4,250	3,406	(318,391)	131,244	(1,985)	(243)	129,016
Accrued compensation and related benefits	-	122,392	7,732	3,570	3,875	3,582	-	141,151	1,840	-	142,991
Estimated third-party settlements	-	210,144	34,664	25,421	24,667	6,430	-	301,326	1,199	-	302,525
Total current liabilities	273,102	478,419	83,526	34,141	33,198	14,281	(318,391)	598,276	1,209	(243)	599,242
Notes payable, related party	-	814,525	-	-	27,718	6,600	(848,843)	-	-	-	-
Long-term debt, excluding current portion	1,050,694	37,373	23,617	24,312	147	10,595	(10,970)	1,135,768	2,762	-	1,138,530
Right of use obligations, excluding current portion	1,203	24,290	1,432	16,429	368	2,698	-	46,420	36	-	46,456
Insurance deposits and related liabilities	-	75,697	475	325	388	220	-	77,105	41	-	77,146
Liability for pension and other postretirement plan benefits, excluding current portion	-	301,907	21,840	-	-	511	-	324,258	(1)	-	324,257
Other liabilities	-	117,631	1,506	384	2,026	-	-	121,547	22,131	-	143,678
Total liabilities	1,324,999	1,849,842	132,396	75,591	63,845	34,905	(1,178,204)	2,303,374	26,178	(243)	2,329,309
Commitments and contingencies											
Net assets											
Net assets without donor restrictions	5,524	242,824	47,729	29,464	36,158	21,247	-	382,946	48,040	40	431,026
Net assets with donor restrictions	355	99,427	7,036	945	4,736	7,310	-	119,809	32,459	(40)	152,228
Total net assets	5,879	342,251	54,765	30,409	40,894	28,557	-	502,755	80,499	-	583,254
Total liabilities and net assets	$ 1,330,878	$ 2,192,093	$ 187,161	$ 106,000	$ 104,739	$ 63,462	$ (1,178,204)	$ 2,806,129	$ 106,677	$ (243)	$ 2,912,563

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

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

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Net Assets without Donor Restrictions
Year Ended June 30, 2021

(in thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	Alice Peck Day Memorial	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Operating revenue and other support											
Patient service revenue	$ -	$ 1,683,612	$ 230,810	$ 82,373	$ 61,814	$ 59,686	$ -	$ 2,118,295	$ 19,992	$ -	$ 2,138,287
Contracted revenue	7,266	129,880	379	-	162	2,963	(55,753)	84,897	380	(14)	85,263
Other operating revenue	29,784	404,547	6,775	1,905	4,370	1,175	(37,287)	411,269	15,490	(1,801)	424,958
Net assets released from restrictions	197	12,631	1,182	61	200	201	-	14,472	729	-	15,201
Total operating revenue and other support	37,247	2,230,670	239,146	84,339	66,546	64,025	(93,040)	2,628,933	36,591	(1,815)	2,663,709
Operating expenses											
Salaries	-	988,595	118,678	40,567	33,611	29,119	(42,565)	1,168,005	16,800	1,105	1,185,910
Employee benefits	-	251,774	29,984	7,141	6,550	7,668	(5,159)	297,958	3,877	307	302,142
Medications and medical supplies	-	481,863	41,669	9,776	7,604	3,275	(85)	544,102	1,421	-	545,523
Purchased services and other	19,503	291,364	33,737	12,396	16,591	14,884	(18,065)	370,410	15,395	(1,856)	383,949
Medicaid enhancement tax	-	57,312	8,315	3,075	2,523	1,716	-	72,941	-	-	72,941
Depreciation and amortization	10	67,666	8,623	3,366	4,364	2,617	-	86,646	2,275	-	88,921
Interest	32,324	24,158	936	875	1,077	510	(29,495)	30,385	402	-	30,787
Total operating expenses	51,837	2,162,732	241,942	77,196	72,320	59,789	(95,369)	2,570,447	40,170	(444)	2,610,173
Operating (loss) margin	(14,590)	67,938	(2,796)	7,143	(5,774)	4,236	2,329	58,486	(3,579)	(1,371)	53,536
Non-operating gains (losses)											
Investment income (losses), net	1,223	172,461	3,546	2,495	4,506	3,875	(137)	187,969	15,807	-	203,776
Other components of net periodic pension and post retirement benefit income	-	13,028	547	-	-	(16)	-	13,559	-	-	13,559
Other (losses) income, net	(3,540)	(653)	(332)	-	2	194	(2,192)	(6,521)	917	1,371	(4,233)
Total non-operating (losses) gains, net	(2,317)	184,836	3,761	2,495	4,508	4,053	(2,329)	195,007	16,724	1,371	213,102
(Deficiency) excess of revenue over expenses	(16,907)	252,774	965	9,638	(1,266)	8,289	-	253,493	13,145	-	266,638
Net assets without donor restrictions											
Net assets released from restrictions for capital	-	1,076	600	-	108	224	-	2,008	9	-	2,017
Change in funded status of pension and other postretirement benefits	-	43,047	16,007	-	-	78	-	59,132	-	-	59,132
Net assets transferred to (from) affiliates	8,859	(13,548)	(42)	-	4,557	-	-	(174)	174	-	-
Other changes in net assets	-	(20)	(35)	(120)	-	-	-	(175)	(11)	-	(186)
Increase in net assets without donor restrictions	$ (8,048)	$ 283,329	$ 17,495	$ 9,518	$ 3,399	$ 8,591	$ -	$ 314,284	$ 13,317	$ -	$ 327,601

Dartmouth-Hitchcock Health and Subsidiaries

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

Year Ended June 30, 2021

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

Dartmouth-Hitchcock Health and Subsidiaries

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

Year Ended June 30, 2020

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

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Net Assets without Donor Restrictions
Year Ended June 30, 2020

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

Dartmouth-Hitchcock Health and Subsidiaries
Note to Supplemental Consolidating Information
June 30, 2021 and 2020

1. Basis of Presentation

The accompanying supplemental consolidating information includes the consolidating balance sheet and the consolidating statement of operations and changes in net assets without donor restrictions of D-HH and its subsidiaries. All significant intercompany accounts and transactions between D-HH and its subsidiaries have been eliminated. The consolidating information presented is prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America consistent with the consolidated financial statements. The consolidating information is presented for purposes of additional analysis of the consolidated financial statements and is not required as part of the basic financial statements.

MARY HITCHCOCK MEMORIAL HOSPTIAL (MHMH)/ DARTMOUTH HITCHCOCK CLINIC (DHC) \ Combined as DARTMOUTH-HITCHCOCK

BOARDS OF TRUSTEES AND OFFICERS

Effective: January 1, 2024

DARTMOUTH-HITCHCOCK

M. Elyse Allan, MBA *Retired President and Chief Executive Officer of General Electric Canada Company, Inc.*
Geraldine "Polly" Bednash, PhD, RN, FAAN *Adjunct Professor, Australian Catholic University*
Laura M. Chiang, MD *Assistant Professor of Anesthesiology and Critical Care; Vice Chair for Education, Dept. of Anesthesiology and Co-Medical Director, Surgical Intensive Care Unit*
Marcus P. Coe, MD, MS *Associate Professor, Residency Director, Department of Orthopaedic Surgery, Dartmouth Hitchcock Medical Center and Geisel School of Medicine*
Duane A. Compton, PhD *Ex-Officio: Dean, Geisel School of Medicine at Dartmouth*
Joanne M. Conroy, MD *Ex-Officio: CEO & President, Dartmouth-Hitchcock/Dartmouth Health*
Gary V. Desir, MD *Yale School of Medicine: Paul B. Beeson Professor of Medicine; Chair, Internal Medicine at Yale School of Medicine and Yale New Haven Hospital; Vice Provost for Faculty Development and Diversity, Yale University*

Celestina "Tina" M. Dooley-Jones, PhD *Retired Senior Foreign Service Officer*
Nancy M. Dunbar, MD *Medical Director, Blood Bank* *Department of Pathology and Laboratory Medicine*
Roberta L. Hines, MD MHMH/DHC Boards' Chair *Nicholas M. Greene Professor and Chair, Dept. of Anesthesiology, Yale School of Medicine*
Keith J. Loud, MD – beginning in March 2024 *Chair, Department of Pediatrics and Adolescent Medicine*
Jennifer L. Moyer, MBA *Managing Director & CAO, White Mountains Insurance Group, Ltd*
Sherri C. Oberg, MBA *CEO and Co-Founder of Particles for Humanity, PBC*
David P. Paul, MBA MHMH/DHC Boards' Secretary & Treasurer *Retired President & COO, JBG SMITH*
Mark S. Speers, MBA *Co-founder & Senior Advisor, Health Advances, LLC*

Jonathan B. Thyng, MD
Medical Director, Dartmouth Hitchcock Clinics Nashua

DARTMOUTH HEALTH

Mark W. Begor, MBA *Chief Executive Officer, Equifax*

Joanne M. Conroy, MD
Ex-Officio: CEO & President, Dartmouth-Hitchcock/Dartmouth Health

Thomas P. Glynn, PhD
Adjunct Lecturer, Harvard Kennedy School of Government

Charles G. Plimpton, MBA
Dartmouth Health Board Treasurer & Secretary
Retired Investment Banker

Richard J. Powell, MD
Section Chief, Vascular Surgery; Professor of Surgery and Radiology

Thomas Raffio, MBA, FLMI *President & CEO, Northeast Delta Dental*

Edward Howe Stansfield, III, MA
Dartmouth Health Board Chair
Retired Senior Financial Advisor, Resident Director, of Bank of America/Merrill Lynch

Paul A. Taheri, MD, MBA *Clinical Partner – Welsh Carson Anderson and Stowe*
Pamela Austin Thompson, MS, RN, CENP, FAAN *Chief executive officer emeritus of the American Organization of Nurse Executives (AONE)*

Exec/Governance Oversight:
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Exec. Coordinator for Exec/Governance & Leadership
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Laura K. Rondeau (603/650-5706)
Exec. Coordinator for Exec/Governance & Leadership
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CURRICULUM VITAE

Date Prepared: October 25, 2022

NAME: Sarah Pratt, Ph.D.

I. EDUCATION

DATES	INSTITUTION	DEGREE
1994-2000	Fordham University	Ph.D. (Clinical Psychology)
1985-1989	Connecticut College	BA

II. POSTDOCTORAL TRAINING

DATES	INSTITUTION	SPECIALTY
2000-2001	Dartmouth College	Postdoctoral Fellowship (Clinical Psychology)
1999-2000	Dartmouth College	Clinical Psychology/Neuropsychology Internship

III. PROFESSIONAL DEVELOPMENT ACTIVITIES

DATE	INSTITUTION	TITLE	CREDITS
2014	Geisel School of Medicine	The Science and Practice of Leading Yourself	N/A
2013-2014	The Dartmouth Institute	Advanced Statistics for Healthcare Research	N/A
2012-2013	Dartmouth Psychiatric Research Center	Statistics Seminar	N/A
2011-2012	Dartmouth Psychiatric Research Center	Statistics Seminar	N/A
2010	Wellcoaches Corporation	Introduction to Core Coaching Competencies in Health, Fitness, and Wellness	N/A
2009	The Dartmouth Institute	Studying Patients' Decision Making ECS 120	N/A

IV. ACADEMIC APPOINTMENTS

DATE	INSTITUTION	TITLE
2019-present	Geisel School of Medicine at Dartmouth	Associate Professor
2019-present	The Dartmouth Institute	Associate Professor
2009-2019	The Dartmouth Institute	Assistant Professor
2005-2019	Geisel School of Medicine at Dartmouth	Assistant Professor in Psychiatry
2004-2005	Geisel School of Medicine at Dartmouth	Research Assistant Professor in Psychiatry

V. INSTITUTIONAL LEADERSHIP ROLES

DATE	INSTITUTION	TITLE
2002-2004	Dartmouth Psychiatric Research Center	Member, Executive Committee
2010-2012	Geisel School of Medicine at Dartmouth	Member, PCIR Committee for CTSA ("SYNERGY")
2011-2012	Geisel School of Medicine at Dartmouth	Member, Curriculum Planning Committee Faculty Leadership Program
2011-2018	Department of Psychiatry, Geisel School of Medicine at Dartmouth	Member, Research Committee
2012-2018	Geisel School of Medicine at Dartmouth	Coordinator and Member, Leadership Tutorial Sponsored by the Dean of the Geisel School of Medicine
2013-2018	Geisel School of Medicine at Dartmouth	Member, SYNERGY Clinical Research Unit Steering Committee
2018-present	Department of Psychiatry, Dartmouth-Hitchcock	Co-Chair, Research Committee

VI. LICENSURE AND CERTIFICATION

N/A

VII. HOSPITAL APPOINTMENTS:

DATE	INSTITUTION	POSITION/TITLE
2000-2001	New Hampshire Hospital	Postdoctoral Fellow
1999-2000	New Hampshire Hospital	Psychology/Neuropsychology Intern
1996-1997	White Plains Hospital	Psychology Extern
1995-1996	Rockland Children's Psychiatric Center	Psychology Extern

VIII. OTHER PROFESSIONAL POSITIONS (NON-DARTMOUTH):

DATE	INSTITUTION	POSITION/TITLE
2000	Department of Veteran's Affairs, Manchester, NH	Clinical Consultant
1998-1999	Fordham University	Senior Teaching Fellow
1997-1999	New York Hospital Cornell Medical Center	Research Coordinator
1997-1998	Riverdale Community Residence	Counselor
1996-1998	Fordham University	Teaching Fellow
1995-1996	Fordham University	Teaching Assistant
1994-1995	Fordham University	Graduate Assistant

1991-1994	Sugarman, Rogers, Barshak, & Cohen	Paralegal
1989-1991	Hill & Barlow	Paralegal

IX. TEACHING ACTIVITIES

A. UNDERGRADUATE (COLLEGE) EDUCATION

DATES	INSTITUTION	COURSE TITLE	ROLE	HOURS
1996-1997	Fordham University	Introduction to Clinical Psychology	Instructor	3 credit hours
1996-1997	Fordham University	Introduction to Statistics	Instructor	3 credit hours
1996-1997	Fordham University	Abnormal Psychology	Instructor	3 credit hours
1997-1998	Fordham University	Introduction to Clinical Psychology	Instructor	3 credit hours
1997-1998	Fordham University	Child Clinical Psychology	Instructor	3 credit hours
1997-1998	Fordham University	Substance Abuse	Instructor	3 credit hours

B. GRADUATE EDUCATION

DATES	INSTITUTION	COURSE TITLE	ROLE	HOURS
1995-1996	Fordham University	Personality Assessment (MMPI)	Teaching Asst	4 credit hours
1995-1996	Fordham University	Personality Assessment (Rorschach)	Teaching Asst	4 credit hours

C. UNDERGRADUATE MEDICAL EDUCATION
N/A

D. GRADUATE MEDICAL EDUCATION

DATES	INSTITUTION	COURSE TITLE	ROLE	HOURS
2020	Dartmouth-Hitchcock	Research Methods	Instructor	7-week course for PGY-3

E. OTHER CLINICAL EDUCATION
N/A

X. ADVISING/MENTORING

A. UNDERGRADUATE STUDENTS

DATES	STUDENT'S NAME	PROGRAM
2008-10	Meghan Driscoll	Massachusetts School of Professional Psychology PhD
2016-present	Cynthia Bianco	Riviere University Psychology Master's Program
2019-present	Nell Mallette	Concord High School

XI. RESEARCH TEACHING/MENTORING

A. UNDERGRADUATE STUDENTS

DATES	STUDENT'S NAME	PROGRAM
2021	Arya Kadakia	Dartmouth College Psychology Department
2020	Alexis Caldwell	St. Anselm College Psychology Department
2016	Celeste Beaulieu	St. Anselm College Psychology Department
2015	Mackenzie Wild	St. Anselm College Psychology Department
2015	Haley Heinrich	St. Anselm College Psychology Department
2014	Hannah Mason	St. Anselm College Psychology Department
2014	Lucas Daniels	Wheaton College Psychology Department
2013	Zachary Wormell	St. Anselm College Psychology Department
2013	Ian Hancock	University of New Hampshire Psychology Department
2011	Vivian Fitzgerald	St. Anselm College Psychology Department
2010	April Theroux	St. Anselm College Psychology Department
2009	Anoosh Nahikian	Riviere University Psychology Department
2008	Amanda Hapenny	St. Anselm College Psychology Department
2008	Melissa Stuart	Endicott College Psychology Department
2007	Joanna Kierska	St. Anselm College Psychology Department

B. GRADUATE STUDENTS

DATES	STUDENT'S NAME	PROGRAM
2021-22	Jordan French	William James College Clinical Psychology PhD
2021-22	Jacquelyn Pack	William James College Clinical Psychology PhD
2020-21	Max Salazar	William James College Clinical Psychology PhD
2020-21	Sarah Schultze	University of New Hampshire Master's in Social Work
2019-20	Misty Brisiel	University of New Hampshire Master's in Social Work
2018-19	Ashley Williams	University of New Hampshire Master's in Social Work
2017-18	Karen Gowell	University of New Hampshire Master's in Social Work
2016-17	Megan Greenberg	University of New Hampshire Master's in Social Work
2016-17	Cameron Holmes	University of New Hampshire Master's in Social Work
2016	Christine McGovern	University of New Hampshire Master's in Social Work
2015-16	Jennifer Carr	University of New Hampshire Master's in Social Work
2014-16	Gail DeMasi	University of New Hampshire Master's in Social Work
2014-15	Jennifer Daler	University of New Hampshire Master's in Social Work
2011-12	Bryan Wilkinson	University of New Hampshire Master's in Social Work
2011-12	Erica Placencia	Southern New Hampshire University Master's in Community Mental Health
2011-12	Marissa Romanovich	University of New Hampshire Master's in Social Work
2010-2011	Melissa Gregg	University of New Hampshire Master's in Social Work

C. MEDICAL STUDENTS

DATES	STUDENT'S NAME	PROGRAM
20015-16	Rachel Kandath	Geisel School of Medicine at Dartmouth
2005	Laura Wheeler	Start MH at Dartmouth

D. RESIDENTS/FELLOWS/RESEARCH ASSOCIATES

DATES	STUDENT'S NAME	SPECIALTY
2008-present	Rosemarie Wolfe, MS	Data Management and Statistics
2011-2014	Laura Barre, MD	T-32 Post-Doctoral Fellow in Geriatric Psychiatry
2010-13	Daniel Jimenez, PhD	T-32 Post-Doctoral Fellow in Geriatric Psychiatry
2007-09	Erica O'Neal, MD	T-32 Post-Doctoral Fellow in Geriatric Psychiatry
2006-08	Alice Andrews, PhD	T-32 Post-Doctoral Fellow in Geriatric Psychiatry

E. FACULTY

DATES	MENTEE'S NAME	SPECIALTY
2022-present	Muhammed El-Sayed	Psychiatry
2022-present	Anne Cooper, MD	OBGYN
2018-present	Karen Fortuna, PhD	Social Work
2015-present	Joelle Ferron, PhD	Social Work
2019-2020	Erin Miers, PhD	Psychiatry
2014-2018	Laura Barre, MD	Nutritional Sciences
2009-2014	Kelly Aschbrenner, PhD	Psychiatry

XII. COMMUNITY SERVICE, EDUCATION, AND ENGAGEMENT

DATES	INSTITUTION	COURSE/ACTIVITY TITLE	ROLE	HOURS/YEAR
2023	Multiple Community Mental Health Centers	Training in HOPES	Trainer	2-Day Training
2022	Multiple Community Mental Health Centers	Training in HOPES	Trainer	2-Day Training
2022	Porter-Starke Services, Oaklawn	Training in Integrated Illness Management and Recovery (Standard & Train the Trainer)	Trainer	4-Day Training
2022	Multiple Community Mental Health Centers	Training in In SHAPE	Trainer	2-Day Training
2021	Maine Medical; UMASS Medical	Training in HOPES	Trainer	2-Day Training

2021	Multiple Community Mental Health Centers	Training in In SHAPE	Trainer	2-Day Training
2020	The Center for Health Care Services	Training in Integrated Illness Management and Recovery (Standard & Train the Trainer)	Trainer	4-Day Training
2020	Fordham University	Training in SWITCH-IT	Trainer	2-Day Training
2020	Multiple Community Mental Health Centers	Training in In SHAPE	Trainer	2-Day Training
2020	Centerstone Tennessee, Seven Counties Services	Training in COVID-19	Trainer	1-Day Training
2019	Centerstone Kentucky	Training in Integrated Illness Management and Recovery	Trainer	2-Day Training
2019	Multiple Community Mental Health Centers	Training in In SHAPE	Trainer	2-Day Training
2019	Centerstone Tennessee	Training in Integrated Illness Management and Recovery	Trainer	2-Day Training
2019	Brattleboro Retreat	Training in Tele-Friend	Trainer	1-Day Training
2018	Mental Health Association of New York City	Training in HOPES-I	Trainer	2-Day Training
2018	Riverbend Mental Health Center	Training in Integrated Illness Management and Recovery	Trainer	1-Day Training
2018	Citizens Advocates	Training in In SHAPE	Trainer	1-day Training
2017	Porter-Starke Services	Training in Integrated Illness Management and Recovery	Trainer	2-Day Training
2017	Gandara Mental Health Center	Training in In SHAPE	Trainer	1-Day Training
2017	Mental Health Association of New York City	Training in Integrated Illness Management and Recovery	Trainer	2-Day Training

2016	NHS Human Services	Training in In SHAPE	Trainer	1-Day Training
2016	Network 180	Training in Heinrichs Quality of Life	Trainer	1-Day Training
2016	Massachusetts Mental	Training in In SHAPE	Trainer	1-Day Training
2015	Mental Health Association of New York City	Training in Integrated Illness Management and Recovery	Trainer	2-Day Training
2015	Mental Health Association of New York City	Training in HOPES	Trainer	2-Day Training
2015	Glencliff Home for the Elderly	HOPES	Trainer	2-Day Training
2015	Bosch Healthcare Telehealth Leadership Series	Using Telehealth to Improve the Care and Outcomes of People Living with Mental Illness and Chronic Medical Conditions	Presenter	Webinar
2014	North Carolina Psychiatric Research Center	Integrated Illness Management and Recovery	Trainer	2-Day Training
2014	Minnesota Center for Mental Health	Integrated Illness Management and Recovery	Trainer	2-Day Training
2013	Lakes Region Mental Health/Mental Retardation Center	Training in In SHAPE	Trainer	1-Day Training
2013	Bronx-Lebanon Hospital	Integrated Illness Management and Recovery	Trainer	2-Day Training
2013	Vinfen Corp & MA Department of Mental Health	Innovations in Health and Wellness for Individuals with Psychiatric Disabilities	Presenter	Workshop
2013	Southwest Counseling Solutions	Training in In SHAPE	Trainer	1-Day Training
2013	Family Services Inc.	Training in Integrated Illness Management and Recovery	Trainer	1-Day Training
2013	Weight Watchers	Managing and Responding to Challenging Behaviors	Lecturer	Webinar
2012	Open Minds	Telehealth at a Community Mental Center	Lecturer	Webinar
2012	Vinfen Corp.	Training in Integrated Illness	Trainer	4-Day Training

		Management and Recovery		
2012	Austin Travis County Integral Care	Training in In SHAPE	Trainer	2-Day Training
2012	Vinfen Corp & MA Department of Mental Health	Innovative Approaches to Health Behavior Change in Psychiatric Disabilities	Presenter	Workshop
2011	Mercy Behavioral Health	Training in In SHAPE	Trainer	1-Day Training
2010	Dartmouth College Summer Research Institute	Balancing Work and Life	Lecturer	Lecture
2010	NH Mental Health & Substance Abuse Coalition	Smoking Cessation and Relapse Prevention for People with Schizophrenia	Presenter	Presentation
2010	Lapeer County Community Mental Health Services Board	Training in In SHAPE	Trainer	2-Day Training
2010	Center for Aging Research at Dartmouth	Developing a Research Career in Mental Health Research: Example of a Path	Lecturer	Lecture
2010	Community Rehab-ilitation Center	Basics of Skills Training and HOPES	Trainer	3-Day Training
2009	Medispin Med-Ed	Research Interviewers/Data Collectors: Hiring, Training, and On-going Supervision	Lecturer	Webinar
2009	St. Anselm College	Research on Interventions for a Lecture Health Disparity Population: Psychosocial Programs for People with SMI	Presenter	Presentation
2008	Medispin Med-Ed	Developing Your Research Materials: Strategies for Developing Effective Intervention Manuals	Presenter	Webinar
2005	Focus on Forensics Annual Conference	Skills Training Using Cognitive Behavioral Techniques	Trainer	2-Day Workshop

XIII. RESEARCH FUNDING

A. CURRENT SUPPORT

DATES	PROJECT TITLE &	ROLE	%EFFORT	SPONSOR	ANNUAL

	AWARD NUMBER				DIRECT COSTS
2022-2026	Reduced-dose OnabotulinumtoxinA for Urgency Incontinence among Elder Females (RELIEF): A Mixed Methods Randomized Controlled Trial	Co-I	5%	PCORI	$1,178,571
2019-2026	PCS-2017C2-7724-IC Integrated Physical and Mental Health Self-Management Compared to Chronic Disease Self-Management	PI	55%	PCORI	$1,247,154
2019-2024 #	CER-2018C3-14701 Comparative Effectiveness of Cognitive Enhancement Therapy vs. Social Skills Training in SMI	Co-I	10%	PCORI	$1,250,000
2018-2023	SM80245 ProHealth NH	Site PI	30%	SAMHSA	$1,999,998

B. PAST SUPPORT

DATES	PROJECT	ROLE	%EFFORT	SPONSOR	ANNUAL DIRECT COSTS
2020-2022	COVID-Related Enhancement to PCS-2017C2-7724-IC	PI	5%	PCORI	$481,879
2016-2021	R01DA041416 The Appeal and Impact of E-cigarettes in Smokers with Serious Mental Illness	PI	0%	NIDA	$499,905
2015-2020	R01MH107625 Automated Telehealth to Improve Psychiatric Symptom Self-Management and Community Tenure	PI	9%	NIMH	$575,723
2014-2019	R01MH102325 (Bartels, PI) RCT of a Learning Collaborative to Implement Health Promotion in Mental Health	Co-I	15%	NIMH	$494,019
2014-2019	U48DP005018 (Bartels, PI) CDC Health Promotion and Disease Prevention Research Center	Co-PI, Core Project	15%		$576,552

2014-2019	R01MH104555 (Bartels, PI) Self-Management Training and Automated Telehealth to Improve SMI Health Outcomes	Co-I	15%	NIMH	$499,228
2016-2017	SYNERGY Adaptation of a Fitness Promotion Program for People with IDD	PI	2%	SYNERGY	$50,000
2014-2016	Smoking Cessation Care Management Program	Co-I	5%	Mass Attorney General's Office	$29,043
2011-2016	1B1CMS330880-01-00 New Hampshire Medicaid Wellness Incentive Program	Co-PI	5%	CMS	$1,170,370
2012-2015	1C1CMS330983-01-00 Community Based Health Homes for Individuals with Serious Mental Illness	Co-I	15%	CMMI	$3,760,000
2009-2015	R01MH089811 Statewide Intervention to Reduce Early Mortality in Persons with Mental Illness	Co-I	25%	NIMH	$3,447,146
2009-2014	1U48DP001935-01 Adapting a Health Promotion Intervention for High-Risk Adults: Pilot Project	Co-I	10%	CDC	$100,000
2010-2012	Evaluation of the Health Buddy Technology in People with Serious Mental Illness	PI	5%	Bosch Healthcare	$300,000
2008-2010	Evaluation of the Health Buddy Technology in a Community Mental Health Center	Co-I	5%	Endowment for Health	$114,700
2008-2013	K23MH080021 Individually Based Psychosocial Rehabilitation for Older Adults with SMI	PI	100%	NIMH	$861,106
2007-2012	R01DA021245 Smoking Cessation and Relapse Prevention in Patients with Schizophrenia	Site PI	10%	NIDA	$3,149,167

2007-2012	R01 MH078052 Health Promotion and Fitness for Younger and Older Adults with SMI	Co-I	50%	NIMH	$3,648,638
2005-2009	R34 MH074786 Integrated Illness Management and Recovery of SMI	Co-I	25%	SAMHSA/ NIMH	$450,000
2006-2009	R01 DD000140 Promoting Health & Functioning in Persons with SMI	Co-I	50%	CDC	$565,611
2004-2007	Loan Repayment Grant	PI		NIMH	$31,805
2004-2006	Evaluation of a Pilot Health Promotion Intervention for Persons with Severe Mental Illness	Co-I	10%	Endowment for Health	$149,569
2003-2005	Development and Evaluation of a Manualized Medication Adherence Module for Older Adults with Severe Mental Illness	PI	10%	Janssen	$63,896
2003-2005	An Investigation of Medication Adherence and Use of Memory Strategies in Older Adults With Schizophrenia	PI	10%	NARSAD	$59,345
2001-2007	R01MH62324 Rehabilitation and Healthcare for Older Adults with SMI	Project Director	80%	NIMH	$3,674,593
1998-1999	Phase 3 Investigation of Aripiprazole	Coordinator		Otsuka America Pharmaceutical	
1997-1999	Clozapine and Skills Training for Schizophrenia: Longitudinal Assessment of Symptoms and Social Skills	Research Assistant		NIMH	

C. PENDING SUPPORT

DATES	**PROJECT**	**ROLE**	**%EFFORT**	**SPONSOR**	**ANNUAL DIRECT COSTS**

N/A

XIV. PROGRAM DEVELOPMENT

2020-2021	SWITCH IT (Coaching support for switching from combustible to e-cigarettes)
2020	COVID-19 Education and Behavioral Coaching Curriculum and Manual
2019-2020	Helping Ourselves Persevere and Experience Success (adaptation of HOPES for young and middle aged adults with serious mental illness)
2016	TeleFriend Tobacco module (Telehealth program of training on smoking cessation)
2015-2016	Telefriend (Telehealth program of illness self-management)
2014	Integrated Illness Management and Recovery ("I-IMR") Curriculum and Manual
2004-2012	In SHAPE Program and Manual (Fitness promotion for people with SMI)
2007-2009	HOPES-I (adaptation of HOPES for individual administration)
2002-2007	Helping Older People Experience Success ("HOPES") Curriculum and Manual

XV. ENTREPRENEURIAL ACTIVITIES

N/A

XVI. MAJOR COMMITTEE ASSIGNMENTS

National/International

DATES	COMMITTEE	ROLE	INSITUTION
2016-present	Mental Health Services Research Conference	Ad-hoc Member	National Institutes for Health
2015-present	Loan Repayment Program Review Committee	Ad-hoc Member	Center for Scientific Review National Institutes of Health
2012-present	Pre-Doctoral/Post-Doctoral Awards Committee	Ad-hoc Member	Center for Scientific Review National Institutes of Health
2011	Health Literacy Review Committee	Ad-hoc Member	Center for Scientific Review National Institutes of Health
2010	The Health Research Board	Ad hoc Member	Dublin, Ireland

Regional

DATES	COMMITTEE	ROLE	INSITUTION
2002-13	Mental Health and Aging Consumer Advisory Council	Member	New Hampshire Bureau of Behavioral Health
2003-06	Committee for the Protection of Human Subjects	Member	New Hampshire Department of Health and Human Services

Institutional

DATES	COMMITTEE	ROLE	INSITUTION
2013-2018	Synergy Clinical Research Unit Steering Committee	Member	Geisel School of Medicine
2009-present	Research Review Committee	C-Chair	Department of Psychiatry, Geisel School of Medicine
2010-2012	Participants and Clinical Interactions Resources Committee	Member	Geisel School of Medicine
2003-2006	Executive Committee	Member	Dartmouth Psychiatric Research Center

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

DATES	SOCIETY	ROLE
2022-present	Schizophrenia International Research Society	Member
2015-present	Society for Research on Nicotine and Tobacco	Member
2015-2019	Society for Behavioral Medicine	Member
2003-2016	American Association of Geriatric Psychiatry	Affiliate Member
1994-2012	American Psychological Association	Member

XVIII. EDITORIAL BOARDS

N/A

XIX. JOURNAL REFEREE ACTIVITY

DATES	JOURNAL NAME	ANNUAL FREQUENCY OF REVIEW
2016-present	American Journal on Addictions	0-2
2015-present	Administration and Policy in Mental Health and Mental Health Services Research	0-2
2015-present	Cognitive Behaviour Therapist	0-2
2015-present	Community Development Journal	0-2
2015-present	Journal of Dual Diagnosis	0-2
2014-present	Annals of Behavioral Medicine	0-2
2014-present	Psychiatric Rehabilitation Journal	0-4
2014-present	Psychiatric Services	0-4
2013-present	International Journal of Sport and Exercise Psychology	0-3
2012-present	Journal of Substance Abuse Treatment	0-2
2011	Schizophrenia Bulletin	0-2
2011-present	Bipolar Disorders	0-2
2010-present	European Psychiatry	0-2

2017-present	Community Mental Health Journal	0-4
2007-present	Archives of General Psychiatry	0-2
2006-present	Psychiatry Research	0-2
2003-present	Schizophrenia Research	0-2
2003-present	International Journal of Geriatric Psychiatry	0-2
2002-present	Journal of Mental Health	0-3
2002-present	American Journal of Geriatric Psychiatry	0-2

XX. AWARDS AND HONORS:

DATE	AWARD
2002	Summer Research Institute in Geriatric Psychiatry
2000	Institute for Intervention Research on Severe Mental Illness
1994-1999	Presidential Scholarship (Full Tuition)
1989	Member, Phi Beta Kappa
1989	Member, National Collegiate Honorary in Political Science (Pi Sigma Alpha)
1989	Winthrop Scholar
1989	Magna Cum Laude with Distinction in Political Science
1985-1989	Dow Jones Scholar

XXI. INVITED PRESENTATIONS

International

DATE	TOPIC/TITLE	ORGANIZATION	LOCATION
2022	#Poster Presentation: RCT of Incentives to Promote Healthy Eating and Exercise in People with Schizophrenia & Other Serious Mental Illnesses	Schizophrenia International Research Society	Florence, Italy
2019	*Innovative Strategies to Address Nicotine Addiction in Smokers with Serious Mental Illness	Global Forum on Nicotine	Warsaw, Poland
2018	*^Whole Health for People with Serious Mental Illness	Eyra Fysio	Gothenburg, Sweden
2018	*The Future of Health and Well-Being For People Challenged by Mental Illness	IIMHL Leadership Exchange	Stockholm, Sweden
2017	#Poster Presentation: What's E-cig Got To Do With It? Electronic Cigarette Use in Smokers with Serious Mental Illness	International Society for Research on Nicotine and Tobacco	Florence, Italy
2013	*Symposium: Telehealth for People	The King's Fund Annual	London, England

	with Serious Mental Illness	Conference	
2010	#Successfully Improving Psychosocial Functioning in Older People with Serious Mental Illness	World Congress of Behavioral and Cognitive Therapies	Boston, MA

National

DATE	TOPIC/TITLE	ORGANIZATION	LOCATION
2023	# RCT Assessing the Effect of E-cigarettes Versus Usual Smoking on NNAL in Chronic Smokers with Serious Mental Illness	Society for Research on Nicotine and Tobacco	San Antonio, TX
2022	*^E-cigarettes as Harm Reduction in Chronic Smokers with Serious Mental Illness	11th Annual Thematic Meeting on Addictions	Park City, UT
2022	*^Age is Only a Number: Evidence-Based Interventions for Older People With Serious Mental Illness	Places for People/Illume Behavioral Health Center of Excellence	St. Louis, MO
2019	*^Preliminary Outcomes of a Randomized Controlled Trial of E-Cigarettes in Serious Mental Illness	10th Annual Thematic Meeting on Addictions	Clearwater, FL
2019	*Strategies to Integrate Physical and Mental Health Care for People with Serious Mental Illness	Santa Cruz County (Grand Rounds)	Santa Cruz, CA
2018	#Poster Presentation: Relationship Between Cognition and Nicotine Dependence in Smokers with Mental Illness	Society for Neuroscience Annual Meeting	San Diego, CA
2017	*^Symposium: An Automated Telehealth Program to Improve Psychiatric Symptoms and Improve Community Tenure in People with SMI	Substance Abuse and Mental Health Services Administration, PBHCI Program National Meeting	Austin, TX
2017	*^Symposium: Integrated Illness Management and Recovery: Training Consumers in Health Self-Management	Substance Abuse and Mental Health Services Administration, PBHCI Program National Meeting	Austin, TX
2016	*^Symposium: Fitness Promotion for People with Serious Mental Illness: NH	Association for Behavioral and Cognitive Therapies	New York, NY

	MIPCD "Healthy Choices, Healthy Changes"		
2016	*^Symposium: Comparing Older and Younger Adults with Serious Mental Illness Engaged in Weight Management and Smoking Cessation	Gerontological Society of America	New Orleans, LA
2015	#Paper Presentation: E-cigarette Substitution for Smokers with Schizophrenia or Bipolar Disorder Who Previously Failed to Quit	Society for Research on Nicotine and Tobacco	Philadelphia, PA
2015	*^Symposium: Exercise Promotion in Community Mental Health Settings: Translating Findings from Clinical Trials	Society for Behavioral Medicine	San Antonio, TX
2014	*^Symposium: Community Picks from the Orchard of Evidence-based Health Interventions	National Academy for State Health Policy Annual State Health Policy	Atlanta, GE
2013	#^Workshop: Integrated Illness Management and Recovery	Massachusetts Psychiatric Rehabilitation Association	Worcester, MA
2011	*Symposium: Telehealth at a Community Mental Health Center: Evaluation of Feasibility and Acceptability	National Association of Home Care & Hospice	Las Vegas, NV
2010	#^Symposium: Informing and Testing Interventions that Promote Health Behavioral Change in People with Severe Mental Illness	Society for Social Work and Research	Tampa, FL
2009	*^Keynote Address: Growing Old Gracefully: Successful Aging in the 21st Century	Annual Behavioral Health, Aging & Wellness Conference	Fairview Heights, IL
2008	#Symposium: Promoting Health and Fitness in People with Serious Mental Illness: Evaluations of the In SHAPE Program	American Association for Geriatric Psychiatry	Orlando, FL
2007	#Symposium: Effect of Psychosocial Rehabilitation Intervention on the Functioning of Older Persons with	American Association for Geriatric Psychiatry	New Orleans, LA

	SMI: Helping Older People Experience Success		
2006	#Symposium: In SHAPE: A Pilot Evaluation of a Health Promotion Intervention for People with Serious Mental Illness	American Association for Geriatric Psychiatry	San Juan, Peurto Rico
2006	#Symposium: Cognitive and Symptom Correlates of Functioning in Older People with Serious Mental Illness	American Association for Geriatric Psychiatry	San Juan, Puerto Rico
2006	#Symposium: Predictors of Functioning And Treatment of Community Dwelling Older People with Bipolar Disorder	American Psychiatric Association	Toronto, Canada
2005	*Recruitment for Psychosocial Interventions Research	American Association of Geriatric Psychiatry Annual Meeting Workshop	San Diego, CA
2005	#Symposium: Long-term Care, Health Management, and Rehabilitation for Elderly with Schizophrenia	American Psychiatric Association	Atlanta, GE
2005	#Symposium: Medication Adherence in Older Adults with Mental Illness	American Association for Geriatric Psychiatry	San Diego, CA
2005	#Paper Presentation: Clinical Variables Associated with Poor Functioning in Older Adults with Severe Mental Illness	American Association for Geriatric Psychiatry	San Diego, CA
2003	#Poster Presentation: Helping Older People Experience Success: the HOPES Study	American Association for Geriatric Psychiatry	Honolulu, HI

Regional/Local

DATE	TOPIC/TITLE	ORGANIZATION	LOCATION
2022	*^Research and Implementation of Fitness Promotion Programs for People with Serious Mental Illness	UMASS Medical School Grand Rounds	Worcester, MA
2020	*^The HOPES Program in Project Success	Maine Medical Center Grand Rounds	Portland, ME
2019	*^The STRIDE Program at NHH	New Hampshire Hospital	Concord, NH

2019	*^ Improvements in Self-Reported Health in Chronic Smokers with SMI Using E-cigs	Norris Cotton Cancer Center	Lebanon, NH
2018	*^Clinical Trial of E-Cigarettes for Smokers with Severe Mental Illness	10th Annual Koop Tobacco Treatment Conference	Lebanon, NH
2018	*^Integrated Illness Management and Recovery: Using Mobile Health to Enhance the Delivery of an Evidence-Based Practice	New Hampshire Hospital Grand Rounds	Concord, NH
2018	*^TeleFriend: A Telehealth Program to Monitor and Improve Self-Management of People with Serious Mental Illness	Vermont Association of Hospitals and Health Systems	Burlington, VT
2018	*^Clinical Trial of E-Cigarettes for Smokers with Serious Mental Illness	Ninth Annual Thematic Meeting on Addictions	Lebanon, NH
2018	*^Evaluating E-cigarette Substitution in Chronic Smokers with SMI: Update on a Clinical Trial	Cancer Control Program	Lebanon, NH
2018	*^TeleFriend Pilot at the Brattleboro Retreat	Vermont Program for Quality in Health Care	Montpelier, VT
2018	*^Electronic Cigarettes: A Potential Harm Reduction Strategy for Chronic Smokers with SMI Who Can't Quit	Center for Technology and Behavioral Health at Dartmouth Research Seminar	Lebanon, NH
2018	*^Tobacco and People with SMI: What's the Harm?	Mental Health Center of Greater Manchester	Manchester, NH
2017	*^Cash to Quit: Rewards for Cessation in a Statewide Medicaid Program for Smokers with Mental Illness	Center for Addiction Medicine, Mass General Grand Rounds	Boston, MA
2017	*Evaluation of the STRIDE Program in an Inpatient Setting	New Hampshire Hospital Journal Club	Concord, NH
2016	*^New Hampshire MIPCD "Healthy Choices, Healthy Changes"	Center for Technology and Behavioral Health at Dartmouth Research Seminar	Lebanon, NH
2016	*Innovative Approaches to Improve	National Alliance on	Lebanon, NH

	the Health and Quality of Life for People with Serious Mental Illness	on Mental Illness Regional Meeting	
2016	*^The Telefriend Study: "Trials" and Tribulations of an R01 to Evaluate a Telehealth Intervention	Center for Technology and Behavioral Health at Dartmouth Research Seminar	Lebanon, NH
2015	*^Impact of E-Cigarettes Among Smokers with Serious Mental Illness Who Struggle to Quit	Norris Cotton Cancer Center Grand Rounds	Lebanon, NH
2014	*^Feasibility and Acceptability of E-Cigarettes Among Recalcitrant Smokers With Serious Mental Illness: A Pilot Study	Dartmouth Psychiatric Research Center Seminar	Lebanon, NH
2013	*^The In SHAPE Program for People with SMI: Moving from Professional to Peer-Enhanced Model	Boston University Center for Psychiatric Rehabilitation Research Seminar	Boston, MA
2013	*^Using a Telehealth Device to Improve Psychiatric illness Management: Results of a Pilot Study Project	Dartmouth Psychiatric Research Center Seminar	Lebanon, NH
2012	*^Telehealth and the Treatment of Serious Mental Illness	New Hampshire Hospital Grand Rounds	Concord, NH
2012	*^A New Frontier for Medicaid: Rewarding Beneficiaries for Good Health	New Hampshire Hospital Grand Rounds	Concord, NH
2011	*^Medicaid Incentives for the Prevention of Chronic Diseases: The NH Wellness Incentives Program	Dartmouth Psychiatric Research Center Seminar	Lebanon, NH
2011	*^Integrated Illness Management and Recovery: Pilot Study Results and Planning an R01 Proposal	Dartmouth Psychiatric Research Center Seminar	Lebanon, NH
2010	*^Preventing Early Mortality in Serious Mental Illness: Integrated Rehabilitation and Health Care	New Hampshire Hospital Grand Rounds	Concord, NH
2010	*^The Road to a Successful K Award	Dartmouth Psychiatric Research Center Seminar	Lebanon, NH
2007	*^Approaches to Integrated	Boston University School	Boston, MA

	Rehabilitation and Wellness Self-Management for People with Serious Mental Illness	of Continuing Medical Education	
2005	*^Preliminary Results of Medication Adherence in Older People with Severe Mental Illness	Dartmouth Psychiatric Research Center Seminar	Lebanon, NH
2005	*^Teaching Old Dogs New Tricks: Psychosocial Rehabilitation for Older People with Mental Illness	New Hampshire Hospital Grand Rounds	Concord, NH
2005	*^Findings from the HOPES Study of Rehabilitation and Health Care for the Elderly with SMI and New Directions for Future Grants	Dartmouth Psychiatric Research Center Seminar	Lebanon, NH
2004	*^Medication Adherence in Older People with Severe Mental Illness	Dartmouth Psychiatric Research Center Seminar	Lebanon, NH
2003	*^Helping Older Adults Experience Success: An Intervention for Older Adults with Severe Mental Illness	New York Presbyterian Hospital Research Seminar	White Plains, NY

XXII. BIBLIOGRAPHY

A. Peer-reviewed Publications

Original Articles:

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11. Van Citters, A. D., **Pratt, S. I.**, Jue, K., Williams, G., Miller, P. T., Xie, H., & Bartels, S. J. (2010). A pilot evaluation of the In SHAPE individualized health promotion intervention for adults with mental illness. *Community Mental Health Journal, 46*, 540-552. DOI: 10.1007/s10597-009-9272-x. PMID: 20012197.
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and Nutrition Examination Survey 1999-2004. *Journal of the American Geriatric Society, 61*, 974-980. PMID: 23647372.

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56. Aschbrenner, K. A., Bond, G. R., **Pratt, S. I.**, Jue, K., Williams, G., Banerjee, S. & Bartels, S. J. Evaluating agency-led adaptions to an evidence-based lifestyle intervention for adults with serious mental illness. *Implementation Research and Practice*. January 2020, doi/10.1177/2633489520943200.
57. Wright, A. C., Browne, J., Cather, C., **Pratt, S. I.**, Bartels, S. J., & Mueser, K. T. (2021). Does self-efficacy predict functioning in older adults with schizophrenia? A cross-sectional and longitudinal mediation analysis. *Cognitive Therapy and Research, 45*, 136-148. https://doi.org/10.1007/s10608-020-10171-8.
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59. **Pratt, S. I.**, Ferron, J. C., Brunette, M. F., Santos, M., Sargent, J., & Xie, H. (2022). E-cigarette provision to promote switching in cigarette smokers with serious mental illness – A randomized trial. *Nicotine & Tobacco Research, 24(9),* 1405-1412. doi.org/10.1093/ntr/ntac082. PMID: 35363874.
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Reviews:

1. **Pratt, S.**, & Moreland, K. (1996). Introduction to treatment outcome: Historical perspectives and current issues. *Residential Treatment for Children & Youth, 13,* 1-27.
2. **Pratt, S. I.**, Bartels, S. J., Mueser, K. T., & Van Citters, A. D. (2004). Integrated services and care management for older people with severe mental illness. *Geriatric Care Management Journal, 14*, 12-18.
3. Van Citters, A.D., **Pratt, S.I.**, Bartels, S.J., & Jeste, D.V. (2005). Evidence-based review of pharmacological and non-pharmacological treatments for older adults with schizophrenia. *Psychiatric Clinics of North America, 28*, 913-939. PMID: 16325735.

4. **Pratt, S. I.**, Van Citters, A. D., Mueser, K. T., & Bartels, S. J. (2008). Psychosocial rehabilitation in older adults with SMI: A review of the research literature and recommendations for development of rehabilitative approaches. *American Journal of Psychiatric Rehabilitation, 11*, 7-40.
5. **Pratt, S. I.**, Bartels, S. J., Mueser, K. T., & Forester, B. (2008). Helping Older People Experience Success (HOPES): An integrated model of psychosocial rehabilitation and health care management for older adults with serious mental illness. *American Journal of Psychiatric Rehabilitation, 11*, 41-60.
6. Bartels, S. J. & **Pratt, S. I.** (2009). Psychosocial rehabilitation and quality of life for older adults with serious mental illness: Recent findings and future research directions. *Current Opinion in Psychiatry, 22*, 381-385. PMID: 19417666.

Book Chapters:

1. **Pratt, S.**, & Moreland, K. (1996). Introduction to treatment outcome: Historical perspectives and current issues. In S. Pfeiffer (Ed.), *Outcome assessment in residential treatment* (pp. 1-27). Binghamton, NY: Haworth.
2. Alfonso, V. C., & **Pratt, S.** (1997). Issues and suggestions for training professionals in assessing intelligence. In D. P. Flanagan, J. L. Genshaft, & P. L. Harrison (Eds.), *Contemporary intellectual assessment: Theories, tests and issues* (pp. 326-344). New York, NY: Guilford.
3. **Pratt, S.** & Moreland, K. (1998). Individuals with other characteristics. In J. Sandoval, C. L. Frisby, K. F. Geisinger, J. D. Scheuneman, & J. R. Grenier (Eds.), *Test interpretation and diversity* (pp. 349-371). Washington, D.C.: American Psychological Association.
4. **Pratt, S.**, Berman, W., & Hurt, S. (1998). Ethics and outcomes in managed behavioral health care: Trust me, I'm a psychologist. In R. F. Small, & L. R. Barnhill (Eds.), *Practicing in the new mental health marketplace: Ethical, legal, and moral issues*. Washington, DC: American Psychological Association.
5. **Pratt, S.**, & Mueser, K. T. (2001). Schizophrenia. In M. M. Antony & D. H. Barlow (Eds.), *Handbook of assessment and treatment planning* (pp. 375-414). New York, NY: Guilford.
6. **Pratt, S.**, & Mueser, K. T. (2002). Social skills training for schizophrenia. In S. G. Hofmann & M. C. Thompson (Eds.), *Handbook of psychosocial treatments for severe mental disorders*, (pp. 18-52). New York, NY: Guilford.
7. Bartels, S. J., Dums, A. R., Oxman, T. E., & **Pratt, S. I.** (2004). The practice of evidence-based geriatric psychiatry. In J. Sadavoy, L. F. Jarvik, G. T. Grossberg, & B. S. Meyers (Eds.), *The comprehensive review of geriatric psychiatry* (3rd ed., pp. 817-844). Washington, DC: American Psychiatric Association.
8. McCarthy, M., Mueser, K. T., & **Pratt, S. I.** (2008). Integrated psychosocial rehabilitation and health care for older people with serious mental illness (pp. 118-134). In D. Gallagher-Thompson, A. Steffen, & L. W. Thompson (Eds.), *Handbook of behavioral and cognitive therapies with older adults* (pp. 118-134). New York, NY: Springer.
9. **Pratt, S. I.**, Brunette, M. B., & Bennett, M. (2019). Evaluation and treatment of co-morbid conditions. In. L. Dixon (Ed.), *The APA Publishing Textbook of Schizophrenia* (2nd ed).
10. **Pratt, S.**, & Mueser, K. T. (2020). Schizophrenia. In M. M. Antony & D. H. Barlow (Eds.), *Handbook of assessment and treatment planning* (2nd ed., pp. 447-493). New York, NY: Guilford.

11. Mueser, K. T., Pratt, S. I., & Browne, J. (2020). In Nangle, D. W. (Ed.) *Social skills across the lifespan: Theory, assessment, and intervention.* Social skills training for persons with schizophrenia. New York, NY: Elsevier.

B. Other Scholarly Work

1. **Pratt, S. I.**, Jerome, G., Schneider, K., Craft, L., Stoutenberg, M., Buman, M., Daumit, G., Bartels, S., & Goodrich, D. (2015). Increasing United States Health plan coverage for exercise programming in community mental health programs for people with serious mental illness. Joint Position Statement: Society of Behavioral Medicine and American College of Sports Medicine. http://www.sbm.org/UserFiles/file/SBMandACSM_exerciseformentalhealthpositionstatement.pdf

C. Abstracts

#1. **Pratt, S. I.**, Bartels, S. J., Mueser, K. T., & Forester, B. (2003). Helping Older People Experience Success: the HOPES Study. Poster Presentation at the American Association for Geriatric Psychiatry Annual Meeting.

#2. Forester, B., Bartels, S., **Pratt, S. I.**, & Mueser, K. T. (2005). Clinical characteristics of schizoaffective disorder in older adults compared to schizophrenia, bipolar disorder, and depression. Poster Presentation at the American Association for Geriatric Psychiatry Annual Meeting.

#3. **Pratt, S. I.**, Mueser, K. T., Forester, B., & Bartels, S. J. (2006). Cognitive and symptom correlates of functioning in older people with serious mental illness. Poster Presentation at the American Association for Geriatric Psychiatry Annual Meeting.

#4. Forester, B. P., **Pratt, S. I.**, Bartels, S. J., & Mueser, K. T. (2006). Health status and preventive health care in older adults with schizophrenia-spectrum and affective disorders: Poster Presentation at the American Association for Geriatric Psychiatry Annual Meeting.

#5. Van Citters, A. D., **Pratt, S. I.**, Miller, T., Williams, G., Jue, K., & Bartels, S. (2006). Characteristics of older and younger adults with SMI enrolled in a health promotion intervention. Poster Presentation at the American Association for Geriatric Psychiatry Annual Meeting.

#6. **Pratt, S. I.**, Bartels, S. J., Mueser, K. T., & Forester, B. (2007). Effect of a psychosocial rehabilitation intervention on the functioning of older persons with SMI: Helping Older People Experience Success (HOPES). Poster Presentation at the American Association for Geriatric Psychiatry Annual Meeting.

#7. Van Citters, A. D., **Pratt, S. I.**, Miller, T., Williams, G., Jue, K., & Bartels, S. J. (2007). Effectiveness of a health promotion intervention for older and younger adults with SMI. Poster Presentation at the American Association for Geriatric Psychiatry Annual Meeting.

Meghan McCarthy Santos, MSW

Education

Boston University, Boston MA — Master of Social Work, Clinical Track, May 2003
University of Miami, Coral Gables FL — Bachelor of Arts, Psychology, May 2001

Licenses and Specialized Training

Licensed Independent Social Worker (LICSW)
State of Massachusetts #114082
State of New Hampshire #1517

Perinatal Mental Health-Certified (PMH-C)
Postpartum Support International, 5/2021.

Eye Movement and Desensitization and Reprocessing (EMDR)
Basic Training, Completed 9/2023

Professional Experience

Perinatal and Women's Mental Health Counseling — **Salem NH**
Therapist — 8/2018 – present

- Provides individual therapy to clients with a variety of presenting problems, but primary population focus is clients navigating issues with fertility, pregnancy or infant loss, or the postpartum period;
- Utilizes EMDR (eye movement desensitization and reprocessing), cognitive behavioral techniques, positive psychology, and mindfulness strategies to support functioning and quality of life for clients;
- Maintains progress notes for all clients to ensure proper documentation of session content and interventions.

Dartmouth Health (formerly Dartmouth-Hitchcock) — **Concord NH**
Department of Psychiatry
Center for Collaborative Mental Health Research
Research Scientist — 1/2022-present
Research Project Manager — 7/2017-1/2022
Research Coordinator — 7/2016-7/2017

Dartmouth College — **Concord, NH**
Geisel School of Medicine at Dartmouth
Community and Family Medicine
Research Coordinator — 6/2007-6/2016

Study Design and Implementation

- Participates in defining the scope and selection of research topics for investigation through conceptually related studies;
- Prepares drafts of grant applications and budgets for funding of projects;
- Manages and supervises program and research staff at sites in recruitment efforts and program implementation, and data collection protocols; and
- Develops research protocols and refines established protocols to ensure successful implementation of projects.

Project Reporting, Analyses and Compliance

- Participates in statistical analysis and drafts project reports to produce scientific content for clinical and regulatory docs;

- Manages and reviews submissions prepared by staff for institutional review board (IRB) reviews and data safety monitoring (DSMB) reports; and
- Prepares draft progress reports to National Institute of Mental Health, Centers for Medicare and Medicaid Services, Patient Centered Outcomes Research Institute and other funding organizations.

Data Collection and Management

- Ensures the quality and integrity of data and safe and proper management of project parameters, in collaboration with the Center's Data Manager;
- Designs and implements data collection and project management systems using REDCap, DataStat, etc. to minimize ongoing data queries, data cleaning, and missing data;
- Manages intervention data collection efforts at the site level to ensure thorough and completeness of data; and
- Uses intervention data to inform refinement of the intervention and to describe the study intervention at the conclusion of research project.

Intervention Design, Training and Supervision

- Develops research interventions including preparation of manuals and training materials for interventionists to use with consumers;
- Trains and supervises clinicians providing a variety of interventions for people with serious mental illness in community mental health settings in Texas, Indiana, California, New York, Massachusetts, and Maryland, and Florida;
- Collaborates with community partners in implementation of research programs and provides technical support to ensure the success of the program at each center;
- Conducts and manages fidelity monitoring of study interventions; and
- Supervises Master of Social Work students providing individually-tailored skills training program, telephone-based CBT for smoking cessation, and wellness/fitness interventions.

Community Council of Nashua — **Nashua, NH**
NIMH-funded R01 (PI: Stephen Bartels, MD, MS) — 6/2003-6/2007
Research Site Coordinator/Study Interventionist

Led skills training groups for older adults with serious mental illness addressing social functioning, independent living, and wellness; ascertained consumers eligible for participation, enrolled and conducted informed consent with interested consumers; and collaborated with the clinical team at the site to provide ongoing engagement in all aspects of the project.

Publications

Pratt S.I., Ferron J.C., Wolfe R., Xie H., Brunette M., Santos M., Williams G., Bartels S., Jue K., Capuchino K. Healthy choices, healthy changes: A randomized trial of incentives to promote healthy eating and exercise in people with schizophrenia and other serious mental illnesses. Schizophr Res. 2023 May;255:1-8. doi: 10.1016/j.schres.2023.03.007. Epub 2023 Mar 16. PMID: 36933290.

Schutt R.K., Xie H., Mueser K.T., Killam M.A., Delman J., Eack S.M, Mesholam-Gately R., Pratt S.I., Sandoval L., **Santos M.M.,** Golden L.R., Keshavan M.S. (2022) Cognitive Enhancement Therapy vs social skills training in schizophrenia: a cluster randomized comparative effectiveness evaluation. BMC Psychiatry. 1;22(1):583. doi: 10.1186/s12888-022-04149-x. Erratum in: BMC Psychiatry. 2022 Sep 16;22(1):613. PMID: 36050663; PMCID: PMC9434502.

Pratt S.I., Ferron J.C., Brunette M.F., **Santos M.,** Sargent J., Xie H. (2022). E-Cigarette Provision to Promote Switching in Cigarette Smokers With Serious Mental Illness-A Randomized Trial. Nicotine & Tobacco Research, 24(9):1405-1412. doi: 10.1093/ntr/ntac082. PMID: 35363874; PMCID: PMC9356685.

Fortuna, K.L., Ferron, J., Bianco, C.L., **Santos M.M.,** Williams, A., Williams, M. Mois, G., & Pratt, S.I. (2021). Loneliness and its association with health behaviors in people with a lived experience of a serious mental illness. Psychiatric Quarterly, 92, 101-106.
PMCID: PMC7688571.

Brunette, M. F., Pratt, S. I., Bartels, S. J., Scherer, E. A., Sigmon, S. C., Ferron, J. C., **Santos, M.,** Williams, G. E., Kosydar, S., Wolfe, R. S., Lotz, D., & Capuchino, K. (2018). Randomized trial of interventions for smoking cessation among medicaid beneficiaries with mental illness. Psychiatric Services, 69, 274-280. doi: 10.1176/appi.ps.201700245. PMID: 29137560.

Pratt, S. I., Mueser, K. T., **Santos, M.M.,** Wolfe, R., & Bartels, S. J. (2017). One size doesn't fit all: A trial of individually tailored skills training. Psychiatric Rehabilitation Journal, 40, 380-386. doi: 10.1037/prj0000261. PMID: 2860415.

Pratt, S.I., Sargent J., Daniels, L., **Santos, M.M.,** Brunette M. (2016). Appeal of electronic cigarettes in smokers with serious mental illness. Addictive Behaviors, 59, 30-34. PMID: 27043170.

Pratt, S.I., Naslund, J.A., Wolfe, R.S., Santos, M., & Bartels, S.J. (2015). Automated telehealth for managing psychiatric instability in people with serious mental illness. Journal of Mental Health, 24(5), 261-265.
PMCID: PMC5506829.

Bartels, S.J., Pratt, S.I., Mueser, K.T., Naslund, J.A., Wolfe, R.S., **Santos, M.,** Xie, H., & Riera, E.G. (2014). Integrated IMR for psychiatric and general medical illness for adults aged 50 or older with serious mental illness. Psychiatric Services, 65(3), 330-7. PMCID: PMC4994884.

Bartels, S.J., Pratt, S.I., Aschbrenner, K.A., Barre, L.K., Jue, K., Wolfe, R.S., Xie, H., McHugo, G., **Santos, M.,** Williams, G.E., Naslund, J.A., & Mueser, K.T. (2013). Clinically significant improved fitness and weight loss among overweight persons with serious mental illness. Psychiatric Services, 64(8), 729-36.
PMCID: PMC5662189.

McGuire, A.B., Stull, L.G., Mueser, K.T., **Santos, M.,** Mook, A., Rose, N., Tunze, C., White, L.M., & Salyers, M.P. (2012). Development and reliability of a measure of clinician competence in providing illness management and recovery. Psychiatric Services, 63(8), 772-8.

Brunette, M.F., Ferron, J.C., Devitt, T., Geiger, P., Martin, W.M., Pratt, S., **Santos, M.,** & McHugo, G.J. (2012). Do smoking cessation websites meet the needs of smokers with severe mental illness? Health Education Research, 27(2), 183-90.

Mueser, K.T., Bartels, S.J., **Santos, M.,** Pratt, S.I., & Riera, E.G. (2012). Integrated Illness Management and Recovery: A program for integrating physical and psychiatric illness self-management in older persons with severe mental illness. American Journal of Psychiatric Rehabilitation, 15(2), 131-56.

McCarthy, M., Mueser, K. T., Pratt, S. I. (2008). Integrated psychosocial rehabilitation and health care for older people with serious mental illness. In D. Gallagher-Thompson, A.M. Steffen, L.W. Thompson (Eds). Handbook of Behavioral and Cognitive Therapies with Older Adults.

Presentations

Co-presented final results, including NNAL in urine, from a randomized trial of e-cigarettes in chronic smokers with serious mental illness, 11th Annual Thematic Meeting on Addictions, Park City, Utah (2022).

Co-presented preliminary findings from a randomized trial of e-cigarettes in chronic smokers with serious mental illness, 10th Annual Thematic Meeting on Addictions, Clearwater Florida (2019).

Co-presented findings from Integrated Illness Management and Recovery Study and TeleHealth and remote monitoring for people serious mental illness and co-morbid medical conditions at the Primary and Behavioral Health Integration, Austin, Texas (2017).

Presented findings from the Evaluation of the Health Buddy Technology for Persons with SMI. The King's Fund, International Telehealth and Telecare Conference, London England (2012).

Presented findings from the Helping Older People Experience Success Study at the American Psychiatric Association Annual Meeting, Toronto, Canada (2006).

Gail Williams

PROFESSIONAL EXPERIENCE

RESEARCH EXPERIENCE

7/2016 – Present Dartmouth Hitchcock Department of Psychiatry Research, Concord NH
Research Project Manager: Coordinate, implement and manage the activities of multiple research projects, including complex multi-site studies with as many as 48 sites across the United States. Provide leadership to project assistants, project interventionists, and project partners. Monitor grants activities, including tracking expenditures budgeted under contracts and purchased services. Monitor data collection and oversee data management, reporting and project communication with partners, IRBs, DSMBs, sponsors & governmental agencies. Specific responsibilities include:

- Organize and run project meetings to track and manage program activity, collaborate with partners to assure integrity of project and timely resolution of problems, and follow up on tasks identified in meetings.
- Monitor ongoing project plans, progress, budgets and expenditures and discuss with PI weekly.
- Participate in leadership meetings to discuss projects and generate ideas for improvement initiatives.
- Coordinate and run meetings to determine project requirements and establish timelines and project organization.
- Develop training and instructional materials, manuals, and toolkits for several key projects.
- Prepare project communications and written materials for partners, sponsors and governmental agencies.
- Assist with proposal writing, mainly large grants to federal agencies (NIH, CDC, CMS, etc.).
- Participate in development of posters and presentations.
- Organize and manage implementation of project activities including evaluations, data collection and management, project coordination, and collaborative relations.
- Participate in the preparation of the design and development of new study protocols.
- Participate in the collection, monitoring and analysis of data and assure that data are successfully collected and managed so that confidentiality and data integrity are maintained.
- for research projects
- Provide training, guidance and primary supervision to students and staff (e.g., research assistants, project interventionists, interns)
- Lead implementation and training to onboard new study sites.
- Facilitate meetings to obtain input on research from key stakeholder groups including people with lived experience of mental illness, clinical providers, policy makers, and research partners.
- Deliver interventions such as chronic disease self-management, skills training and positive psychology to individuals with serious mental illness.
- Present at conferences and sponsor annual meetings.
- Contribute to publications for scientific journals.
- Prepare and initiate completion timelines and ensures all required project close out documents are obtained.
- Perform all other duties as required or assigned.

10/2008 – 6/2016 Dartmouth College, Centers for Health & Aging, Concord NH 03301
Research Project Manager: Coordinated and managed the activities of various research projects. Responsibilities included:

- Coordinated grant activities and compliance requirements with The Centers for Medicaid and Medicare Services, The New Hampshire Department of Health and Human Services, and 10 Community Mental Health Centers in NH, to implement the $10 million Medicaid Incentives for Prevention of Chronic Diseases grant.
- Presented at conferences and sponsor annual meetings.

- Participated in the preparation of the design and development of study protocols, statistical analysis and study reports.
- Participated in the collection and monitoring of data for research projects.
- Contributed to publications for scientific journals.
- Led implementation and training at new study sites.
- Provided oversight and training to research assistants, interventionists, and interns.
- Participate in grant writing and reporting.
- Delivered interventions such as skills training and positive psychology to individuals with serious mental illness.

CLINICAL EXPERIENCE

12/2021 – Present Maps Counseling Services, Keene NH

Part-time Resident Clinician

- Complete intake assessments.
- Provide individual therapy to children and adults.
- Provide therapy to couples and families.
- Treatment planning and documentation.

10/2003 – 9/2008 Monadnock Family Services (MFS), Keene NH 03431

In SHAPE Director: Management of all aspects of the original In SHAPE program. Responsibilities included:

- Engaged and contracted with community partners, funding partners, and CMHC management on program development and marketing strategies.
- Hired and supervised staff of 6-10 including health mentors, project assistant, volunteers and interns.
- Enrolled over 200 program participants.
- Tracked member participation and project outcomes.
- Implemented and managed four year, Robert Wood Johnson Foundation, Local Initiative Funding Partners grant.
- Presented at conferences and sponsor annual meetings.
- Recruited and consented 100 participants for a pilot evaluation of the program.
- Promoted program to other organizations for replication.
- Provided training and consultation for replication of program in other communities.

10/2001 – 10/2003 Monadnock Family Services (MFS), Keene NH 03431

MANY Options After-school Program Coordinator: In addition to coordinating and providing parent education (see below), coordinated after-school program for at risk youth grades 6-12. Responsibilities included:

- Partnered with community agencies to access activities.
- Worked with parents and schools to identify and engage youth.
- Facilitated after school activities for middle school youth.
- Hired and supervised staff and volunteers.
- Budget management.
- Grant reporting.

3/2000 – 10/2003 Monadnock Family Services (MFS), Keene NH 03431

Parent Outreach Project Coordinator: Provided support and education to parents through groups, educational workshops, and individual consultations. Responsibilities included:

- Facilitated groups and made educational presentations.
- Initiated support groups for single parents, fathers, and stepparents.
- Collaborated with other community organizations striving to prevent child abuse and neglect by supporting at-risk families.
- Organized groups and activities aimed at preventing teen pregnancy and helping teens with children reach their full potential as parents and adults.
- Grant writing and reporting.
- Budget management.

6/1993-4/1996 Monadnock Developmental Services, Keene NH
Lead Staff / Support Staff: Utilized gentle teaching approach to promote self-esteem, independence, social/ daily living skills of adults with developmental disabilities in their homes and in the community. Other responsibilities included:

- Supervised and trained other staff in gentle teaching.
- Participated in Individual Service Plan planning and implementation.
- Dispensed and monitored medications.
- Scheduled staff and activities.

6/1991-12/1991 Spofford Hall Substance Abuse Treatment Hospital, Spofford NH
Continuing Care Counselor: Worked with up to 36 patients and their treatment teams to design individualized continuing care plans. Made necessary referrals and arrangements. Facilitated a continuing care group for families.

6/1990-6/1991 Spofford Hall Substance Abuse Treatment Hospital, Spofford NH
Case Manager: Conducted bio-psychosocial assessments. Provided individual counseling. Co-facilitated therapy groups. Facilitated conferences with patients and concerned persons. Documented patient needs and progress through all phases of treatment.

12/1988-6/1990 Spofford Hall Substance Abuse Treatment Hospital, Spofford NH
Primary Care Counselor: Counseled new patients to stay in treatment through physical withdrawal period. Facilitated didactic groups. Oriented new patients to treatment. Participated in master treatment team planning.

EDUCATION

Plymouth State University
Masters of Science in Marriage and Family Therapy

Keene State College, Keene NH
Bachelor of Arts, Psychology
Associate Degree, Chemical Dependency

Additional Training
Master Trainer for Chronic Disease Self-Management, and Chronic Pain Self-Management Workshops
Child Impact Program Trainer
40 hours of Motivational Interviewing training.
Mediation Training (15 hours), Keene State College Office of Mediation / Dispute Resolution.

Publications

Stephen J. Bartels, Sarah I. Pratt, Kelly A. Aschbrenner, Laura K. Barre, Kenneth Jue, Rosemarie S. Wolfe, Haiyi Xie, Gregory McHugo, Meghan Santos, **Gail E. Williams**, John A. Naslund, and Kim T. Mueser (2013) Clinically Significant Improved Fitness and Weight Loss Among Overweight Persons With Serious Mental Illness Psychiatric Services 64:8, 729-736. doi: 10.1007/s10597-009-9272-x. PMID: 20012197

Van Citters, A. D., Pratt, S. I., Jue, K., **Williams, G.**, Miller, P. T., Xie, H., & Bartels, S. J. (2010). A Pilot Evaluation of the In SHAPE Individualized Health Promotion Intervention for Adults with Mental Illness. Community Mental Health Journal, 46(6), 540–552 J. 2010 Dec; 46(6): 540-52. doi: 10.1007/s10597-009-9272-x. PMID: 2001219

Aschbrenner, K.A., Bond, G., Pratt, S.I., **Williams, G.**, Jue, K., & Bartels, S.J. (2017 December). Adaptations to Health Promotion Programs in Mental Health Settings. Poster presented at the 10th Annual Conference on the Science of Dissemination and Implementation in Health, Washington, D.C.

Bartels SJ, Aschbrenner KA, Pratt SI, Naslund JA, Scherer EA, Zubkoff L, Cohen MJ, **Williams GE**, Wolfe RS, Jue K, Brunette MF. Implementation of a Lifestyle Intervention for People with Serious Mental Illness in State-Funded Mental Health Centers. Psychiatr Serv. 2018 Apr 2; doi: 10.1176/appi.ps.201700368.PMID: 29606077

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Bartels S., Aschbrenner, KA, Pratt, SI, Zubkoff L, Jue K, **Williams G**, Godfrey MM, Cohen MJ, Banerjee S, Xie H, Wolfe R, Naslund JA, Bond GR. Virtual Learning Collaborative Compared to Technical Assistance as a Strategy for Implementing Health Promotion in Routine Mental Health Settings: A Hybrid Type 3 Cluster Randomized Trial. Administration and Policy in Mental Health and Mental Health Services Research. https://doi.org/10.1007/s10488-022-01215-0

CURRICULUM VITAE

NAME: **Joelle C. Ferron, PhD, MSW**

I. EDUCATION

DATES	INSTITUTION	DEGREE
2003-2007	University of North Carolina	PhD (Social Work Research)
1997-1999	Boston University	MSW (Clinical Social Work)
1992-1996	Boston University	BA (with honors and distinction)

II. POSTDOCTORAL TRAINING

DATES	INSTITUTION	SPECIALTY
2007-2010	Dartmouth College	Postdoctoral Fellow (Psychiatric Research)

III. PROFESSIONAL DEVELOPMENT ACTIVITIES

DATE	INSTITUTION	TITLE	CREDITS
2023	Statistical Horizons	Psychometrics	N/A
2022	Statistical Horizons	Causal Mediation Analysis	N/A
2019	SAS	Macro Language	N/A
2019	SAS	SAS Programming II	N/A
2018	SAS	SAS Programming I	N/A
2017	NHTI	Pre-Calculus and Calculus	N/A
2016	National Institute of Health	Multiphase Optimization Strategies	N/A
2010	UMass Medical School	Tobacco Treatment Specialist Training	N/A
2008	Inter-university Consortium for Political and Social Research	Item Response Theory	N/A
2006	Inter-university Consortium for Political and Social Research	Latent Growth Curve Modeling	N/A
2005	Inter-university Consortium for Political and Social Research	Survival Analysis using SAS	N/A
2004	Inter-university Consortium for Political and Social Research	Hierarchical Linear Models using SAS	N/A

IV. ACADEMIC APPOINTMENTS

DATE	INSTITUTION	TITLE
2021-Present	Dartmouth-Hitchcock Hospital	Scientist
2021-Present	Geisel School of Medicine at Dartmouth	Research Assistant Professor in Psychiatry
2014-2019	Geisel School of Medicine at Dartmouth	Adjunct Assistant Professor in Psychiatry
2012-2014	Geisel School of Medicine at Dartmouth	Research Assistant Professor in Psychiatry

V. INSTITUTIONAL LEADERSHIP ROLES

DATE	INSTITUTION	TITLE
N/A		

VI. LICENSURE AND CERTIFICATION

2002-2018 Massachusetts Independent Clinical License in Social Work

VII. HOSPITAL APPOINTMENTS:

DATE	INSTITUTION	POSITION/TITLE
2019-2020	Dartmouth-Hitchcock	Project Manager

VIII. OTHER PROFESSIONAL POSITIONS (NON-DARTMOUTH):

DATE	INSTITUTION	POSITION/TITLE
2004-2007	Duke University	Senior Data Analyst
2003-2004	University of North Carolina, Chapel Hill	Research Assistant
1999-2003	Somerville Mental Health Center	ACT Team Leader
1998-1999	UMASS Boston Counseling Center	Social Work Intern
1997-1998	Youth Opportunities Upheld, Inc.	Social Work Intern
1996-1997	Tri-City Mental Health, Inc.	Crisis Counselor/Group Counselor
1995-1997	Emerge	Group Counselor Intern
1994-1996	Vinfen	Residential Counselor

IX. TEACHING ACTIVITIES

A. UNDERGRADUATE (COLLEGE) EDUCATION

DATES	INSTITUTION	COURSE TITLE	ROLE	HOURS
N/A				

B. GRADUATE EDUCATION

DATES	INSTITUTION	COURSE TITLE	ROLE	HOURS
Winter 2024	TDI	Measurement	Professor	10 wks/2 hrs
Fall 2023	TDI	Research Methods	Professor	10 wks/2 hrs
2009-2012	Dartmouth PRC	Statistics Seminar	Instructor	20 wks/yr
2008-2009	Dartmouth PRC	Evidence-based Practice for the Non-Practitioner	Instructor	1hr/5 wks
2005-2006	UNC	Social Policy	TA	4 credit hrs.
2005-2006	UNC	Intro. To Clinical Practice	TA	4 credit hrs.

C. UNDERGRADUATE MEDICAL EDUCATION

N/A

D. GRADUATE MEDICAL EDUCATION

2022 Department of Psychiatry, Journal Club Discussant
2023 Department of Psychiatry, Journal Club Discussant

E. OTHER CLINICAL EDUCATION

2016-2017	Bloomsburg U.	Social Work Field Practice	Adjunct Professor	4 credit hrs.

X. ADVISING/MENTORING

A. UNDERGRADUATE STUDENTS

DATES	STUDENT'S NAME	PROGRAM

N/A

XI. RESEARCH TEACHING/MENTORING

A. UNDERGRADUATE STUDENTS

DATES	STUDENT'S NAME	PROGRAM
2009-2010	Kelly Erickson	Psychology Major, Dartmouth College
2012-2013	R. Scott Carson	Biomedical Engineering, University of Wisconsin
2012-2013	Zach Vargas	Biomedical Engineering, University of Wisconsin
2012-2013	Sayed Sadeghi	Biomedical Engineering, University of Wisconsin
2012-2013	Zac Balsigar	Biomedical Engineering, University of Wisconsin
2012-2013	Ahmad Khattab	Biomedical Engineering, University of Wisconsin

B. GRADUATE STUDENTS

DATES	STUDENT'S NAME	PROGRAM
2012-13	Saira Nawaz	The Dartmouth Institute, Doctoral Student
2012-13	Keith Drake	The Dartmouth Institute, Doctoral Student
2012-13	Will Haslett	The Dartmouth Institute, Doctoral Student
2017-19	Stephanie Kelly	The Dartmouth Institute, MPH
2023-24	Jesse Boggis	The Dartmouth Institute, Doctoral Student
2023-24	Alena Berube	The Dartmouth Institute, Doctoral Student
2023-24	Rebecca Smith	The Dartmouth Institute, Doctoral Student
2023-24	Min-Young Kim	The Dartmouth Institute, Doctoral Student

C. MEDICAL STUDENTS

DATES	STUDENT'S NAME	PROGRAM
2018-2019	Jordan Wong	Geisel School of Medicine at Dartmouth
2016-2018	Samuel Kosydar	Start Medical School at UW

D. RESIDENTS/FELLOWS/RESEARCH ASSOCIATES

DATES	STUDENT'S NAME	SPECIALTY
2009-2012	Rosemarie Wolfe, MS	Data Management/Analyst
2009-2012	Kelly Aschbrenner, PhD	Research Associate/Post-Doc
2009-2012	Daniel Jimenez, PhD	Research Associate/Post-Doc
2009-2012	Laura Barre, MD	Research Associate/Post-Doc

E. FACULTY

DATES	MENTEE'S NAME	SPECIALTY
2019-2023	Karen Fortuna, PhD	Psychiatry

XII. COMMUNITY SERVICE, EDUCATION, AND ENGAGEMENT

DATES	INSTITUTION	COURSE/ACTIVITY TITLE	ROLE	HOURS/YEAR
2013-2015	Riverbend Mental Center	EDSS Training	Trainer	10hrs/yr
2012-2015	Dover Mental Health	EDSS Training	Trainer	5 hrs/yr
2012-2015	West Central Mental Health	EDSS Training	Trainer	5 hrs/yr
2003-2007	Compeer Program Greensboro, NC	Mentee		156/yr

XIII. RESEARCH FUNDING

A. CURRENT SUPPORT

DATES	PROJECT TITLE & AWARD NUMBER	ROLE	%EFFORT	SPONSOR	ANNUAL DIRECT COSTS
2022-2027	Reduced-dose onabotuLinumtoxinA for urgency incontinence among older females (RELIEF): A mixed methods randomized controlled trial	Co-I	10%	PCORI	$6,632,428
2019-2024	Integrated Physical and Mental Health Self-Management Compared To Chronic Disease Self-Management	Co-I	80%	PCORI	$1,386,128

B. PAST SUPPORT

DATES	PROJECT	ROLE	% EFFORT	SPONSOR	ANNUAL DIRECT COSTS
2022-2023	Targeting factors related to failed	PI	20%	AIRS	$25,000

	Smoking cessation to improve telephone -delivered cognitive behavioral treatment for smokers with serious mental illness				
2016-2019	HSRP20193316	Co-I	70%	NIDA	$1,000,000
	Comparing Two Programs for Managing Long-Term Health Problems for People with Lived Experience of Mental Illness				
2016-2020	R01DA041416	Co-I	10%	NIDA	$499,905
	The Appeal and Impact of E-cigarettes In Smokers with Serious Mental Illness				
2015-2020	R01MH107625	Co-I	10%	NIMH	$575,723
	Automated Telehealth to Improve Psychiatric Symptom Self-Management and Community Tenure				
2014-2019	U48DP005018 (Bartels, PI)	Co-I	10%	CDC	$576,552
	Health Promotion and Disease Prevention Research Center				
2014-2020	R01MH104555 (Bartels, PI)	Co-I	10%	NIMH	$499,228
	Self-Management Training and Automated Telehealth to Improve SMI Health Outcomes				
2011-2016	1B1CMS330880-01-00	Co-I	10%	CMS	$1,170,370
	New Hampshire Medicaid Wellness Incentive Program				
2013-2016	R01CA168778	Co-I	50%	NCI	$449,810
	RCT of a Motivational Decision Support System for adults with SMI				
2013-2014	Evaluating Mobile Applications for Smoking Cessation among Smokers with Schizophrenia	PI	0%	Gary Tucker	$30,000
2012-2014	Decision support for smoking cessation in young adults with severe mental illness	PD	50%	NCI	$397,802
2012-2013	P30 –DA029926	PI	0%	NIDA	$20,000
	Initial Testing of the Pack Pal System for Smokers with Schizophrenia			Pilot in Center Grant	
2011-2012	A randomized trial of an Electronic Decision Aid with and without Carbon Monoxide monitor feedback	Co-I	30%	NIDRR Center Grant Core Research	

2009-2012	Dual Disparity Project: Tailoring an electronic decision support system on smoking cessation for racial minorities with severe mental illness	Co-I	50%	Bristol Myers Squibb	
2009-2010	A Smoking Cessation Decision Aid for People with Serious Mental Illness	PI	50%	FIMDM	$35,000
2008-2009	Pilot of the Smoking Cessation Decision Aid	Co-I	50%	West Family	
2008-2009	Loan Repayment Grant	PI		NIMH	$32,100
2007-2009	R01MH068252 A randomized-control trial of the trauma recovery and empowerment model	Analyst	50%	NIMH	$461,821
2003-2006	R01MH063949 Effectively Implementing Psychiatric Advance Directives	Analyst	100%	NIMH	$1,739,676

C. PENDING SUPPORT

DATES	PROJECT	ROLE	%EFFORT	SPONSOR	ANNUAL DIRECT COSTS

XIV. PROGRAM DEVELOPMENT

2023-Present Positive Psychotherapy For Smoking Cessation in Adults with Severe Mental Illness
2018-Present Smoke-Free Together (Combined App and Group Treatment for Cessation)
2014-2020 Smoking Cessation App for Low SES Smokers (Calm.Cope.Quit)
2013-2019 Cognitive Behavioral Therapy for Smoking Cessation Website
2007-2021 Smoking Cessation Decision Support Tool (EDSS)
2012-2013 Pack Pal with Companion Mobile Application for Cessation (with U of Wisc students)

XV. ENTREPRENEURIAL ACTIVITIES

N/A

XVI. MAJOR COMMITTEE ASSIGNMENTS

National/International

DATES	COMMITTEE	ROLE	INSITUTION
2023-2024	Program Committee	Member	SRNT Annual Meeting

Regional

DATES	COMMITTEE	ROLE	INSITUTION
2017-present	New Hampshire Committee for the Protection of Human Subjects	Co-Chair	State of NH

Institutional

DATES	COMMITTEE	ROLE	INSITUTION
2023-Present	Data Safety and Monitoring Board	Member	Department of Psychiatry, DH

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

DATES	SOCIETY	ROLE
2015-2016	Society for Behavioral Medicine	Member
2011-Present	Society for Research on Nicotine and Tobacco	Member
2004-present	Society for Social Work Research	Member
2004-present	SAS User Group International	Member

XVIII. EDITORIAL BOARDS

2010-2011	Journal of the Society for Social Work Research

XIX. JOURNAL REFEREE ACTIVITY

DATES	JOURNAL NAME	ANNUAL FREQUENCY OF REVIEW
2023-present	Journal of Addictive Behaviors	0-2
2019-present	Tobacco Induced Diseases	0-1
2015-present	Nicotine and Tobacco Research	1-3
2014-present	Psychiatric Rehabilitation Journal	0-2
2014-present	Psychiatric Services	0-1
2013-present	Journal of Medical Internet Research	1-5
2013-present	Social Work	0-1
2012-present	Journal of Behavioral Health Services and Research	0-2
2011-present	Journal of Dual Diagnosis	0-2
2010-present	Archives of Physical Medicine and Rehabilitation (statistical)	1-5
2010-present	Journal of the Society for Social Work Research	0-2
2008-present	Journal of Substance Abuse Treatment	0-4
2008-present	Community Mental Health Journal	0-2

XX. AWARDS AND HONORS:

DATE	AWARD
2006-2007	John Turner Dissertation Award
2006	Qualifying Paper with Distinction
1996	Cum Laude with Distinction in Psychology

XXI. INVITED PRESENTATIONS

International

DATE	TOPIC/TITLE	ORGANIZATION	LOCATION
N/A			

National

DATE	TOPIC/TITLE	ORGANIZATION	LOCATION
2016	Panelist: Using mHealth to Address Health Behaviors in High Risk Populations: Challenges and Opportunities to Advance a Research Agenda	Society for Behavioral Medicine	Washington, DC
2014	Symposium: Evaluating a Brief Computerized Intervention for Smoking Cessation among People with Severe Mental Illness	Society for Social Work Research	San Antonio, TX
2011	Symposium: A Website Designed to Motivate and Educate Adults with Severe Mental Illness Quit Smoking	Society for Social Work Research	Tampa, FL
2010	Paper: An Electronic Decision Support System Increases Motivation for Smoking Cessation Treatment among Persons with Serious Mental Illness	Case Western Evidence-Based Practice Conference	Columbus, OH
2010	Paper: An Electronic Decision Support System Increases Motivation for Smoking Cessation Treatment among Persons with Serious Mental Illness	Society for Research on Nicotine and Tobacco	Baltimore, MD
2009	Paper: Ten-Year Smoking Rates for Clients with Co-Occurring Severe Mental Illness and Substance Use Disorders	Integrated Services Conference	Bethesda, MD
2007	Paper: Validity and Reliability of the Treatment Motivation Questionnaire Among People with Severe Mental Illness	Society for Social Work Research	San Francisco, CA
2007	Paper: Psychiatric Advance Directives: What Do (and Should) Social Workers Know	Society for Social Work Research	San Francisco, CA
2006	Paper: Competence to Complete Psychiatric Advance Directives	American-Psychology Law Society Annual	St. Petersburg, FL

Conference

Regional/Local

DATE	TOPIC/TITLE	ORGANIZATION	LOCATION
2023	AIRS Program	Department of Psychiatry	Lebanon, NH
2023	Seizing an Opportunity to Minimize Re-initiation of Smoking: Providing Cessation Services on a Smoke Free Unit	Levy Incubator, Pitch Night	Lebanon, NH
2015	Mobile Applications for Smoking Cessation	Cancer Control Program	Lebanon, NH
2015	Use of Mobile Apps for Smoking Cessation among People with Schizophrenia	Psychiatry Grand Rounds	Lebanon, NH
2015	Evaluating Mobile Applications for Smoking Cessation in People with Schizophrenia	Geisinger Health System Psychiatry Grand Rounds	Danville, PA
2014	Introduction to Structural Equation Modelling	Dartmouth Psychiatric Research Center Seminar	Lebanon, NH
2013	Nicotine Dependence in Severe Mental Illness: Motivation, Treatment, and Technology	Dartmouth Psychiatric Research Center Seminar	Lebanon, NH
2013	Electronic Decision Support for SMI Smokers	Dartmouth Psychiatric Research Center Seminar	Lebanon, NH
2012	Is Feedback for Carbon Monoxide Necessary?	Dartmouth Psychiatric Research Center Seminar	Lebanon, NH
2010	Culturally-Tailoring a Smoking Cessation Computer Program	Dartmouth Psychiatric Research Center Seminar	Lebanon, NH
2009	An Electronic Decision Support System for Smokers with Serious Mental Illness	Dartmouth Psychiatric Research Center Seminar	Lebanon, NH
2009	Item Response Theory	Dartmouth Psychiatric Research Center Seminar	Lebanon, NH
2008	Designing a Motivational Smoking Cessation Intervention for People with Severe Mental Illness	Dartmouth Psychiatric Research Center Seminar	Lebanon, NH

XXII. BIBLIOGRAPHY

A. Peer-reviewed Publications

Original Articles:

1. Fortuna, KL, Rhee, T, PhD, Leininger, JL, **Ferron, J**, Elwyn, G, Raue, P, Heller, R, &Werlin, J. (in press). Estimates of Loneliness Among Racially and Ethnically Diverse Adults with Serious Mental Illness in New York City Boroughs. *Journal of the American Geriatrics Society.*
2. Fortuna, K.L., Lebby, S., Geiger, P., Johnson, D., Macdonald, S., Chefetz, I., **Ferron, J.C.,** St George, L., Rossom, R., Kalisa, J., Mestrovic, T., Nicholson, J., Pringle, W., Rotondi, A.J., Sippel, L.M., Sica, A., Solesio, M.E., Wright, M., Zisman-Ilani, Y., Gambee, D., Hill, J., Brundrett, A., Cather, C., Rhee, T.G., Daumit, G.L., Angel, J., Manion, I., Deegan, P.E., Butler, J.A., Pitts, N., Brodey, D.E., Williams, A.M., Parks, J., Reimann, B., Wahrenberger, J.T., Morgan, O., Bradford, D.W., Bright, N., Stafford, E., Bohm, A.R., Carney, T., Haragirimana, C., Gold, A., Storm, M., Walker, R., 2023. Lived Experience–Led Research Agenda to Address Early Death in People With a Diagnosis of a Serious Mental Illness. JAMA Network Open 6, e2315479.https://doi.org/10.1001/jamanetworkopen.2023.15479
3. Pratt SI, **Ferron JC**, Wolfe R, Xie H, Brunette M, Santos M, Williams G, Bartels S, Jue K, Capuchino K. Healthy choices, healthy changes: A randomized trial of incentives to promote healthy eating and exercise in people with schizophrenia and other serious mental illnesses. Schizophr Res. 2023 May;255:1-8. doi: 10.1016/j.schres.2023.03.007. Epub 2023 Mar 16. PMID: 36933290.
4. Fortuna K, Hill J, Chalker S, **Ferron J**. Certified Peer Support Specialists Training in Technology and Delivery of Digital Peer Support Services: Cross-sectional Study. JMIR Form Res. 2022 Dec 7;6(12):e40065. doi: 10.2196/40065. PMID: 36476983; PMCID: PMC9773021.
5. Pratt SI, **Ferron JC**, Brunette MF, Santos M, Sargent J, Xie H. E-Cigarette Provision to Promote Switching in Cigarette Smokers With Serious Mental Illness-A Randomized Trial. Nicotine Tob Res. 2022 Aug 6;24(9):1405-1412. doi: 10.1093/ntr/ntac082. PMID: 35363874; PMCID: PMC9356685.
6. Wong JA, Pratt SI, **Ferron JC**, Gowarty M, Brunette MF. Characteristics of and reasons for electronic cigarette use among adult smokers with schizophrenia/schizoaffective disorder. Ann Clin Psychiatry. 2022 Feb;34(1):89-96. doi: 10.12788/acp.0050. PMID: 35166668.
7. Fortuna KL, Myers AL, **Ferron J**, Kadakia A, Bianco C, Bruce ML, Bartels SJ. Assessing a digital peer support self-management intervention for adults with serious mental illness: feasibility, acceptability, and preliminary effectiveness. J Ment Health. 2022 Dec;31(6):833-841. doi: 10.1080/09638237.2021.2022619. Epub 2022 Jan 28. PMID: 35088619; PMCID: PMC9329481.
8. Myers AL, Collins-Pisano C, **Ferron JC**, Fortuna KL (2021). Feasibility and preliminary effectiveness of a peer-developed and virtually delivered community mental health training program (Emotional CPR): Pre-post study. *J Particip Med., 13(1)*:e25867. doi: 10.2196/25867
9. Fortuna KL, **Ferron JC**, Bianco CL, Santos MM, Williams A, Williams M, Mois G, Pratt SI (2020). Loneliness and its association with health behaviors in people with a lived experience of a serious mental illness. *Psychiatr Q., 18(7).* 10.1007/s11126-020-09777-8. doi: 10.1007/s11126-020-09777-8. Online ahead of print. PMID: 32458342
10. Brunette MF, **Ferron JC**, McGurk SR, Williams JM, Harrington A, Devitt T, Xie H (2020). Brief, web-based interventions to motivate smokers with schizophrenia: Randomized trial. *JMIR Ment Health,* Feb 8;7(2):e16524. doi: 10.2196/16524. PMID: 32039811
11. Bianco CL, Pratt SI, **Ferron JC** (2019). Deficits in sexual interest among adults with schizophrenia: Another look at an old problem. *Psychiatric Services, 11,* 1000-1005. doi: 10.1176/appi.ps.201800403. PMID: 31401908.
12. Brunette MF, **Ferron JC**, Geiger P, Guarino S, Pratt SI, Lord SE, Aschbrenner KA, Adachi-Mejia, A (2019). Pilot study of a mobile smoking cessation intervention for low-income smokers with serious mental illness. *Journal of Smoking Cessation,* 1-8. doi:10.1017/jsc.2019.7

13. Fortuna KL, **Ferron JC**, Pratt SI, Muralidharan A, Aschbrenner KA, Williams AM, Deegan PE, & Salzer M (2019). Unmet needs of people with serious mental illness: Perspectives from certified peer specialists. *Psychiatric Quarterly, 90(3)*, 579-586. doi.org/10.1007/s11126-019-09647-y. PMID: 31154551.
14. Bianco CL, Pratt SI, **Ferron JC**, & Brunette MF (2019). Electronic cigarette use during a randomized trial of interventions for smoking cessation among Medicaid beneficiaries with mental illness. *Journal of Dual Diagnosis, 15(3),* 1-8. doi: 10.1080/15504263.2019.1620400. PMID: 31169077.
15. Pratt SI, Brunette MF, Wolfe R, Scherer EA, Xie H, Bartels S, **Ferron JC**, Capuchino K (2019). Incentivizing healthy lifestyle behaviors to reduce cardiovascular risk in people with serious mental illness: An equipoise randomized controlled trial of the wellness incentives program. *Contemporary Clinical Trials; 81*, 1-10. doi: 10.1016/j.cct.2019.04.005. PMID: 30991110.
16. Brunette MF, **Ferron JC**, Aschbrenner KA, Pratt SI, Geiger P, Kosydar S. (2019). Attitudes about smoking cessation treatment, intention to quit, and cessation treatment utilization among young adult smokers with severe mental illnesses. *Addict Behav., Feb;89,* 248-255. doi: 10.1016/j.addbeh.2018.09.028. PMID: 30343187.
17. Brunette MF, **Ferron JC**, Geiger P, Villanti AC. (2018). Menthol cigarette use in young adult smokers with severe mental illnesses. *Nicotine Tob Res., 21(5),* 691-694. doi: 10.1093/ntr/nty064. PMID: 29660059.
18. Brunette MF, Pratt SI, Bartels SJ, Scherer EA, Sigmon SC, **Ferron JC**, Santos M, Williams GE, Kosydar S, Wolfe RS, Lotz D, Capuchino K. (2018). Randomized trial of interventions for smoking cessation among Medicaid beneficiaries with mental illness. *Psychiatr Serv., 69(3),* 274-280. doi: 10.1176/appi.ps.201700245. Epub 2017 Nov 15. PMID: 29137560.
19. **Ferron, JC**, Brunette, MF, Geiger, P, Marsch, L, Adachi-Mejia, A, & Bartels, SJ (2017). Mobile phone apps for smoking cessation: Quality and usability among smokers with psychosis. *JMIR: Human Factors, 4(1).* doi: 10.2196/humanfactors.5933. PMID: 28258047.
20. Brunette, MF, Aschbrenner, KA, **Ferron, JC**, Ustinich, L, Kelly, M, & Grinley, T (2017). Use of computers and internet among people with severe mental illnesses at peer support centers. *Psychiatric Rehabilitation Journal, 40(4),* 405-408. PMID: 28182473.
21. **Ferron, JC.**, Devitt, T, McHugo, GJ, Cook, TA, & Brunette, MF (2016). Abstinence and use of community-based cessation treatment after a decision-support intervention among smokers with severe mental illness. *Community Mental Health Journal, 52(4),* 446-56. PMID 26932324.
22. Brunette, MF, **Ferron, JC**, Gottlieb, J, Devitt, T, & Rotundi, A (2016). Development and usability testing of a web-based smoking cessation treatment for smokers with schizophrenia. *Internet Interventions, 4*, 113-119. doi: 10.1016/j.invent.2016.05.003. PMID: 30135797.
23. Carpenter-Song, E, **Ferron, JC**, & Kobylenski, S (2016). Families on the edge: Lived experiences of homelessness in Northern New England. *Journal of Social Distress and the Homeless, 5(1),* 41-52. doi: 10.1080/10530789.2016.1138603.
24. Brunette, MF, Dzebisashvili, N, Xie, H, Akerman, S, **Ferron, JC**, & Bartels, S (2015). Expanding cessation pharmacotherapy via videoconference educational outreach to prescribers. *Nicotine and Tobacco Research, 17(8)*, 960-7. PMID: 26180220.
25. Aschbrenner KA, **Ferron JC**, Mueser KT, Bartels SJ, & Brunette MF (2015). Social predictors of cessation treatment use among smokers with Serious Mental Illness. *Addictive Behaviors, 41(1),* 161-174. PMID: 25452062.
26. Brunette, MF, Gunn, W, Alvarez, H, Finn, PC, Geiger, P, **Ferron, JC**, & McHugo, GJ (2015). A pre-post pilot study of a brief, web-based intervention to engage disadvantaged smokers into cessation treatment. *Addiction Science & Clinical Practice, 10(1),* 3. PMID: 25638283.
27. Brunette, MF, **Ferron, JC**, Drake, RE, Devitt, T, Geiger, P, McHugo, GJ, Jonikas, JA, & Cook, JA (2013). Carbon monoxide feedback in a motivational decision support system for nicotine dependence among smokers with severe mental illnesses. *Journal of Substance Abuse Treatment, 45(4),* 319-24. doi: 10.1016/j.jsat.2013.04.005.

28. Glover, C, **Ferron, JC**, Whitley, R. (2013). Barriers to exercise among people with severe mental illnesses. *Psychiatric Rehabilitation, 36(1),* 45-7. doi: 10.1037/h0094747. PMID: 23477650.
29. **Ferron, JC**, Brunette, MF, McGurk, SR, Xie, H, Frounfelker, R, Cook, JA, Jonikas, JA, & McHugo, JG (2012). Do symptoms and cognitive problems affect the use and efficacy of a web-based decision support system for smokers with serious mental illness? *Journal of Dual Diagnosis, 8(4),* 315-325. doi: 10.1080/15504263.2012.723316.
30. Nawaz, S, Frounfelker, R, **Ferron, JC**, Carpenter-Song, EA, Davis, K & Brunette, MF (2012). Smoking and quitting beliefs, attitudes, and behaviors among smokers with severe mental illness from three race/ethnicity groups. *Journal of Dual Diagnosis, 8(3),* 180-7. doi: 16.10.1080/15504263.2012.697449.
31. Mistler, LA, Brunette, MF, **Ferron, JC**, & Zeidonis, DM (2012). Shared decision making and behavioral support interventions for people with severe mental illness and tobacco dependence. *Journal of Dual Diagnosis 8(2),* 99-103. doi:10.1080/15504263.2012.671093.
32. Brunette, MF, **Ferron, JC**, Devitt, T, Geiger, P, Martin, WM, Pratt, S, Santos, M, McHugo, GJ (2012). Do smoking cessation websites meet the needs of smokers with severe mental illness? *Health Education Research, 27(2),* 183-90. doi: 10.1093/her/cyr092. PMID: 21987478.
33. **Ferron, JC**, Brunette, MF, McHugo, GJ, Devitt, T, Martin, WM, & Drake, RE (2011). Developing a quit smoking website that is usable by people with severe mental illnesses. *Psychiatric Rehabilitation Journal, 35(2),* 111-116. doi: 10.2975/35.2.2011.111.116. PMID: 22020840.
34. Barre, L, **Ferron, JC**, Davis, K & Whitley, R (2011). Healthy eating in persons with serious mental illnesses: Understanding and barriers. *Psychiatric Rehabilitation, 34(3),* 304-310. doi: 10.2975/34.4.2011.304.310. PMID: 21459746.
35. **Ferron, J C**, Brunette, MF, He, X, Xie, H, McHugo, GJ & Drake, RE (2011). Longitudinal course of smoking and quit attempts in clients with co-occurring severe mental illness and substance use disorders. *Psychiatric Services, 62(4)* 353-359. doi: 10.1176/ps.62.4.pss6204_0353. PMID: 21459985.
36. Brunette, M, **Ferron, JC**, Davis, K, Devitt, T, Wilkniss, S, McHugo, GJ, & Drake, RE (2011). Testing an electronic decision support system to increase motivation for smoking cessation among people with severe mental illnesses. *Psychiatric Services, 62(4),* 360-366.
37. **Ferron, JC**., Elbogen, EB., Swanson, JW, Swartz, M S, & McHugo, GJ (2011). A conceptually based scale to measure consumers' treatment motivation. *Research on Social Work Practice, 21(1),* 98-105.
38. Davis, K, Brunette, MF, Vorhies, V, **Ferron, JC**, & Whitley, R (2010). A qualitative study of how individuals with severe mental illness assess smoking risks. *Mental Health and Substance Abuse: Dual Diagnosis, 3(2),* 110-123.
39. **Ferron, JC**, Alterman, AI, McHugo, GJ, Brunette, MF & Drake, RE (2009). A review of research on smoking cessation interventions for adults with schizophrenia spectrum disorders. *Mental Health and Substance Abuse: Dual Diagnosis, 2(1),* 64-79.
40. Scheyett, AM, Kim, M, Swanson, JW, Swartz, MS, Elbogen, EB, Van Dorn, RA, & **Ferron, JC** (2009). A review of research on smoking cessation interventions for adults with schizophrenia spectrum disorders. *Work in Mental Health, 7(4),* 283-306.
41. Macy, RJ, **Ferron, JC**, & Crosby, C (2009). Partner violence and survivors' chronic health problems: Informing social work practice. *Social Work, 54(1),* 29-42. doi: 10.1093/sw/54.1.29. PMID: 19205255.
42. Van Dorn, RA, Swanson, JW, Swartz, MS, Elbogen, Eric, & **Ferron JC** (2008). Reducing barriers to completing psychiatric advance directives. *Administration and Policy in Mental Health and Mental Health Services Research, 35(5)* 440-448. doi: 10.1007/s10488-008-0187-6. PMID: 18633699.
43. Scheyett, A, Kim, M, Swanson, J, Swartz, MS, Elbogen, E, Van Dorn, R, & **Ferron, JC** (2008). Social workers' knowledge of psychiatric advance directives: Implications for education, practice, and research. *Families in Society: The Journal of Contemporary Social Services, 89(2),* 228-36.
44. Elbogen, EB, **Ferron, JC**, Swartz, MS, Swanson, JW, & Wilder, C (2007). Characteristics of representative payeeship involving families of beneficiaries with psychiatric disabilities. *Psychiatric Services, 58 (11),* 1433-40. doi: 10.1176/ps.2007.58.11.1433. PMID: 17978253.

45. Elbogen, EB, Swanson, JW, Swartz, MS, Van Dorn, R, **Ferron, JC**, Wagner, HR, & Wilder, C (2007). Effectively implementing psychiatric advance directives to promote self-determination of treatment among people with mental illness. *Psychology, Public Policy, and Law, 13(4),* 273-288. doi: 10.1037/1076-8971.13.4.273. PMID: 24198456.
46. Elbogen, EB, Swanson, JW, Appelbaum, P, Swartz, MS, **Ferron, JC**, & Van Dorn, R (2007). Competence to complete psychiatric advance directives: Effects of facilitated decision making. *Law and Human Behavior, 31,* 275-289. doi: 10.1007/s10979-006-9064-6. PMID: 17294136.
47. Swanson, JW, Swartz, MS, Elbogen, EB, Van Dorn, RA, **Ferron, JC**, Wagner, HR, McCauley, BJ, & Kim, M (2006). Facilitated psychiatric advance directives: a randomized trial of an intervention to foster advance treatment planning among persons with severe mental illness. *American Journal of Psychiatry, 163(11),* 1943-51. doi: 10.1176/ajp.2006.163.11.1943. PMID: 17074946.
48. Kim M, Scheyett AM, Elbogen EB, Van Dorn RA, McDaniel LA, Swartz MS, Swanson JW & **Ferron, JC** (2007). Front line workers' attitudes towards psychiatric advance directives. *Community Mental Health Journal, 44,* 28-46. doi: 10.1007/s10597-007-9104-9. PMID: 17721821.
49. Van Dorn RA, Swartz MS, Elbogen EB, Swanson JW, Kim M, **Ferron JC**, McDaniel LA, & Scheyett AM (2006). Clinicians' attitudes regarding barriers to the implementation of Psychiatric Advance Directives. *Administration and Policy in Mental Health and Mental Health Services Research,* October. *33 (4),* 449-60. doi: 10.1007/s10488-005-0017-z. PMID: 16237505.
50. Swanson JW, Swartz MS, **Ferron JC**, Elbogen EB, & Van Dorn RA (2006). Psychiatric advance directives among public mental health consumers in five U.S. cities: Prevalence, demand, and correlates. *Journal of the American Academy of Psychiatry & Law. 34,(1),* 43-57. PMID: 16585234.
51. Swartz MS, Swanson JW, **Ferron JC**, Elbogen EB, Van Dorn RA, Kim M, & Scheyett A (2005). Psychiatrists' views and attitudes about psychiatric advance directives. *International Journal of Forensic Mental Health, 4(2),* 107-17.

Reviews:

1. **Ferron, JC**, Alterman, AI, McHugo, GJ, Brunette, MF & Drake, RE (2009). A review of research on smoking cessation interventions for adults with schizophrenia spectrum disorders. *Mental Health and Substance Abuse: Dual Diagnosis. 2(1)* 64-79.

Book Chapters:

N/A

B. Other Scholarly Work

N/A

C. Abstracts

#1. Ferron, JC & Malley, K (1996). Psychological Abuse, Positive Behaviors, and Interpersonal Attitudinal Interactions with the Length and Commitment of College Dating Relationships. Poster Presentation at the Greater Boston Psychology Undergraduate Research Conference.

#2. Ferron, JC & Brunette, MF (2009). Usability Pilot of Smoking Cessation Decision Support Tool for People with Serious Mental Illness. Poster Presentation at the NIDA Funded Conference.

#3. Ferron, JC & Brunette, MF (2013). Use of Community Based Treatment and Abstinence after a Motivational Intervention for Smoking Cessation among adults with Serious Mental Illness. Poster Presentation at the Annual Meeting for the Society for Research on Nicotine and Tobacco.

#4. Ferron, JC, Brunette, MF, McHugo, GJ, Adachi-Mejia, A, & Bartels, S (2016). Are top-rated quit smoking mobile Apps usable by people with Schizophrenia? Poster Presentation at the Annual Meeting for the Society for Research on Nicotine and Tobacco.

#5 Brunette, MF, Ferron, JC, Robinson, D, Colletti, D, Devitt, T, Xie, H, Greene, M, Geiger, P, Ziedonis, D, Gottlieb, J, & McHugo, GJ (2017). Computerized Strategies to Motivate Young Adult Smokers with Severe Mental Illness. Poster Presentation at the Annual Meeting for the Society for Research on Nicotine and Tobacco.

#6 Brunette, MF, Pratt, SI, Scherer, E, Ferron, JC, Kosydar, S, Capuchino, K, Lotz, D, Wolfe, R, Santos, M, Sigmon, S, & Bartels, S (2017). Cash to Quit for Impoverished Smokers? Treatment with Incentives for Smoking Cessation among Medicaid Recipients with Mental Illness. Poster Presentation at the Annual Meeting for the Society for Research on Nicotine and Tobacco.

#7 Ferron, JC, Aschbrenner, K, Brunette, MF, Pratt, SI, & Scherer, E (2017) Do Social Context And Social Support Help Financially Disadvantaged Smokers With Severe Mental Illness Quit? Poster Presentation at the Annual Meeting for the Society for Research on Nicotine and Tobacco.

#8 Brunette, MF & Ferron, JC (2018). Interventions Tailored For Young Adult Smokers With SMI. Poster Presentation at the Annual Meeting for the Society for Research on Nicotine and Tobacco.

#9 Ferron, JC, Kelly, S, Pratt, SI, Adachi-Mejia, A, & Brunette, MB (2018). Mobile App Pilot for Low Income Smokers Trying to Quit. Poster Presentation at the Koop Conference.

#10 Ferron, JC, Pratt, SI, Santos, M, Brunette, MB (2023). Time To Relapse In Adults With Severe Mental Illness Engaged In Smoking Cessation Treatment; Results From An Equipoise Randomized Design Trial. Poster Presentation for the Society for Research on Nicotine and Tobacco.

Cynthia Bianco, MS

EDUCATION

Master of Science Anticipated Fall 2026
Purdue University, Graduate School, West Lafayette, IN
Applied Statistics

Master of Science May 2018
Rivier University, Department of Psychology, Nashua, NH
Clinical Psychology
GPA: 4.0

Bachelor of Science May 2012
Syracuse University, College of Arts and Sciences, Syracuse, NY
Psychology and Neuroscience

TRAINING AND PROFESSIONAL EXPERIENCE

Clinical Research Coordinator, Concord, NH Sept 2019 – Present
Dartmouth-Hitchcock, Department of Psychiatry Research
Supervisors: Sarah Pratt, PhD & Gail Williams
Responsibilities:
Contribute to the management and conduct of several ongoing research projects focused on testing interventions to improve the health, functioning, and quality of life of people with serious mental illness. Tasks include, but are not limited to: data monitoring (running queries and providing feedback to staff at research sites); data analyses for papers, posters, presentations and meetings; literature searches and reviews; manuscript writing and editing; assisting with IRB submissions; maintaining study and regulatory documentation; data collection (including interviewing study participants using research questionnaires, standardized scales, neuropsychological measures, and semi-structured clinical tools); providing education and support to study participants; conducting phone screens for study recruitment; traveling to investigator meetings and study trainings; other administrative tasks as required.

Research Assistant, Concord, NH August 2015 – Sept 2019
Dartmouth-Hitchcock, Department of Psychiatry Research
Geisel School of Medicine at Dartmouth, Department of Psychiatry
Supervisors: Sarah Pratt, PhD & Gail Williams
Responsibilities:
Similar to those described above.

PEER-REVIEWED PUBLICATIONS

Pratt, S.I., Ferron, J.C., Santos, M., Brunette, M.F., **Bianco, C.,** Sargent, J., Xie, H. (2023). Cancer harm reduction in a randomized controlled study comparing e-cigarette provision to assessment only smokers with serious mental illness. *In press.*

Lim, C., Moak, G., Fortuna, K.L., **Bianco, C.L.,** Shakhau, A., Bruce, M.L., & Bartels, S. (2022). Attitudes and beliefs on aging among middle-aged and older adults with serious mental illness. *American Journal of Geriatric Psychiatry,* 30(3), 419-423. doi: 10.1016/j.jagp.2021.07.005

Fortuna, K.L., Myers, A.L., Ferron, J., Kadakia, A., **Bianco, C.,** Bruce, M.L., & Bartels, S.J. (2022). Assessing a digital peer support self-management intervention for adults with serious mental illness: feasibility, acceptability, and preliminary effectiveness. *Journal of Mental Health.* doi: 10.1080/09638237.2021.2022619

Fortuna, K.L., Williams, A., Mois, G., Jason, K., & **Bianco, C.L.** (2022). Social processes associated with health and health behaviors linked to early mortality in people with a diagnosis of a serious mental illness. *Perspectives on Psychological Science,* 17(1), 183-190. doi: 10.1177/1745691621990613.

Fortuna, K.L., Myers, A.L., **Bianco, C.,** Mois, G., Mbao, M., Morals, M.J., Brinen, A.P., Bartels, S.J., Hamilton, J. (2021). Advancing the science of recovery: The utility of the recovery assessment scale in the prediction of self-directed health and wellness outcomes in adults with a diagnosis of a serious mental illness. *Psychiatric Quarterly.* doi: 10.1007/s11126-021-09963-2.

Bianco, C.L., Myers, A.L., Smagula, S., & Fortuna, K.L. (2021). Can smartphone apps assist people with serious mental illness in taking medications as prescribed? *Sleep Medicine Clinics,* 16(1), 213-222. doi: 10.1016/j.jsmc.2020.10.010.

Fortuna, K.L., Naslund, J.A., LaCroix, J.M., **Bianco, C.L.,** Brooks, J.M., Zisman-Ilani, I., Muralidharan, A., & Deegan, P. (2020). Systematic review of peer-supported digitial mental health interventions for people with a lived experience of a serious mental illness. *JMIR: Mental Health, 7*(3), e16460. doi: 10.2196/16460

Almeida, M., Day, A., Smith, B., **Bianco, C.,** Fortuna, K. (2020). Actionable items to address challenges incorporating peer support specialists within an integrated mental health and substance use disorder system: Co-designed qualitative study. *Journal of Participatory Medicine*, 12(4), e17053. doi: 10.2196/17053

Fortuna, K.L., Vengas, M., **Bianco, C.L.**, Smith, B., Batsis, B., Walker, R., Brooks, J., & Umre, E. (2020). The relationship between hopelessness and risk factors for early mortality in people with a lived experience of a serious mental illness. *Social Work and Mental Health,* 18(4), 369-382. doi: 10.1080/15332985.2020.1751772

Fortuna, K.L., Ferron, J., **Bianco, C.L.,** Santos, M.M., Williams, A., Williams, M., Mois, G., Pratt, S.I. (2020). Loneliness and its association with health behaviors in people with a lived experience of a serious mental illness. *Psychiatric Quarterly,* 92(1), 101-106.

Bianco, C.L., Pratt, S.I., Ferron, J.C. & Brunette, M.F. (2019). Electronic cigarette use during a randomized trial of interventions for smoking cessation among Medicaid beneficiaries with mental illness. *Journal of Dual Diagnosis, 15*(3), 184-191. doi: 10.1080/15504263.2019.1620400

Bianco, C.L., Pratt, S.I., & Ferron, J.C. (2019). Sexual interest in adults with schizophrenia: Another look at an old problem. *Psychiatric Services, 70*(11), 1000-1005. doi: 10.1176/appi.ps.201800403

Bianco, C.L. (2018). Rates of electronic cigarette use among adults with a chronic mental illness. *Addictive Behaviors*, 89, 1-4. doi: 10.1016/j.addbeh.2018.08.033

BOOK CHAPTERS

Fortuna, K.L. & **Bianco, C.L.** (2021). Chapter 40 – Integrated medical and psychiatric self-management smartphone technologies for older adults with serious mental illness. In C.R., Martin, V. Preedy, and R. Rajendram (Eds.), *Assessments, Treatments and Modeling in Aging and Neurological Disease: The Neuroscience of Aging.*

INVITED PRESENTATIONS

Fortuna, K.L. & **Bianco, C.L.** (2019, September). Sociocultural determinants of health to address early mortality health disparities. *Guest lecture graduate class RCTH 5315 Social engagement and community participation in recreational therapy.* Temple University. Philadelphia, PA.

Bianco, C.L. & Pratt, S.I. (2018, November). Electronic cigarette use among people with serious mental illness – prevalence and impact on smoking cessation. *Behavioral Health Research Seminar*. Dartmouth Center for Technology and Behavioral Health, Lebanon, NH.

PRESENTATIONS

Brunette, M., Pratt, S., Bourassa, J., Ferron, J., Aschbrenner, K., Santos, M., Williams, G., **Bianco, C.**, & Gowarty, M. (2023, March). *Multicomponent intervention in community clinics for smoking cessation in serious mental illness (SMI).* Poster presented at the Society for Nicotine and Tobacco Research, San Antonio, TX.

Bianco, C.L., Pratt, S.I., Brunette, M.F. & Ferron, J.C. (2018, November). *Relationship between cognition and nicotine dependence in smokers with mental illness.* Poster presented at the Annual Society for Neuroscience Meeting, San Diego, CA.

Bianco, C.L. (2018, September). *Rates of electric cigarette use among adults with a chronic mental illness.* Poster presented at the Tenth Annual C. Everett Koop Conference, Lebanon, NH.

Bianco, C.L., Pratt, S.I., Mueser, K.T. & Wolfe, R.S. (2018, February). *Does cognitive functioning impact participation and outcomes of a fitness intervention for people with serious mental illness (SMI)?* Poster presented at the Annual Rehabilitation Psychology Conference, Dallas, TX.

Bianco, C.L., Ferron, J. & Pratt, S.I. (2017, October). *Sexual interest among people with schizophrenia.* Poster presented at the Annual Meeting of the New England Psychological Association, Newton, MA.

SERVICE

Ad hoc reviewer

Fatigue: Biomedicine, Health & Behavior
Psychology of Addictive Behaviors
Addictive Behaviors
BMJ Open

MEDIA

Interview with *Psychiatric News*
D'Arrigo, T. (2019, October 18). Impaired sexual interest one of the challenges of schizophrenia treatment. *Psychiatric News, (54)*20, 24-25. doi: 10.1176/appi.pn.2019.10b5. Retrieved from https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2019.10b5

HONORS

Psi Chi International Honor Society in Psychology	April 2017
Alpha Phi Pi National Honor Society	Sept 2013
Dean's List, College of Arts & Sciences, Syracuse University	Spring 2011
Dean's List, College of Arts & Sciences, Syracuse University	Fall 2010

MEMBERSHIPS

American Association for the Advancement of Science (AAAS)	July 2018
Society for Neuroscience – Graduate Student Member	March 2018
National Alliance on Mental Illness (NAMI) – New Hampshire	Dec 2017
New England Psychological Association	October 2017
American Psychological Association Graduate Student Affiliate	Dec 2016

TEACHING EXPERIENCE

Adjunct Professor **September 2018-Present**
Department of Psychology
Rivier University
Nashua, NH

On Campus Courses
General Psychology (PSY 101)
Lifespan Development (PSY 212)
Adult Psychology (PSY 306)
Introductory Statistics (MA 110)

Online Courses
General Psychology (PSY 101)
Adult Psychology (PSY 306)
Introduction to Neuroscience (PSY 407)
Research Methods (PSY 242)
Health Psychology (PSY 309)

Responsibilities:

- On Campus: Instruct class of 30-35 students for 75 minutes twice a week; create syllabus, assignments, quizzes, and exams; grade all assignments, quizzes, and exams; plan lectures and structure class time; utilize multiple technology platforms.
- Online: Design and create online course in Canvas; facilitate course material; ensure student participation; grade assignments and provide feedback.

CONSULTATION

NSG620AO – Biostatistics for Health Sciences
Rivier University
Nashua, NH
Summer, 2017

SPECIAL SKILLS

Computer programs:

SPSS – opening data from other source documents, merging data, aggregating data, recoding and transforming variables, selecting cases, splitting files, restructuring data, creating specific syntax for data checks, creating graphs, running and interpreting descriptives and frequencies, mean tables and cross tabs, t-tests, one-way ANOVA, general linear models, correlations, regression, and linear mixed models.
R – Basic R operations and programming.
Excel – creating graphs and charts, using equation functions, sorting data, formatting, and conditional formatting
REDCap – creating projects and surveys, reports, data exports
SAS – Graduate level training

Administration and Scoring:

Delis-Kaplan Executive Function System (DKEFS) – a neuropsychological battery measuring verbal and nonverbal executive functioning
Wechsler Adult Intelligence Scale (WAIS) – IQ test for adults
Brief Psychiatric Rating Scale (BPRS) – semi structured interview assessing psychiatric symptoms including depression, anxiety, and psychosis
Scale for the Assessment of Negative Symptoms (SANS) – semi structured interview assessing negative symptoms of schizophrenia

Jenna Bourassa

EDUCATION

Middlebury College — Middlebury, VT
Bachelor of Arts with a Major in Psychology and English and American Literatures — February 2022

- **Honors:** summa cum laude; GPA: 3.90/4.00; Recipient of Charles Baker Wright Prize
- **Course Work:** Research Methods in Psychology, Statistics for Psychology, Psychological Disorders, Child Development, Brain and Behavior
- **Language Skills:** Proficient in oral/written Spanish. Proficient in oral/ written German
- **Activities:** Community Friends, Equestrian Club, Free Heelers Telemark Skiing Club, Ceramics Club

EXPERIENCE

Dartmouth Health: Department of Psychiatry — Concord, NH
Research Coordinator — July 2022-Present

- IRB, study procedures, manuscript, data management,
- Analyzed data, performed statical tests and produced graphs using SPSS

Neurodevelopmental Institute of New Hampshire — Hooksett, NH
Community Outreach Worker — February 2022-Present

- Provided in-home mental health support and case management to families with a history of traumatic experiences
- Maintained records and facilitated communication between families and organizations such as DCYF

New Hampshire Hospital — Concord, NH
Research Assistant — Summer 2021

- Co-authored research papers on the topic of risk reduction strategies for not guilty by reason of insanity patients
- Analyzed data, performed statical tests and produced graphs using SPSS

Fordham University — Bronx, NY
Department of Psychology – Laboratory of Professor Elizabeth Raposa — Summer 2020
Research Assistant

- Organized data in SPSS for studies related to the impact of childhood stress on the transition to adulthood
- Transcribed interviews of first-generation college students for coding purposes

Middlebury College — Middlebury, VT
Department of Psychology – Laboratory of Professor Isabelle Elisha — Academic Year 2019-2020
Research Intern

- Gathered data for a literature review of bilingual education and cultural hierarchies in the French Caribbean
- Synthesized information for the design of a study

Wiñarina Foundation — Quito, Ecuador
Clinical Psychology Intern — Winter 2020

- Engaged children of incarcerated families in developmentally meaningful activities
- Shadowed and supported psychologists in individual and group therapy with Spanish speaking children

Riverbend Community Mental Health — Franklin, NH
Summer Intern — Summer 2019

- Shadowed and supported therapists and psychiatrists in providing mental health care to clients, ages five to seventeen, and their families
- Gained skills and experience through various trainings in evidence based mental health care

SKILLS AND INTERESTS

- **Computer skills**: REDCap, EPIC, AdvancedMD, SPSS, Microsoft Office Applications; Outlook, Word, Excel, PowerPoint
- **Trainings:** HIPPA, SPSS, CITI, IRB, Trust-Based Relational Intervention, First Aid, CPR, AED
- **Interests**: Play therapy, language acquisition, child development, alpine skiing, swimming, hiking, traveling

CURRICULUM VITAE

Date prepared: October 10, 2023

NAME: Pablo Martinez-Camblor, PhD

OFFICE ADDRESS:	Department of Anesthesiology Dartmouth-Hitchcock Medical Center 1 Medical Center Drive Lebanon, NH 03756 E-mail: pablo.martinez-camblor@hitchcock.org pablo.martinez.camblor@dartmouth.edu

I. EDUCATION

DATE	INSTITUTION	DEGREE
1997	University of Oviedo (Spain)	Licenciado in Mathematics (with mention in Statistics)
2000	University of Oviedo (Spain)	M.S. Mathematical Statistics
2005	University of Oviedo (Spain)	PhD, Mathematical Statistics

II. POSTDOCTORAL TRAINING

DATE	INSTITUTION	TITLE
2016-2018	The Dartmouth Institute for Health Policy and Clinical Practice, Geisel School of Medicine at Dartmouth College	Visiting Assistant Professor

III. ACADEMIC APPOINTMENTS

DATE	INSTITUTION	TITLE
2001-2005	University of Oviedo (Spain)	Researcher
2005-2006	University Autonomous of Tamaulipas (Mexico)	Full Professor
2006-2007	University of Balearic Island (Spain)	Associate Professor
2006-2007	International Center of Respiratory Medicine (CIMERA), Balearic Island (Spain)	Head of Statistics
2007-2009	Public Health Department of Guipuzkoa (Spain)	Researcher
2009-2016	University Hospital of Oviedo (Spain)	Biostatistician
2010-2016	University of Oviedo (Spain)	Associate Professor
2014-2017	Autonomous University of Chile (Chile)	Associate Researcher
2018-2019	The Dartmouth Institute for Health Policy and Clinical Practice, Geisel School of Medicine at Dartmouth College	Scientific Research
2019-2021	Department of Biomedical Data Science, Geisel School of Medicine at Dartmouth College	Senior Scientific Research
2019-2021	The Dartmouth Institute for Health Policy and Clinical Practice, Geisel School of Medicine at Dartmouth College	Senior Scientific Research
2021-Present	Department of Anesthesiology, Geisel School of Medicine at Dartmouth College	Assistant Professor

2021-Present	Biomedical Data Sciences Department, Geisel School of Medicine at Dartmouth College	Assistant Professor
2022-Present	Autonomous University of Chile (Chile)	Associate Researcher

IV. DARTMOUTH INSTITUTIONAL LEADERSHIPS ROLES

DATE	INSTITUTION	TITLE
N/A		

V. LICENSURE/CERTIFICATIONS

DATE	LICENSURE/CERTIFICATIONS
1999	Pedagogical Attitude Accreditation
2012	Positive evaluation for being Full Professor in the Spanish Public Academic System ANECA: www.aneca.es/eng - Home (aneca.es). Maximum degree without having occupied a Full Professor position.

VI. HOSPITAL APPOINTMENTS

DATE	INSTITUTION	TITLE
2021-Present	Dartmouth-Hitchcock Medical Center	Research Biostatistician

VII. OTHER PROFESSIONAL POSITIONS (NON-DARTMOUTH)

DATE	INSTITUTION	TITLE
1997-2001	University of Oviedo (Spain)	Statistical Consultant
2001-Present	Pediatric Intensive Care Unit (PICU), University Hospital of Asturias (Spain)	Statistical Consultant
2010-2020	COPD Cohorts Collaborative International Assessment (3CIA) initiative. (Mallorca-Spain)	Statistical Advisor
2013-2016	Current management of secondary hyperparathyroidism: a multi-center observational study (COSMOS) (Oviedo-Spain)	Statistical Advisor
2016-Present	Dermatology Department, University Hospital of Asturias (Spain)	Statistical Advisor

VIII. TEACHING ACTIVITIES

A. UNDERGRADUATE

DATE	INSTITUTION	NAME OF COURSE/ACTIVITY	ROLE	FREQUENCY	HOURS/YEAR
2005-2006	Autonomous University of Tamaulipas (Victoria-Mexico)	Statistics	Lecturer	2 per year	45

2007-2008	Universitat de les Illes Balears (Mallorca-Spain)	Multivariate Statistics	Lecturer	1 per year	90
2011-2014	University of Oviedo (Spain)	Adaptation course to Bolonia's Engineering Plan	Lecturer	2 per year	30
2010-2016	Oviedo University (Department of Statistics)	Teaching Statistics Undergradate Courses	Lecturer	1 per year	90

B. GRADUATE

DATE	INSTITUTION	NAME OF COURSE/ACTIVITY	ROLE	FREQUENCY	HOURS/YEAR
2008	Pompey i Fabra University (Barcelona-Spain)	Statistical Methods for Diagnostic Medicine	Lecturer	1 per year	3
2016	University of Oviedo (Spain)	Survival Analysis	Lecturer	1 per year	30
2018-Present	Geisel School of Medicine at Dartmouth (QBS)	Biostatistics Journal Club (Fall term) at QBS	Lecturer	1 per year	13.5

C. FORMATION FOR RESEARCHERS/PROFESSIONALS

DATE	INSTITUTION	NAME OF COURSE/ACTIVITY	ROLE	FREQUENCY	HOURS/YEAR
1999	University of Oviedo (Research Department)	Biostatistics	Instructor	1 pear year	20
2000	Estudios Estadisticos SA (Madrid-Spain)	Data Mining with SPSS	Instructor	4 per year	60
2001-2004	University of Oviedo (Postgraduate Department)	Statistical Methods for Research I	Lecturer	3 per year	45
2001-2004	University of Oviedo (Postgraduate Department)	Statistical Methods for Research II	Lecturer	3 per year	45
2017	Autonomous University of Chile (Santiago-Chile)	Biostatistics	Lecturer	1 per year	20
2020	Centro de Matemáticas (CMAT) de la universidade do Minho (Braga-Portugal)	Summarizing the difference between populations	Lecturer	1 per year	1

D. FORMATION FOR PHYCICIANS

DATE	INSTITUTION	NAMEOF COURSE/ACTIVITY	ROLE	FREQUENCY	HOURS/YEAR
2010	Asturias Health Service (Nephrology	Introduction to Bio-sanitary Research	Lecturer	1 per year	10

	and Urology Department)				
2010	Asturias Health Service (Mental Health Department)	Introduction to Bio-sanitary Research	Lecturer	1 per year	10
2011-2016	Asturias Health Service (Resident Formation)	Biostatistics	Lecturer	2per year	20
2016	Asturias Medical Society (Oviedo-Asturias)	Statistical Inference for Emergency Room Research	Lecturer	1 per year	3
2021	Vascular Department (DHMC) (NH-USA)	Summarizing the difference between populations	Lecturer	1 per year	1
2021	Anesthesiology Department (DHMC) (NH-USA)	Ethiological versus Prediction studies: common pitfalls	Lecturer	1 per year	1

E. COMMUNITY EDUCATION

DATE	INSTITUTION	NAME OF COURSE/ACTIVITY	ROLE	FREQUENCY	HOURS/YEAR
2004	University of Oviedo (Extension Department)	Introduction to Statistics and Data Mining Techniques in the Exploratory Data Analysis	Lecturer	1 per year	10

F. INVITED SHORT COURSE AND TUTORIALS

DATE	INSTITUTION	NAME OF COURSE/ACTIVITY	ROLE	FREQUENCY	HOURS/YEAR
2005	Business School, Autonomous University of Tamaulipas (Mexico)	Introduction to SPSS	Lecturer	1 per year	20
2005	Nursery School, Autonomous University of Tamaulipas (Mexico)	Introduction to SPSS	Lecturer	1 per year	10
2005	Agronomy School, Autonomous University of Tamaulipas (Mexico)	Statistics with SPSS	Lecturer	1 per year	20
2006	University of Vigo (Spain)	The Common Area Estimator: Theory and Practice of the k-sample problem	Lecturer	1 per year	1

2007	Fundacio Caubet-Cimera (Mallorca-Spain)	Parametric vs. Non-parametric comparisons	Lecturer	1 per year	1
2008	Public Health Department of Gipuzkoa (Spain)	Studies about the alcohol effects in the EPIC-Spain cohort	Lecturer	1 per year	1
2011	Institute of Dairy Products of Asturias (IPLA-CSIC) (Spain)	Introduction to Multivariate Statistics	Lecturer	1 per year	15
2012	University of Balearic Islands (Mallorca, Spain)	Introduction to Statistics	Lecturer	1 per year	12
2013	Valencian Society of Respiratory Medicine (Spain)	How to do a dataset	Lecturer	1 per year	1
2019	University of Oviedo (Spain)	Biostatistics Seminary	Organization & Lecturer	1 per year	4

IX. ADVISING AND MENTORING

DATE	NAME OF STUDENT	ROLE	PROGRAM	TITLE
2012	Rubén Orihuela Sancho	Supervisor	TFG (Engineering) University of Oviedo	Plan de trabajo con riesgo de amianto: Retirada del recubrimiento de tuberías del compresor de aire de locomotoras de ferrocarril. Tratamiento estadístico de los muestreos
2013	Juan Carlos Fernández Suárez	Supervisor	TFM (Mathematics) University of Oviedo	Métodos para la ayuda a la toma de decisiones
2013	Jessica Méndez Rodríguez	Supervisor	TFM (Mathematics) University of Oviedo	Curvas ROC para datos censurados
2014	Cristina Martínez Reglero	Supervisor	TFM (Mathematics) University of Oviedo	El estimador de Kaplan-Meier bajo riesgos competitivos
2014	Belén Díaz Ruíz	Supervisor	TFM (Mathematics) University of Oviedo	Introducción al meta-análisis
2010-2014	Clara García Cendón	Supervisor	PhD (Medicine) University of Oviedo	Peptido Natriuretico Atrial (PNA) y Copeptina: Marcadores pronósticos en el niño críticamente enfermo
2015	Alberto Rey Noriega	Supervisor	TFM (Mathematics) University of Oviedo	Árboles de decisión basados en curvas ROC aplicados a biomedicina
2011-2015	David Arango Sánchez	Supervisor	PhD (Medicine) University of Oviedo	Vitamina D: Nuevo marcador pronóstico en el niño críticamente enfermo

2014-2015	Sonia Pérez-Fernández	Supervisor	MSC (Statistics) University of Oviedo	Estimación de la curva ROC acumulativa/dinámica
2015-2021	Sonia Pérez-Fernández	Supervisor	PhD (Statistics) University of Oviedo	ROC curves for multivariate markers
2016-2021	Susana Diaz-Coto	Supervisor	PhD (Statistics) University of Oviedo	Two-stage receiver operating-characteristic curve estimator for cohort studies
2022-2024	Rocio Fernandez- Iglesias	Informal Supervisor	PhD (Epidemiology) University of Oviedo	Tracking of Cardiovascular Risk Factors in the INMA-Asturias Cohort
2021-Present	Haobin Chen	Informal Supervisor	PhD (QBS program) Geisel School of Medicine	Instrumental Variable and Causal Inference
2023-2023	Sonia Perez-Fernancez	Supervisor	Post Doc visiting stay at Dartmouth (Fall 2023)	Looking for the optimal marker transformation

X. RESEARCH FUNDING

DATE	PROJECT TITLE/NUMBER	ROLE	SPONSOR
2023-2025	Nuevas estrategias diagnósticas y terapéuticas en carcinomas escamosos de cabeza y cuello. (PI22/00167)	Collaborator	Instituto de Salud Calos III (Spain)
2021-2024	Statistical Methods with Application to Biomedical and Social Sciences. GRUPIN AYUD/2021/50897	Collaborator	Asturies Government (Spain)
2021-2024	Nuevos avances metodologicos y computacionales en estadistica no parametrica y semiparametrica. PID2020-118101GB-I00	Collaborator	Ministerio de Ciencia, Innovacion y Universidades (Spanish Government)
2020-2023	Progress in comparing, classifying and analyzing data from socio-economic and bio-sanitary environments	Collaborator	Ministerio de Ciencia, Innovacion y Universidades (Spanish Government)
2020-2023	Interacciones del tumor y su microambiente como fuente de nuevos biomarcadores y dianas terapeuticas para el diagnóstico y manejo clínico de pacientes con cancer de cabeza y cuello. (PI19/00560)	Collaborator	Instituto de Salud Calos III (Spain)

2015-2020	Accelerating the Use of Evidence-based Innovations in Healthcare Systems	Researcher-Statistician	Agency for Healthcare Research and Quality (USA)
2018-2021	Measuring Coproduction Using coopeRATE: A Validation Study	Researcher-Statistician	Cystic Fibrosis Foundation (USA)
2016-2021	Scaling-Up Science-based Mental Health Interventions in Latin America	Researcher-Statistician	NIH/NIMH (USA)
2019-2021	Statistical Methods with Application to Biomedical and Social Sciences. (FC-15-GRUPIN14-101)	Collaborator	Asturies Government (Spain)
2018-2021	Nuevos Avances Metodológicos y Computacionales en Estadística No Paramétrica y Semi-paramétrica. MTM2017-89422P.	Collaborator	Ministerio de Educación (Spain)
2016	Advancing Patient Centered Outcomes Research in Survival Data with Unmeasured Confounding to Improve Patient Risk Communication. (ME-1503-28261)	Researcher-Statistician	PCORI (USA)
2015	Validación modelo de impacto presupuestario	Principal Investigator (PI)	Bayer Diabetes Care (Spain)
2015-2018	Avances Metodológicos y Computacionales en Estadística No Paramétrica y Semiparamétrica. MTM2014-55966.	Collaborator	Ministerio de Educación (Spain)
2014-2017	Métodos estadísticos con aplicaciones a las ciencias biomédicas y sociales	Researcher	Consejería de Educación del Principado de Asturias (Spain)
2014	Análisis estadístico de datos para el curso como escribir y publicar un artículo científico	Co-Principal Investigator (co-PI)	Laboratorios Famacéuticos ROVI SA (Spain)
2012	Análisis agrupado (pooled analysis) de cohortes españolas para determinar factores pronósticos y resultados clínicos de EPOC	Co-Principal Investigator (co-PI)	Spanish Society of Pulmonar Medicine (SEPAR)

2011-2014	Flexible inference statistics: methodological advances and new biomedicine applications, engineering and health. MTM2011-23204	Researcher	Spanish Ministry of Science and Innovation (FEDER support included) (Spain)
2011-2014	Historia natural del SAHS y su solapamiento con EPOC: Estudio multicéntrico en Mallorca, Requena y Zaragoza	Researcher	Instituto de Salud Carlos III. (Spain)
2009	Estudio estadístico para valorar la viabilidad de una ecuación de regresión que estime el perímetro del pecho partiendo de los diámetros antero-posterior y transverso del pecho y su porcentaje de error máximo	Principal Investigator (PI)	Soluciones Antropométricas SL. (Spain)
2007	ISOLDE: International Study on Obstructive Lung Disease	Co-Principal Investigator (co-PI)	Fundación Caubet-Cimera Illes Balears (Spain)
2007	CORSAIB: Estudio Cor Sà a les Illes Balears	Researcher-Statistician	Instituto de Salud Carlos III and Fundación Barceló (Spain)
2007	Framingham: Historia Natural de la Función Pulmonar	Researcher-Statistician	Fundación Caubet-Cimera Illes Balears. (Spain)
2006	BODEX: Prediction of risk of COPD exacerbations by the BODE index	Co- Principal Investigator (PI)	Fundación Caubet-Cimera Illes Balears. (Spain)
2006	Análisis Multivariado en la Evaluación de la Influencia del Ambiente en Distintos Genotipos de Maíz	Principal Investigator (PI)	COTACYT (México)
2006-2009	Metodología de contrastes de hipótesis basada en variables aleatorias difusas y técnicas bootstrap. MEC-05-MTM2005-00045.	Researcher	Ministerio de Educación y Ciencia (Spain)
2005-2007	Factores que determinan la satisfacción en la UAMAC. Universidad Autónoma de Tamaulipas. 103.5/05/1951	Principal Investigator (PI)	PROMEP (México)
2005	Análisis e implementación de algoritmos para la automatización del modelado de hormas a partir de la captura digitalizada en 3D de las características antropometricas del pie de una población aleatoria de individuos	Principal Investigator (PI)	Soluciones Antropométricas SL. (Spain)

2001	Realización de informe sobre "Nuevo procedimiento de encuesta al profesorado"	Researcher-Statistician	Oviedo University (Spain)
2001	"The youngs and the European challenge"	Statistician	Fundacion "La Caixa" (Spain)

XI. ENTREPRENEURIAL ACTIVITIES:

DATE	PATENTS	ROLE	REGISTRY NUMBER
2011	Indice translacional predictivo de ingreso hospitalario (ITI) al ano en ancianos mediante un model institucionalizado	Member	05/2011/332 (Spain)
2011	Indice translacional predictivo de mortalidad (ITM) al ano en ancianos mediante un model institucionalizado	Member	05/2011/333 (Spain)

XII. MAJOR COMMITTEE ASSIGNMENTS:

DATE	COMMITTEE	ROLE	INSTITUTION
2003	6th "Toulon-Verona" Quality Conference Organization Committee	Member	University of Oviedo (Spain)
2007	Evaluation Committee of PhD dissertation	Member	University of Sevilla (Spain)
2008-2015	Multicomponent indices to predict survival in COPD: The COllaborative COhorts to assess multicomponent indices of COPD in Spain-COCOMICS study	Member of the Steering Committee	Multi-center
2009	Scientific Committee of "Research in Community Social work"	Member	Spanish Community of Social Workers Association
2010-2014	Statistical Council	Member	CAIBER (Spanish Consortium for Clinical Trials)
2011-2014	Committee for the Final Dissertation evaluation for Software Engineering School	Member	University of Oviedo
2014	Evaluation Committee of PhD dissertation	Member	University of Vigo (Spain)
2016	Evaluation Committee of PhD dissertation	Member	University of Santiago de Compostela (Spain)

2021	Evaluation Committee of PhD dissertation	Member	University of Santiago de Compostela (Spain)

XIII. MEMBERSHIPS, OFFICE AND COMMITTEE ASSIGMENTS IN PROFESSIONAL SOCIETIES:

DATE	SOCIETY	ROLE
2012-Present	International Society for Clinical Biostatistics	Member
2021-2022	American Statistical Society	Member
2022-Present	International Biometics Society	Member

XIV. EDITORIAL BOARDS

DATE	SOCIETY	ROLE
2013-2016	Advances in Statistics (www.hindawi.com/journals/as)	Associate Editor
2017-2019	The Lancet Group	Statistical Advisor
2017-	Anales de Pediatria (www.analesdepediatria.org/)	Associate Editor
2018-Present	Computational Statistics (www.springer.com/statistics/journal/180)	Associate Editor
2018-Present	European Respiratory Journal (http://erj.ersjournals.com/journal/editorial-board)	Statistical Editor
2018-2020	Journal of Hospital Management and Health Policy (http://jhmhp.amegroups.com/)	Associate Editor
2020-2023	International Journal of Environmental Research and Public Health (https://www.mdpi.com/journal/ijerph)	Associate Editor

XV. JOURNAL REFEREE ACTIVITY (Most relevant):

DATE	JOURNAL NAMES
2002-Present	Journal of Applied Statistics
2004-Present	Colombian Journal of Statistics
2006-Present	Computational Statistics
2008-Present	European Respiratory Journal
2009-Present	Computational Statistics and Data Analysis
2010-Present	Communication in Statistics – Theory and Methods
2011-Present	International Journal of Sports Medicine
2012-Present	Journal of Non Parametric Statistics
2013-Present	Physical Sciences Research International
2013-Present	BMC Surgery
2014-Present	The Australian and New Zealand Journal of Statistics
2014-Present	BMC Medical Research Methodology
2014-Present	Journal of Statistical Planning and Inference
2014-Present	Plos ONE
2014-Present	Austin Mathematics
2014-Present	Journal of Royal Statistical Society
2015-Present	Mathematical Reviews/MathSciNet Reviewer
2015-Present	Biometrics

2015-Present	Statistics and Probability Letters
2015-Present	Nephrology Dialysis Transplantation
2015-Present	Journal of Clinical Medicine
2016-Present	Communication in Statistics – Simulation and Computation
2016-Present	The Lancet
2016-Present	The Lancet Global Health
2016-Present	The Lancet Oncology
2016-Present	Hacettepe Journal of Mathematics and Statistics
2016-Present	Journal of Statistical Computation and Simulation
2016-Present	Scandinavian Journal of Statistics
2017-Present	Annals of Applied Statistics
2016-Present	Statistica Neerlendica
2016-Present	Biometrical Journal
2016-Present	International Journal of Biostatistics
2016-Present	Statistics in Medicine
2018-Present	Royal Society Open Science
2018-Present	AsTA – Advance in Statistical Analisys
2018-Present	Annals of Epidemiology
2018-Present	Chronic Disease and Translational Medicine
2019-Present	Journal of Affective Disorders
2019-Present	European Journal of Pharmacology
2019-Present	International Journal of Epidemiology
2019-Present	Diagnostic
2019-Present	Statistical Methods in Medical Research
2020-Present	Annals of the Institute of Statistical Mathematics
2020-Present	The Lancet Regional Health - Western Pacific
2020-Present	Healthcare
2021-Present	Regional Anesthesia and Pain Medicine
2021-Present	Frontiers in Medicine
2021-Present	The Lancet Regional Health - America
2021-Present	JAMA Oncology
2021-Present	Exposure and Health
2022-Present	The Lancet Regional Health - Europe
2022-Present	Journal of the American Statistical Association
2022-Present	The Lancet Public Health
2022-Present	Advances in Data Analysis and Classification
2022-Present	Scientific Report
2022-Present	Healthcare Analytics
2022-Present	TEST
2023-Present	Pharmaceutical Statistics
2023-Present	Heliyon
2023-Present	Artificial Intellegence Reviews
2023-Present	Toxics

XVI. AWARDS AND HONORS

DATE	DESCRIPTION
1999-2001	Research Grant, Oviedo University
2012	Mobility Grant, Oviedo University
2014	Award to the best international paper in neurology, Spanish Society of Neurology
2014	Award Baxter-Gambro to the best paper in nephrology, Spanish Society of Nephrology
2015	Third Prize at the XVII National Sport Medicine Research Award (Spain)
2016	Award to the best international paper of basic research, Spanish Society of Rhinology-CCC
2017	First Prize at the XIV Research conference of Sanitary Region VIII (Asturies, Spain)
2021	Premio de la Academia Nacional de Medicina a la Investigación Científica por el Proyecto DIADA (Colombia)

XVII. INVITED PRESENTATIONS [Selected]

DATE	TOPIC/TITLE	ORGANIZATION	LOCALIZATION
2006	Análisis Multivariado en la Evaluación de la Influencia del Ambiente en Distintos Genotipos de Maíz	Mexico-Cuba statistician meeting	La Habana, Cuba
2006	Research in Statistical Mathematics	Autonomous University of Yukatan	Merida, Mexico
2006	Study and Comparison of diagnostic markers	Fundacio Caubet-Cimera Illes Balears	Bunyola (Malloca), Spain
2007	k-Sample test based on the common area estimator	University of Santiago de Compostela (Spain)	Santiago de Compostela, Spain
2008	Studying the bandwidth effects in k-sample smooth tests	University of Vigo (Spain)	Vigo, Spain
2013	General bootstrap algorithm for hypothesis testing	Royal Spanish Mathematical Society	Santiago de Compostela, Spain
2013	On correlated z-values distribution in hypothesis testing	University of Vigo (Spain)	Vigo, Spain
2013	Estudios Observacionales: El azar y otros Dioses	Research Committee, Oviedo Hospital (Asturias-Spain)	Oviedo, Spain
2014	ROC curves: past, present, future	University of Vigo (Spain)	Vigo, Spain
2015	Generalizations of the receiver operating characteristic (ROC) curve	The Victorian Centre for Biostatistics	Melbourne, Australia
2015	Metodos matematicos aplicados a la investigacion biomedica	University of Vigo (Spain)	Vigo, Spain
2016	Time-dependent ROC curves	The Dartmouth Institute for Health Policy and clinical practice	New Hampshire, USA
2016	C/D ROC curve estimation	University of Vigo (Spain)	Vigo, Spain
2018	Adjusting for bias introduced by instrumental variable in the Cox proportional hazards model	International Conference on Health Policy Statistics	Charleston, South Carolina, USA
2018	Instrumental variable in the Cox proportional hazards model	Biomedical Data Science Department, Geisel School of Medicine at Dartmouth	New Hampshire, USA

2018	Studying causal effects in Cox models from observational studies	University of Vigo (Spain)	Vigo, Spain
2018	ROC curve estimation for meta-analysis	Biostatistics Department, Brown University	Providence, RI, USA
2019	Improving the biomarker diagnostic capacity via functional transformations	International Conference of the ERCIM working group, Computational and Methodology Statistics	London, UK
2020	A robust hazard ratio for general modeling of survival-times	University of Vigo (Spain)	Vigo, Spain
2021	A common language effect size derived from marginalizing the Cox model: Estimating causal effects from observational studies	Joint Statistical Meeting – Conference of American Statistical Society	Seattle, WA, USA
2022	Kernel density estimations in the Machine Learning world	Biomedical Data Science Department at Geisel School of Medicine	Hanover, NH, USA
2023	Smooth estimator for the length of the receiver operating characteristic curve	University of Vigo (Spain)	Vigo, Spain

XVIII. BIBLIOGRAPHY

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A. Peer-reviewed publications in print or other media

Original Articles

1. Marcos C, Llorca MA, **Martínez-Camblor P**, Verdeja LF, (2000) Caracterización mineralógica y textural de refractarios monolíticos moldeables. Cadernos do Laboratorio Xeolóxico de Laxe, 25. 185-187. ISSN: 00213-4497. http://hdl.handle.net/2183/6461
2. Marcos C, Llorca MA, **Martínez-Camblor P**, Verdeja LF, (2002) Caracterización de refractarios monolíticos, Boletín de la Sociedad Española de Cerámica y Vidrio, 41(2), 241-251. ISSN: 0366-3175.
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7. **Martínez-Camblor P**, (2007) Comparación de pruebas diagnósticas desde la curva ROC. Revista Colombiana de Estadística, 30(2), 163-176. ISSN: 0120-1751.

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13. Salinas A, Morales-Lozano JA, **Martínez-Camblor P**, (2008) Satisfacción del estudiante y calidad universitaria: un análisis exploratorio en la unidad académica de la multidisciplinaria de agronomía y ciencias de la Universidad Autónoma de Tamaulipas, México, Revista de Educación Universitaria, 31, 39-55. ISSN 1131-5245.
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2. Almagro P, **Martinez-Camblor P**, (2017) Letter to the editor regarding: "Development of the ProPal-COPD tool to identify patients with COPD for proactive palliative care", International Journal of COPD, 13(12), 2731-2734. doi: 10.2147/COPD.S148601.
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1. Vázquez-Nava F, Vázquez-Nava A, Sánchez Nuncio HR, Lin Ochoa D, Barrientos Gomez M, Quezada Castillo A, Vázquez Rodríguez EM, Pérez Rodríguez P, **Martínez-Camblor P**, Almeida VM, (2006) Asthma symptoms under two years old after suffering meconium aspiration syndrome. Journal of Allergy and Clinical Imnunology, 117(2). DOI: https://doi.org/10.1016/j.jaci.2005.12.617
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11. Cernuda-Morollón E, Ramón C, **Martínez-Camblor P**, Serrano-Pertierra E, Larrosa D, Pascual J, (2015) OnabotulinumtoxinA wirkt über das vasoaktive Peptid CGRP, Journal Club Schmerzmedizin
12. García-Cabo C, **Martínez Camblor P**, Pérez Álvarez A, Martínez Ramos J, Benavente Fernández L, Pascual J, Calleja Puerta S, (2015) Hyperacute management new prehospital stroke scale: The NIHSS-AS: ESOC-0585, International Journal of Stroke, 10, 115-116.
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14. Dusso A, Fernández-Martín JL, **Martínez-Camblor P**, Dionisi MP, Floege J, Ketteler M, London G, Locatelli F, Gorriz JL, Rutkowski J, Bos W-J, Tielemans C, Martin P-Y, Wüthrich RP, Pavlovic D, Benedik M, Rodríguez-Puyol D, Carrero JJ, Zoccali C, Cannata-Andía JB (2016) Interdialytic period for blood collection influences serum phosphorus and the risk of mortality in the COSMOS study, Nephrology Dialysis Transplantation 31.
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18. **Martinez-Camblor P** (2022) Kernel density estimations in the Machine Learning world, XXIII International Symposium of Mathematical Methods Applied to Sciences.

B. Non-peer-reviewed publications in print or other media

Technical Reports:

1. **Martínez-Camblor P**, de Uña-Álvarez J, (2009) Studying the bandwidth in k-sample smooth tests, Discussion Papers in Statistics and Operation Research, Universidade de Vigo, Dpto. Estadística e Investigación Operativa. Report 09/02.
2. **Martínez-Camblor P**, de Uña Álvarez J, (2008) Non-parametric k-sample tests: density functions vs. distribution functions. Discussion Papers in Statistics and Operation Research, Universidade de Vigo, Dpto. de Estadística e Investigación Operativa. Report 08/09. ISSN: 1888-5756
3. **Martínez-Camblor P**, de Uña Álvarez J, Corral N, (2007) k-Sample test based on the common area of kernel density estimators, Reports in Statistics and Operations Research, Universidad de Santiago de Compostela, Dpto. de Estadística e Investigación Operativa. Report 07-04.

4. O'Malley J, **Martinez-Camblor P**, MacKenzie T, Goodney P, Elwyn G, Staiger D, Hill D, Columbo J, Scalia P. (2020). Developing methods to account for bias from unmeasured sources when analyzing time until a health event. Patient-Centered Outcomes Research Institute (PCORI). DOI: 10.25302/07.2020.ME.150328261

C. Most significant publications

1. **Martínez-Camblor P**, de Uña J, Corral N, (2008) k-Sample test based on the common area of kernel density estimators, Journal of Statistical Planning and Inference, 138(12), 4006-4020.
2. Kohansal R, **Martinez-Camblor P**, Agusti A, Buist S, Mannino DM, Soriano JB (2009). The natural history of chronic airflow obstruction revisited: an analysis of the Framingham Offspring cohort, American Journal of Respiratory and Critical Care Medicine, 180, 3-10.
3. **Martínez-Camblor P**, Corral N, Rey C, Pascual J, Cernuda-Morollón E, (2017) Receiver operating characteristic curve generalization for non-monotone relationships, Statistical Methods in Medical Research, 26-1, 113–123.
4. **Martinez-Camblor P**, MacKenzie TA, Staiger DO, Goodney PP, O'Malley AJ, (2019) Adjusting for bias introduced by instrumental variable in the Cox proportional hazards model, Biostatistics, 20(1), 80-96.
5. **Martinez-Camblor P**, Pardo-Fernandez JC (2019). Parametric estimates for the receiver-operating characteristic curve generalization for non-monotone relationships, Statistical Methods in Medical Research, 28(7):2032-2048.

PERSONAL STATEMENT

Having a strong theoretical origin (I studied Mathematics in the College and my PhD was on mathematical-statistics), my professional career begun as a statistical consultant in different research projects in my Alma Mater institution, University of Oviedo (North-West coast of Spain). Therefore, the primary motivation of my methodological research was in the intersection of theory and practical applications.

I have developed statistical tests for comparing different populations from different approaches. That is, for solving the so-called k-sample problem. I proposed the so-called *common area* (AC) statistics, which is a valuable index for depicting the level of similarity between k-populations and has been applied to a number of different fields including economy, astronomy or genomic. Now, the index has gained some popularity in the binary classification problem context, and it is called overlap index. I have highlighted the seminal paper in which the AC statistics was developed since it is the landmark for one of my main research interests, which, with the years, has recovered popularity and interest. Related problems, such as the comparison of survival curves or developing techniques for approximating the distribution (under the null) of a given statistics, have also been the focus of my research. The paper was finally published in an emblematic journal.

The natural evolution was to deal with diagnostic, and then with prognosis tasks in the so-called binary classification problem. I have study and developed different techniques for evaluating the diagnostic/prognostic capacity of a biomarker of interest and some of the proposed procedures, e.g. the gROC curve, are currently hot topics in this area. I have also highlighted the main two papers dealing with this approach, which have been published in the prestigious journal *Statistical Methods in Medical Research*. However, my research in this area has been very productive and I have participated in a number of academic publications. Besides, I frequently review papers dealing with the binary classification problem, and my work is a source of discussion and a landmark for the experts who frequently references some of my papers in their publications and in international meetings. I have also actively participated in several PhD dissertations in this area of research.

In the last years, I have included the evaluation of treatment outcomes from observational studies among my research interests. I have participated in the proposal of the so-called two-stage residual inclusion with frailty term (2SRI-F) procedure, which allows estimate the conditional causal hazard ratio from observational studies. The related paper, published in the prestigious journal *Biostatistics*, marks another landmark in my professional carreer. We continue working and mentoring students interested in this relevant topic.

Both my methodological background and my statistical support has led to advances in different medical field including Dermatology, Oncology, Vascular Surgery, Cardiology, Genetic, Hematology, Immunology, Nephrology, Anesthesiology, etc. My work focused for a while in Respiratory Medicine. In this area, I have actively participated in a number of relevant projects. I have highlighted the work "The natural history of chronic airflow obstruction revisited: an analysis of the Framingham Offspring cohort" in which we evaluated for the very first time the natural history of COPD using real data. I played the role of an active biostatistician, participating from the very beginning in the design of the study and helping to correctly formulate the research questions. Then, I decided the methodology to be used and actively participated in the results interpretation.

Conventionally, as most of the statisticians in Academy, I have received invitations for teaching a number of courses at different levels and have participated, as Faculty, in teaching courses of statistics for physicians, professionals and at both undergraduate and graduate levels. Besides, as member of a team in a standard biomedical research group, I always try to be didactic with the non-statistician colleage, while I try to learn non-statistics related topics. My philodophy in this regards is participating at the level I am required to. Sometimes helping with the design and with the problem formulation, others acting as consultant, writing part of the manuscript, or even building the data set. Recently, I have acted as analist constructing a dataset from Medicare. The idea is that statistics will not be a barrier in the projects, or in the carreer development of the involved physician, and that in these projects, the statistical methodology and its interpretation will be the adequate, and that everyone will be confortable with both.

I have taught courses and seminaries about diagnostic and prognostic problems and on survival analysis. Besides, I have taugh different courses dealing with basic methodological aspects of biomedical research. I have mentored students at different levels (undergraduate, master degree, and PhD), and have participated in different methodological research projects, mainly related with the binary classification problem, from which I have a number of relevant contributions.

In recognition of many of the above contributions, I have received invitations from a number of international conferences, to review papers and to be part of Editorial Boards of prestigious journals. As biostatistician, I have participated in projects awared with different prized. Besides, the methodological research group in which I have been member for most part of my career (SiDOR: statisticial inference, decision and operational research, Home (uvigo.es)) is being honored as competitive group of reference by the Government of Galicia (Spain) since 2008.

CURRICULUM VITAE

GILLIAN L. SOWDEN, M.D.

DARTMOUTH HITCHCOCK MEDICAL CENTER,
PSYCHIATRY DEPARTMENT

DATE PREPARED: 7/27/23

I. Education

Dates	Institution	Degree	Related Information
09/2006-05/2011	Harvard Medical School	M.D.	Doctor of Medicine *Magna Cum Laude*
09/2002-05/2006	Williams College	B.A.	*Summa Cum Laude*, Biology, Biochemistry minor

II. Postdoctoral Training

Dates	Institution	Specialty	Related Information
06/2011-06/2015	Cambridge Health Alliance, Harvard Medical School	Psychiatry	

III. Academic Appointments

a. Current Dartmouth/Geisel Affiliations

Dates	Institution	Title	Related Information
07/2015 - present	Geisel School of Medicine at Dartmouth	Assistant Professor of Psychiatry	

b. Other Current Academic Affiliations

c. Past Academic Affiliations

Dates	Institution	Title	Related Information
2012-2016	Massachusetts General Hospital	Researcher	PI: Jeffrey Huffman, M.D.
06/2011-06/2015	Harvard Medical School	Clinical Fellow in Psychiatry	

IV. Institutional Leadership Roles

Dates	Institution	Title	Related Information
11/2020-present	Dartmouth Hitchcock Medical Center	Program Director	Adult Psychiatry Residency Program
07/2018-10/2020	Dartmouth Hitchcock Medical Center	Assistant Program Director	Adult Psychiatry Residency Program
07/2018 – 07/2021	Geisel School of Medicine at Dartmouth	Psychiatry Course director	2nd year Medical Student Psychiatry Course
07/2014-06/2015	Cambridge Health Alliance	Chief Resident in Medical Education	

V. Licensure and Certification

Date	Title of Licensure/Certification	State	Number	Related Information
04/2020 - present	Full Medical License	VT	042-0014769	Active
07/2015 - present	Full Medical License	NH	17087	Active
11/2013-12/2016	Full Medical License	MA	257596	Lapsed
9/24/2015	American Board of Psychiatry and Neurology			Board Certified
2015-present	Certified Buprenorphine Prescriber		XS5012909	

VI. Hospital or Health System Appointments

Dates	Institution/Organization	Position/Title	Related Information
07/2015-present	Dartmouth Hitchcock Medical Center	Staff Psychiatrist	Assistant Program director, adult psychiatry residency program
06/2011-06/2015	Cambridge Health Alliance	Resident	Adult Psychiatry

VII. Other Professional Positions

Dates	Institution	Title	Related Information
7/2023- present	New Hampshire Psychiatric Society	Vice President	

VIII. Professional Development Activities

Dates	Institution	Name of Program	Duration	Role	Certificate	Related Information
9/18/2021	LA Human Rights Institute	Forensic Evaluation Training	8 hours	Participant	completed	Training for completing Forensic evaluations for asylum seekers
August – December 2021	AADPRT	Becoming a more equitable teacher course	10 hours	participant	Completed	Race, Equity and Inclusion training course
9/2021	Association for Academic Psychiatry	Master Educator Program	8 hours	Participant	Course completed	Completed 3rd year of a 3 year course
March – May 2021	New Hampshire listens	Race and Equity Learning exchange	8 hours	participant	completed	Race, Equity and Inclusion training course
March-May 2021	Dartmouth-Hitchcock	Leading at DHH	40 hours	participant	Course completed	Leadership course
9/2020	Association for Academic Psychiatry	Master Educator Program	8 hours	Participant	Pending	Completed 2nd year of a 3 year course
9/2019	Association for Academic Psychiatry	Master Educator Program	12 hours	participant	Pending	Completed 1st year of a 3 year course
9/2019	Mental Health Center of Greater Manchester	Transgender Assessment Training	8 hours	participant		Training by Deb Coolhart, PhD
8/2019	Dartmouth Hitchcock Medical Center	Yellowbelt training	8 hours	Participant	Course completed	Quality improvement training
2/2018	American Psychoanalytic Association	Psychodynamic Teacher's Academy	1 year	participant	APsaA Teaching Scholar	Scholarship to attend teaching academy at APsaA national meeting, and

						yearlong mentorship to assist with teaching projects
2018-2020	National Neuroscience Curriculum (NNCI)	BRAIN conference and NNCI program consultation		participant		Attended NNCI workshops at the BRAIN conference. Completed an NNCI SWOT analysis of our program, and helped facilitate two NNCI scholars in the residency program

IX. Teaching Activities

A. Undergraduate Teaching

Dates	Title	Institution	Role	Hours/ Year	# of Students	Related Information
Oct 2021	Psychiatric case studies	Dartmouth College	Psychiatry talk	2	20	Presentation to pre-med students

B. Undergraduate Medical Education: Classroom

Dates	Title	Institution	Role	Hours/ Year	# of Students	Related Information
2021-present	Psychiatry course	Geisel school of medicine at Dartmouth	Large group lecturer	3	90	Mood disorders lecture to 2nd year Geisel students
2019-2021	Psychiatry course	Geisel school of	Course director,	100	90	2nd year medical student course

Dates	Title	Institution	Role	Hours/ Year	# of Students	Related Information
		medicine at Dartmouth	large group lecturer			
2018-2020	Capstone course	Geisel School of Medicine at Dartmouth	Small group leader	15	10	4th year medical student course on Quality Improvement project
2018-2019	Scientific basis of medicine	Geisel School of Medicine at Dartmouth	Course director, small group leader, large group lecturer	100	90	2nd year medical student course
2014-2015	Cambridge Integrated clerkship	Harvard Medical School	Instructor	50	8	Taught didactic series to 3rd year clerkship students
2014	Psychopathology and Introduction to Clinical Psychiatry	Harvard Medical School	Small group leader and discussion section leader	75	30	2nd year medical student course
07/2010-06/2011	Senior preceptorship in clinical teaching	Harvard Medical School	Instructor	150	10	2nd year medical student course

C. Undergraduate Medical Education: Clerkship or Other Clinical Teaching

Dates	Title	Institution	Role	Hours/Year	# of Students	Related Information
2014-2015	Cambridge Integrated clerkship	Harvard Medical School	Preceptor	150	2	Yearlong preceptorship of two medical students

D. Graduate Medical Education (GME) teaching

Dates	Title	Institution	Role	Hours/ Year	# of Students	Related Information
2016-present	Managing the agitated patient via simulation	Dartmouth Hitchcock Medical Center	Course leader	4-6	9	PGY1 residents
2021-present	Various topics and sessions at residency didactics	Dartmouth -Hitchcock	Instructor	20	35	All residents
2016-2021	Psychodynamic therapy crash course	Dartmouth Hitchcock Medical Center	Course leader	10	8	PGY2 residents
2015-present	Adult psychiatry clinic	Dartmouth Hitchcock Medical Center	Supervisor	250	7	Clinical supervision and didactic teaching of PGY2 – PGY4 residents
2018-present	Neuroscience curriculum	Dartmouth Hitchcock Medical Center	instructor	10	16	NNCI teaching
2018-present	Psychopathology	Dartmouth Hitchcock Medical Center	Instructor	8	4-8	Psychopathology lectures to PGY1 residents
2015	Introduction to psychopharmacology	Cambridge Health Alliance	Instructor	10	8	Didactics to PGY1 residents
2014-2015	Acute Care Psychiatric Service	Cambridge Health Alliance	Supervisor	75	1	Supervision of PGY3 resident

E. Other Clinical Education Programs

Dates	Title	Institution	Role	Hours/Year	# of Students	Related Information
1/2017-4/2017	Nurse Practitioner Practicum	Dartmouth Hitchcock Medical Center	Preceptor	40	1	Nurse Practitioner student

F. Graduate Teaching

G. Other Professional/Academic Programs

X. Primary Research Advising

A. Undergraduate Students

B. Graduate Students

C. Medical Students

D. Residents/Fellows

E. Others

XI. Advising/Mentoring (Other)

A. Undergraduate Students

Dates	Name	Program	Related Information
9/2018-9/2019	Quinn McCormick	Nathan Smith Society, Dartmouth College	Dartmouth pre-med student

B. Graduate Students

C. Medical

Dates	Name	Program	Related Information
07/2019-present	Deirdre Caffrey	Geisel School of Medicine at Dartmouth	Advised on two separate case reports
06/2014-05/2015	Josh Wong	Harvard Medical School	Cambridge Integrated Clerkship student
06/2014-05/2015	Margueritte Basilico	Harvard Medical School	Cambridge Integrated Clerkship student

D. Residents/Fellows

Dates	Name	Program	Related Information

7/2018 - present	Oakland Walters	Transgender evaluation clinic	Advisor in the establishment of a psychiatry resident transgender clinic

E. Non-degree Program Students

Dates	Name	Program	Related Information
2017	Todd Gardner	Nurse Practitioner training	Clinical training site for NP student

F. Faculty

G. Others

XII. Engagement, Community Service/Education

Dates	Institution	Title	Role	Hours/Year	Related Information
2020-resent	Dartmouth Hitchcock	Residency Personal Statement Workshop	Advisor	2	Assist with panel ran annually by Alison Holmes prior to recruitment season
2021-present	Dartmouth-Hitchcock	Forensic Asylum interviewing clinic	Supervisor	10	Oversee and supervise residents completing Asylum evaluations
2017-resent	Dartmouth Hitchcock Medical Center	Residency Journal Club	Supervisor	30	Oversee journal club with the residents and participate most weeks
2018	Dartmouth Hitchcock Medical Center	Helping hands APA grant	Advisor	10	
2017-2019	Dartmouth Hitchcock Medical Center	Psychiatry interest group	Advisor	5	
07/2014 – 06/2015	Cambridge Health Alliance	Residency Journal club	Co-Leader	40	
2014-2015	Harvard Medical School	Resident and Fellow Collaborative Medical Student Teaching	Member	30	
2007-2009	Harvard Medical School	Psychiatry Interest Group	Co-leader	50	

XIII. Research Activities

A. Sponsored Activity (Grants and Contracts)

B. Pending Submissions

C. Non- Protected Time Activities (no FTE allocation)

Dates	Institution	Title	Role	Hours/Year	Related Information
2021 - present	Dartmouth-Hitchcock	Reverse integration care at community mental health clinics	Research assistant	100	Working under mentorship of Mary Brunette MD. No protected time for this activity (using spare time, no FTE allocation)

XIV. Program Development

Dates	Title	Type	Aim	Role	Cohort	Assessments	Related Information
11/2020 - present	Adult psychiatry residency program	Educational and Clinical	Creating an environment that promotes clinical learning and scholarship within the residency program	Program Director	Psychiatry residents and faculty	Various	Projects that enhance the residency program, resident and faculty development, resident and faculty well-being
4/2019	Neuroscience tools for psychiatry resident education	Educational	To educate faculty on skills and tools for teaching neuroscience to residents	Co-presenter	Psychiatry faculty and residents		Grand rounds and various didactics teaching, introducing residents and faculty to content of the National Neuroscience Curriculum (NNCI)
7/2015 - present	Adult psychiatry resident clinics	Clinical	To improve patient care and resident educational experiences	Participant	Psychiatry residents and patients	Various QI projects and resident feedback	Have worked on various projects to help improve the outpatient psychiatry clinics, including updating the no show policy, controlled substance agreements, assessment tools, note templates, clinic work flows.

7/2018 - 2021	Geisel School of Medicine pre-clinical curriculum redesign	Educational	To improve medical education at Geisel School of Medicine	Psychiatry course director	Medical students	Various	The pre-clinical education was shortened, and each course was to be redesigned to improve continuity and integration of the pre-clinical courses
7/2017-2020	Adult psychiatry residency program	Educational and Clinical	To continually improve the educational and clinical aspects of the adult psychiatry program	Assistant program director	Psychiatry residents	Various	Various projects including resident wellness, psychotherapy curriculum, supervision oversight, psychotherapy note templates, improving neuroscience didactics, enhancing didactics as a whole, resident feedback tools.

XV. Major Committee Assignments, Inclusive of Professional Societies

XVI. National/International

Dates	Committee Name	Role	Institution/Organization	Related Information
2022 - present	AADPRT recruitment committee	Member	American association of directors of psychiatric residency training (AADPRT)	Have been involved in PsychSIGN student panels on recruitment, and involved in other projects related to residency recruitment
2021	AADPRT workshop selection committee	Member	American association of directors of psychiatric residency training (AADPRT)	Reviewed and voted on workshops for the AADPRT national meeting
2018-2019	AADPRT psychotherapy committee	Member	American association of directors of psychiatric residency training (AADPRT)	Worked on psychotherapy tools for resident education
2017-present	Professional society	Member	AADPRT	Attended workshops and presented posters at the national meeting
2017-2019	Professional Society	Member	Association for Academic Psychiatry	Attended workshops at the national meeting
2010-present	Professional Society	Member	American Psychiatry Association	

A. Regional

Dates	Committee Name	Role	Institution/Organization	Related Information
2015-present	Professional Society	member	New Hampshire Psychiatric Society	
2010-2015	Professional Society	member	Massachusetts Psychiatric Society	

B. Institutional

Dates	Institution/Organization	Committee Name	Role	Related Information
3/2021 - present	Dartmouth-Hitchcock Medical Center	GMEC curriculum committee	member	
3/2021 - present	Dartmouth-Hitchcock Medical Center	GMEC wellness committee	member	
2017-present	Dartmouth Hitchcock Medical Center	Program Evaluation Committee	member	
2017-present	Dartmouth Hitchcock Medical Center	Clinical Competency Committee	Member	
2017-2019	Geisel School of Medicine at Dartmouth	Admissions Committee	Member	
2016-2017	Geisel School of Medicine at Dartmouth	Committee on Student Performance and Conduct	Voting member	
10/2014-01/2015	Cambridge Health Alliance	Resident Selection Committee	Member	
2014-2015	Cambridge Health Alliance	Institutional Review Board	Voting member	
2010-2012	Harvard Medical School	Cambridge Branch of Crimson Care Collaborative	Planning Committee member	
2008-2009	Harvard Medical School	Admissions Committee		

XVII. Institutional Center or Program Affiliations

XVIII. Editorial Boards

XIX. Journal Referee Activity

Dates	Society/Journal	Role	Frequency of Review	Related Information
June 2020	Academic psychiatry	Reviewer		
August 2017	General hospital psychiatry (GHP_2017_308)	reviewer		
June 20, 2017	Journal of Psychiatry and Mental Health	reviewer		
March 6, 2017	Academic Psychiatry (ACPS-D-16-00299R1)	reviewer		

XX. Awards and Honors

Date	Award Name	Related Information
2023	2nd place AADPRT National Poster Competition	Placed 2nd in poster competition at AADPRT national meeting in San Diego based on advocacy poster with Jessica Weeks
2022	DHMC Program Director Scholarship	Received up to $3,500 to attend and present at specialty-specific training director meeting
2022	Dartmouth-Hitchcock Residency teacher of the year award	Award granted by the residents of the Adult Psychiatry Residency Program
2017	American Psychoanalytic Association Teachers Academy scholarship	Award for junior faculty interested in teaching psychodynamic therapy – fully paid expenses to the APsaA national meeting and a year of mentorship
2011	Harvard Medical School Dr. Sanger Award	Excellence and Accomplishment in research, clinical investigation or scholarship in psychiatry
2011	Harvard Medical School Joseph B. Martin Loan Forgiveness award	$60,000 loan forgiveness scholarship awarded to qualified individuals pursuing a career in primary care, family practice or psychiatry
2008	Psychosomatic Medicine Trainee Travel Award	For the Academy of Psychosomatic Medicine annual meeting in Miami, Florida, November 19-22, 2008
2006	Williams College W. Marriott Canby, Class of 1891, Athletic Scholarship Prize	Highest GPA among graduating student-athletes
2006	Williams College Erastus C. Benedict, Class of 1821, Biology prize	Graduating biology prize
2006	American Physiology Association David Bruce Award	Excellence in undergraduate research
2005	Williams College Phi Beta Kappa	Admitted junior year

XXI. Presentations

A. International

B. National

Date	Title	Sponsoring Organization	Location	Related Information
4/6/23	ProHealth New Hampshire	NASMHPD (National Association of State Mental Health Program Directors)	Virtual	Presented findings of work on reverse integration with Dr. Brunette
March 2023	. Managing Agitated Patients; How to Design, Implement and Adapt a Simulation Training Program for Psychiatry Residents	AADPRT	San Diego, CA	Leader of Workshop
1/26/23	ProHealth New Hampshire	PIPBHC (Promoting Integration of Primary and Behavioral Healthcare) Learning Community	Virtual	Presented findings of work on reverse integration with Dr. Brunette
9/23/22	New Training Director Forum with focus on recruitment	AADPRT	Virtual	Participated as a representative of the AADPRT recruitment committee
5/7/22	Program Director Panel	PsychSIGN	Virtual	Participated as a representative of the AADPRT recruitment committee
3/3/2021	CORE5 Collaborative Call	AAMC	Virtual	Presentation on eConsults
2018	Salary Coaching for Women Workshop	Salary Coaching for Women	Hanover, NH	Presentation and Q and A on women's mental health via video
03/2015	Resident as Supervisor	AADPRT national meeting	Orlando, Florida	Workshop

March 2015	Simulation based training in the Management of Acute Agitation	American Association for Directors of Psychiatric Residency Training	Orlando, Florida	poster
2008	Depression screening and interventions among cardiac inpatients	American Psychosomatic Annual meeting	Miami, Florida	Oral presentation

C. Regional/Local

Date	Title	Sponsoring Organization	Location	Related Information
6/2/23	Roles, Responsibilities and Resources for Resident & Fellow Leaders	DHMC Chief Resident Conference	Lebanon, NH	Panelist
2019	Mental health and substance abuse ECHO presentation	Project ECHO at Dartmouth Hitchcock Medical Center	Lebanon, NH	Presentation and Q&A on ADHD
2019	Treatment of mood and anxiety disorders	DHMC hematology/oncology department	Lebanon, NH	
February, 2017	Day to day questions asked of a psychiatrist in primary care	Dartmouth Coop Annual Meeting	Meredith, NH	
2014	Management of acute agitation	Cambridge Health Alliance	Cambridge, MA	Role playing and didactic session with psychiatry residents
2014	Sleep: A multidisciplinary approach	Cambridge Health Alliance	Malden, MA	
2014	Neurobiology of cocaine and methamphetamine addiction	Cambridge Health Alliance	Cambridge, MA	
2013	Psychopharmacology of Bipolar Disorder	Cambridge Health Alliance	Cambridge, MA	PGY2 residents
2013	Assessment of Malingering	Cambridge Health Alliance	Malden, MA	Psychiatry inpatient faculty and staff
2012	Mental Illness of Heart Disease	Cambridge Health Alliance	Cambridge, MA	
2012	Legally high: synthetic drugs of abuse	Cambrige Health Alliance	Cambridge, MA	Substance use disorder treatment program
2011	Build a Better Speculum	ELEVATE Pitch Contest, Harvard	Cambridge, MA	Finalist
2009, 2010	Fish bowl demonstration of problem based learning	Harvard Macy Institute	Boston, MA	
2008	Depression screening in cardiac patients	Cambridge Health Alliance	Cambridge, MA	Medicine grand rounds

XXII. Bibliography

A. Peer-Reviewed Publications in Print or Other Media

1. **Sowden G MD**, Shoemaker A MD, Batliner M MD, Duncan M MD. Psychiatric e-Consults: A Guide for the Referring Physician. Fam Pract Manag. 2022 Jul;29(4):9-14.. ***co-author with resident**

2. Avery J, Dwan D, **Sowden G**, Duncan M. Primary Care Psychiatry eConsults at a Rural Academic Medical Center: Descriptive Analysis. J Med Internet Res. 2021 Sep 1;23(9):e24650. doi: 10.2196/24650. PMID: 34468329; PMCID: PMC8444033 ***co-author with medical students**

3. Caffrey D, **Sowden GL**. A missed case of lurasidone induced laryngospasm: A case study and overview of extrapyramidal symptom identification and treatment. Int J Psychiatry Med. 2021 Mar;56(2):73-82. PMID: 32660283***co-author with medical student**

4. Deirdre Caffrey, **Gillian Sowden**, Cybele Arsan. "A Possible Case of Escitalopram-Induced Tardive Dystonia."Psychosomatics,2019, ISSN 0033-3182, ***co-author with medical student and resident**

5. **Sowden G**, Vestal H, Stoklosa J, Valcourt S, Peabody et al. "Clinical Case Vignettes: A Promising Tool to Assess Competence in the Management of Agitation." Acad Psychiatry. 2017 Jun;41(3):364-368. doi: 10.1007/s40596-016-0604-1

6. Vestal HS, **Sowden G**, Nejad S, Stoklosa J, Valcourt SC, Keary C, et al. Simulation-Based Training for Residents in the Management of Acute Agitation: A Cluster Randomized Controlled Trial. Acad Psychiatry. 2017 Feb;41(1):62-67. doi: 10.1007/s40596-016-0559-2. Epub 2016 Apr 25.

7. **Sowden** GL, Mastromauro CA, Seabrook RC, Celano CM, Rollman BL, Huffman JC. "Baseline physical health-related quality of life and subsequent depression outcomes in cardiac patients." *Psychiatry Research*. 2013 Aug 15;208(3):288-90

8. Caro MA, **Sowden** GL, Mastromauro CA, Mahnks S, Beach SR, Januzzi JL, Huffman JC. "Risk factors for positive depression screens in hospitalized cardiac patients." *Journal of Cardiology*. 2012 Jul;60(1):72-7

9. Huffman J, Mastromauro C, **Sowden** G, Fricchione G, Healy B, Januzz J. "Impact of Depression care management program for hospitalized cardiac patients." *Circ Cardiovasc Qual Outcomes*. 2011 Mar;4(2):198-205

10. Huffman JC, Mastromauro CA, **Sowden** GL, Wittmann C, Rodman R, Januzzi JL. "A collaborative care depression management program for cardiac inpatients: depression characteristics and in-hospital outcomes." *Psychosomatics*. 2011 Jan-Feb;52(1):26-33

11. **Sowden** G, Mastromauro CA, Januzzi JL, Fricchione GL, Huffman JC. "Detection of depression in cardiac inpatients: feasibility and results of systematic screening." *The American Heart Journal*. 2010 May;159(5):780-7

12. **Sowden** GL, Drucker DJ, Weinshenker D, Swoap SJ. "Oxyntomodulin increases intrinsic heart rate in mice independent of the glucagon-like peptide-1 receptor." *Am J Physiol Regul Integr Comp Physiol* (October 12, 2006).

Reviews

1. **Sowden** GL, Huffman JC. "The impact of mental illness on cardiac outcomes: A review for the cardiologist." *International Journal of Cardiology.* 2009 Feb 6;132(1):30-7

Books/Book Chapters/Monographs

1. Ley-Thomson M, *Arsan C, Finn CT, Sowden G. Call and Nightfloat. Resident and Training Director Handbook: A Survival Guide for Psychiatric Residency. Digolia SA, Wang R. APA Publishing. 2022.

B. Other Scholarly Work in Print or Other Media:

Editorially-Reviewed Publications

Print Resources

Electronic Resources

Large-Team Publications

White Papers/Position Papers

Others

1. Khouzam HR, Bhatia R, **Sowden GL**. A Review of Mirtazapine Use for Primary Providers. "A Review of Mirtazapine Use for Primary Providers". *EC Neurology* 4.4 (2017): 119-134.

2. **Sowden GL**, Huffman JC. Systematic Depression Screening and a Collaborative Care Depression Management Program for Cardiac Patients [Medical School Thesis]. Harvard Medical School, Boston, MA, 2011

3. **#. Sowden GL**, Swoap S. Oxyntomodulin and its cardiovascular effects in mice [Undergraduate Honors Thesis]. Williams College, Williamstown, MA, 2006.

C. Posters

1. Weeks J, **Sowden G**, Ho P. Learning How to Advocate: Guide for Psychiatry Residents. Poster presented at AADPRT National Meeting, San Diego, 2023 (won 2nd place in poster competition). Presented at NH Psychiatric Society Annual Meeting, May 2023 (won 1st place in poster competition). ***co-author with resident**

2. Nagarajan T, Frew J, **Sowden G**. Examining the Impact of an Anti-Racist and Structural Discrimination Curriculum in a Rural Psychiatry Residency Program. Presented at APA meeting, New Orleans, LA, May 2022 ***co-author with resident**

3. Walters O, Nagarajan T, **Sowden G**. Residency in transition: Advancing Gender-Affirming Practices in Psychiatry Training. Presented at AADPRT Virtual Annual Meeting, March 2021 ***co-author with medical students**

4. Wong J, Michaelson N, Davila C, Connerney M, Avery J, Abarcar K, Farrag K, Luckow P, Bond P, **Sowden G**. Recommendations for Standardization of Psychiatry Resident Handovers. Presented at patient safety week at DHMC, April 2019. ***co-author with medical students**

5. **# Sowden GL**, Silverio A, Smith N, Chen X, Schwartz E. Factors influencing no-show rate in a resident-staffed adult outpatient psychiatry clinic. Presented at AADPRT Annual Meeting, San Diego, CA, 2019. ***co-author with residents**

6. # Silverio A, Ho P, **Sowden G**. Weekly peer-led, guided mindfulness in an adult psychiatry residency program. Presented at AADPRT Annual Meeting, San Diego, CA, March 2019. ***co-author with residents**

7. **.# Sowden G,** Vestal H, Nejad S, Caminis A, Keary C, Huffman J. Simulation-Based Training in the Management of Acute Agitation: A Randomized Controlled Study. Presented at AADPRT Annual Meeting, Orlando, FL, 2015

XXIII. Personal Statement

Clinical Experience

I have a particular interest in outpatient psychiatric care, and my training has included diverse experiences in psychopharmacology and psychotherapy practices. Clinical interests include adult psychopharmacology for mood, anxiety, personality, and trauma related disorders. I also enjoy providing psychodynamic psychotherapy. Currently, my clinical work is divided between caring for my own patients at Hanover Psychiatry, and supervising residents in the resident psychopharmacology clinic. I previously spent several years as a consultant responding to electronic consultations (eConsults).

Teaching and Education

I have a particular interest in teaching and medical education, and sought additional teaching opportunities in residency as a Chief Resident in Medication Education. As program director for the Dartmouth adult psychiatry residency program, I am involved in enhancing the clinical, didactic and professional experiences of residents in training. In 2022, I was the recipient of the Dartmouth Hitchcock Psychiatry Residency Teacher of the Year award. I was previously co-director of the 2nd year psychiatry course at Geisel School of Medicine at Dartmouth, and was involved in redesigning the curriculum for this course as part of the overhauling of the entire pre-clinical curriculum at Geisel.

Research

In 2007, I became involved in research with Dr. Jeffrey Huffman at MGH. Initially this work involved working on a randomized trial assessing the feasibility and efficacy of collaborative care in the treatment of hospitalized cardiac patients with co-morbid depression. Other research involved a randomized trial assessing the efficacy of a simulation-based intervention for teaching the management of acutely agitated patients to psychiatry interns. These works have led to several first author publications, poster presentations and oral presentations at local and national levels. I am now enjoying implementing a simulation teaching among psychiatry interns at DHMC. I regularly engage in research, quality improvement and academic projects with residents and medical students. I have authored/co-authored several case reports, review articles, posters and workshops with residents and medical students, as well as a research project assessing psychiatric eConsult outcomes. Recently, I have been working with Dr. Brunette's multidisciplinary team, assessing outcomes of integrated primary at community mental health clinics in New Hampshire.

Non-clinical achievements

Prior to entering the medical profession, I was a competitive athlete and a member of the British Biathlon Team. In 1998, I left my home in Scotland and moved to Norway to pursue a career in Biathlon. I competed in International biathlon races, including two junior world championships and several World Cups. During this time, I learned to speak fluent Norwegian. In 2002, I moved to the US to attend Williams College, where I was a member of the varsity Nordic ski team. I continue to enjoy an active outdoor lifestyle, and have developed a keen interest in Cross Fit.

KEY PERSONNEL

List those primarily responsible for meeting the terms and conditions of the agreement.
(Job descriptions not required for vacant positions.)

NH Department of Health and Human Services

Contractor Name: Mary Hitchcock Memorial Hospital/ Dartmouth-Hitchcock Clinic

NAME	JOB TITLE	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Sarah Pratt, PhD	Site PI, Evaluation Director	25.00%	$48,409.00
Meghan Santos, LICSW	Project Manager	15.00%	$17,438.00
Gail Williams	Project Manager	15.00%	$14,250.00
Joelle Ferron	Data Manager	25.00%	$31,336.00
Cynthia Bianco	Data Assistant	25.00%	$14,589.00
Jenna Bourassa	Data Assistant	30.00%	$11,667.00
Pablo Martinez-Camblor	Statistician	10.00%	$13,896.00
Gillian Sowden	Content expert/report writer	5.00%	$15,649.00

ARC

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Lori A. Weaver
Commissioner

Katja S. Fox
Director

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

129 PLEASANT STREET, CONCORD, NH 03301
603-271-9544 1-800-852-3345 Ext. 9544
Fax: 603-271-4332 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

October 20, 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 **Sole Source** amendment to an existing contract with Mary Hitchcock Memorial Hospital (VC#177160), Lebanon, NH, for the continued evaluation of integrated primary care, community behavioral health care and wellness services for young people with serious emotional disturbance (SED), severe mental illness (SMI), severe and persistent mental illness (SPMI), by exercising a contract renewal option by increasing the price limitation by $314,561 from $455,688 to $770,249 and extending the completion date from December 31, 2023 to September 29, 2024, effective December 31, 2023, upon Governor and Council approval. 100% Federal Funds.

The original contract was approved by Governor and Council on November 22, 2021, item #22.

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.

05-95-092-922010-23400000 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVCS, HHS: BEHAVIORAL HEALTH DIV, BUREAU OF MENTAL HEALTH SERVICES, PROHEALTH NH GRANT

State Fiscal Year	Class / Account	Class Title	Job Number	Current Budget	Increased (Decreased) Amount	Revised Budget
2022	102-500731	Contracts for Prog Svc	92202340	$209,938	$0	$209,938
2023	102-500731	Contracts for Prog Svc	92202340	$197,000	$0	$197,000
2024	102-500731	Contracts for Prog Svc	92202340	$48,750	$242,009	$290,759
2025	102-500731	Contracts for Prog Svc	92202340	$0	$72,552	$72,552
			Total	$455,688	$314,561	$770,249

EXPLANATION

This request is **Sole Source** because MOP 150 requires all amendments to agreements previously approved as sole source to be identified as sole source. The Contractor was identified in the original federal ProHealth NH grant application submitted to the Substance Abuse and Mental Health Services Administration (SAMHSA). On September 20, 2023, SAMHSA notified the Department of the approval of continued ProHealth NH grant funds. The use of federal funding is contingent upon the Department continuing to contract with the current Contractor, therefore the Contractor is the only authorized contractor able to perform the services.

The purpose of this request is for the Contractor to continue providing evaluation on community-based treatment and recovery options that promote recovery from mental illness and wellness interventions through the continued implementation of the ProHealth NH Partnership Grant. The Contractor will finalize collection of all data points and evaluate the program as a whole as well as provide orderly close-out to SAMHSA on behalf of the Department.

The Department will continue monitoring services by reviewing:

- Reports on the proportion of individuals enrolled in ProHealth NH who received evidence-based mental health treatment and health education for weight management and tobacco use.
- Reports on the proportion of individuals enrolled in ProHealth NH who received Breath Well, Live Well Tobacco Program and Healthy Choices Healthy Changes Weight program.

As referenced in Exhibit A, Revisions to Standard Agreement Provisions, of the original agreement, the parties have the option to extend the agreement for up to one (1) additional year, contingent upon satisfactory delivery of services, available funding, agreement of the parties and Governor and Council approval. The Department is exercising its option to renew services for nine (9) months of the one (1) year available.

Should the Governor and Council not authorize this request, the evaluation outcomes will not be finalized, and the Department will be limited in its ability to close out the ProHealth NH Partnership Grant.

Area served: Greater Manchester, Greater Nashua, and Strafford County.

Source of Federal Funds: Assistance Listing Number #93.243, FAIN #H79SM080245.

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

State of New Hampshire
Department of Health and Human Services
Amendment #1

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

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on November 22, 2021 (Item #22), the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract and in consideration of certain sums specified; and

WHEREAS, pursuant to Form P-37, General Provisions, the Contract may be amended upon written agreement of the parties and approval from the Governor and Executive Council; and

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

1. Form P-37 General Provisions, Block 1.7, Completion Date, to read:

   September 29, 2024

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

   $770,249

3. Form P-37, General Provisions, Block 1.9, Contracting Officer for State Agency, to read:

   Robert W. Moore, Director

4. Modify Exhibit C, Payment Terms, Section 3, to read:

   3. Payment shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this Agreement, and shall be in accordance with the approved line items, as specified in Exhibits C-1, Budget trough Exhibit C-4, Budget, Amendment #1.

5. Modify Exhibit C-3, Budget, it in its entirety with Exhibit C-3, Budget, Amendment #1, which is attached hereto and incorporated by reference herein.

6. Add Exhibit C-4, Budget, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract not modified by this Amendment remain in full force and effect. This Amendment shall be effective December 31, 2023, upon Governor and Council approval.

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

State of New Hampshire
Department of Health and Human Services

11/14/2023
Date

DocuSigned by:
Katja S. Fox
Name: Katja S. Fox
Title: Director

Mary Hitchcock Memorial Hospital

11/14/2023
Date

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

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

OFFICE OF THE ATTORNEY GENERAL

11/20/2023
Date

DocuSigned by:
Robyn Guarino
Name: Robyn Guarino
Title: Attorney

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

OFFICE OF THE SECRETARY OF STATE

Date

Name:
Title:

New Hampshire Department of Health and Human Services

Bidder/Program Name: Mary Hitchcock Memorial Hospital

Budget Request for: Evaluation of ProHealth New Hampshire

Budget Period: July 1, 2023 - June 30, 2024 (FY2024)

Line Item	Total Program Cost: Direct	Total Program Cost: Indirect	Total Program Cost: Total	Contractor Share / Match: Direct	Contractor Share / Match: Indirect	Contractor Share / Match: Total	Funded by DHHS contract share: Direct	Funded by DHHS contract share: Indirect	Funded by DHHS contract share: Total
1. Total Salary/Wages	$ 135,468.00	$ 13,547.00	$ 149,015.00	$ -	$ -	$ -	$ 135,468.00	$ 13,547.00	$ 149,015.00
2. Employee Benefits	$ 44,179.00	$ 4,418.00	$ 48,597.00	$ -	$ -	$ -	$ 44,179.00	$ 4,418.00	$ 48,597.00
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Educational	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Lab	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medical	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Office	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6. Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7. Occupancy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Telephone	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Postage	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subscriptions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Audit and Legal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Board Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11. Staff Education and Training	$ 15,866.00	$ 1,587.00	$ 17,453.00	$ -	$ -	$ -	$ 15,866.00	$ 1,587.00	$ 17,453.00
12. Subcontracts/Agreements	$ 73,269.00	$ 2,425.00	$ 75,694.00	$ -	$ -	$ -	$ 73,269.00	$ 2,425.00	$ 75,694.00
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Web Based Interventions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 268,782.00	$ 21,977.00	$ 290,759.00	$ -	$ -	$ -	$ 268,782.00	$ 21,977.00	$ 290,759.00
Indirect As A Percent of Direct		8.2%							

DS
EJM

11/14/2023

New Hampshire Department of Health and Human Services

Bidder/Program Name: Mary Hitchcock Memorial Hospital

Budget Request for: Evaluation of ProHealth New Hampshire

Budget Period: July 1, 2024 – September 29, 2024 (SFY2025)

Line Item	Total Program Cost: Direct	Total Program Cost: Indirect	Total Program Cost: Total	Contractor Share / Match: Direct	Contractor Share / Match: Indirect	Contractor Share / Match: Total	Funded by DHHS contract share: Direct	Funded by DHHS contract share: Indirect	Funded by DHHS contract share: Total
1. Total Salary/Wages	$ 31,788	$ 3,177	$ 34,943	$ -	$ -	$ -	$ 31,788	$ 3,177	$ 34,943
2. Employee Benefits	$ 10,387	$ 1,039	$ 11,426	$ -	$ -	$ -	$ 10,387	$ 1,039	$ 11,426
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Educational	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Lab	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medical	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Office	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6. Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7. Occupancy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Telephone	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Postage	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subscriptions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Audit and Legal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Board Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11. Staff Education and Training	$ 4,742	$ 474	$ 5,216	$ -	$ -	$ -	$ 4,742	$ 474	$ 5,216
12. Subcontracts/Agreements	$ 20,392	$ 576	$ 20,967	$ -	$ -	$ -	$ 20,392	$ 576	$ 20,967
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Web Based Interventions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 67,237	$ 5,265	$ 72,552	$ -	$ -	$ -	$ 67,237	$ 5,265	$ 72,552
Indirect As A Percent of Direct		7.8%							

DS
EJH

11/14/2023

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Lori A. Shibinette
Commissioner

Katja S. Fox
Director

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

129 PLEASANT STREET, CONCORD, NH 03301
603-271-9544 1-800-852-3345 Ext. 9544
Fax: 603-271-4332 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

November 2, 2021

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

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division for Behavioral Health, to enter into a **Sole Source** contract with Mary Hitchcock Memorial Hospital, (VC#177160), Lebanon, NH in the amount of $455,688 for the evaluation of integrated primary care, community behavioral health care and wellness services for young people with serious emotional disturbance (SED), severe mental illness (SMI), severe and persistent mental illness (SPMI), with the option to renew for up to one (1) additional year effective July 1, 2021 or upon Governor and Council approval, whichever is later, through December 31, 2023. 100% Federal Funds.

Funds are available in the following account for State Fiscal Years 2022 and 2023, and are anticipated to be available in State Fiscal Year 2024, upon the availability and continued appropriation of funds in the future operating budget, with the authority to adjust budget line items within the price limitation and encumbrances between state fiscal years through the Budget Office, if needed and justified.

05-95-092-922010-23400000- HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVCS, HHS: BEHAVIORAL HEALTH DIV, BUREAU OF MENTAL HEALTH SERVICES, PROHEALTH NH GRANT

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2022	074-500585	Contracts for Prog Svc	92202340	$209,938
2023	074-500585	Contracts for Prog Svc	92202340	$197,000
2024	074-500585	Contracts for Prog Svc	92202340	$48,750
			Total	$455,688

EXPLANATION

This request is **Sole Source** because the Contractor was identified in the original federal ProHealth NH grant application submitted to the Substance Abuse and Mental Health Services Administration (SAMHSA). Consequently, the availability of federal funding is contingent upon the Department continuing to contract with the current Contractor. Additionally, the existing

ProHealth contracts with the Community Mental Health Centers who subcontracted with the Contractor expired June 30, 2021. The ProHealth scope of services is incorporated into amendments with the Community Mental Health Centers for the remaining months of the grant. The Contractor will continue to conduct the evaluation and reporting of outcomes consistent with federal project requirements.

The purpose of this request is to provide evaluation, training, and consultation on community-based treatment and recovery options that promote recovery from mental illness and wellness interventions through continued implementation of the ProHealth NH Partnership Grant. The Contractor will provide training and consultation on evaluation and evidence-based wellness interventions to the Community Mental Health Centers and federally qualified health center partnerships. The Contractor will provide evaluation services in accordance with SAMHSA guidance. Evaluations will measure effectiveness in identifying and addressing serious emotional disturbance, severe mental illness, severe and persistent mental illness, and physical health indicators earlier and improving health outcomes for youth and young adults with mental illness.

The Department will monitor contracted services by reviewing:

- Reports on the proportion of individuals enrolled in ProHealth NH who received evidence-based mental health treatment and health education for weight management and tobacco use.
- Reports on the proportion of individuals enrolled in ProHealth NH who received Breath Well, Live Well Tobacco Program and Healthy Choices Healthy Changes Weight program.
- Two annual presentations, and an annual report detailing outcomes demonstrating the value in documentation of primary care, coordinated and collaborative care, health homes, and wellness interventions.

As referenced in Exhibit A of the attached contract, the parties have the option to extend the agreement for up one (1) additional year, 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 evaluation, training, and consultation will cease and the SAMHSA will discontinue the grant award because requirements would not be met. The services provided by the Contractor would not aid the Community Mental Health Centers providing ProHealth services to individuals with serious emotional disturbance, severe mental illness and severe and persistent mental illness.

Area served: Greater Manchester, Greater Nashua, and Strafford County.

Source of Funds: CFDA #93.243, FAIN #H79SM080245

Respectfully submitted,

On behalf of Commissioner Shibinette

Lori A. Shibinette
Commissioner

FORM NUMBER P-37 (version 12/11/2019)

Subject: Evaluation of ProHealth New Hampshire (SS-2022-DBH-01-EVALU-01)

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

AGREEMENT

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

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name New Hampshire Department of Health and Human Services	1.2 State Agency Address 129 Pleasant Street Concord, NH 03301-3857
1.3 Contractor Name Mary Hitchcock Memorial Hospital	1.4 Contractor Address 1 Medical Center Drive Lebanon, NH 03765
1.5 Contractor Phone Number (603) 650-5000	1.6 Account Number 05-95-092-922010-23400000
1.7 Completion Date December 31, 2023	1.8 Price Limitation $ 455,688
1.9 Contracting Officer for State Agency Nathan D. White, Director	1.10 State Agency Telephone Number (603) 271-9631
1.11 Contractor Signature Barbara A. Vance Date: 10/21/2021	1.12 Name and Title of Contractor Signatory Barbara A. Vance Vice President of Research Operations
1.13 State Agency Signature DocuSigned by: Katja S. Fox Date: 10/26/2021	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: J. Christopher Marshall On: 10/26/2021	
1.17 Approval by the Governor and Executive Council *(if applicable)* G&C Item number: G&C Meeting Date:	

Contractor Initials BAV

Date 10/21/2021

2. **SERVICES TO BE PERFORMED.** The State of New Hampshire, acting through the agency identified in block 1.1 ("State"), engages contractor identified in block 1.3 ("Contractor") to perform, and the Contractor shall perform, the work or sale of goods, or both, identified and more particularly described in the attached EXHIBIT B which is incorporated herein by reference ("Services").

3. **EFFECTIVE DATE/COMPLETION OF SERVICES.**

3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, if applicable, this Agreement, and all obligations of the parties hereunder, shall become effective on the date the Governor and Executive Council approve this Agreement as indicated in block 1.17, unless no such approval is required, in which case the Agreement shall become effective on the date the Agreement is signed by the State Agency as shown in block 1.13 ("Effective Date").

3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

4. **CONDITIONAL NATURE OF AGREEMENT.**

Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including, without limitation, the continuance of payments hereunder, are contingent upon the availability and continued appropriation of funds affected by any state or federal legislative or executive action that reduces, eliminates or otherwise modifies the appropriation or availability of funding for this Agreement and the Scope for Services provided in EXHIBIT B, in whole or in part. In no event shall the State be liable for any payments hereunder in excess of such available appropriated funds. In the event of a reduction or termination of appropriated funds, the State shall have the right to withhold payment until such funds become available, if ever, and shall have the right to reduce or terminate the Services under this Agreement immediately upon giving the Contractor notice of such reduction or termination. The State shall not be required to transfer funds from any other account or source to the Account identified in block 1.6 in the event funds in that Account are reduced or unavailable.

5. **CONTRACT PRICE/PRICE LIMITATION/ PAYMENT.**

5.1 The contract price, method of payment, and terms of payment are identified and more particularly described in EXHIBIT C which is incorporated herein by reference.

5.2 The payment by the State of the contract price shall be the only and the complete reimbursement to the Contractor for all expenses, of whatever nature incurred by the Contractor in the performance hereof, and shall be the only and the complete compensation to the Contractor for the Services. The State shall have no liability to the Contractor other than the contract price.

5.3 The State reserves the right to offset from any amounts otherwise payable to the Contractor under this Agreement those liquidated amounts required or permitted by N.H. RSA 80:7 through RSA 80:7-c or any other provision of law.

5.4 Notwithstanding any provision in this Agreement to the contrary, and notwithstanding unexpected circumstances, in no event shall the total of all payments authorized, or actually made hereunder, exceed the Price Limitation set forth in block 1.8.

6. **COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/ EQUAL EMPLOYMENT OPPORTUNITY.**

6.1 In connection with the performance of the Services, the Contractor shall comply with all applicable statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal employment opportunity laws. In addition, if this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all federal executive orders, rules, regulations and statutes, and with any rules, regulations and guidelines as the State or the United States issue to implement these regulations. The Contractor shall also comply with all applicable intellectual property laws.

6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.

6.3. The Contractor agrees to permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

7. **PERSONNEL.**

7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.

7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this Agreement. This provision shall survive termination of this Agreement.

7.3 The Contracting Officer specified in block 1.9, or his or her successor, shall be the State's representative. In the event of any dispute concerning the interpretation of this Agreement, the Contracting Officer's decision shall be final for the State.

Contractor Initials BAV

Date 10/21/2021

8. EVENT OF DEFAULT/REMEDIES.

8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"):

8.1.1 failure to perform the Services satisfactorily or on schedule;

8.1.2 failure to submit any report required hereunder; and/or

8.1.3 failure to perform any other covenant, term or condition of this Agreement.

8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:

8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely cured, terminate this Agreement, effective two (2) days after giving the Contractor notice of termination;

8.2.2 give the Contractor a written notice specifying the Event of Default and suspending all payments to be made under this Agreement and ordering that the portion of the contract price which would otherwise accrue to the Contractor during the period from the date of such notice until such time as the State determines that the Contractor has cured the Event of Default shall never be paid to the Contractor;

8.2.3 give the Contractor a written notice specifying the Event of Default and set off against any other obligations the State may owe to the Contractor any damages the State suffers by reason of any Event of Default; and/or

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

8.3. No failure by the State to enforce any provisions hereof after any Event of Default shall be deemed a waiver of its rights with regard to that Event of Default, or any subsequent Event of Default. No express failure to enforce any Event of Default shall be deemed a waiver of the right of the State to enforce each and all of the provisions hereof upon any further or other Event of Default on the part of the Contractor.

9. TERMINATION.

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

9.2 In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall, at the State's discretion, deliver to the Contracting Officer, not later than fifteen (15) days after the date of termination, a report ("Termination Report") describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination Report shall be identical to those of any Final Report described in the attached EXHIBIT B. In addition, at the State's discretion, the Contractor shall, within 15 days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement.

10. DATA/ACCESS/CONFIDENTIALITY/ PRESERVATION.

10.1 As used in this Agreement, the word "data" shall mean all information and things developed or obtained during the performance of, or acquired or developed by reason of, this Agreement, including, but not limited to, all studies, reports, files, formulae, surveys, maps, charts, sound recordings, video recordings, pictorial reproductions, drawings, analyses, graphic representations, computer programs; computer printouts, notes, letters, memoranda, papers, and documents, all whether finished or unfinished.

10.2 All data and any property which has been received from the State or purchased with funds provided for that purpose under this Agreement, shall be the property of the State, and shall be returned to the State upon demand or upon termination of this Agreement for any reason.

10.3 Confidentiality of data shall be governed by N.H. RSA chapter 91-A or other existing law. Disclosure of data requires prior written approval of the State.

11. CONTRACTOR'S RELATION TO THE STATE. In the performance of this Agreement the Contractor is in all respects an independent contractor, and is neither an agent nor an employee of the State. Neither the Contractor nor any of its officers, employees, agents or members shall have authority to bind the State or receive any benefits, workers' compensation or other emoluments provided by the State to its employees.

12. ASSIGNMENT/DELEGATION/SUBCONTRACTS.

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

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

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

Contractor Initials BAV

Date 10/21/2021

Contractor, or subcontractors, including but not limited to the negligence, reckless or intentional conduct. The State shall not be liable for any costs incurred by the Contractor arising under this paragraph 13. Notwithstanding the foregoing, nothing herein contained shall be deemed to constitute a waiver of the sovereign immunity of the State, which immunity is hereby reserved to the State. This covenant in paragraph 13 shall survive the termination of this Agreement.

14. INSURANCE.

14.1 The Contractor shall, at its sole expense, obtain and continuously maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:

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

14.1.2 special cause of loss coverage form covering all property subject to subparagraph 10.2 herein, in an amount not less than 80% of the whole replacement value of the property.

14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.

14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than ten (10) days prior to the expiration date of each insurance policy. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference.

15. WORKERS' COMPENSATION.

15.1 By signing this agreement, the Contractor agrees, certifies and warrants that the Contractor is in compliance with or exempt from, the requirements of N.H. RSA chapter 281-A *("Workers' Compensation")*.

15.2 To the extent the Contractor is subject to the requirements of N.H. RSA chapter 281-A, Contractor shall maintain, and require any subcontractor or assignee to secure and maintain, payment of Workers' Compensation in connection with activities which the person proposes to undertake pursuant to this Agreement. The Contractor shall furnish the Contracting Officer identified in block 1.9, or his or her successor, proof of Workers' Compensation in the manner described in N.H. RSA chapter 281-A and any applicable renewal(s) thereof, which shall be attached and are incorporated herein by reference. The State shall not be responsible for payment of any Workers' Compensation premiums or for any other claim or benefit for Contractor, or any subcontractor or employee of Contractor, which might arise under applicable State of New Hampshire Workers' Compensation laws in connection with the performance of the Services under this Agreement.

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

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

18. CHOICE OF LAW AND FORUM. This Agreement shall be governed, interpreted and construed in accordance with the laws of the State of New Hampshire, and is binding upon and inures to the benefit of the parties and their respective successors and assigns. The wording used in this Agreement is the wording chosen by the parties to express their mutual intent, and no rule of construction shall be applied against or in favor of any party. Any actions arising out of this Agreement shall be brought and maintained in New Hampshire Superior Court which shall have exclusive jurisdiction thereof.

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

20. THIRD PARTIES. The parties hereto do not intend to benefit any third parties and this Agreement shall not be construed to confer any such benefit.

21. HEADINGS. The headings throughout the Agreement are for reference purposes only, and the words contained therein shall in no way be held to explain, modify, amplify or aid in the interpretation, construction or meaning of the provisions of this Agreement.

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

23. SEVERABILITY. In the event any of the provisions of this Agreement are held by a court of competent jurisdiction to be contrary to any state or federal law, the remaining provisions of this Agreement will remain in full force and effect.

24. ENTIRE AGREEMENT. This Agreement, which may be executed in a number of counterparts, each of which shall be deemed an original, constitutes the entire agreement and understanding between the parties, and supersedes all prior agreements and understandings with respect to the subject matter hereof.

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Date 10/21/2021

EXHIBIT A

Revisions to Standard Agreement Provisions

1. Revisions to Form P-37, General Provisions

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

3.3. The parties may extend the Agreement for up to one (1) additional year from the Completion Date, contingent upon satisfactory delivery of services, available funding, agreement of the parties, and approval of the Governor and Executive Council.

1.2. Paragraph 7, Personnel, is amended by modifying subparagraph 7.1 to read:

7.1. The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor certifies that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.

1.3. Paragraph 7, Personnel, is amended by modifying subparagraph 7.2 to read:

7.2. Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor's employees involved in this project, shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this Agreement. This provision shall survive termination of this Agreement.

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

9.2 In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall, at the State's discretion, deliver to the Contracting Officer, not later than thirty (30) days after the date of termination, a report ("Termination Report") describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination Report shall be identical to those of any Final Report described in the attached EXHIBIT B. In addition, at the State's discretion, the Contractor shall, within thirty (30) days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement.

1.5. Paragraph 10, Data/Access/Confidentiality/Preservation, is amended by modifying subparagraph 10.3 to read:

10.3 Confidentiality of data shall, to the extent applicable, be governed by N.H. RSA chapter 91-A or other existing law. Disclosure of data provided by the State requires prior written approval of the State.

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

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

12.4. Paragraph 14, Insurance, is amended by modifying subparagraph 14.1.2 to read:

14.1.2. The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire or registered to conduct business in the State of New Hampshire.

12.5. Paragraph 14, Insurance, is amended by modifying subparagraph 14.3 to read:

14.3. The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than thirty (30) days prior to the expiration date of each insurance policy. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference.

2. Revisions to Exhibit I, Health Insurance Portability and Accountability Act, Business Associate Agreement

2.1. Section 3, Obligations and Activities of Business Associate, Subsection b. is amended as follows:

b. The Business Associate shall immediately perform a risk assessment when it becomes aware of any of the above situations. The risk assessment shall include, but not be limited to:

- The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person used the protected health information or to whom the disclosure was made;
- Whether the protected health information was actually acquired or viewed; and
- The extent to which the risk to the protected health information has been mitigated.

The Business Associate shall complete the risk assessment report as soon as the investigation is completed and report the findings of the risk assessment report in writing to the Covered Entity as soon as possible thereafter.

Scope of Services

1. Statement of Work

1.1. The Contractor shall provide evaluation services for the ProHealth New Hampshire (NH) program in accordance with the Substance Abuse and Mental Health Services Administration (SAMHSA) guidance and applicable federal and state law, including administrative rules and regulations.

1.2. The Contractor shall provide training and consultation on the latest community-based treatment and recovery options that are intended to promote health wellness and recovery from mental illness and are based on scientific research and the best evidence-based practices.

2. Evaluation Services

2.1. The Contractor shall maintain required regulatory oversight of the evaluation pertaining to the Institutional Review Board (IRB) and Protection of Human Subjects in Clinical Trials.

2.2. The Contractor shall provide training and consultation to the Community Mental Health Centers (CMHCs) that includes, but is not limited to:

2.2.1. Obtaining consent from individuals participating in ProHealth NH evaluation and wellness services.

2.2.2. Ensuring client data includes an identification number (ID) for all enrolled individuals.

2.2.3. Collecting and reporting information that includes, but is not limited to:

2.2.3.1. Individual demographic and encounter data.

2.2.3.2. Medical history and primary care provider information.

2.2.3.3. Documentation related to all contact with a primary care provider.

2.2.3.4. Most recent physical exam and wellness visit.

2.2.3.5. De-identified information that includes height, weight, body mass index (BMI), waist circumference, blood pressure, tobacco use and/or breath carbon monoxide, and plasma glucose and lipids.

2.2.4. Screening and reporting of the following:

2.2.4.1. Trauma;

2.2.4.2. Depression;

2.2.4.3. Substance use;

2.2.4.4. Medication misuse;

2.2.4.5. Interest or Involvement in employment and education activities;

2.2.4.6. Assertive Community Treatment services; and

2.2.4.7. Symptom management.

2.2.5. Entering demographic and encounter data into the SAMHSA Performance Accountability and Review System (SPARS) system and RedCap.

2.2.6. Providing individual demographic and encounter data to the Department to include content in the format, frequency, method and timeliness as specified by the Department.

2.2.7. Conducting quality review on quarterly aggregate data identified in Subsections 10.5 and 10.6, SPARS, and RedCap.

2.3. The Contractor shall conduct qualitative assessments of ProHealth NH for routine quality improvement that must include input from individuals, caregivers, youth, peers, providers, and other stakeholders.

3. Coordinated and Collaborative Care

3.1. The Contractor shall provide training to support referrals to evidence-based practice (EBPs) for individuals with SMI, SPMI, and SED based on need

3.2. The Contractor shall provide quarterly consultation on effective methodology to engage individuals with Serious Mental Illness (SMI), Serious and Persistent Mental Illness (SPMI), and Serious Emotional Disturbance (SED) in evaluation and services to meet the needs of individuals, including motivational enhancement and referrals for case management, integrated services, and EBP integrated treatment.

4. Integrated Health Home

4.1. The Contractor shall provide monthly consultation on integrated health interventions in 3.2 for individuals' with SMI, SPMI, and SED behavioral health care EBP assessment and treatment.

4.2. The Contractor shall provide training and consultation on person centered-shared decision making and decisions aids that support youth decision making and informed consent with treatment providers about treatment options, including pharmacotherapy.

5. Health Counseling and Wellness Interventions

5.1. The Contractor shall provide training and consultation on wellness programs for health coaches assisting individuals with selecting options that best match individual needs and interests. The Contractor shall ensure options include, but are not limited to:

5.1.1. One-time brief Motivational Enhancement interventions that include:

5.1.1.1. Let's Talk About Smoking (LTAS);

5.1.1.2. Vaping Education;

5.1.1.3. Let's Talk About Feeling Good; and

5.1.1.4. Health Education.

5.1.2. Breathe Well Live Well (BWLW) program. The Contractor shall ensure the program includes:

5.1.2.1. Health coaching with components of motivational interviewing, cognitive behavioral therapy, and stages of change-based interventions to motivate risk reduction and quit attempts.

5.1.2.2. Manualized BWLW cessation counseling for the participant as well as Care2Quit counseling for of a person in the individuals support system to support quit attempts;

5.1.2.3. Provision of nicotine replacement therapy and referrals for cessation pharmacotherapy; and

5.1.2.4. Structured incentivizes program for participation and quit attempts.

5.1.3. Health Coaches for Hypertension Control program for individuals who are overweight or obese. The Contractor shall ensure the program includes:

5.1.3.1. Health coaching with components of Motivational Interviewing, Cognitive behavioral therapy, and Stages of change-based interventions;

5.1.3.2. A local gym membership for twelve (12) months;

5.1.3.3. A wellness specialist and an InSHAPE health mentor;

5.1.3.4. A Weight Watchers membership for one (1) year to include:

5.1.3.4.1. The Weight Watchers application for individuals above the age 18 years;

5.1.3.4.2. MyFitnessPal application for youth under age 18 years; and

5.1.3.4.3. Structured incentives program for participation and initiating behavior change.

5.2. The Contractor shall provide intervention manuals for the interventions outlined in 5.1 that include alternative treatment options and referrals to wellness treatment services. The Contractor shall ensure wellness treatment services and referrals based on the outcomes of health screening and treatment planning goals include:

5.2.1. Web-based application and text subscriptions, Quitline NH telephonic counseling, MyLifeMyQuit, tobacco and obesity education, diabetes education programs, and other related programs.

5.2.2. Access to medications associated with wellness interventions, such as nicotine replacement therapy (NRT), nicotine replacement (NRT) starter

packs, and onsite prescribing and pharmacy to maintain NRT supply or to access other smoking cessation medication (varenicline, bupropion).

6. Quality Improvement

6.1. The Contractor shall perform, or cooperate with the performance of, quality improvement and/or utilization review activities as determined and requested by the Department.

6.2. The Contractor shall conduct surveys and biannual forums, as requested by the Department, to obtain feedback and input from individuals, peers, and community health workers.

6.3. The Contractor shall provide a report, in the format and frequency requested by the Department, that summarizes activities that includes, but is not limited to:

6.3.1. Quality Improvement activities;

6.3.2. Utilization review activities;

6.3.3. Surveys and biannual forums; and

6.3.4. Implementation of the activities identified above.

6.4. The Contractor shall develop management and self-review tools for wellness interventions identified in Section 5, as approved by the Department.

7. Staffing

7.1. The Contractor shall maintain staff or subcontractors that include, but are not limited to:

7.1.1. 0.3 FTE director with an advanced degree in psychology or related field who provides oversight of and training for the ProHealth NH program.

7.1.2. 0.1 FTE data analyst who performs the following activities:

7.1.2.1. Data quality review;

7.1.2.2. Data analysis;

7.1.2.3. Training and support for data entry into the RedCap and federal SPARS data repositories;

7.1.3. Two (2) program managers, who possess master's degrees in a psychology related field or equivalent and are licensed to practice in New Hampshire as required by applicable state and federal laws to provide training and consultation on :

7.1.3.1. Wellness interventions;

7.1.3.2. Recruitment and retention; and

7.1.3.3. Interview and data collection techniques.

8. Deliverables

8.1. The Contractor shall submit enrollment, service use and outcomes reports to the Department, by the twentieth (20th) day after the end of each quarter. Reports shall contain de-identified and aggregate data that pertains to:

8.1.1. Integrated mental health and primary care health homes.

8.1.2. Wellness interventions delivered within the integrated health home program.

8.2. The Contractor shall submit an annual report, by the tenth (10th) day of August, to the Department that identifies evaluation and health outcomes required by SAMHSA.

8.3. The Contractor shall provide two (2) annual presentations on the aggregate data and outcomes in EBP's by the tenth (10th) day of August and six (6) months later, or as requested by the Department.

9. Maintenance of Fiscal Integrity

9.1. The Contractor shall submit a summary within thirty five (35) calendar days to the Department that includes:

9.1.1. The number of interventions completed by individuals at each CMHC;

9.1.2. The number of hours of training and consultation, including the hours for preparation; and

9.1.3. Additional information as requested by the Department.

10. Data Management

10.1. The Contractor shall conduct human subjects data collection, management and reporting according to procedures approved and monitored by an Institutional Review Board.

10.2. The Contractor shall ensure all releases of confidentiality and prohibitions on disclosure of information are in compliance with all state and federal laws, including administrative rules, including the prohibition for re-disclosure of 42 CFR Part 2 information.

10.3. The Contractor shall collaborate with the Department to streamline, automate and align reporting with existing reports where possible.

10.4. The Contractor shall provide training and quality assurance of real-time National Outcome Measures (NOMs) data with the ProHealth NH Partnerships through a Department approved secure portal.

10.5. The Contractor shall collaborate with ProHealth NH Partnerships to provide quarterly reports to the Department that include National Outcome Measure (NOMs) and New Hampshire specific CMHC data points including, but not limited to:

10.5.1. Number of participants screened for ProHealth NH;

10.5.2. Number of participants newly enrolled in ProHealth NH;

10.5.3. Number of participants who received ProHealth NH health and behavioral screening and assessments;

10.5.4. Number of participants screened for trauma; depression; substance use disorders; medication use; involvement or interest in employment or education; need for assertive community treatment; and desire for symptom management;

10.5.5. Number of participants referred to each treatment based on needs identified in screenings;

10.5.6. Total number of participants who received each of the screenings and assessments in Section 2;

10.5.7. Total number of individuals of age group served by ProHealth NH in care at the CMHC; and

10.5.8. National Outcome Measures (NOMs) obtained.

10.6. The Contractor shall report quarterly aggregate summaries of the following items from CMHC and Federally Qualified Health Center electronic medical records:

10.6.1. Number of participants in supportive housing or independent living programs;

10.6.2. Number of participants who attended social and rehabilitative programs;

10.6.3. Number of participants who participated in each of the EBP services listed in Section 2;

10.6.4. Number of participants who attended a scheduled medical appointment;

10.6.5. Number of participants who attended a scheduled mental health appointment;

10.6.6. Number of participants who completed tobacco education;

10.6.7. Number of participants who completed obesity education;

10.6.8. Number of participants who attended Breathe Well Live Well;

10.6.9. Number of participants who attended Health Choices Healthy Changes; and

10.6.10. Cumulative totals of participants engaged in each of the EBP activities and Health Counseling and Wellness Interventions.

10.7. The Contractor shall establish follow-up rates in quarterly intervals for reporting on the proportion of individuals enrolled in ProHealth NH who received the following services:

10.7.1. Evidence-based mental health treatment for those whose mental health screening indicates a need;

10.7.2. Healthy lifestyle education following health screening;

10.7.3. Health education for tobacco among those who use tobacco as indicated in health screening;

10.8. The Contractor shall establish baseline rates for the following performance measures, reporting on the proportion of individuals enrolled in ProHealth NH who received the following health behavior change services:

10.8.1. Breathe Well Live Well Tobacco Program for those who use tobacco; and

10.8.2. Healthy Choices Healthy Changes Weight, nutrition and fitness program for those with obesity.

10.9. The Contractor shall report additional data as requested by the Department, which includes, but is not limited to:

10.9.1. Focus groups and qualitative interviews;

10.9.2. Participants' satisfactory performance in work and school settings;

10.9.3. The level of compliance with prescribed medication regimes;

10.9.4. The attendance at scheduled medical and behavioral health appointments; and

10.9.5. Any additional ProHealth NH data specified by SAMHSA.

10.10. The Contractor shall provide quarterly reports on financial incentives distributed from advanced payments for incentives to the Department by the fifteenth (15) day of the following month.

10.11. The Contractor shall provide evaluation, training, and consultation for ProHealth NH consistent with the data collections and infrastructure efforts of the Department.

11. Exhibits Incorporated

11.1. The Contractor shall use and disclose Protected Health Information in compliance with the Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) (45 CFR Parts 160, 162 and 164) under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and as applicable 42 CFR Part 2 for the protection of substance use disorder records, and in accordance with the attached Exhibit I, Business Associate Agreement, which has been executed by the parties.

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

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

12. Additional Terms

12.1. Impacts Resulting from Court Orders or Legislative Changes

12.1.1. 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.

12.2. Credits and Copyright Ownership

12.2.1. All documents, notices, press releases, research reports and other materials prepared during or resulting from the performance of the services of the Agreement shall include the following statement, "The preparation of this (report, document etc.) was financed under an Contract with the State of New Hampshire, Department of Health and Human Services, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services."

12.2.2. All materials produced under the Agreement shall be done in collaboration with the Department and must be approved before printing, production, distribution or use except for use of "Let's Talk About Feeling Good" and any academic publications.

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

12.2.3.1. Brochures.

12.2.3.2. Resource directories.

12.2.3.3. Protocols or guidelines.

12.2.3.4. Posters.

12.2.3.5. Reports.

12.2.4. Prior to any publication of the materials produced hereunder, Contractor shall forward to Department a copy of the disclosure for review and comment at least thirty (30) days prior to submission for publication. Contractor shall consider all comment from the Department in good faith and remove any confidential information the Department identified during such review. Contractor shall acknowledge the Department's contributions in all such publications.

12.3. Operation of Facilities: Compliance with Laws and Regulations

12.3.1. In the operation of any facilities for providing services, the Contractor shall comply with all laws, orders and regulations of federal, state, county and municipal authorities and with any direction of any Public Officer or officers pursuant to laws which shall impose an order or duty upon the contractor with respect to the operation of the facility or the provision of the services at such facility. If any governmental license or permit shall be required for the operation of the said facility or the performance of the said services, the Contractor will procure said license or permit, and will at all times comply with the terms and conditions of each such license or permit. In connection with the foregoing requirements, the Contractor hereby covenants and agrees that, during the term of this Agreement the facilities shall comply with all rules, orders, regulations, and requirements of the State Office of the Fire Marshal and the local fire protection agency, and shall be in conformance with local building and zoning codes, by-laws and regulations.

13. Records

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

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

13.1.2. 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.

13.1.3.

13.2. During the term of this Agreement and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives shall have access to all reports and records maintained pursuant to the Agreement for purposes of audit, examination, excerpts and transcripts. Upon the purchase by the Department of the maximum number of units provided for in the Agreement and upon payment of the price limitation hereunder, the Agreement and all the obligations of the parties hereunder (except such obligations as, by the terms of the Agreement are to be performed after the end of the term of this Agreement and/or survive the termination of the Agreement) shall terminate, provided however, that if, upon review of the Final Expenditure Report the Department

shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

Payment Terms

1. This Agreement is funded by:
   1.1. 100%, Prohealth NH Grant, awarded by the Substance Abuse Mental Health Services Administration, CFDA 93.243, FAIN H79SM080245.
2. For the purposes of this Agreement:
   2.1. The Department has identified the Contractor as a Contractor, in accordance with 2 CFR 200.331.
3. Payment shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this Agreement, and shall be in accordance with the approved line item, as specified in Exhibits C-1, Budget through Exhibit C-3, Budget.
4. The Contractor shall submit an invoice in a form satisfactory to the Department by the twenty fifth (25th) working day of the following month, which identifies and requests reimbursement for authorized expenses incurred in the prior month. The Contractor shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
5. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to dhhs.dbhinvoicesmhs@dhhs.nh.gov, or invoices may be mailed to:

   Financial Manager
   Department of Health and Human Services
   129 Pleasant Street
   Concord, NH 03301
6. The Department shall make payment to the Contractor within thirty (30) days of receipt of each invoice, subsequent to approval of the submitted invoice and if sufficient funds are available, subject to Paragraph 4 of the General Provisions Form Number P-37 of this Agreement.
7. The final invoice shall be due to the Department no later than sixty (60) days after the contract completion date specified in Form P-37, General Provisions Block 1.7 Completion Date.
8. The Contractor must provide the services in Exhibit B, Scope of Services, in compliance with funding requirements.
9. The Contractor agrees that funding under this Agreement may be withheld, in whole or in part in the event of non-compliance with the terms and conditions of Exhibit B, Scope of Services.
10. Notwithstanding anything to the contrary herein, the Contractor agrees that funding under this agreement may be withheld, in whole or in part, in the event of non-compliance with any Federal or State law, rule or regulation applicable

to the services provided, or if the said services or products have not been satisfactorily completed in accordance with the terms and conditions of this agreement.

11. 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.

12. Audits

12.1. The Contractor is required to submit an annual audit to the Department if any of the following conditions exist:

12.1.1. 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.

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

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

12.2. If Condition A exists, the Contractor shall submit an annual single audit performed by an independent Certified Public Accountant (CPA) to the Department within 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.

12.3. 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.

12.4. Any Contractor that receives an amount equal to or greater than $250,000 from the Department during a single fiscal year, regardless of the funding source, may be required, at a minimum, to submit annual financial audits performed by an independent CPA if the Department's risk assessment determination indicates the Contractor is high-risk.

12.5. In addition to, and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions and shall return to the Department all payments made under the

Contract to which exception has been taken, or which have been disallowed because of such an exception.

Exhibit C-1 Budget

New Hampshire Department of Health and Human Services

Bidder/Program Name: Mary Hitchcock Memorial Hospital

Budget Request for: Evaluation of ProHealth New Hampshire

Budget Period: July 1, 2021 - June 30, 2022

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 111,432.00	$ 11,143.00	$ 122,575.00	$ -	$ -	$ -	$ 111,432.00	$ 11,143.00	$ 122,575.00
2. Employee Benefits	$ 33,914.00	$ 3,391.00	$ 37,305.00	$ -	$ -	$ -	$ 33,914.00	$ 3,391.00	$ 37,305.00
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Educational	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Lab	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medical	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Office	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6. Travel	$ 507.00	$ 51.00	$ 558.00	$ -	$ -	$ -	$ 507.00	$ 51.00	$ 558.00
7. Occupancy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Telephone	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Postage	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subscriptions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Audit and Legal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Board Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11. Staff Education and Training	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12. Subcontracts/Agreements	$ 45,000.00	$ 4,500.00	$ 49,500.00	$ -	$ -	$ -	$ 45,000.00	$ 4,500.00	$ 49,500.00
13. Other (specify below) mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 190,853.00	$ 19,085.00	$ 209,938.00	$ -	$ -	$ -	$ 190,853.00	$ 19,085.00	$ 209,938.00
Indirect As A Percent of Direct		10.0%							

Exhibit C-2 Budget

New Hampshire Department of Health and Human Services

Bidder/Program Name: Mary Hitchcock Memorial Hospital

Budget Request for: Evaluation of ProHealth New Hampshire

Budget Period: July 1, 2021 – June 30, 2023

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 104,946.00	$ 10,495.00	$ 115,441.00	$ -	$ -	$ -	$ 104,946.00	$ 10,495.00	$ 115,441.00
2. Employee Benefits	$ 33,695.00	$ 3,369.00	$ 37,064.00	$ -	$ -	$ -	$ 33,695.00	$ 3,369.00	$ 37,064.00
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Educational	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Lab	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medical	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Office	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6. Travel	$ 450.00	$ 45.00	$ 495.00	$ -	$ -	$ -	$ 450.00	$ 45.00	$ 495.00
7. Occupancy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Telephone	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Postage	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subscriptions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Audit and Legal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Board Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11. Staff Education and Training	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12. Subcontracts/Agreements	$ 40,000.00	$ 4,000.00	$ 44,000.00	$ -	$ -	$ -	$ 40,000.00	$ 4,000.00	$ 44,000.00
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 179,091.00	$ 17,909.00	$ 197,000.00	$ -	$ -	$ -	$ 179,091.00	$ 17,909.00	$ 197,000.00
Indirect As A Percent of Direct		10.0%							

BKV

10/21/2021

Exhibit C-3 Budget

New Hampshire Department of Health and Human Services

Bidder/Program Name: Mary Hitchcock Memorial Hospital

Budget Request for: Evaluation of ProHealth New Hampshire

Budget Period: July 1, 2021 – June 30, 2023

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 29,719.00	$ 2,972.00	$ 32,691.00	$ -	$ -	$ -	$ 29,719.00	$ 2,972.00	$ 32,691.00
2. Employee Benefits	$ 9,599.00	$ 900.00	$ 10,599.00	$ -	$ -	$ -	$ 9,599.00	$ 900.00	$ 10,599.00
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Educational	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Lab	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medical	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Office	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6. Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
7. Occupancy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Telephone	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Postage	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subscriptions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Audit and Legal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Board Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11. Staff Education and Training	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12. Subcontracts/Agreements	$ 5,000.00	$ 500.00	$ 5,500.00	$ -	$ -	$ -	$ 5,000.00	$ 500.00	$ 5,500.00
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Data Based Interventions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 44,318.00	$ 4,432.00	$ 48,750.00	$ -	$ -	$ -	$ 44,318.00	$ 4,432.00	$ 48,750.00
Indirect As A Percent of Direct		10.0%							

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

This certification is required by the regulations implementing Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.). The January 31, 1989 regulations were amended and published as Part II of the May 25, 1990 Federal Register (pages 21681-21691), and require certification by grantees (and by inference, sub-grantees and sub-contractors), prior to award, that they will maintain a drug-free workplace. Section 3017.630(c) of the regulation provides that a grantee (and by inference, sub-grantees and sub-contractors) that is a State may elect to make one certification to the Department in each federal fiscal year in lieu of certificates for each grant during the federal fiscal year covered by the certification. The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment. Contractors using this form should send it to:

Commissioner
NH Department of Health and Human Services
129 Pleasant Street,
Concord, NH 03301-6505

1. The grantee certifies that it will or will continue to provide a drug-free workplace by:
   1.1. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
   1.2. Establishing an ongoing drug-free awareness program to inform employees about
      1.2.1. The dangers of drug abuse in the workplace;
      1.2.2. The grantee's policy of maintaining a drug-free workplace;
      1.2.3. Any available drug counseling, rehabilitation, and employee assistance programs; and
      1.2.4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
   1.3. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by subparagaph 1.1.
   1.4. Notifying the employee in the statement required by subparagraph 1.1 that, as a condition of employment under the grant, the employee will
      1.4.1. Abide by the terms of the statement; and
      1.4.2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
   1.5. Notifying the agency in writing, within ten calendar days after receiving notice under subparagraph 1.4.2 from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer on whose grant activity the convicted employee was working, unless the Federal agency

has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

1.6. Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph 1.4.2, with respect to any employee who is so convicted

1.6.1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

1.6.2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

1.7. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs 1.1, 1.2, 1.3, 1.4, 1.5, and 1.6.

2. The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant.

Place of Performance (street address, city, county, state, zip code) (list each location)

One Medical Center Drive, Lebanon, NH 03756

Check ☐ if there are workplaces on file that are not identified here.

Contractor Name: Mary Hitchcock Memorial Hospital

10/21/2021
Date

Barbara A. Vance
Name: Barbara A. Vance
Title: Vice President of Research Operations

CERTIFICATION REGARDING LOBBYING

The Vendor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Section 319 of Public Law 101-121, Government wide Guidance for New Restrictions on Lobbying, and 31 U.S.C. 1352, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

Programs (indicate applicable program covered):
*Temporary Assistance to Needy Families under Title IV-A
*Child Support Enforcement Program under Title IV-D
*Social Services Block Grant Program under Title XX
*Medicaid Program under Title XIX
*Community Services Block Grant under Title VI
*Child Care Development Block Grant under Title IV

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor).

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor), the undersigned shall complete and submit Standard Form LLL, (Disclosure Form to Report Lobbying, in accordance with its instructions, attached and identified as Standard Exhibit E-I.)

3. The undersigned shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Vendor Name: Mary Hitchcock Memorial Hospital

10/21/2021
Date

Barbara A. Vance
Name: Barbara A. Vance
Title: Vice President of Research Operations

CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

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

INSTRUCTIONS FOR CERTIFICATION

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

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

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

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

5. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549: 45 CFR Part 76. See https://www.govinfo.gov/app/details/CFR-2004-title45-vol1/CFR-2004-title45-vol1-part76/context.

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

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

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

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

information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

10. Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal government, DHHS may terminate this transaction for cause or default.

PRIMARY COVERED TRANSACTIONS

11. The prospective primary participant certifies to the best of its knowledge and belief, that it and its principals:
    - 11.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;
    - 11.2. have not within a three-year period preceding this proposal (contract) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or a contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
    - 11.3. are not presently indicted for otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (I)(b) of this certification; and
    - 11.4. have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

12. Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal (contract).

LOWER TIER COVERED TRANSACTIONS

13. By signing and submitting this lower tier proposal (contract), the prospective lower tier participant, as defined in 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:
    - 13.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
    - 13.2. where the prospective lower tier participant is unable to certify to any of the above, such prospective participant shall attach an explanation to this proposal (contract).

14. The prospective lower tier participant further agrees by submitting this proposal (contract) that it will include this clause entitled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion - Lower Tier Covered Transactions," without modification in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

Contractor Name: Mary Hitchcock Memorial Hospital

10/21/2021
Date

Barbara A. Vance
Name: Barbara A. Vance
Title: Vice President of Research Operations

CERTIFICATION OF COMPLIANCE WITH REQUIREMENTS PERTAINING TO FEDERAL NONDISCRIMINATION, EQUAL TREATMENT OF FAITH-BASED ORGANIZATIONS AND WHISTLEBLOWER PROTECTIONS

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

Contractor will comply, and will require any subgrantees or subcontractors to comply, with any applicable federal nondiscrimination requirements, which may include:

- the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. Section 3789d) which prohibits recipients of federal funding under this statute from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act requires certain recipients to produce an Equal Employment Opportunity Plan;

- the Juvenile Justice Delinquency Prevention Act of 2002 (42 U.S.C. Section 5672(b)) which adopts by reference, the civil rights obligations of the Safe Streets Act. Recipients of federal funding under this statute are prohibited from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act includes Equal Employment Opportunity Plan requirements;

- the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, which prohibits recipients of federal financial assistance from discriminating on the basis of race, color, or national origin in any program or activity);

- the Rehabilitation Act of 1973 (29 U.S.C. Section 794), which prohibits recipients of Federal financial assistance from discriminating on the basis of disability, in regard to employment and the delivery of services or benefits, in any program or activity;

- the Americans with Disabilities Act of 1990 (42 U.S.C. Sections 12131-34), which prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation;

- the Education Amendments of 1972 (20 U.S.C. Sections 1681, 1683, 1685-86), which prohibits discrimination on the basis of sex in federally assisted education programs;

- the Age Discrimination Act of 1975 (42 U.S.C. Sections 6106-07), which prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance. It does not include employment discrimination;

- 28 C.F.R. pt. 31 (U.S. Department of Justice Regulations – OJJDP Grant Programs); 28 C.F.R. pt. 42 (U.S. Department of Justice Regulations – Nondiscrimination; Equal Employment Opportunity; Policies and Procedures); Executive Order No. 13279 (equal protection of the laws for faith-based and community organizations); Executive Order No. 13559, which provide fundamental principles and policy-making criteria for partnerships with faith-based and neighborhood organizations;

- 28 C.F.R. pt. 38 (U.S. Department of Justice Regulations – Equal Treatment for Faith-Based Organizations); and Whistleblower protections 41 U.S.C. §4712 and The National Defense Authorization Act (NDAA) for Fiscal Year 2013 (Pub. L. 112-239, enacted January 2, 2013) the Pilot Program for Enhancement of Contract Employee Whistleblower Protections, which protects employees against reprisal for certain whistle blowing activities in connection with federal grants and contracts.

The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment.

In the event a Federal or State court or Federal or State administrative agency makes a finding of discrimination after a due process hearing on the grounds of race, color, religion, national origin, or sex against a recipient of funds, the recipient will forward a copy of the finding to the Office for Civil Rights, to the applicable contracting agency or division within the Department of Health and Human Services, and to the Department of Health and Human Services Office of the Ombudsman.

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this proposal (contract) the Contractor agrees to comply with the provisions indicated above.

Contractor Name: Mary Hitchcock Memorial Hospital

10/21/2021
Date

Barbara A. Vance
Name: Barbara A. Vance
Title: Vice President of Research Operations

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, Part C - Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 per day and/or the imposition of an administrative compliance order on the responsible entity.

The Contractor identified in Section 1.3 of the General Provisions agrees, by signature of the Contractor's representative as identified in Section 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this contract, the Contractor agrees to make reasonable efforts to comply with all applicable provisions of Public Law 103-227, Part C, known as the Pro-Children Act of 1994.

Contractor Name: Mary Hitchcock Memorial Hospital

10/21/2021
Date

Barbara A. Vance

Name: Barbara A. Vance
Title: Vice President of Research Operations

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT BUSINESS ASSOCIATE AGREEMENT

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

(1) Definitions.

a. "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

b. "Business Associate" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

c. "Covered Entity" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

d. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR Section 164.501.

e. "Data Aggregation" shall have the same meaning as the term "data aggregation" in 45 CFR Section 164.501.

f. "Health Care Operations" shall have the same meaning as the term "health care operations" in 45 CFR Section 164.501.

g. "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act, TitleXIII, Subtitle D, Part 1 & 2 of the American Recovery and Reinvestment Act of 2009.

h. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160, 162 and 164 and amendments thereto.

i. "Individual" shall have the same meaning as the term "individual" in 45 CFR Section 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.501(g).

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

k. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR Section 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

l. "Required by Law" shall have the same meaning as the term "required by law" in 45CFR Section 164.103.

m. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

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

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

p. Other Definitions - All terms not otherwise defined herein shall have the meaning established under 45 C.F.R. Parts 160, 162 and 164, as amended from time to time, and the HITECH
Act.

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

a. Business Associate shall not use, disclose, maintain or transmit Protected Health Information (PHI) except as reasonably necessary to provide the services outlined under Exhibit A of the Agreement. Further, Business Associate, including but not limited to all its directors, officers, employees and agents, shall not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

b. Business Associate may use or disclose PHI:
   I. For the proper management and administration of the Business Associate;
   II. As required by law, pursuant to the terms set forth in paragraph d. below; or
   III. For data aggregation purposes for the health care operations of Covered Entity.

c. To the extent Business Associate is permitted under the Agreement to disclose PHI to a third party, Business Associate must obtain, prior to making any such disclosure, (i) reasonable assurances from the third party that such PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (ii) an agreement from such third party to notify Business Associate, in accordance with the HIPAA Privacy, Security, and Breach Notification Rules of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.

d. The Business Associate shall not, unless such disclosure is reasonably necessary to provide services under Exhibit A of the Agreement, disclose any PHI in response to a request for disclosure on the basis that it is required by law, without first notifying Covered Entity so that Covered Entity has an opportunity to object to the disclosure and to seek appropriate relief. If Covered Entity objects to such disclosure, the Business

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

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

(3) Obligations and Activities of Business Associate.

a. The Business Associate shall notify the Covered Entity's Privacy Officer immediately after the Business Associate becomes aware of any use or disclosure of protected health information not provided for by the Agreement including breaches of unsecured protected health information and/or any security incident that may have an impact on the protected health information of the Covered Entity.

b. The Business Associate shall immediately perform a risk assessment when it becomes aware of any of the above situations. The risk assessment shall include, but not be limited to:

- The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person used the protected health information or to whom the disclosure was made;
- Whether the protected health information was actually acquired or viewed
- The extent to which the risk to the protected health information has been mitigated.

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

c. The Business Associate shall comply with all sections of the Privacy, Security, and Breach Notification Rule.

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

e. Business Associate shall require all of its business associates that receive, use or have access to PHI under the Agreement, to agree in writing to adhere to the same restrictions and conditions on the use and disclosure of PHI contained herein, including the duty to return or destroy the PHI as provided under Section 3 (l). The Covered Entity shall be considered a direct third party beneficiary of the Contractor's business associate agreements with Contractor's intended business associates, who will be receiving PHI

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

f. Within five (5) business days of receipt of a written request from Covered Entity, Business Associate shall make available during normal business hours at its offices all records, books, agreements, policies and procedures relating to the use and disclosure of PHI to the Covered Entity, for purposes of enabling Covered Entity to determine Business Associate's compliance with the terms of the Agreement.

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

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

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

j. Within ten (10) business days of receiving a written request from Covered Entity for a request for an accounting of disclosures of PHI, Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill its obligations to provide an accounting of disclosures with respect to PHI in accordance with 45 CFR Section 164.528.

k. In the event any individual requests access to, amendment of, or accounting of PHI directly from the Business Associate, the Business Associate shall within two (2) business days forward such request to Covered Entity. Covered Entity shall have the responsibility of responding to forwarded requests. However, if forwarding the individual's request to Covered Entity would cause Covered Entity or the Business Associate to violate HIPAA and the Privacy and Security Rule, the Business Associate shall instead respond to the individual's request as required by such law and notify Covered Entity of such response as soon as practicable.

l. Within ten (10) business days of termination of the Agreement, for any reason, the Business Associate shall return or destroy, as specified by Covered Entity, all PHI received from, or created or received by the Business Associate in connection with the Agreement, and shall not retain any copies or back-up tapes of such PHI. If return or destruction is not feasible, or the disposition of the PHI has been otherwise agreed to in the Agreement, Business Associate shall continue to extend the protections of the Agreement, to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business

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

(4) **Obligations of Covered Entity**

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

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

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

(5) **Termination for Cause**

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

(6) **Miscellaneous**

a. Definitions and Regulatory References. All terms used, but not otherwise defined herein, shall have the same meaning as those terms in the Privacy and Security Rule, amended from time to time. A reference in the Agreement, as amended to include this Exhibit I, to a Section in the Privacy and Security Rule means the Section as in effect or as amended.

b. Amendment. Covered Entity and Business Associate agree to take such action as is necessary to amend the Agreement, from time to time as is necessary for Covered Entity to comply with the changes in the requirements of HIPAA, the Privacy and Security Rule, and applicable federal and state law.

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

d. Interpretation. The parties agree that any ambiguity in the Agreement shall be resolved to permit Covered Entity to comply with HIPAA, the Privacy and Security Rule.

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

f. Survival. Provisions in this Exhibit I regarding the use and disclosure of PHI, return or destruction of PHI, extensions of the protections of the Agreement in section (3) I, the defense and indemnification provisions of section (3) e and Paragraph 13 of the standard terms and conditions (P-37), shall survive the termination of the Agreement.

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

Department of Health and Human Services	Mary Hitchcock Memorial Hospital
The State	Name of the Contractor
DocuSigned by: Katja S. Fox B0900300400C83442...	Barbara A. Vance
Signature of Authorized Representative	Signature of Authorized Representative
Katja S. Fox	Barbara A. Vance
Name of Authorized Representative	Name of Authorized Representative
Director	Vice President of Research Operations
Title of Authorized Representative	Title of Authorized Representative
10/26/2021	10/21/2021
Date	Date

CERTIFICATION REGARDING THE FEDERAL FUNDING ACCOUNTABILITY AND TRANSPARENCY ACT (FFATA) COMPLIANCE

The Federal Funding Accountability and Transparency Act (FFATA) requires prime awardees of individual Federal grants equal to or greater than $25,000 and awarded on or after October 1, 2010, to report on data related to executive compensation and associated first-tier sub-grants of $25,000 or more. If the initial award is below $25,000 but subsequent grant modifications result in a total award equal to or over $25,000, the award is subject to the FFATA reporting requirements, as of the date of the award.
In accordance with 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), the Department of Health and Human Services (DHHS) must report the following information for any subaward or contract award subject to the FFATA reporting requirements:

1. Name of entity
2. Amount of award
3. Funding agency
4. NAICS code for contracts / CFDA program number for grants
5. Program source
6. Award title descriptive of the purpose of the funding action
7. Location of the entity
8. Principle place of performance
9. Unique identifier of the entity (DUNS #)
10. Total compensation and names of the top five executives if:
    - 10.1. More than 80% of annual gross revenues are from the Federal government, and those revenues are greater than $25M annually and
    - 10.2. Compensation information is not already available through reporting to the SEC.

Prime grant recipients must submit FFATA required data by the end of the month, plus 30 days, in which the award or award amendment is made.
The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of The Federal Funding Accountability and Transparency Act, Public Law 109-282 and Public Law 110-252, and 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:
The below named Contractor agrees to provide needed information as outlined above to the NH Department of Health and Human Services and to comply with all applicable provisions of the Federal Financial Accountability and Transparency Act.

Contractor Name: Mary Hitchcock Memorial Hospital

10/21/2021
Date

Barbara A. Vance
Name: Barbara A. Vance
Title: Vice President of Research Operations

FORM A

As the Contractor identified in Section 1.3 of the General Provisions, I certify that the responses to the below listed questions are true and accurate.

1. The DUNS number for your entity is: 06-991-0297

2. In your business or organization's preceding completed fiscal year, did your business or organization receive (1) 80 percent or more of your annual gross revenue in U.S. federal contracts, subcontracts, loans, grants, sub-grants, and/or cooperative agreements; and (2) $25,000,000 or more in annual gross revenues from U.S. federal contracts, subcontracts, loans, grants, subgrants, and/or cooperative agreements?

   X NO _____ YES

   If the answer to #2 above is NO, stop here

   If the answer to #2 above is YES, please answer the following:

3. Does the public have access to information about the compensation of the executives in your business or organization through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C.78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986?

   _____ NO X YES

   If the answer to #3 above is YES, stop here

   If the answer to #3 above is NO, please answer the following:

4. The names and compensation of the five most highly compensated officers in your business or organization are as follows:

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

A. Definitions

The following terms may be reflected and have the described meaning in this document:

1. "Breach" means the loss of control, compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, or any similar term referring to situations where persons other than authorized users and for an other than authorized purpose have access or potential access to personally identifiable information, whether physical or electronic. With regard to Protected Health Information, "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

2. "Computer Security Incident" shall have the same meaning "Computer Security Incident" in section two (2) of NIST Publication 800-61, Computer Security Incident Handling Guide, National Institute of Standards and Technology, U.S. Department of Commerce.

3. "Confidential Information," "Confidential Data," or "Data" (as defined in Exhibit K), means all confidential information disclosed by one party to the other such as all medical, health, financial, public assistance benefits and personal information including without limitation, Substance Abuse Treatment Records, Case Records, Protected Health Information and Personally Identifiable Information.

   Confidential Information also includes any and all information owned or managed by the State of NH - created, received from or on behalf of the Department of Health and Human Services (DHHS) or accessed in the course of performing contracted services - of which collection, disclosure, protection, and disposition is governed by state or federal law or regulation. This information includes, but is not limited to Protected Health Information (PHI), Personal Information (PI), Personal Financial Information (PFI), Federal Tax Information (FTI), Social Security Numbers (SSN), Payment Card Industry (PCI), and or other sensitive and confidential information.

4. "End User" means any person or entity (e.g., contractor's employee, business associate, subcontractor, other downstream user, etc.) that receives DHHS data or derivative data in accordance with the terms of this Contract.

5. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.

6. "Incident" means an act that potentially violates a security policy, which includes successful attempts) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or

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

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

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

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

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

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

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

I. RESPONSIBILITIES OF DHHS AND THE CONTRACTOR

A. Business Use and Disclosure of Confidential Information.

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

Contractor Initials BRV

Date 10/21/2021

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

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

II. METHODS OF SECURE TRANSMISSION OF DATA

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

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

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

III. RETENTION AND DISPOSITION OF IDENTIFIABLE RECORDS

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

A. Retention

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

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

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

B. Disposition

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

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

IV. PROCEDURES FOR SECURITY

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

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

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

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

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

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

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

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

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

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

health information and as applicable under State law.

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

11. Contractor agrees to maintain a documented breach notification and incident response process. The Contractor must notify the DHHS Security Office and the Program Contact via the email addresses provided in Section VI of this Exhibit, immediately upon the Contractor determining that a breach or security incident has occurred and that DHHS confidential Information/data may have been exposed or compromised. This includes a confidential information breach, computer security incident, or suspected breach which affects or includes any State of New Hampshire systems that connect to the State of New Hampshire network.

12. Contractor must restrict access to the Confidential Data obtained under this Contract to only those authorized End Users who need such DHHS Data to perform their official duties in connection with purposes identified in this Contract.

13. The Contractor is responsible for End User oversight and compliance with the terms and conditions of the contract and Exhibit K.

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

V. LOSS REPORTING

The Contractor must immediately notify the State's Privacy Officer, Information Security Office and Program Manager of any Security Incidents and Breaches as specified in Section IV, paragraph 11 above.

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

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

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

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

VI. PERSONS TO CONTACT

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

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

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

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

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