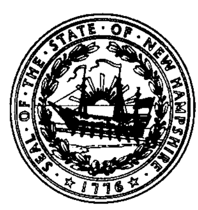
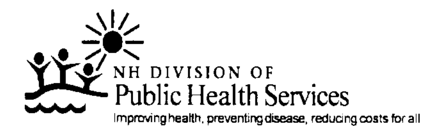


STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES



29 HAZEN DRIVE, CONCORD, NH 03301-6527
603-271-4535 1-800-852-3345 Ext. 4535
Fax: 603-271-4506 TDD Access: 1-800-735-2964

Nicholas A. Toumpas
Commissioner

José Thier Montero
Director

March 28, 2014

Her Excellency, Governor Margaret Wood Hassan
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Public Health Services, to amend agreements with 13 vendors by increasing the total price limitation by $4,293,569 from $5,173,800 to $9,467,369 to provide primary care services. This amount includes a request to **retroactively** enter into **sole-source** amendments in an amount of $648,347, effective **retroactive** to July, 1, 2013 through June 30, 2014 and to exercise a one-year renewal option with the same 13 vendors in an amount of $3,645,222, extending the completion date from June 30, 2014 to June 30, 2015, effective upon Governor and Council approval. Twelve of these agreements were originally approved by Governor and Council on June 20, 2012, Item numbers 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, and one agreement was originally approved by Governor and Council on July 11, 2012, Item number 31.

Summary of contracted amounts by vendor:

Vendor	Location	SFY 2014 Amount	SFY 2015 Amount	Total Increase
Ammonoosuc Community Health	North Grafton/ South Coos	$42,661	$254,172	$296,833
Concord Hospital, Inc.	Merrimack/ Hillsborough	$64,413	$376,377	$440,790
Coos County Family Health	Eastern Coos	$24,351	$159,685	$184,036
Families First of the Greater Seacoast	Seacoast Area	$41,892	$242,094	$283,986
Goodwin Community Health	Strafford County	$74,293	$420,579	$494,872
Health First Family Care Center	Central/Eastern Belknap	$55,968	$292,214	$348,182
Indian Stream Health Center	Northern Coos & Colebrook	$18,030	$100,409	$118,439
Lamprey Health Care, Inc.	Central Southern/Eastern NH	$119,828	$654,249	$774,077
Manchester Community Health Center	Greater Manchester Area	$71,392	$407,637	$479,029
Mid-State Health Center	Central Northern Belknap	$35,001	$175,511	$210,512
The New London Hospital, Inc.	Sullivan County	$39,566	$225,093	$264,659
Weeks Medical Center	Western Coos	$20,652	$113,557	$134,209
White Mountain Community Health	Northern Carroll	$40,300	$223,645	$263,945
TOTAL		**$648,347**	**$3,645,222**	**$4,293,569**

Funds to support this request are available in the following accounts for SFY 2014 and SFY 2015, with authority to adjust amounts within the price limitation and amend the related terms of the contract without further approval from Governor and Executive Council.

05-95-90-902010-5190 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES, MATERNAL AND CHILD HEALTH

05-95-90-902010-5659 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES, COMPREHENSIVE CANCER

05-95-90-901010-7965 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF PUBLIC HEALTH SYSTEMS, POLICY & PERFORMANCE, RURAL HEALTH AND PRIMARY CARE

See attachment for financial details

EXPLANATION

Approval is requested **retroactive** to July 1, 2013. The services provided by these contracts are consistent with prior contracts and were included in the operating budget for SFY 2014 and SFY 2015. Contracts were delayed, however, since the exact amount of funding available was only recently determined. The SFY 2014 amendments are **sole source** because they exceed more than 10% of the original contract amount.

This requested action seeks approval of 13 amendments that represents $4,293,569 total anticipated to be spent statewide to continue breast and cervical cancer screening and office-based primary care services for low-income and uninsured families. In the interest of efficiency, the contract amendments are being bundled as they are providing the same services, and because of the size of the resulting Governor and Council submission, the copies provided are abbreviated in the interest of saving resources. The Councilors and the public can view the entire submission package on the Secretary of State's website.

Primary health care services include preventive and episodic health care for acute and chronic health conditions for people of all ages, including pregnant women, children, adolescents, adults, and the elderly. Community health agencies that receive support through the Division of Public Health Services deliver primary and preventive health care services to underserved people who face barriers to accessing health care, due to issues such as a lack of insurance, inability to pay, language barriers, and geographic isolation. In addition to medical care, community health centers are unique among primary care providers for the array of patient-centered services they offer, including care coordination, translation, transportation, outreach, eligibility assistance, and health education. These services help individuals overcome barriers to getting the care they need and achieving their optimal health. One area of particular success has been in ensuring that eligible families maintain consistent enrollment in Medicaid for their children. Community health centers provide support for families in filling out applications and ensuring that children have continuity of care.

In addition, breast and cervical cancers continue to be ongoing public health issues for New Hampshire. The Division of Public Health Services, Breast and Cervical Cancer Screening Program

provides support for breast and cervical cancer screening services that include clinical examinations, pap smears and referral for mammography. Through this program, women found to have abnormal screening results, following their testing, receive additional coverage for diagnostic work-up and, if necessary, have their care coordinated through the initiation of treatment.

Should Governor and Executive Council not authorize this Request, low-income individuals statewide may not have adequate access to primary care services, and eligible women may not receive recommended breast and cervical cancer screenings. A strong primary care infrastructure reduces costs for uncompensated care, improves health outcomes, and reduces health disparities. Additionally women that receive recommended breast and cervical cancer screenings are at lower risk of late diagnosis of breast and cervical cancers.

Contracts were awarded to Primary Care agencies through a competitive bid process. A Request for Proposals was posted on the Department of Health and Human Services' web site from January 10, 2012 through February 16, 2012. In addition, a bidder's conference, conference call, and web conference were held on January 19, 2012 to alert agencies to this bid.

Thirteen proposals were received in response to the posting. Each proposal was scored by teams of three professionals. All reviewers have between three to 20 years' experience managing agreements with vendors for various public health programs. Areas of specific expertise include maternal and child health; quality assurance and performance improvement; chronic and communicable diseases and public health infrastructure. The reviewers used a standardized form to score agencies' relevant experience and capacity to carry out the activities outlined in the proposal. Reviewers look for realistic targets when scoring performance measures in addition to detailed workplans including evaluation components. Budgets were reviewed to be reasonable, justified and consistent with the intent of the program goals and outcomes. There were no competing applications within each of the separate service areas. Scores were averaged and all proposals were recommended for funding. The Bid Summary is attached.

As referenced in the Request for Proposals, Renewals Section, these competitively procured Agreements have the option to renew for two (2) additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties and approval of the Governor and Council. The Department is exercising one year of this renewal option.

Community health agencies throughout New Hampshire have demonstrated success in meeting the health care needs of the uninsured and under-insured citizens of the state. Division of Public Health Services funded primary care providers participate in rigorous quality improvement efforts utilizing standard performance measures that focus attention on improving health outcomes for patients. All Primary Care vendors are making adequate progress in meeting clinical performance measures and the Departments wishes to continue working with the vendors for another year.

The performance measures as described in the contract amendment Exhibit A – Amendment 1 – Performance Measures, will be used to continue to measure the effectiveness of the agreement.

Area to be served is statewide.

Source of Funds: 13.09% Federal Funds from US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau; Centers for Disease Control and Prevention and 86.91% General Funds.

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

Respectfully submitted,

José Thier Montero, MD, MHCDS
Director

Approved by: Nicholas A. Toumpas
Commissioner

FINANCIAL DETAIL ATTACHMENT SHEET
Primary Care Services

05-95-90-902010-5190 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES, MATERNAL AND CHILD HEALTH
100% General Funds

Ammonoosuc Community Health Services, Inc., Vendor # 177755-B003 PO # 1024251

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080400	-	-	-
SFY 2014	102/500731	Contracts for Program Svcs	90080400	-	42,661	42,661
SFY 2015	102/500731	Contracts for Program Svcs	90080400	-	-	-
			Sub-Total	$0	$42,661	$42,661

Concord Hospital, Inc., Vendor # 177653-B011 PO # 1024253

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080400	-	-	-
SFY 2014	102/500731	Contracts for Program Svcs	90080400	-	64,413	64,413
SFY 2015	102/500731	Contracts for Program Svcs	90080400	-	-	-
			Sub-Total	$0	$64,413	$64,413

Coos County Family Health Services, Inc., Vendor # 155327-B001 PO # 1024252

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080400	-	-	-
SFY 2014	102/500731	Contracts for Program Svcs	90080400	-	24,351	24,351
SFY 2015	102/500731	Contracts for Program Svcs	90080400	-	-	-
			Sub-Total	$0	$24,351	$24,351

Families First of the Greater Seacoast, Vendor # 166629-B001 PO # 1024254

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080400	-	-	-
SFY 2014	102/500731	Contracts for Program Svcs	90080400	-	41,892	41,892
SFY 2015	102/500731	Contracts for Program Svcs	90080400	-	-	-
			Sub-Total	$0	$41,892	$41,892

Goodwin Community Health, Vendor # 154703-B001 PO # 1024256

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080400	-	-	-
SFY 2014	102/500731	Contracts for Program Svcs	90080400	-	74,293	74,293
SFY 2015	102/500731	Contracts for Program Svcs	90080400	-	-	-
			Sub-Total	$0	$74,293	$74,293

Health First Family Care Center, Vendor # 158221-B001 PO # 1024257

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080400	-	-	-
SFY 2014	102/500731	Contracts for Program Svcs	90080400	-	55,968	55,968
SFY 2015	102/500731	Contracts for Program Svcs	90080400	-	-	-
			Sub-Total	$0	$55,968	$55,968

FINANCIAL DETAIL ATTACHMENT SHEET
Primary Care Services

Indian Stream Health Center, Vendor # 165274-B001 PO # 1024258

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080400	-	-	-
SFY 2014	102/500731	Contracts for Program Svcs	90080400	-	18,030	18,030
SFY 2015	102/500731	Contracts for Program Svcs	90080400	-	-	-
			Sub-Total	$0	$18,030	$18,030

Lamprey Health Care, Inc., Vendor # 177677-R001 PO # 1024259

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080400	-	-	-
SFY 2014	102/500731	Contracts for Program Svcs	90080400	-	119,828	119,828
SFY 2015	102/500731	Contracts for Program Svcs	90080400	-	-	-
			Sub-Total	$0	$119,828	$119,828

Manchester Community Health Center, Vendor # 157274-B001 PO # 1024260

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080400	-	-	-
SFY 2014	102/500731	Contracts for Program Svcs	90080400	-	71,392	71,392
SFY 2015	102/500731	Contracts for Program Svcs	90080400	-	-	-
			Sub-Total	$0	$71,392	$71,392

Mid-State Health Center, Vendor # 158055-B001 PO # 1024350

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080400	-	-	-
SFY 2014	102/500731	Contracts for Program Svcs	90080400	-	35,001	35,001
SFY 2015	102/500731	Contracts for Program Svcs	90080400	-	-	-
			Sub-Total	$0	$35,001	$35,001

The New London Hospital, Inc., Vendor # 177167-R005 PO # 1024262

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080400	-	-	-
SFY 2014	102/500731	Contracts for Program Svcs	90080400	-	39,566	39,566
SFY 2015	102/500731	Contracts for Program Svcs	90080400	-	-	-
			Sub-Total	$0	$39,566	$39,566

Weeks Medical Center, Vendor # 177171-R001 PO # 1024400

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080400	-	-	-
SFY 2014	102/500731	Contracts for Program Svcs	90080400	-	20,652	20,652
SFY 2015	102/500731	Contracts for Program Svcs	90080400	-	-	-
			Sub-Total	$0	$20,652	$20,652

FINANCIAL DETAIL ATTACHMENT SHEET
Primary Care Services

White Mountain Community Health Center, Vendor # 174170-R001 PO # 1024263

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080400	-	-	-
SFY 2014	102/500731	Contracts for Program Svcs	90080400	-	40,300	40,300
SFY 2015	102/500731	Contracts for Program Svcs	90080400	-	-	-
			Sub-Total	$0	$40,300	$40,300
			SUB TOTAL	**$0**	**$648,347**	**$648,347**

05-95-90-902010-5190 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES, MATERNAL AND CHILD HEALTH
6.7% Federal Funds and 93.3% General Funds (FAIN# MC26681)

Ammonoosuc Community Health Services, Inc., Vendor # 177755-B003 PO # 1024251

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080000	142,819	-	142,819
SFY 2014	102/500731	Contracts for Program Svcs	90080000	142,819	-	142,819
SFY 2015	102/500731	Contracts for Program Svcs	90080000	-	213,921	213,921
			Sub-Total	$285,638	$213,921	$499,559

Concord Hospital, Inc., Vendor # 177653-B011 PO # 1024253

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080000	215,637	-	215,637
SFY 2014	102/500731	Contracts for Program Svcs	90080000	215,637	-	215,637
SFY 2015	102/500731	Contracts for Program Svcs	90080000	-	322,992	322,992
			Sub-Total	$431,274	$322,992	$754,266

Coos County Family Health Services, Inc., Vendor # 155327-B001 PO # 1024252

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080000	81,519	-	81,519
SFY 2014	102/500731	Contracts for Program Svcs	90080000	81,519	-	81,519
SFY 2015	102/500731	Contracts for Program Svcs	90080000	-	122,103	122,103
			Sub-Total	$163,038	$122,103	$285,141

Families First of the Greater Seacoast Vendor # 166629-B001 PO # 1024254

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080000	140,243	-	140,243
SFY 2014	102/500731	Contracts for Program Svcs	90080000	140,243	-	140,243
SFY 2015	102/500731	Contracts for Program Svcs	90080000	-	210,063	210,063
			Sub-Total	$280,486	$210,063	$490,549

Goodwin Community Health Vendor # 154703-B001 PO # 1024256

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080000	248,712	-	248,712
SFY 2014	102/500731	Contracts for Program Svcs	90080000	248,712	-	248,712
SFY 2015	102/500731	Contracts for Program Svcs	90080000	-	372,533	372,533
			Sub-Total	$497,424	$372,533	$869,957

FINANCIAL DETAIL ATTACHMENT SHEET
Primary Care Services

Health First Family Care Center, Vendor # 158221-B001 — PO # 1024257

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080000	187,367	-	187,367
SFY 2014	102/500731	Contracts for Program Svcs	90080000	187,367	-	187,367
SFY 2015	102/500731	Contracts for Program Svcs	90080000	-	280,648	280,648
			Sub-Total	$374,734	$280,648	$655,382

Indian Stream Health Center, Vendor #165274-B001 — PO # 1024258

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080000	60,359	-	60,359
SFY 2014	102/500731	Contracts for Program Svcs	90080000	60,359	-	60,359
SFY 2015	102/500731	Contracts for Program Svcs	90080000	-	90,409	90,409
			Sub-Total	$120,718	$90,409	$211,127

Lamprey Health Care, Inc., Vendor # 177677-R001 — PO # 1024259

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080000	401,151	-	401,151
SFY 2014	102/500731	Contracts for Program Svcs	90080000	401,151	-	401,151
SFY 2015	102/500731	Contracts for Program Svcs	90080000	-	600,864	600,864
			Sub-Total	$802,302	$600,864	$1,403,166

Manchester Community Health Center, Vendor # 157274-B001 — PO # 1024260

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080000	239,002	-	239,002
SFY 2014	102/500731	Contracts for Program Svcs	90080000	239,002	-	239,002
SFY 2015	102/500731	Contracts for Program Svcs	90080000	-	357,989	357,989
			Sub-Total	$478,004	$357,989	$835,993

Mid-State Health Center, Vendor # 158055-B001 — PO # 1024350

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080000	117,175	-	117,175
SFY 2014	102/500731	Contracts for Program Svcs	90080000	117,175	-	117,175
SFY 2015	102/500731	Contracts for Program Svcs	90080000	-	175,511	175,511
			Sub-Total	$234,350	$175,511	$409,861

The New London Hospital, Inc., Vendor # 177167-R005 — PO # 1024262

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080000	132,457	-	132,457
SFY 2014	102/500731	Contracts for Program Svcs	90080000	132,457	-	132,457
SFY 2015	102/500731	Contracts for Program Svcs	90080000	-	198,401	198,401
			Sub-Total	$264,914	$198,401	$463,315

FINANCIAL DETAIL ATTACHMENT SHEET
Primary Care Services

Weeks Medical Center, Vendor # 177171-R001 PO # 1024400

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080000	69,137	-	69,137
SFY 2014	102/500731	Contracts for Program Svcs	90080000	69,137	-	69,137
SFY 2015	102/500731	Contracts for Program Svcs	90080000	-	103,557	103,557
			Sub-Total	$138,274	$103,557	$241,831

White Mountain Community Health Center, Vendor # 174170-R001 PO # 1024263

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080000	134,913	-	134,913
SFY 2014	102/500731	Contracts for Program Svcs	90080000	134,913	-	134,913
SFY 2015	102/500731	Contracts for Program Svcs	90080000	-	202,079	202,079
			Sub-Total	$269,826	$202,079	$471,905
			SUB TOTAL	**$4,340,982**	**$3,251,070**	**$7,592,052**

05-95-90-902010-5659 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES, COMPREHENSIVE CANCER 100% Federal Funds (FAIN #U58DP003930)

Ammonoosuc Community Health Services, Inc., Vendor # 177755-B003 PO # 1024251

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080081	32,608	-	32,608
SFY 2014	102/500731	Contracts for Program Svcs	90080081	32,608	-	32,608
SFY 2015	102/500731	Contracts for Program Svcs	90080081	-	30,251	30,251
			Sub-Total	$65,216	$30,251	$95,467

Concord Hospital, Inc., Vendor # 177653-B011 PO # 1024253

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080081	60,067	-	60,067
SFY 2014	102/500731	Contracts for Program Svcs	90080081	60,067	-	60,067
SFY 2015	102/500731	Contracts for Program Svcs	90080081	-	53,385	53,385
			Sub-Total	$120,134	$53,385	$173,519

Coos County Family Health Services, Inc., Vendor # 155327-B001 PO # 1024252

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080081	30,034	-	30,034
SFY 2014	102/500731	Contracts for Program Svcs	90080081	30,034	-	30,034
SFY 2015	102/500731	Contracts for Program Svcs	90080081	-	27,582	27,582
			Sub-Total	$60,068	$27,582	$87,650

Families First of the Greater Seacoast Vendor # 166629-B001 PO # 1024254

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080081	30,034	-	30,034
SFY 2014	102/500731	Contracts for Program Svcs	90080081	30,034	-	30,034
SFY 2015	102/500731	Contracts for Program Svcs	90080081	-	32,031	32,031
			Sub-Total	$60,068	$32,031	$92,099

FINANCIAL DETAIL ATTACHMENT SHEET
Primary Care Services

Goodwin Community Health Vendor # 154703-B001 PO # 1024256

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080081	51,486	-	51,486
SFY 2014	102/500731	Contracts for Program Svcs	90080081	51,486	-	51,486
SFY 2015	102/500731	Contracts for Program Svcs	90080081	-	48,046	48,046
			Sub-Total	$102,972	$48,046	$151,018

Health First Family Care Center, Vendor # 158221-B001 PO # 1024257

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080081	12,871	-	12,871
SFY 2014	102/500731	Contracts for Program Svcs	90080081	12,871	-	12,871
SFY 2015	102/500731	Contracts for Program Svcs	90080081	-	11,566	11,566
			Sub-Total	$25,742	$11,566	$37,308

Lamprey Health Care, Inc., Vendor # 177677-R001 PO # 1024259

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080081	60,067	-	60,067
SFY 2014	102/500731	Contracts for Program Svcs	90080081	60,067	-	60,067
SFY 2015	102/500731	Contracts for Program Svcs	90080081	-	53,385	53,385
			Sub-Total	$120,134	$53,385	$173,519

Manchester Community Health Center, Vendor # 157274-B001 PO # 1024260

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080081	47,196	-	47,196
SFY 2014	102/500731	Contracts for Program Svcs	90080081	47,196	-	47,196
SFY 2015	102/500731	Contracts for Program Svcs	90080081	-	49,648	49,648
			Sub-Total	$94,392	$49,648	$144,040

The New London Hospital, Inc., Vendor # 177167-R005 PO # 1024262

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080081	29,175	-	29,175
SFY 2014	102/500731	Contracts for Program Svcs	90080081	29,175	-	29,175
SFY 2015	102/500731	Contracts for Program Svcs	90080081	-	26,692	26,692
			Sub-Total	$58,350	$26,692	$85,042

White Mountain Community Health Center, Vendor # 174170-R001 PO # 1024263

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90080081	12,871	-	12,871
SFY 2014	102/500731	Contracts for Program Svcs	90080081	12,871	-	12,871
SFY 2015	102/500731	Contracts for Program Svcs	90080081	-	11,566	11,566
			Sub-Total	25,742	11,566	37,308
			SUB TOTAL	**$732,818**	**$344,152**	**$1,076,970**

FINANCIAL DETAIL ATTACHMENT SHEET
Primary Care Services

05-95-90-901010-5149 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF PUBLIC HEALTH SYSTEMS, POLICY & PERFORMANCE, RURAL HEALTH AND PRIMARY CARE
100% General Funds

Ammonoosuc Community Health Services, Inc., Vendor # 177755-B003 PO # 1024251

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90073001	10,000	-	10,000
SFY 2014	102/500731	Contracts for Program Svcs	90073001	10,000	-	10,000
SFY 2015	102/500731	Contracts for Program Svcs	90073001	-	-	-
			Sub-Total	$20,000	$0	$20,000

Coos County Family Health Services, Inc., Vendor # 155327-B001 PO # 1024252

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90073001	10,000		10,000
SFY 2014	102/500731	Contracts for Program Svcs	90073001	10,000	-	10,000
SFY 2015	102/500731	Contracts for Program Svcs	90073001	-	-	-
			Sub-Total	$20,000	$0	$20,000

Indian Stream Health Center, Vendor #165274-B001 PO # 1024258

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90073001	10,000	-	10,000
SFY 2014	102/500731	Contracts for Program Svcs	90073001	10,000	-	10,000
SFY 2015	102/500731	Contracts for Program Svcs	90073001	-	-	-
			Sub-Total	$20,000	$0	$20,000

Weeks Medical Center, Vendor # 177171-R001 PO # 1024400

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90073001	10,000	-	10,000
SFY 2014	102/500731	Contracts for Program Svcs	90073001	10,000	-	10,000
SFY 2015	102/500731	Contracts for Program Svcs	90073001	-	-	-
			Sub-Total	$20,000	$0	$20,000

White Mountain Community Health Center, Vendor # 174170-R001 PO # 1024263

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90073001	10,000	-	10,000
SFY 2014	102/500731	Contracts for Program Svcs	90073001	10,000	-	10,000
SFY 2015	102/500731	Contracts for Program Svcs	90073001	-	-	-
			Sub-Total	$20,000	$0	$20,000
			SUB TOTAL	**$100,000**	**$0**	**$100,000**

FINANCIAL DETAIL ATTACHMENT SHEET
Primary Care Services

05-95-90-901010-7965 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF PUBLIC HEALTH SYSTEMS, POLICY & PERFORMANCE, RURAL HEALTH AND PRIMARY CARE
100% General Funds

Ammonoosuc Community Health Services, Inc., Vendor # 177755-B003 PO # 1024251

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90073001	-	-	-
SFY 2014	102/500731	Contracts for Program Svcs	90073001	-	-	-
SFY 2015	102/500731	Contracts for Program Svcs	90073001	-	10,000	10,000
			Sub-Total	$0	$10,000	$10,000

Coos County Family Health Services, Inc., Vendor # 155327-B001 PO # 1024252

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90073001	-		-
SFY 2014	102/500731	Contracts for Program Svcs	90073001	-	-	-
SFY 2015	102/500731	Contracts for Program Svcs	90073001	-	10,000	10,000
			Sub-Total	$0	$10,000	$10,000

Indian Stream Health Center, Vendor #165274-B001 PO # 1024258

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90073001	-	-	-
SFY 2014	102/500731	Contracts for Program Svcs	90073001	-	-	-
SFY 2015	102/500731	Contracts for Program Svcs	90073001	-	10,000	10,000
			Sub-Total	$0	$10,000	$10,000

Weeks Medical Center, Vendor # 177171-R001 PO # 1024400

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90073001	-	-	-
SFY 2014	102/500731	Contracts for Program Svcs	90073001	-	-	-
SFY 2015	102/500731	Contracts for Program Svcs	90073001	-	10,000	10,000
			Sub-Total	$0	$10,000	$10,000

White Mountain Community Health Center, Vendor # 174170-R001 PO # 1024263

Fiscal Year	Class / Account	Class Title	Job Number	Current Modified Budget	Increased (Decreased) Amount	Revised Modified Budget
SFY 2013	102/500731	Contracts for Program Svcs	90073001	-	-	-
SFY 2014	102/500731	Contracts for Program Svcs	90073001	-	-	-
SFY 2015	102/500731	Contracts for Program Svcs	90073001	-	10,000	10,000
			Sub-Total	$0	$10,000	$10,000
			SUB TOTAL	**$0**	**$50,000**	**$50,000**
			TOTAL	**$5,173,800**	**$4,243,569**	**$9,417,369**

Program Name — DPHS, Maternal and Child Health

Contract Purpose — Primary Care Services and Breast and Cervical Cancer Screening

RFP Score Summary

RFA/RFP CRITERIA	Max Pts	Ammonoosuc Community Health Services, Inc., 25 Mount Eustis Rd., Littleton, NH 03561	Coos County Family Health Services, Inc., 54 Willow St., Berlin, NH 03570	Concord Hospital, Inc., 250 Pleasant St, Concord, NH 03301	Families First of the Greater Seacoast, 100 Campus Drive, Portsmouth, NH 03801	Goodwin Community Health, 311 Route 108, Somersworth, NH 03878	Health First Family Care Center, 841 Central St., Franklin, NH 03235	Manchester Community Health Center, 145 Hollis St., Manchester, NH 03101	Mid-State Health Center, 101 Boulder Point Dr., Plymouth, NH 03264
Agy Capacity	30	29.00	28.00	28.00	29.00	29.00	25.00	29.00	28.00
Program Structure	50	46.00	45.00	47.00	48.00	48.00	39.00	46.00	45.00
Budget & Justification	15	14.00	15.00	15.00	15.00	12.00	13.00	15.00	12.00
Format	5	4.00	5.00	5.00	5.00	4.00	4.00	5.00	5.00
Total	100	93.00	93.00	95.00	97.00	93.00	81.00	95.00	90.00

BUDGET REQUEST									
Year 01		$339,156.25	118,959.00	$275,704.00	$163,793.00	$292,302.00	$199,127.00	$278,202.00	$117,175.00
Year 02		$347,976.97	118,959.00	$275,704.00	$163,793.00	$292,302.00	$199,127.00	$278,202.00	$117,175.00
Year 03		$0.00	-	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
TOTAL BUDGET REQUEST		$687,133.22	237,918.00	$551,408.00	$327,586.00	$584,604.00	$398,254.00	$556,404.00	$234,350.00
BUDGET AWARDED									
Year 01		$185,427.00	$121,553.00	$275,704.00	$170,277.00	$300,198.00	$200,238.00	$286,198.00	$117,175.00
Year 02		$185,427.00	$121,553.00	$275,704.00	$170,277.00	$300,198.00	$200,238.00	$286,198.00	$117,175.00
Year 03		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
TOTAL BUDGET AWARDED		$370,854.00	$243,106.00	$551,408.00	$340,554.00	$600,396.00	$400,476.00	$572,396.00	$234,350.00

RFP Reviewers

#	Name	Job Title	Dept/Agency
1	Rebecca Ewing, MD	OB/GYN	Retired-Volunteer
2	Rhonda Siegel	IP/Adolescent Health Program Manager	NH DHHS, DPHS, MCH
3	Lia Baroody	Program Coordinator	NH DHHS, DPHS, BCCP
4	Martha Jean Madison	Co-Director	NH DHHS, DPHS
5	Alisa Druzba	Administrator	NH DHHS, DPHS, RHPC
6	Jill Fournier	QA Nurse Consultant	NH DHHS, DPHS, MCH
7	Terry Ohlson-Martin	Co-Director	Family Voices
8	Teresa Brown	Health Promotion Advisor, Tobacco Program	NH DHHS, DPHS
9	Lindsay Dearborn	Supervisor, Asthma Program	NH DHHS, DPHS
10	Anne Diefendorf	Executive Director/VP Quality & Patient Safety	Foundation for Healthy Comm
11	Lissa Sirois	Health Promotion Advisor, WIC Program	NH DHHS, DPHS
12	Susan Knight	Program Planner, Asthma Program	NH DHHS, DPHS

Qualifications

All reviewers have between three to twenty years experience either in clinical settings, providing community-based family support services and or managing agreements with vendors for various public health programs. Areas of specific expertise include maternal & child health, quality assurance & performance improvement, chronic and communicable diseases and public health infrastructure

Program Name: DPHS, Maternal and Child Health

Contract Purpose: Primary Care Services and Breast and Cervical Cancer Screening

RFP Score Summary

RFA/RFP CRITERIA	Max Pts	The New London Hospital, Inc., 273 County Rd., New London, NH 03257	Weeks Medical Center, 170 Middle St., Lancaster, NH 03584	White Mountain Community Health Center, 298 White Mountain Hwy, Conway, NH 03818	Lamprey Health Care, Inc., 207 South Main St., Newmarket, NH 03857	Indian Stream Health Center, 141 Corless Lane, Colebrook, NH 03576	0	0	0
Agy Capacity	30	27.00	28.00	21.00	29.00	23.00	0.00	0.00	0.00
Program Structure	50	40.00	43.00	38.00	45.00	35.00	0.00	0.00	0.00
Budget & Justification	15	9.00	15.00	15.00	13.00	9.00	0.00	0.00	0.00
Format	5	4.00	5.00	3.00	5.00	5.00	0.00	0.00	0.00
Total	100	80.00	91.00	77.00	92.00	72.00	0.00	0.00	0.00

BUDGET REQUEST									
Year 01		$156,450.00	$79,137.00	$156,673.00	$456,331.00	$136,356.00	-	-	-
Year 02		$156,450.00	$79,137.00	$156,673.00	$456,331.00	$136,356.00	-	-	-
Year 03		$0.00	$0.00	$0.00	$0.00	$0.00	-	-	-
TOTAL BUDGET REQUEST		$312,900.00	$158,274.00	$313,346.00	$912,662.00	$272,712.00	-	-	-
BUDGET AWARDED									
Year 01		$161,632.00	$79,137.00	$157,784.00	$461,218.00	$70,359.00	-	-	-
Year 02		$161,632.00	$79,137.00	$157,784.00	$461,218.00	$70,359.00	-	-	-
Year 03		$0.00	$0.00	$0.00	$0.00	$0.00	-	-	-
TOTAL BUDGET AWARDED		$323,264.00	$158,274.00	$315,568.00	$922,436.00	$140,718.00	-	-	-

RFP Reviewers

	Name	Job Title	Dept./Agency	Qualifications
1	Rebecca Ewing, MD	OB/GYN	Retired-Volunteer	All reviewers have between three to twenty years experience either in clinical settings, providing community-based family support services and or managing agreements with vendors for various public health programs. Areas of specific expertise include maternal & child health, quality assurance & performance improvement, chronic and communicable diseases and public health infrastructure
2	Rhonda Siegel	IP/Adolescent Health Program Manager	NH DHHS, DPHS, MCH	
3	Lia Baroody	Program Coordinator	NH DHHS, DPHS, BCCP	
4	Martha Jean Madison	Co-Director	NH DHHS, DPHS	
5	Alisa Druzba	Administrator	NH DHHS, DPHS, RHPC	
6	Jill Fournier	QA Nurse Consultant	NH DHHS, DPHS, MCH	
7	Terry Ohlson-Martin	Co-Director	Family Voices	
8	Teresa Brown	Health Promotion Advisor, Tobacco Program	NH DHHS, DPHS	
9	Lindsay Dearborn	Supervisor, Asthma Program	NH DHHS, DPHS	
10	Anne Diefendorf	Executive Director/VP Quality & Patient Safety	Foundation for Healthy Comm	
11	Lissa Sirois	Health Promotion Advisor, WIC Program	NH DHHS, DPHS	
12	Susan Knight	Program Planner, Asthma Program	NH DHHS, DPHS	

State of New Hampshire
Department of Health and Human Services
Amendment #1 to the
Ammonoosuc Community Health Services, Inc.

This 1st Amendment to the Ammonoosuc Community Health Services, Inc., contract (hereinafter referred to as "Amendment One") dated this 11 day of March, 2014, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Ammonoosuc Community Health Services, Inc., (hereinafter referred to as "the Contractor"), a corporation with a place of business at 25 Mount Eustis Road, Littleton, New Hampshire 03561.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on June 20, 2012, 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, the State and the Contractor have agreed to make changes to the scope of work, payment schedules and terms and conditions of the contract; and

WHEREAS, pursuant to the General Provisions, Paragraph 18, the State may modify the scope of work and the payment schedule of the contract by written agreement of the parties;

WHEREAS, the Department desires to provide additional primary health care services for preventive and episodic health care for acute and chronic health conditions for people of all ages.

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 as follows:

To amend as follows:

- Form P-37, to change:
  Block 1.7 to read: June 30, 2015
  Block 1.8 to read: $667,687

- Exhibit A, Scope of Services to add:
  Exhibit A – Amendment 1

- Exhibit B, Purchase of Services, Contract Price, to add:

  Paragraph 1.1 to Paragraph 1:
  The contract price shall increase by $42,661 for SFY 2014 and $254,172 for SFY 2015.

  Paragraph 1.2 to Paragraph 1:
  Funding is available as follows:
- $42,661 from 05-95-90-902010-5190-102-500731, 100% General Funds;
- $213,921 from 05-95-90-902010-5190-102-500731, 6.7% Federal Funds from the US Department of Health and Human Services Administration, Maternal and Child Health Bureau, CFDA #93.994 and 93.3% General Funds;

Contractor Initials: EDS
Date: 03/11/2014

- $30,251 from 05-95-90-902010-5659-102-500731, 100% Federal Funds from the US Department of Health and Human Services, Centers for Disease Control and Prevention, CFDA #93.283;
- $10,000 from 05-95-90-901010-7965-102-500731, 100% General Funds.

  Add Paragraph 8
  8. Notwithstanding paragraph 18 of the General Provisions P-37, an amendment limited to adjustments to amounts between and among account numbers, within the price limitation, may be made by written agreement of both parties and may be made without obtaining approval of the Governor and Executive Council.

- Budget, to add:
  Exhibit B-1 (2014) - Amendment 1,
  Exhibit B-1 (2015) - Amendment 1

This amendment shall be in effect July 1, 2013, effective upon the date of Governor and Executive Council approval.

Contractor Initials: GBS LT
Date: 03/11/2014

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

3/27/14
Date

Brook Dupee
Bureau Chief

Ammonoosuc Community Health Services, Inc.

03/11/2014
Date

Name: Edward D Shanshala II
Title: CEO

Acknowledgement:

State of NH, County of Grafton on March 11, 2014, before the undersigned officer, personally appeared the person identified above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.

Signature of Notary Public or ~~Justice of the Peace~~

CAROL A. HEMENWAY, Notary Public
My Commission Expires November 17, 2015

Name and Title of Notary ~~or Justice of the Peace~~

Contractor Initials: EDS II
Date: 03/11/2014

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

OFFICE OF THE ATTORNEY GENERAL

4-2-14
Date

Name: Rosemary Wiant
Title: Assistant Attorney General

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

OFFICE OF THE SECRETARY OF STATE

Date

Name:
Title:

EXHIBIT A – AMENDMENT 1

Scope of Services

The Department desires to continue the relationship with the primary care agencies to provide additional primary health care services for preventive and episodic health care for acute and chronic health conditions for people of all ages.

I. General Provisions

A) Eligibility and Income Determination

1. Office-based primary care services will be provided to low-income individuals and families (defined as ≤ 185% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), in the State of New Hampshire.

2. Breast and Cervical Cancer screening services will be provided to low-income (defined as ≤ 250% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), New Hampshire women age 21– 64, uninsured or underinsured. BCCP changes.

3. The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing if, at any time, the practice is closed to new patients, or maintains a wait list for new patients, or any other mechanism is used that limits access for new patients for more than a one month period.

4. The Contractor shall document annually, for each client enrolled in the program, family income and family size, and calculate percentage of the federal poverty level. If calculations indicate that the client may be eligible for enrollment in Medicaid, the Contractor shall complete with the client the most recent version of the 800P form.

5. The Contractor shall implement, and post in a public and conspicuous location, a sliding fee payment schedule, approved in advance by the Division of Public Health Services (DPHS), for low-income patients. Signage must state that no client will be denied services for inability to pay.

   a. As an alternative, the contractor may post, in a public and conspicuous location, a notice to clients that a sliding fee scale is available and that no client will be denied services for inability to pay. The sliding fee scale must be updated annually based on USDHHS Poverty guidelines as published in the Federal Register, submitted to and approved by DPHS prior to implementation.

6. The primary care contract entered into here shall be the payer of last resort. The contractor shall make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid, for all reimbursable services rendered.

B) Numbers Served

1. The contract funds shall be expended to provide the above services to a minimum of 9600 users annually with 30,000 medical encounters, as defined in the Data and Reporting Requirements. Breast and Cervical Cancer Screening for eligible women, as defined by the Breast and Cervical Cancer Program (BCCP), shall be provided to 170 women annually and billed directly to the BCCP. Clinical service reimbursements shall not exceed the Medicare rate.

C) Culturally and Linguistically Appropriate Standards of Care

The Department of Health and Human Services (DHHS) recognizes that culture and language have considerable impact on how consumers access and respond to public health services. Culturally and linguistically diverse populations experience barriers in efforts to access health services. To ensure equal access to quality health services, the Division of Public Health Services (DPHS) expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.
2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.
3. Provide clients of limited English proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.
4. Offer consumers a forum through which clients have the opportunity to provide feedback to providers and organizations regarding cultural and linguistic issues that may deserve response.
5. The contractor shall maintain a program policy that sets forth compliance with Title VI, Language Efficiency and Proficiency Citation 45 CFR 80.3(b) (2). The policy shall describe the way in which the items listed above were addressed and shall indicate the circumstances in which interpretation services are provided and the method of providing service (e.g. trained interpreter, staff person who speaks the language of the client, language line).

D) State and Federal Laws

The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. The Contractor shall report all cases of communicable diseases according to New Hampshire RSA 141-C and He-P 301, adopted 6/3/08.

2. Persons employed by the contractor shall comply with the reporting requirements of New Hampshire RSA 169:C, Child Protection Act; RSA 161:F46, Protective Services to Adults, RSA 631:6, Assault and Related Offences and RSA 130:A, Lead Paint Poisoning and Control.

3. Immunizations shall be conducted in accordance with RSA 141-C and the Immunization Rules promulgated hereunder.

E) Relevant Policies and Guidelines

1. The Contractor shall design and provide the services described above to meet the unique and identified health needs of the populations within the contracted service area.

2. Primary Care funds shall be targeted to populations in need. Populations in need are defined as follows:

   a) uninsured;

   b) under-insured;

   c) families and individuals with significant psychosocial and economic risk, including low income status;

   d) all life cycles including perinatal, child, adolescent, adult, and elderly who meet one or more of the above criteria.

3. The Contractor shall design and implement systems of governance, administration, financial management, information management, and clinical services which are adequate to assure the provision of contracted services, and to meet the data and reporting requirements. These systems shall meet the most current minimum standards described in at least one of the following: Health Resources and Services Administration (HRSA) Office of Performance Review protocols, Joint Commission on Accreditation of Health Care Organizations (JCAHO), Accreditation Association for Ambulatory Healthcare (AAAHC), Community Health Accreditation Program (CHAP), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey.

4. The Contractor shall have an agency emergency preparedness and response plan in accordance with HRSA Health Center Emergency Management Program Expectations, Document #2007-15 or most recent version. Such plan shall also include a Continuity of Operations plan.

5. The Contractor shall carry out the work as described in the performance Workplan submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

6. No Workplan is required by the Breast and Cervical Cancer Program (BCCP). The contractor shall be required to respond to the Quality Improvement Feedback Report twice a year.

7. The Contractor shall carry out the work as described in the Supplemental Funding Form submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

F) Publications Funded Under Contract

1. The DHHS and/or its funders will retain COPYRIGHT ownership for any and all original materials produced with DHHS contract funding, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports.

2. All documents (written, video, audio, electronic) produced, reproduced, or purchased under the contract shall have prior approval from DPHS before printing, production, distribution, or use.

3. The Contractor shall credit DHHS on all materials produced under this contract following the instructions outlined in Exhibit C (14).

G) Subcontractors

If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing and approve the subcontractual agreement, prior to initiation of the subcontract.

1. If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing and approve the subcontractual agreement, prior to initiation of the subcontract.

2. In addition, the original DPHS contractor will remain liable for all requirements included in this Exhibit and carried out by subcontractors.

II. <u>Minimal Standards of Core Services</u>

A. Service Requirements

1. Medical Home

The Contractor shall provide a Medical Home that:

a) Facilitates partnerships between individual patients and their personal physicians, **and when appropriate, the patient's family.**

EXHIBIT A – AMENDMENT 1

b) Provides care facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

2. Primary Care Services

The Contractor shall provide office-based primary care services to populations in need who reside in the contractor's service area. Primary care services shall include:

a) Health care provided by a New Hampshire licensed MD, DO, APRN, or PA, including diagnosis and treatment of acute and chronic illnesses within the scope of family practice; preventive services, screenings, and health education according to established, documented state or national guidelines; assessment of need for social and nutrition services, and appropriate referrals to health, oral health, and behavioral health specialty providers.

b) Referral to the WIC Nutrition Program for all eligible pregnant women, infants and children.

c) In-hospital care for conditions within the scope of family practice must be provided at a hospital, within the agency service area, through a staff clinician with full hospital privileges, or in the alternative, through a formal referral and admissions procedure available to clients on a 24 hour/7 day a week basis.

d) Access to a healthcare provider, directly or by referral or subcontract, by telephone twenty-four hours per day, seven days per week.

e) Assessment of psychosocial risk for all clients at least annually and for children at scheduled preventive care visits, including, at a minimum, age appropriate assessment of safety in the home, domestic violence, adequacy of food and housing, care and welfare of children, transportation needs, and provision of necessary social services to address the priority needs and safety issues of clients and families.

f) Falls prevention screening for patients 65 years and older using the algorithm and guidelines of the American Geriatrics Society.

g) Behavioral health care directly or by referral to an agency or provider with a sliding fee scale.

h) Nutrition assessment for all clients as part of the health maintenance visit. Therapeutic nutrition services shall be provided as indicated directly or by referral to an agency or provider with a sliding fee scale. These services shall be recorded in the medical record.

i) Formal arrangements with a local hospital for emergency care must be in place and reviewed annually.

EXHIBIT A – AMENDMENT 1

j) Home health care directly or by referral to an agency or provider with a sliding fee scale.

k) Assisted living and skilled nursing facility care by referral.

l) Oral screening annually for all clients 21 years and older to note obvious dental decay and soft tissue abnormalities with a reminder to the patient that poor oral health impacts total health.

m) Diagnosis and management of pediatric and adult patients with asthma provided according to National Heart Lung Blood Institute, National Asthma Education and Prevention Program, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, 2007.

3. Breast and Cervical Cancer Screening

a) Women age 21 to 64 who are eligible for Breast and Cervical Cancer Program (BCCP) services according to income (equal to or under 250% of poverty, underinsured/uninsured) and insurance status criteria shall be provided the following services, following USPSTF screening recommendations:

i. cervical cancer screening including a pelvic examination and Pap smear;
ii. breast cancer screening including a clinical breast exam, mammogram and,
iii. referrals for diagnostic and treatment services based on screening results,
iv. case management services.

b) All referrals under this provision shall be to approved certified laboratory, pathology, radiology, and surgical services. Mammography units shall be accredited by the American College of Radiology, and must be FDA certified under MQSA. Laboratories shall be CLIA certified.

c) All services shall be provided in accordance with the Breast and Cervical Cancer Program (BCCP) Policy and Procedure Manual.

d) Follow-up and tracking of all tests done, and referrals made shall be provided in accordance with the minimum standards outlined in the Breast and Cervical Cancer Program Policy and Procedure Manual.

e) All services for women enrolled in the Breast and Cervical Cancer Program (BCCP) shall be billed directly to the BCCP in accordance with protocols established by the Breast and Cervical Cancer Program.

f) The Contractor shall provide the NH Breast and Cervical Cancer Program with breast and cervical cancer screening rates for all women served by the practice as requested, but not more than twice per SFY.

g) The contractor shall work with the NH Breast and Cervical Cancer Program staff to increase the breast and cervical cancer screening rates among all women serviced by the practice.

4. Reproductive Health Services

The Contractor shall provide prenatal, interconceptional and preconception medical care, social services, nutrition services, education, and nursing care to all women of childbearing age. Preconceptional care includes the preconception, interconceptional, and postpartum periods in women's health. It is recommended that preconceptional and interconceptional care visits focus on maintaining or achieving the optimal health of the mother, lowering the risk of future adverse pregnancy outcomes, the family's future plans, and how additional children fit into that plan. Preconceptional counseling may be done during an office, group or home visit.

a) In the event prenatal care is not provided directly by the Contractor a formal Memorandum/a of Agreement for coordinated referral to an appropriately qualified provider must be maintained.

b) Prenatal care shall, at minimum, be provided in accordance with the Guidelines for Perinatal Care, sixth or most current edition, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and /or the Centers for Disease Control.

c) Age appropriate reproductive health care shall, at a minimum, be provided in accordance with the American College of Obstetricians and Gynecologists, or the USDHHS Centers for Disease Control (CDC) current guidelines.

d) Pregnant women enrolled in the WIC Nutrition Program shall be referred to WIC for breastfeeding education and referral to the WIC Nutrition Program peer counselors.

e. Family planning counseling for prevention of subsequent pregnancy following an infant's birth shall be discussed with the infant's mother at the first postpartum visit and at the infant's 2-month visit and other visits as appropriate. Rationale for birth intervals of 18-24 months shall be presented.

f) A referral to a Title X Family Planning Clinic or other reproductive health care provider shall be made as appropriate.

5. Services for Children and Adolescents

The Contractor shall provide as a minimum, comprehensive and age-appropriate health care, screenings, and health education according to the American Academy of Pediatrics' most recent periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent. Children and adolescent visits shall include:

a) The World Health Organization (WHO) growth charts shall be used to monitor growth for infants and children birth up to age 2 years. The Centers for Disease Control and Prevention (CDC) growth charts shall be used for children age 2 years and older.

b) Blood lead testing shall be performed in accordance with "New Hampshire Childhood Lead Poisoning Screening and Management Guidelines", issued by the New Hampshire Department of Health and Human Services, 2009 or subsequent revisions.

c) All children enrolled in either Medicaid, Head Start, or the Women, Infant, and Children (WIC) Program and/or who are ≤ 185%_poverty, regardless of town of residence, are required to have a blood lead test at ages one and two years. All children ages three to six years who have not been previously tested shall have a blood lead test performed.

d) All children shall be screened for iron deficiency anemia as outlined in the Centers for Disease Control and Prevention document "Recommendations to Prevent and Control Iron Deficiency in the United States (4/2/98)".

e) Age-appropriate anticipatory guidance, dietary guidance, and *feeding practice counseling* for optimal oral health shall be provided at each well child visit according to the American Academy of Pediatrics' periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent edition. Starting at age 6 months, it is recommended that all children receive an oral health assessment at every well child visit, and a referral for the child's first visit to the dentist by age one as recommended by the American Academy of Pediatrics and the American Academy of Pediatric Dentistry.

f) Supplemental fluoride shall be prescribed as needed based upon the fluoride levels in the child's drinking water supply. The fluoride dosage regimen accepted by the American Academy of Pediatrics shall be followed. No fluoride shall be prescribed without obtaining water from private wells or noting the presence or absence of fluoride in the public water supply. Supplemental fluoride may include bottled water containing fluoride and topical applications such as varnishes.

g) For infants enrolled in the WIC Nutrition Program, parents shall be referred to WIC for breastfeeding support and referral to the WIC Nutrition Program peer counselors.

6. Sexually Transmitted Infections

Primary Care Services shall provide age appropriate screening and treatment of sexually transmitted infections.

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a) Treatment for sexually transmitted infections shall be provided according to the United States Centers for Disease Control Sexually Transmitted Diseases Treatment Guidelines, 2010 or subsequent revisions.

b) All clients, including women, shall be offered HIV testing following the most current recommendations of the United States Centers for Disease Control.

c) The contractor shall be responsible for ensuring referral to appropriate treatment services for any woman found to screen positive.

d) Appropriate risk reduction counseling shall be provided based on client needs.

7. Substance Use Services

a) A substance use screening history using a formal, validated screening tool shall be obtained for all clients as soon after entry into care as possible. Substance use counseling or other substance abuse intervention, treatment, or recovery services by an appropriately credentialed provider shall be provided on-site, or by referral, to clients with identified needs for these services. For these identified clients, ongoing primary care services should include follow up monitoring relative to substance abuse.

b) All clients, including pregnant women, identified as smokers shall receive counseling using the 5A's (ask, advise, assess, assist, and arrange) treatment available through the NH Tobacco Helpline as cited in the US Public Health Services report "Tobacco Use and Dependence", 2008, or "Smoking Cessation During Pregnancy: A Clinician's Guide to Helping Pregnant Women Quit Smoking", American College of Obstetricians and Gynecologists, 2011. With prior approval, agencies may also opt to participate in the DPHS best practice initiative of the 2A's and R (ask, advise and refer).

8. Immunizations

a) The Contractor shall adhere to the most current version of the "Recommended Adult Immunization Schedule for Adults (19 years and older) by Age and Medical Condition - United States", approved by the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

b) The Contractor shall administer vaccines according to the most current version of the "Recommended Immunization Schedule for Persons Aged 0 Through 6 Years - United States", and "Recommended Immunization Schedule for Persons Aged 7 Through 18 Years – United States" approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians, based upon availability of vaccine from the New Hampshire Immunization Program.

9. Prenatal Genetic Screening

EXHIBIT A – AMENDMENT 1

a) A genetic screening history shall be obtained on all prenatal clients as soon after entry into care as possible.

b) All pregnant women should be offered voluntary genetic screening for fetal chromosomal abnormalities at the appropriate time following recommendations found in the American College of Obstetricians and Gynecologists' "Screening for Fetal Chromosomal Abnormalities (2007)" or more recent guidelines. The Contractor shall be responsible for ensuring referral to appropriate genetic testing and counseling for any woman found to have a positive screening test.

10. Additional Requirements

a) The Contractor's Medical Director shall participate in the development and approval of specific guidelines for medical care that supplement minimal clinical standards. Supplemental guidelines should be reviewed, signed, and dated annually, and updated as indicated.

b) Contractors considering clinical or sociological research using clients as subjects must adhere to the legal requirements governing human subjects research. Contractors must inform the DPHS, MCHS prior to initiating any research related to this contract.

c) The Contractor shall provide information to all employees annually about the Medical Reserve Corps Unit within their Public Health Region to enhance recruitment.

d) The Contractor shall provide information to all employees annually regarding the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) managed by the NH Department of Health and Human Services' Emergency Services Unit, to enhance recruitment.

B) Staffing Provisions

The Contractor shall have, at minimum, the following staff positions:

a) executive director

b) fiscal director

c) registered nurse

d) clinical coordinator

e) medical service director

f) nutritionist (on site or by referral)

g) social worker

Staff positions required to provide direct services on-site include:

a) registered nurse

b) clinical coordinator

c) social worker

1. Qualifications

All health and allied health professionals shall have the appropriate New Hampshire licenses whether directly employed, contracted, or subcontracted.

In addition the following minimum qualifications shall be met for:

a) Registered Nurse
   a. A registered nurse licensed in the state of New Hampshire, Bachelor's degree preferred. Minimum of one-year experience in a community health setting.

b) Nutritionists:
   a. A Bachelor's degree in nutritional sciences or dietetics, or a Master's degree in nutritional sciences, nutrition education, or public health nutrition or current Registered Dietitian status in accordance with the Commission on dietetic Registration of the American Dietetic Association.
   b. Individuals who perform functions similar to a nutritionist but do not meet the above qualifications shall not use the title of nutritionist.

c) Social Workers shall have:
   a. A Bachelor's or Master's degree in social work or Bachelor's or Master's degree in a related social science or human behavior field. A minimum of one year of experience in a community health or social services setting is preferred.
   b. Individuals who perform functions similar to a social worker but do not meet the above qualifications shall not use the title of social worker.

d) Clinical Coordinators shall be:
   a. A registered nurse (RN), physician, physician assistant, or nurse practitioner with a license to practice in New Hampshire.
   b. The coordinator is a clinical position that oversees and takes responsibility for the clinical and administrative functions of each program.
   c. The coordinator may be responsible for more than one MCH funded program.

2. New Hires

EXHIBIT A – AMENDMENT 1

The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing within one month of hire when a new administrator, clinical coordinator, or any staff person essential to carrying out contracted services is hired to work in the program. A resume of the employee shall accompany the aforesaid notification.

3. Vacancies

   a) The Contractor must notify the MCHS in writing if any critical position is vacant for more than one month, or if at any time funded under this contract does not have adequate staffing to perform all required services for more than one month. This may be done through a budget revision.

   b) Before an agency hires new program personnel that do not meet the required staff qualifications, the agency shall notify the MCHS in writing requesting a waiver of the applicable staffing requirements. The Section may grant waivers based on the need of the program, individuals' experience, and additional training.

C) Coordination of Services

1. The Contractor shall coordinate, where possible, with other service providers within the contractor's community. At a minimum, such collaboration shall include interagency referrals and coordination of care.

2. The Contractor shall participate in activities in the Public Health Region in which they provide services as appropriate. These activities enhance the integration of community-based public health prevention and health care initiatives that are being implemented by the contractor and may include community needs assessments, public health performance assessments, and/or the development of regional health improvement plans.

3. The Contractor agrees to participate in and coordinate public health activities as requested by the Division of Public Health Services during any disease outbreak and/or emergency, natural or man-made, affecting the public's health.

4. The Contractor is responsible for case management of the client enrolled in the program and for program follow-up activities. Case management services shall promote effective and efficient organization and utilization of resources to assure access to necessary comprehensive medical, nutritional, and social services for clients.

5. The Contractor shall assure that appropriate, responsive, and timely referrals and linkages for other needed services are made, carried through, and documented. Such services shall include, but not be limited to: dental services, genetic counseling, high risk prenatal services, mental health, social services, including domestic violence crisis centers, substance abuse services; and family planning services, Early Supports and Services Program, local WIC/CSF Program, Home Visiting New Hampshire Programs and health and social service agencies which serve children and families in need of those services.

EXHIBIT A – AMENDMENT 1

D) Meetings and Trainings

The contractor will be responsible for sending staff to meetings and training required by the MCHS program, including but not limited to:

1. MCHS Agency Directors' meetings
2. Prenatal and Child Health Coordinators' meetings
3. MCHS Agency Medical Services Directors' meetings

III. Quality or Performance Improvement (QI/PI)

A) Workplans

1. Performance Workplans are required for this program and are used to monitor achievement of standard measures of performance of the services provided under this contract. The workplans are a key component of the RHPCS and the MCHS performance-based contracting system and of this contract. Outcomes shall be reported by clinical site.

2. Performance Workplans and Workplan Outcome reports according to the schedule and instructions provided by the MCHS. The MCHS shall notify the Contractor at least 30 days in advance of any changes in the submission schedule.

3. The Contractor shall incorporate required and developmental performance measures, defined by the MCHS into the agency's Performance Workplan. Reports on Workplan Progress/Outcomes shall detail the Performance Workplan plans and activities that monitor and evaluate the agency's progress toward performance measure targets.

4. The Contractor shall comply with modifications and/or additions to the workplan and annual report format as requested by RHPCS and MCHS. MCHS will provide the contractor with reasonable notice of such changes.

5. Agencies contracting for Primary Care Services must submit the workplans for Primary Care Clinical and Financial, Child Health, and Prenatal Care.

B) Additional Reporting requirements

In addition to Performance Workplans, the Contractor shall submit to MCHS the following data and information listed below which are used to monitor program performance:

1. In years when contracts or amendments are not required, the DPHS Budget Form, Budget Justification, Sources of Revenue and Program Staff list forms must be

completed according to the relevant instructions and submitted as requested by DPHS and, at minimum, by April 30 of each year.

2. The Sources of Revenue report must be resubmitted at any point when changes in revenue threaten the ability of the agency to carry out the planned program.

3. Completed Uniform Data Set (UDS) tables reflecting program performance in the previous calendar year, by March 31 of each year.

4. The Perinatal Client Data Form (PCDF) shall be submitted electronically according to the instructions set forth by the MCHS.

5. A copy of the agency's updated Sliding Fee Scale including the amount(s) of any client fees and the schedule of discounts must be submitted by March 31st of each year. The agency's sliding fee scale must be updated annually based on the US DHHS Poverty guidelines as published in the Federal Register.

6. An annual summary of program-specific patient satisfaction results obtained during the prior contract period and the method by which the results were obtained shall be submitted annually as an addendum to the Workplan Outcome/Progress reports.

C) On-site reviews

1. The contractor shall allow a team or person authorized by the Division of Public Health Services to periodically review the contractor's systems of governance, administration, data collection and submission, clinical and financial management, and delivery of education services in order to assure systems are adequate to provide the contracted services.

2. Reviews shall include client record reviews to measure compliance with this exhibit.

3. The contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.

4. On-Site reviews may be waived or abbreviated at the discretion of MCHS, upon submission of satisfactory reports of reviews such as Health Services Resources Administration (HRSA): Office of Performance Review (OPR), or reviews from nationally accreditation organizations such as the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), Medicare, the Community Health Accreditation Program (CHAP), Accreditation Association for Ambulatory Healthcare (AAAHC), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey. Abbreviated reviews will focus on any deficiencies found in previous reviews, issues of compliance with this exhibit, and actions to strengthen performance as outlined in the agency Performance Workplan.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE CHILD HEALTH DIRECT CARE SERVICES
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Please note, for all measures, the following should be used **unless otherwise indicated:**

- Less than 19 years of age
- Served within the scope of this MCH contract during State Fiscal Year 2015 (July 1, 2014 – June 30, 2015)
- Each client can only be counted once (unduplicated)

Child Health Direct (CH – D) Performance Measure #1

Measure: 92%* of eligible children will be enrolled in Medicaid

Goal: To increase access to health care for children through the provision of health insurance

Definition: **Numerator-**
Of those in the denominator, the number of children enrolled in Medicaid.

Denominator-
Number of children who meet all of the following criteria:

- Less than 19 years of age
- Had 3 or more visits/encounters** during the reporting period
- As of the last visit during the reporting period were eligible for Medicaid

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**An encounter is face to face contact between a user and a provider who exercises independent judgment in the provision of services to the individual (UDS Table Definition).

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #2

Measure: 85%* of at-risk** children who were screened for blood lead between 18 and 30 months of age

Goal: To prevent childhood lead poisoning through early identification of lead exposure

Definition: **Numerator-**
Of those in the denominator, number of children screened for blood lead by capillary or venous on or after their 18-month birthday and prior to their 30-month birthday.

Denominator-
Number of at-risk** children who reached age 30 months during the reporting period. If discharged prior to 30 months, do not include in denominator.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**At risk = During the reporting period, the children were 18-29 months of age, and fit at least one of the following criteria:

- "Low income" (less than 185% poverty guidelines)
- Over 185% and resided in a town considered needing "Universal" screening per NH Childhood Lead Poisoning Prevention Program
- Over 185%, resided in a town considered "Target" and had a positive response to the risk questionnaire
- Refugee children -A refugee is defined as a person outside of his or her country of nationality who is unable or unwilling to return because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion (U.S. Citizenship and Immigration Services definition).

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #3

Measure: 71%* of children age two to nineteen years receiving primary care preventive health services with a Body Mass Index (BMI) percentile greater than or equal to the 85%ile with documented discussion of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Goal: To increase the percent of children receiving primary care preventive health services who have an elevated BMI percentile who receive guidance about promoting a healthier lifestyle.

Definition: **Numerator-**
Of those in the denominator, the number of children who had documentation in their medical record of there being discussion at least once during the reporting period of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Denominator-
Number of children who turned twenty-four months during or before the reporting period, up to the age of nineteen years, with one or more well child visit after their twenty-fourth month of age within the reporting year, and had an age and gender appropriate BMI percentile greater than or equal to the 85 % percentile at least once during the reporting period.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

Rationale: Children between the 85th – 94th percentiles BMI are encouraged to have 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks. (Discussion of the importance of family meal time, limiting eating out, consuming a healthy breakfast, preparing own foods, and promotion of breastfeeding is also encouraged.) American Academy of Pediatrics' guidance for Prevention and Treatment of Childhood Overweight and Obesity, (http://www.aap.org/obesity/health_professionals.html), from AAP Policy Statement: *Prevention of Pediatric Overweight and Obesity* and the AAP endorsed Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Children and Adolescent Overweight and Obesity, 2007.

*Target based on 2012 & 2013 Data Trend Table averages.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) #4

Measure: 75%* of eligible** infants and children with client record documentation of enrollment in WIC

Goal: To increase access to nutrition education, breastfeeding support, and healthy food through enrollment in the WIC Nutrition Program

Definition: **Numerator** -
Of those in the denominator, the number of infants and children who, as of the last well child visit during the reporting period, had client record documentation that infant or child was enrolled in WIC.

Denominator -
Unduplicated number of infants and children less than 5 years of age, enrolled in the agency, during the reporting period, who were eligible** for WIC.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**WIC Eligibility Requirements:

- Infants, and children up to their fifth birthday
- Must be income eligible (income guidelines are up to 185% of federal gross income, and are based on family size)

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #5

Measure: 23%* of infants who were exclusively** breastfed for the first three months, at their four month well baby visit

Goal: To provide optimum nutrition to infants in their first three months of life

Definition: **Numerator -**
Of those in the denominator, the number of infants who had client record documentation that the infant had been exclusively breastfed for their first three months when checked at their four month well baby visit.

Denominator -
Number of infants who received one or more visits during or before the reporting period and were seen for a four-month well baby visit during the reporting period.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

Benmarks: 2011 PedNSS (WIC) exclusive at 3 months: NH 22.9%, National (2010) 10.7%
2013 CDC Report Card (NIS, provisional 2010 births): NH 49.5%, National 37.7%
Healthy People 2020 goal: 44%

Rationale: The AAP recommends exclusive breastfeeding for about 6 months, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant, a recommendation concurred to by the World Health Organization and the Institute of Medicine. (American Academy of Pediatrics Policy Statement on Breastfeeding and the Use of Human Milk, 2012)

*Target based on 2012 & 2013 Data Trend Table averages.
**Exclusive means breast milk only, no supplemental formula, cereal/baby food, or water/fluids.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE: ADULT

PERFORMANCE MEASURES DEFINITIONS

State Fiscal Year 2015

Primary Care: Adult Performance Measure #1

Measure:* 58%** of adult patients 18 – 85 years of age diagnosed with hypertension will have a blood pressure measurement less than 140/90*** mm at the time of their last measurement.

Goal: To ensure patients diagnosed with hypertension are adequately controlled.

Definition: **Numerator-** Number of patients from the denominator with blood pressure measurement less than 140/90 mm at the time of their last measurement.

Denominator- Number of patients age 18 – 85 with diagnosed hypertension must have been diagnosed with hypertension 6 or more months before the measurement date. (Excludes pregnant women and patients with End Stage Renal Disease.)

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

*Measure based on the National Quality Forum 0018

**Health People 2020 National Target is 61.2%

***Both the numerator and denominator must be less that 140/90 mm

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE CLINICAL
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Primary Care Clinical Adolescent (PC-C) Performance Measure #1

Measure: 61%* of adolescents aged 11-21 years received an annual health maintenance visits in the past 12 months.

Goal: To enhance adolescent health by assuring annual, recommended, adolescent well -visits.

Definition: **Numerator-**
Number of adolescents in the denominator who received an annual health maintenance "well" visit during the reporting year.

Denominator-
Total number of adolescents aged 11-21 years who were enrolled in the primary care clinic as primary care clients during the reporting year period.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

***Target based on 2012 & 2013 Data Trend Table averages.**

Primary Care Clinical Prenatal (PC-C) Performance Measure #2

Measure: 31%* of women and adolescent girls aged 15-44 take multi-vitamins with folic acid.

Goal: To enhance pregnancy outcomes by reducing neural tube defects.

Definition:

Numerator-
The number of women and adolescent girls aged 15-44 who take a multi-vitamin with folic acid.

Denominator-
The number of women and adolescent girls aged 15-44 who were seen in primary care for a well visit in the past year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

***Target based on 2012 & 2013 Data Trend Table averages.**

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE - FINANCIAL
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Primary Care (PC) Performance Measure #1

Measure: Patient Payor Mix

Goal: To allow monitoring of payment method trends at State funded primary care sites.

Definition: Patients enrolled in Medicare, Medicaid, Commercial insurance, or uninsured.

Data Source: Provided by agency

Primary Care (PC) Performance Measure #2

Measure: Accounts Receivables (AR) Days

Goal: To allow monitoring of financial sustainability trends at State funded primary care sites.

Definition: AR Days: Net Patient Accounts Receivable **multiplied by** 365 **divided by** Net Patient Revenue

Data Source: Provided by agency

Primary Care (PC) Performance Measure #3

Measure: Current Ratio

Goal: To allow monitoring of financial sustainability trends at State funded primary care sites.

Definition: Current Ratio = Current Assets **divided by** Current Liabilities

Data Source: Provided by agency

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRENATAL
PERFORMANCE MEASURES DEFINITIONS
State Fiscal Year 2015

Prenatal (PN) Performance Measure #1

Measure: **85%* of pregnant women who are enrolled in the agency's prenatal** program will begin prenatal care during the first trimester of pregnancy.

Goal: To enhance pregnancy outcomes by assuring early entrance into prenatal care.

Definition:

Numerator-
Number of women in the denominator who had a documented prenatal visit during the first trimester (on or before 13.6 weeks gestation).

Denominator-
Number of women enrolled in the agency prenatal program who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

* Target based on 2012 & 2013 Data Trend Table averages.

Prenatal (PN) Performance Measure #2

Measure: 20%* of pregnant women who are identified as cigarette smokers will be referred to QuitWorks-New Hampshire.

Goal: To reduce tobacco use during pregnancy through focused tobacco use cessation activities at public health prenatal clinics.

Definition:

Numerator-
Number of women in the denominator who received at least one referral to QuitWorks-New Hampshire during pregnancy.

A referral is defined as signing the patient up for QuitWorks-NH via phone, fax, or EMR. It is not defined as discussing QuitWorks-NH with the patient and encouraging her to sign up.

Denominator-
Number of women enrolled in the agency prenatal program and identified as tobacco users who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

*Target set in consultation with the NH Tobacco Program & FY13 Data Trend Table average.

Prenatal (PN) Performance Measure #3

Measure: 79%* of pregnant women will be screened, using a formal valid screening tool, for alcohol and other substance use during every trimester they are enrolled in the prenatal program.

Goal: To reduce prenatal substance use through systematic screening and identification.

Definition: **Numerator-** Number of women in the denominator who were screened for substance and alcohol use, using a formal and valid screening tool, during each trimester that they were enrolled in the prenatal program.

Denominator- Number of women enrolled in the agency prenatal program and who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

* Target based on 2012 & 2013 Data Trend Table averages.

Exhibit B-1 (2014) -Amendment 1
Budget

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: Ammonoosuc Community Health Services, Inc.,

Budget Request for: MCH Primary Care
(Name of RFP)

Budget Period: SFY 2014

1. Total Salary/Wages	$ 34,685.00	$ -	$ 34,685.00
2. Employee Benefits	$ 7,976.00	$ -	$ 7,976.00
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	$ -	$ -	$ -
13. Other (specific details mandatory):	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
TOTAL	**$ 42,661.00**	**$ -**	**$ 42,661.00**

Indirect As A Percent of Direct 0.0%

Contractor Initials: KLR

Date: 03/6/2014 2/19/2014

Exhibit B-1 (2015) -Amendment 1
Budget

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: Ammonoosuc Community Health Services, Inc.,

Budget Request for: MCH Primary Care & BCCP
(Name of RFP)

Budget Period: SFY 2015

1. Total Salary/Wages	$ 194,114.00	$ 8,333.00	$ 202,447.00	Clinical Direct/Admin Indirect
2. Employee Benefits	$ 38,823.00	$ 1,666.00	$ 40,489.00	Clinical Direct/Admin Indirect
3. Consultants	$ -	$ -	$ -	0
4. Equipment:	$ -	$ -	$ -	0
Rental	$ -	$ -	$ -	0
Repair and Maintenance	$ -	$ -	$ -	0
Purchase/Depreciation	$ -	$ -	$ -	0
5. Supplies:	$ -	$ -	$ -	0
Educational	$ -	$ -	$ -	0
Lab	$ -	$ -	$ -	0
Pharmacy	$ -	$ -	$ -	0
Medical	$ -	$ -	$ -	0
Office	$ -	$ -	$ -	0
6. Travel	$ -	$ -	$ -	0
7. Occupancy	$ -	$ -	$ -	0
8. Current Expenses	$ -	$ -	$ -	0
Telephone	$ -	$ -	$ -	0
Postage	$ -	$ -	$ -	0
Subscriptions	$ -	$ -	$ -	0
Audit and Legal	$ -	$ -	$ -	0
Insurance	$ -	$ -	$ -	0
Board Expenses	$ -	$ -	$ -	0
9. Software	$ -	$ -	$ -	0
10. Marketing/Communications	$ -	$ -	$ -	0
11. Staff Education and Training	$ -	$ -	$ -	0
12. Subcontracts/Agreements	$ -	$ -	$ -	0
13. Other (specific details mandatory):	$ -	$ -	$ -	0
Clinical Services	$ 11,236.00	$ -	$ 11,236.00	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
TOTAL	**$ 244,173.00**	**$ 9,999.00**	**$ 254,172.00**	0

Indirect As A Percent of Direct 4.1%

Contractor Initials: [illegible]

Date: 03/11/2014

State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that Ammonoosuc Community Health Services, Inc. is a New Hampshire nonprofit corporation formed March 24, 1975. I further certify that it is in good standing as far as this office is concerned, having filed the return(s) and paid the fees required by law.

n TESTIMONY WHEREOF, I hereto
set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 23rd day of April A.D. 2013

William M. Gardner
Secretary of State

CERTIFICATE OF VOTE

I, Beth Harwood, of Ammonoosuc Community Health Services, Inc., do hereby certify that:

1. I am the duly elected President of Ammonoosuc Community Health Services;
2. The following are true copies of two resolutions duly adopted at a meeting of the Board of Directors of the corporation, duly held on March 4, 2014;

   RESOLVED: Be it resolved that this corporation enters into a contract with the State of New Hampshire, acting through its Department of Health and Human Services, Division of Public Health Services.

   RESOLVED: Be it resolved that the Chief Executive Officer/Executive Director is hereby authorized on behalf of this corporation to enter into said contract with the State and to execute any and all documents, agreements, and other instruments; and any amendments, revisions, or modifications thereto, as he/she may deem necessary, desirable, or appropriate. Edward D. Shanshala, II is the duly elected Chief Executive Officer/Executive Director of the corporation.

3. The foregoing resolutions have not been amended or revoked and remain in full force and effect as of March 11, 2014.

IN WITNESS WHEREOF, I have hereunto set my hand as the President of the corporation this 11 day of March, 2014.

Board President

STATE OF NH
COUNTY OF Grafton

The foregoing instrument was acknowledged before me this 11th day of March, 2014 by Beth Harwood.

Notary Public/Justice of the Peace
My Commission Expires:

CAROL A. HEMENWAY, Notary Public
My Commission Expires November 17, 2015

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 2/24/2014

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 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
E & S Insurance Services LLC
21 Meadowbrook Lane
P O Box 7425
Gilford NH 03247-7425

CONTACT NAME: Pat Mack
PHONE (A/C, No, Ext): (603) 293-2791 | FAX (A/C, No): (603) 293-7188
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Hanover Insurance Company	22292
INSURER B : Atlantic Charter	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Ammonoosuc Community Health Services
25 Mount Eustis Road
Littleton NH 03561

COVERAGES CERTIFICATE NUMBER: 2013 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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC			OBV9707763-02	10/4/2013	10/4/2014	EACH OCCURRENCE	$ 2,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 300,000
							MED EXP (Any one person)	$ 5,000
							PERSONAL & ADV INJURY	$ 2,000,000
							GENERAL AGGREGATE	$ 4,000,000
							PRODUCTS - COMP/OP AGG	$ 4,000,000
								$
	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS HIRED AUTOS NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident)	$
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
A	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DED RETENTION $			OBV9707763-02	10/4/2013	10/4/2014	EACH OCCURRENCE	$ 1,000,000
							AGGREGATE	$ 1,000,000
								$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		WCA00550000	7/10/2013	7/10/2014	WC STATU-TORY LIMITS / OTH-ER	
							E.L. EACH ACCIDENT	$ 500,000
							E.L. DISEASE - EA EMPLOYEE	$ 500,000
							E.L. DISEASE - POLICY LIMIT	$ 500,000

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

CERTIFICATE HOLDER

NH Dept of Health & Human Services
129 Pleasant Street
Concord, NH 03301-6504

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
Pat Mack/PAT Pat M Mack

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AMMONOOSUC COMMUNITY HEALTH SERVICES, INC.

AUDITED FINANCIAL STATEMENTS

JUNE 30, 2013 AND 2012

BRAD BORBIDGE, P.A.
CERTIFIED PUBLIC ACCOUNTANTS
197 LOUDON ROAD, SUITE 350
CONCORD, NEW HAMPSHIRE 03301

TELEPHONE 603/224-0849
FAX 603/224-2397

Independent Auditor's Report on Financial Statements

Board of Directors
Ammonoosuc Community Health Services, Inc.
Littleton, New Hampshire

We have audited the accompanying financial statements of Ammonoosuc Community Health Services, Inc., which comprise the balance sheet as of June 30, 2013, the related statements of operations and changes in net assets, and cash flows for the year then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the 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 entity'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 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 financial statements referred to above present fairly, in all material respects, the financial position of Ammonoosuc Community Health Services, Inc. as of June 30, 2013, and the results of its operations and its cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The accompanying schedule of expenditures of federal awards and related notes are presented for purposes of additional analysis as required by U.S. Office of Management and Budget Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations, and are not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

The financial statements of Ammonoosuc Community Health Services, Inc. as of June 30, 2012 were audited by other auditors who expressed an unmodified opinion and whose report was dated November 15, 2012.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated October 30, 2013, on our consideration of the Organization's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and important for assessing the results of our audit.

Concord, New Hampshire
October 30, 2013

AMMONOOSUC COMMUNITY HEALTH SERVICES, INC.

BALANCE SHEETS

JUNE 30, 2013 AND 2012

ASSETS

	2013	2012
Current Assets		
Cash and cash equivalents	$ 171,483	$ 120,217
Patient accounts receivable, net of allowance of for uncollectible accounts of $146,350 and $94,451 at June 30, 2013 and 2012, respectively	581,149	499,936
Grants receivable	27,179	30,608
Other receivables	5,412	24,054
Due from third party payers	29,802	73,122
Inventory	78,270	44,948
Prepaid expenses	46,318	60,025
Total Current Assets	939,613	852,910
Assets Limited As To Use	14,760	14,760
Beneficial Interest In Perpetual Trusts Held By Others	84,174	76,658
Property And Equipment, Net	3,946,966	4,116,867
TOTAL ASSETS	$ 4,985,513	$ 5,061,195

LIABILITIES AND NET ASSETS

	2013	2012
Current Liabilities		
Line of credit	$ -	$ 125,000
Accounts payable and accrued expenses	179,949	153,847
Accrued payroll and related expenses	433,046	380,240
Advance from third party payers	38,822	-
Deferred revenue	-	11,231
Current maturities of long-term debt	35,512	33,570
Total Current Liabilities	687,329	703,888
Long-term Debt, Less Current Maturities	714,307	752,941
Total Liabilities	1,401,636	1,456,829
Net Assets		
Unrestricted	3,521,576	3,542,065
Permanently restricted	62,301	62,301
Total Net Assets	3,583,877	3,604,366
TOTAL LIABILITIES AND NET ASSETS	$ 4,985,513	$ 5,061,195

(See accompanying notes to these financial statements)

AMMONOOSUC COMMUNITY HEALTH SERVICES, INC.

STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS

FOR THE YEARS ENDED JUNE 30, 2013 AND 2012

	2013	2012
Operating Revenue		
Patient service revenue	$ 5,164,844	$ 4,443,124
Provision for bad debts	(134,511)	(52,111)
Net patient service revenue	5,030,333	4,391,013
Grant revenue	1,711,549	1,779,755
Other operating revenue	326,520	25,401
Total Operating Revenue	7,068,402	6,196,169
Operating Expenses		
Salaries and benefits	5,176,111	4,808,465
Other operating expenses	1,762,936	1,205,789
Depreciation	214,393	183,864
Interest expense	40,547	51,960
Total Operating Expenses	7,193,987	6,250,078
OPERATING LOSS	(125,585)	(53,909)
Non-Operating Revenue and Gains		
Contributions	97,039	91,705
Interest income	541	634
Change in fair value of beneficial interest in perpetual trusts held by others	7,516	(2,398)
Total Non-Operating Revenue and Gains	105,096	89,941
(DEFICIT) EXCESS OF REVENUE OVER EXPENSES AND (DECREASE) INCREASE IN UNRESTRICTED NET ASSETS	(20,489)	36,032
Net assets, beginning of year	3,604,366	3,568,334
NET ASSETS, END OF YEAR	$ 3,583,877	$ 3,604,366

(See accompanying notes to these financial statements)

AMMONOOSUC COMMUNITY HEALTH SERVICES, INC.

STATEMENTS OF CASH FLOWS

FOR THE YEARS ENDED JUNE 30, 2013 AND 2012

	2013	2012
Cash Flows From Operating Activities		
Change in net assets	$ (20,489)	$ 36,032
Adjustments to reconcile change in net assets to net cash provided (used) by operating activities		
Bad debt expense	134,511	52,111
Depreciation	214,393	183,864
Change in fair value of beneficial interest in perpetual trusts held by others	(7,516)	2,398
(Increase) decrease in the following assets:		
Patient accounts receivable	(215,724)	(95,425)
Grants receivable	3,429	217,744
Other receivables	18,642	(23,450)
Due from third party payers	43,320	(18,056)
Inventory	(33,322)	(44,948)
Prepaid expenses	13,707	(7,546)
Increase (decrease) in the following liabilities:		
Accounts payable and accrued expenses	26,102	(404,340)
Accrued payroll and related expenses	52,806	(6,719)
Advance from third party payers	38,822	-
Deferred revenue	(11,231)	11,231
Net Cash Provided (Used) by Operating Activities	257,450	(97,104)
Cash Flows From Investing Activities		
Decrease in assets limited as to use	-	41,400
Capital acquisitions	(44,492)	(105,142)
Net Cash Used by Investing Activities	(44,492)	(63,742)
Cash Flows From Financing Activities		
Proceeds from line of credit	65,000	
Payments on line of credit	(190,000)	(50,000)
Proceeds from issuance of long-term debt	-	600,000
Payments on long-term debt	(36,692)	(300,542)
Net Cash (Used) Provided by Financing Activities	(161,692)	249,458

AMMONOOSUC COMMUNITY HEALTH SERVICES, INC.

STATEMENTS OF CASH FLOWS (CONTINUED)

FOR THE YEARS ENDED JUNE 30, 2013 AND 2012

	2013	2012
Net Increase in Cash and Cash Equivalents	51,266	88,612
Cash and Cash Equivalents, Beginning of Year	120,217	31,605
CASH AND CASH EQUIVALENTS, END OF YEAR	$ 171,483	$ 120,217
Supplemental Disclosures of Cash Flow Information:		
Cash paid for interest	$ 40,547	$ 51,960

(See accompanying notes to these financial statements)

It is the *mission* of
Ammonoosuc Community Health Services
to provide a stable network of comprehensive
Primary Health Care Services
to individuals and families throughout
the communities we serve.

In support of this mission, ACHS provides
evidenced based, outcome specific, systematic care that is:

- patient centered
- focused on prevention
- accessible and affordable to all

Ammonoosuc Community Health Services, Inc.
2014 Board of Directors (02/17/2014)

Beth Harwood, *President (2014)* **Term:** End of Term 2015	**Alan Smith, *Co-Vice President (2014)*** **Term:** End of Term 2014
Lynn Davis, *Co-Vice President (2014)* **Term:** End of Term 2014	**Inga Johnson, *Secretary (2014)*** **Term:** End of Term 2017
Ned Densmore, *Treasurer (2014)* **Term:** End of Term 2015	**Ray Lobdell** **Term:** End of Term 2017
Bob Tortorice **Term:** End of Term 2014	**Ronald Spaulding, DDS** **Term:** End of First Term 2015
Bruce Brown **Term:** End of Term 2017	**Gary Boyle** **Term:** End of Term 2015
Judy Day **Term:** End of First Term 2016	**Mark Secord, CPA** **Term:** End of Term 2016
John Rapoport, Ph.D. **Term:** End of Term 2016	

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KEY ADMINISTRATIVE PERSONNEL

NH Department of Health and Human Services

Contractor Name: Ammonoosuc Community Health Services, Inc.

Name of Bureau/Section: MCH Primary Care

BUDGET PERIOD: SFY 14

Program Area: MCH Primary Care

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Edward Shanshala	CEO	$127,608	0.00%	$0.00
Kenneth Riebel	CFO	$100,443	0.00%	$0.00
		$0	0.00%	$0.00
		$0	0.00%	$0.00
		$0	0.00%	$0.00
		$0	0.00%	$0.00
		$0	0.00%	$0.00
		$0	0.00%	$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$0.00**

KEY ADMINISTRATIVE PERSONNEL

NH Department of Health and Human Services

Contractor Name: Ammonoosuc Community Health Services, Inc.

Name of Bureau/Section: MCH Primary Care & BCCP

BUDGET PERIOD: SFY 15

Program Area: MCH Primary Care Services

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Edward Shanshala	CEO	$127,608	1.96%	$2,501.12
Kenneth Riebel	CFO	$100,443	2.49%	$2,501.03
		$0	0.00%	$0.00
		$0	0.00%	$0.00
		$0	0.00%	$0.00
		$0	0.00%	$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$5,002.15**

Program Area: Breast and Cervical Cancer Program Services

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Edward Shanshala	CEO	$127,608	0.78%	$995.34
Kenneth Riebel	CFO	$100,443	0.75%	$753.32
		$0	0.00%	$0.00
		$0	0.00%	$0.00
		$0	0.00%	$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$1,748.66**

Program Area: Rural Health and Primary Care Services

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Edward Shanshala	CEO	$127,608	0.00%	$0.00
Kenneth Riebel	CFO	$100,443	0.00%	$0.00
		$0	0.00%	$0.00
		$0	0.00%	$0.00
		$0	0.00%	$0.00
		$0	0.00%	$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$0.00**

Edward D Shanshala II, MSHSA, MSEd

Email ed.shanshala@achs-inc.org

Experience:

Position	Dates
Ammonoosuc Community Health Services, Inc. - *Chief Executive Officer*	07/2007 - Present
Ammonoosuc Community Health Services, Inc. - *Chief Operating Officer*	12/ 2005 – 06/2007
Roberts Wesleyan College - *Adjunct Faculty*	11/ 2005 – 12/2005
Semper Unum - *Principal Consultant*	01/ 2004 – Present
Rochester Primary Care Network Inc. - *Interim CEO and Vice President of Operations*	03/ 2003 – 01/ 2005
Rochester Institute of Technology - *Adjunct Faculty*	01/2002 – 01/2004
Keuka College - *Adjunct Faculty*	08/2002 – 08/2005
Finger Lakes VNS & Ontario Yates Hospice Inc. - *Director of QI, Education Enhancement & CCO*	03/1997- 03/2003
Strong Memorial Hospital, University of Rochester Medical Center - *Reengineering Project Coordinator*	05/1995- 03/1997
University of Rochester Medical Center: Department of Pharmacology *Professional* - *Tech. Assoc. II*	06/1987 – 05/1995

Education

Degree	Institution
Masters of Science in Health Systems Administration, 2000	Rochester Institute of Technology
Masters of Science in Education, 1994	University of Rochester
Bachelors of Science in Biotechnology, 1987	Rochester Institute of Technology
Associates of Science in Chemistry, 1985	Rochester Institute of Technology

Grants, Scholarships, Awards. and Professional Leadership:

- 2000 Academic Excellence Award, Masters of Science Health Systems Administration
- 2000 Distance Learning 20/2000 Competitive Graduate Scholarship, Rochester Institute of Technology
- 2000 Program Chair American Society for Quality Rochester Section Annual Conference Committee
- 1998-2000 Graduate Scholarship, Rochester Institute of Technology, College of Applied Science and Technology
- 1999 American Society for Quality Research Fellowship
- 1999 Performance Concepts International Matching Research Grant
- 1999 Award for Outstanding Volunteer Leadership in Editing, American Society for Training and Development

Publications:

Winchester K, and Shanshala II ED., (Winter 1998). Corporate Team Building *Performance in Practice*

Shanshala II ED., (Fall 1998). Chartering Teams. *Performance in Practice*

Shanshala II ED., (1997). Building in Quality. *Quality Progress*, Vol. 30, No. 10: 67-69.

Hinkle PM, and Shanshala II ED., and Nelson EJ (1992). Measurement of intracellular cadmium with fluorescent dyes: Further evidence for the role of calcium channels in cadmium uptake. *J.Biol. Chem.* 267: 25553-25559.

Hinkle PM, Shanshala II ED., (1992). Prolactin and secretogrannin II, a marker for the regulated pathway, are secreted in parallel by pituitary GH4C1 cells. *Endocrinology* 130: 3503-3511.

Hinkle PM, Shanshala II ED., (1991). Epidermal growth factor decreases the concentration of pituitary TRH receptors and TRH responses. *Endocrinology* 129: 1283-1288.

Hinkle PM, Shanshala II ED., (1989). Pituitary thyrotropin-releasing hormone (TRH) receptors: Effects of TRH, drugs mimicking TRH action, and Chlordiazepoxide. *Mol.Endocrinol.* 89: 1337-1344.

Federal Consulting and Grant Reviewing:

Consult and review federal grant applications for Health Resources and Services Administration's Division of Independent Review

Volunteering and Leadership:

Board of Directors; Hospeace House, Interlakes Foundation Wellness Program, St. Michaels School, Hospice of Littleton Area,

Kenneth L. Riebel

Email Ken.Riebel@achs-inc.org

Experience:

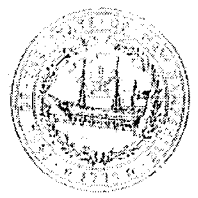
Ammonoosuc Community Health Services, Inc.- *Chief Financial Officer*	06/1994 – Present
Cargill Blake Construction Co., Inc. – Controller	05/1985– 06/1994
Courier Printing Company, Inc. – Controller	02/1981 – 05/1985
Franconia Paper Company, Inc. – Chief Accountant	1979 – 1981
Littleton Regional Hospital – Accountant	1977 – 1979
Glassboro State College – Junior Accountant	1974 – 1976

Education

Bachelors of Science in Accounting with Computer Science minor, 1974	Drexel University
A.S. in Accounting with Computer Science minor, 1972	Gloucester County College

Volunteering and Leadership:

- Member of State of NH Family Planning Formulary Work Group 2004-2005
- Member of State of NH Medicaid Prospective Payment System Work Group 2002 - 2003
- Member of Town of Bethlehem Task Force for Solid Waste Disposal Alternatives 1999



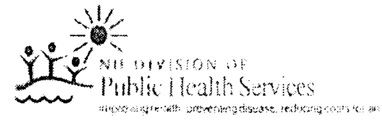
Nicholas A. Toumpas
Commissioner

José Thier Montero
Director

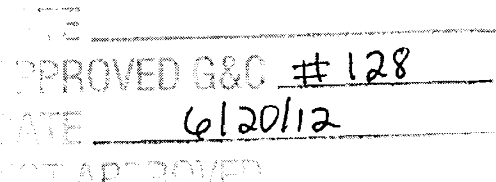
STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

29 HAZEN DRIVE, CONCORD, NH 03301-6527
603-271-4517 1-800-852-3345 Ext. 4517
Fax: 603-271-4519 TDD Access: 1-800-735-2964



May 10, 2012



His Excellency, Governor John H. Lynch
and the Honorable Executive Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Public Health Services, Bureau of Population Health and Community Services, Maternal and Child Health Section, to enter into an agreement with Ammonoosuc Community Health Services, Inc. (Vendor #177755-B003), 25 Mount Eustis Road, Littleton, New Hampshire 03561, in an amount not to exceed $370,854.00, to provide primary care services and breast and cervical cancer screening, to be effective July 1, 2012 or date of Governor and Executive Council approval, whichever is later, through June 30, 2014. Funds are available in the following accounts for SFY 2013, and are anticipated to be available in SFY 2014 upon the availability and continued appropriation of funds in the future operating budgets.

05-95-90-902010-5190 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES, MATERNAL AND CHILD HEALTH

Fiscal Year	Class/Object	Class Title	Job Number	Total Amount
SFY 2013	102-500731	Contracts for Program Services	90080000	$142,819
SFY 2014	102-500731	Contracts for Program Services	90080000	$142,819
			Sub-Total	$285,638

05-95-90-901010-5149 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF PUBLIC HEALTH SYSTEMS, POLICY AND PERFORMANCE, RURAL HEALTH AND PRIMARY CARE

Fiscal Year	Class/Object	Class Title	Job Number	Total Amount
SFY 2013	102-500731	Contracts for Program Services	90073001	$10,000
SFY 2014	102-500731	Contracts for Program Services	90073001	$10,000
			Sub-Total	$20,000

05-95-90-902010-5659 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES, COMPREHENSIVE CANCER

Fiscal Year	Class/Object	Class Title	Job Number	Total Amount
SFY 2013	102-500731	Contracts for Program Services	90080081	$32,608
SFY 2014	102-500731	Contracts for Program Services	90080081	$32,608
			Sub-Total	$65,216
			Total	$370,854

EXPLANATION

Funds in this agreement will be used to provide breast and cervical cancer screening and office-based primary care services for low-income and uninsured families. This agreement provides funds for services as a last resort; contractor is required to make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid.

Primary health care services include preventive and episodic health care for acute and chronic health conditions for people of all ages, including pregnant women, children, adolescents, adults, and the elderly. Community health agencies that receive support through the Division of Public Health Services deliver primary and preventive health care services to underserved people who face barriers to accessing health care, due to issues such as a lack of insurance, inability to pay, language barriers, and geographic isolation. In addition to medical care, community health centers are unique among primary care providers for the array of patient-centered services they offer, including care coordination, translation, transportation, outreach, eligibility assistance, and health education. These services help individuals overcome barriers to getting the care they need and achieving their optimal health. These services help individuals overcome barriers to getting the care they need and achieving their optimal health. One area of particular success has been in ensuring that eligible families maintain consistent enrollment in Medicaid for their children. Community health centers provide support for families in filling out applications and ensuring that children have continuity of care.

Community health agencies throughout New Hampshire have demonstrated success in meeting the health care needs of the uninsured and under-insured citizens of the state. Division of Public Health Services funded primary care providers participate in rigorous quality improvement efforts utilizing standard performance measures that focus attention on improving health outcomes for patients. For example, in State Fiscal Year 2011:

- 88% of eligible children served were enrolled in Medicaid/Healthy Kids Gold.
- 86% of children 24-35 months, served received the appropriate schedule of immunizations.
- 82% of infants born to women served received prenatal care beginning in the first trimester of pregnancy.

In addition, breast and cervical cancers continue to be ongoing public health issues for New Hampshire. The Division of Public Health Services, Breast and Cervical Cancer Screening Program provides support for breast and cervical cancer screening services that include clinical examinations, pap smears and referral for

mammography. Through this program, women found to have abnormal screening results, following their testing, receive additional coverage for diagnostic work-up and, if necessary, have their care coordinated through the initiation of treatment.

Should Governor and Executive Council not authorize this Request, a minimum of 16,000 low-income individuals from the Northern Grafton and Southern Coos area may not have access to primary care services, and eligible women may not receive recommended breast and cervical cancer screenings. A strong primary care infrastructure reduces costs for uncompensated care, improves health outcomes, and reduces health disparities. Additionally women that receive recommended breast and cervical cancer screenings are at lower risk of late diagnosis of breast and cervical cancers.

Ammonoosuc Community Health Services, Inc. was selected for this project through a competitive bid process. A Request for Proposals was posted on the Department of Health and Human Services' web site from January 10, 2012 through February 16, 2012. In addition, a bidder's conference, conference call, and web conference were held on January 19, 2012 to alert agencies to this bid.

Thirteen proposals were received in response to the posting. Each proposal was scored by three professionals, who work internal and external to the Department of Health and Human Services. All reviewers have between three to twenty years experience either in clinical settings, providing community-based family support services, and managing agreements with vendors for various public health programs. Areas of specific expertise include maternal and child health; quality assurance and performance improvement; chronic and communicable diseases and public health infrastructure. The reviewers used a standardized form to score agencies' relevant experience and capacity to carry out the activities outlined in the proposal. Reviewers look for realistic targets when scoring performance measures in addition to detailed workplans including evaluation components. Budgets were reviewed to be reasonable, justified and consistent with the intent of the program goals and outcomes. There were no competing applications within each of the separate service areas. Scores were averaged and all proposals were recommended for funding. In those instances where scores were less than ideal, agency specific remedial actions were recommended and completed. Some primary care agencies are being funded at levels higher than they requested. Agencies were instructed to develop budgets based on previous allocations. While some proposed budgets higher than what was available for funding, others proposed budgets lower than what was available. There was an increase in breast and cervical cancer screening funds that bidders were unaware of when they drafted budgets. Adjustments were made accordingly for those agencies that proposed budgets at levels lower than available funds. The Bid Summary is attached.

As referenced in the Request for Proposals, Renewals Section, this competitively procured Agreement has the option to renew for two additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties and approval of the Governor and Executive Council. These services were contracted previously with this agency in SFY 2011 and SFY 2012 in the amount of $670,146. This represents a decrease of $299,292. The decrease is due to budget reductions.

The performance measures used to measure the effectiveness of the agreement are attached.

Area served: Northern Grafton and Southern Coos Counties.

Source of Funds: 32.95% Federal Funds from US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau and 67.05% General Funds.

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

Respectfully submitted,

José Thier Montero, MD
Director

Approved by:
Nicholas A. Toumpas
Commissioner

JTM/PMT/sc

Primary Care Performance Measures

State Fiscal Year 2013

Primary Care Prenatal (PN) Performance Measure #1

Measure: Percent of infants born to women receiving prenatal care beginning in the first trimester of pregnancy.

Primary Care Prenatal (PN) Performance Measure #2

Measure: Percent of pregnant women identified as cigarette smokers that are referred to QuitWorks-New Hampshire.

Primary Care Prenatal (PN) Performance Measure #3

Measure: Percent of pregnant women who were screened, using a formal valid screening tool, for alcohol and other drug use during every trimester the patient was enrolled.

Primary Care Child Health Direct (CH – D) Performance Measure #1

Measure: Percent of eligible children enrolled in Medicaid

Primary Care Child Health Direct (CH – D) Performance Measure #2

Measure: Percent of at-risk children who were screened for blood lead between 18 and 30 months of age

Primary Care Child Health Direct (CH – D) Performance Measure #3

Measure: Percent of children age two to nineteen years receiving primary care preventive health services with a Body Mass Index (BMI) percentile greater than or equal to the 85th percentile with documented discussion of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Primary Care Child Health Direct (CH – D) Performance Measure #4

Measure: Percent of eligible infants and children with client record documentation of enrollment in Women Infant Children Program.

Primary Care Child Health Direct (CH – D) Performance Measure #5

Measure: Percent of infants who were exclusively breastfed for the first three months, at their four month well baby visit.

Primary Care Financial (PC) Performance Measure #1

Measure: Patient Payor Mix

Primary Care Financial (PC) Performance Measure #2

Measure: Accounts Receivables (AR) Days

Primary Care Financial (PC) Performance Measure #3

Measure: Current Ratio

Primary Care Performance Measures

State Fiscal Year 2013

Primary Care Clinical Adolescent (PC-C) Performance Measure #1

Measure: Percent of adolescents aged 10-21 years who received annual health maintenance visits in the past 12 months.

Primary Care Clinical Prenatal (PC-C) Performance Measure #2

Measure: Percent of women and adolescent girls aged 15-44 who take a multi-vitamin with folic acid.

Subject: Primary Care Services

AGREEMENT

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

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name NH Department of Health and Human Services Division of Public Health Services		**1.2 State Agency Address** 29 Hazen Drive Concord, NH 03301-6504	
1.3 Contractor Name Ammonoosuc Community Health Services, Inc.		**1.4 Contractor Address** 25 Mount Eustis Road Littleton, New Hampshire 03561	
1.5 Contractor Phone Number 603-444-8223	**1.6 Account Number** 010-090-5190-102-500731 010-090-5149-102-500731 010-090-5656-102-500731	**1.7 Completion Date** June 30, 2014	**1.8 Price Limitation** $370,854
1.9 Contracting Officer for State Agency Joan H. Ascheim, Bureau Chief		**1.10 State Agency Telephone Number** 603-271-4501	
1.11 Contractor Signature [signature]		**1.12 Name and Title of Contractor Signatory** Edward D Shanshala II CEO	

1.13 Acknowledgement: State of NH, County of Grafton

On 4/27/12 before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.

1.13.1 Signature of Notary Public ~~or Justice of the Peace~~

[Seal] [signature] CAROL A. HEMENWAY, Notary Public My Commission Expires November 17, 2015

1.13.2 Name and Title of Notary ~~or Justice of the Peace~~

Carol A. Hemenway Admin. Asst., Ammonoosuc Community Health Services, Inc.

1.14 State Agency Signature [signature]	**1.15 Name and Title of State Agency Signatory** Joan H. Ascheim, Bureau Chief

1.16 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)*

By: Director, On:

1.17 Approval by the Attorney General (Form, Substance and Execution)

By: [signature] Jeanne P. Herrick, Attorney On: 29 May 2012

1.18 Approval by the Governor and Executive Council

By: On:

NH Department of Health and Human Services

Exhibit A

Scope of Services

Primary Care Services

CONTRACT PERIOD: July 1, 2012 or date of G&C approval, whichever is later, through June 30, 2014

CONTRACTOR NAME: Ammonoosuc Community Health Services, Inc.

ADDRESS: 25 Mount Eustis Road
Littleton, New Hampshire 03561
Executive Director: Edward Shanshala
TELEPHONE: 603-444-8223

The Contractor shall:

I. General Provisions

A) Eligibility and Income Determination

1. Office-based primary care services will be provided to low-income individuals and families (defined as ≤ 185% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), in the State of New Hampshire.

2. Breast and Cervical Cancer screening services will be provided to low-income (defined as ≤ 250% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), New Hampshire women age 18 – 64, ***uninsured or underinsured***.

3. The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing if, at any time, the practice is closed to new patients, or maintains a wait list for new patients, or any other mechanism is used that limits access for new patients for more than a one month period.

4. The Contractor shall document annually, for each client enrolled in the program, family income and family size, and calculate percentage of the federal poverty level. If calculations indicate that the client may be eligible for enrollment in Medicaid, the Contractor shall complete with the client the most recent version of the 800P form.

5. The Contractor shall implement, and post in a public and conspicuous location, a sliding fee payment schedule, approved in advance by the Division of Public Health Services (DPHS), for low-income patients. Signage must state that no client will be denied services for inability to pay.

   a. As an alternative, the contractor may post, in a public and conspicuous location, a notice to clients that a sliding fee scale is available and that no client will be denied services for inability to pay. The sliding fee scale must be updated annually based on USDHHS Poverty guidelines as published in the Federal Register, submitted to and approved by DPHS ***prior to implementation.***

6. The primary care contract entered into here shall be the payer of last resort. The contractor shall make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid, for all reimbursable services rendered.

B) Numbers Served

1. The contract funds shall be expended to provide the above services to a minimum of 8,000 users annually with 30,000 medical encounters, as defined in the Data and Reporting Requirements. Breast and Cervical Cancer Screening for eligible women, as defined by the Breast and Cervical Cancer Program (BCCP), shall be provided to 190 women annually and billed directly to the BCCP. Clinical service reimbursements shall not exceed the Medicare rate.

C) Culturally and Linguistically Appropriate Standards of Care

The Department of Health and Human Services (DHHS) recognizes that culture and language have considerable impact on how consumers access and respond to public health services. Culturally and linguistically diverse populations experience barriers in efforts to access health services. To ensure equal access to quality health services, the Division of Public Health Services (DPHS) expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.

2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.

3. *Provide* clients of limited English proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.

4. Offer consumers a forum through which clients have the opportunity to provide feedback to providers and organizations regarding cultural and linguistic issues that may deserve response.

5. The contractor shall maintain a program policy that sets forth compliance with Title VI, Language Efficiency and Proficiency Citation 45 CFR 80.3(b) (2). The policy shall describe the way in which the items listed above were addressed and shall indicate the circumstances in which interpretation services are provided and the method of providing service (e.g. trained interpreter, staff person who speaks the language of the client, language line).

D) State and Federal Laws

The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. The Contractor shall report all cases of communicable diseases according to New Hampshire RSA 141-C and He-P 301, adopted 6/3/08.

2. Persons employed by the contractor shall comply with the reporting requirements of New Hampshire RSA 169:C, Child Protection Act; RSA 161:F46, Protective Services to Adults, RSA 631:6, Assault and Related Offences and RSA 130:A, Lead Paint Poisoning and Control.

3. Immunizations shall be conducted in accordance with RSA 141-C and the Immunization Rules promulgated hereunder.

E) Relevant Policies and Guidelines

1. The Contractor shall design and provide the services described above to meet the unique and identified health needs of the populations within the contracted service area.

2. Primary Care funds shall be targeted to populations in need. Populations in need are defined as follows:

   a) uninsured;

   b) under-insured;

   c) families and individuals with significant psychosocial and economic risk, including low income status;

   d) all life cycles including perinatal, child, adolescent, adult, and elderly who meet one or more of the above criteria.

3. The Contractor shall design and implement systems of governance, administration, financial management, information management, and clinical services which are adequate to assure the provision of contracted services, and to meet the data and reporting requirements. These systems shall meet the most current minimum standards described in at least one of the following: Health Resources and Services Administration (HRSA) Office of Performance Review protocols, Joint Commission on Accreditation of Health Care Organizations (JCAHO), Accreditation Association for Ambulatory Healthcare (AAAHC), Community Health Accreditation Program (CHAP), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey.

4. *The Contractor shall have an agency emergency preparedness and response plan in accordance with HRSA Health Center Emergency Management Program Expectations, Document #2007-15 or most recent version. Such plan shall also include a Continuity of Operations plan.*

5. The Contractor shall carry out the work as described in the performance Workplan submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

6. No Workplan is required by the Breast and Cervical Cancer Program (BCCP). The contractor shall be required to respond to the Quality Improvement Feedback Report twice a year.

7. The Contractor shall carry out the work as described in the Supplemental Funding Form submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

F) Publications Funded Under Contract

1. The DHHS and/or its funders will retain COPYRIGHT ownership for any and all original materials produced with DHHS contract funding, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports.

2. All documents (written, video, audio, *electronic*) produced, reproduced, or purchased under the contract shall have prior approval from DPHS before printing, production, distribution, or use.

3. The Contractor shall credit DHHS on all materials produced under this contract following the instructions outlined in Exhibit C (14).

G) Subcontractors

1. If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing *and approve the subcontractual agreement,* prior to initiation of the subcontract.

2. In addition, the original DPHS contractor will remain liable for all requirements included in this Exhibit and carried out by subcontractors.

II. Minimal Standards of Core Services

A) Service Requirements

1. *Medical Home*

The Contractor shall provide a Medical Home that:

a) *Facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family.*

b) *Provides care facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.*

2. Primary Care Services

The Contractor shall provide office-based primary care services to populations in need who reside in the contractor's service area. Primary care services shall include:

a) Health care provided by a New Hampshire licensed MD, DO, APRN, or PA, including diagnosis and treatment of acute and chronic illnesses within the scope of family practice; preventive services, screenings, and health education according to established, documented state or national guidelines; assessment of need for social and nutrition services, and appropriate referrals to health, *oral health*, and behavioral health specialty providers.

b) *Referral to the WIC Nutrition Program for all eligible pregnant women, infants and children.*

c) In-hospital care for conditions within the scope of family practice must be provided at a hospital, within the agency service area, through a staff clinician with full hospital privileges, or in the alternative, through a formal referral and admissions procedure available to clients on a 24 hour/7 day a week basis.

d) Access to a healthcare provider, directly or by referral or subcontract, by telephone twenty-four hours per day, seven days per week.

e) Assessment of psychosocial risk for all clients at least annually and for children at scheduled preventive care visits, including, at a minimum, age appropriate assessment of safety in the home, domestic violence, adequacy of food and housing, care and welfare of children, transportation needs, and provision of necessary social services to address the priority needs and safety issues of clients and families.

f) Falls prevention screening for patients 65 years and older using the algorithm and guidelines of the American Geriatrics Society.

g) Behavioral health care directly or by referral to an agency or provider with a sliding fee scale.

h) *Nutrition assessment for all clients as part of the health maintenance visit.* Therapeutic nutrition services shall be provided *as indicated* directly or by referral to an agency or provider with a sliding fee scale. These services shall be recorded in the medical record.

i) Formal arrangements with a local hospital for emergency care must be in place and reviewed annually.

Contractor Initials: GDGA

Date: 04/27/2012

j) Home health care directly or by referral to an agency or provider with a sliding fee scale.

k) Assisted living and skilled nursing facility care by referral.

l) *Oral screening annually for all clients 19 years and older to note obvious dental decay and soft tissue abnormalities with a reminder to the patient that poor oral health impacts total health.*

m) *Diagnosis and management of pediatric and adult patients with asthma provided according to National Heart Lung Blood Institute, National Asthma Education and Prevention Program, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, 2007.*

2. Breast and Cervical Cancer Screening

a) Women age 18 to 64 who are eligible for Breast and Cervical Cancer Program (BCCP) services according to income (equal to or under 250% of poverty, underinsured/uninsured) *and insurance status* criteria shall be provided the following services:

i. cervical cancer screening including a pelvic examination and Pap smear;
ii. annual breast cancer screening including a clinical breast exam, mammogram and,
iii. referrals for diagnostic and treatment services based on screening results,
iv. ~~case management services~~

b) All referrals under this provision shall be to approved certified laboratory, pathology, radiology, and surgical services. Mammography units shall be accredited by the American College of Radiology, and must be FDA certified under MQSA. Laboratories shall be CLIA certified.

c) All services shall be provided in accordance with the Breast and Cervical Cancer Program (BCCP) Policy and Procedure Manual.

d) Follow-up and tracking of all tests done, and referrals made shall be provided in accordance with the minimum standards outlined in the Breast and Cervical Cancer Program Policy and Procedure Manual.

e) All services for women enrolled in the Breast and Cervical Cancer Program (BCCP) shall be billed directly to the BCCP in accordance with protocols established by the Breast and Cervical Cancer Program.

3. Reproductive Health Services

The Contractor shall provide prenatal, interconceptional and preconception medical care, social services, nutrition services, education, and nursing care to all women of childbearing age. Preconceptional care includes the preconception, interconceptional, and postpartum periods in women's health. It is recommended that preconceptional and interconceptional care visits focus on maintaining or achieving the optimal health of the mother, lowering the risk of future adverse pregnancy outcomes, the family's future plans, and how additional children fit into that plan. Preconceptional counseling may be done during an office, group or home visit.

a) In the event prenatal care is not provided directly by the Contractor a formal Memorandum/a of Agreement for coordinated referral to an appropriately qualified provider must be maintained.

b) Prenatal care shall, at minimum, be provided in accordance with the Guidelines for Perinatal Care, sixth or most current edition, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and /or the Centers for Disease Control.

Contractor Initials: CDGH
Date: 04/27/2012

c) Age appropriate reproductive health care shall, at a minimum, be provided in accordance with the American College of Obstetricians and Gynecologists, or the USDHHS Centers for Disease Control (CDC) current guidelines.

d) *Pregnant women enrolled in the WIC Nutrition Program shall be referred to WIC for breastfeeding education and referral to the WIC Nutrition Program peer counselors.*

e. Family planning counseling for prevention of subsequent pregnancy following an infant's birth shall be discussed with the infant's mother *at the first postpartum visit and at the infant's 2-month visit and other visits as appropriate.* Rationale for birth intervals of 18-24 months shall be presented.

f) A referral to a Title X Family Planning Clinic or other reproductive health care provider shall be made as appropriate.

4. Services for Children and Adolescents

The Contractor shall provide as a minimum, comprehensive and age-appropriate health care, screenings, and health education according to the American Academy of Pediatrics' most recent periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent. Children and adolescent visits shall include:

a) Blood lead testing shall be performed in accordance with "New Hampshire Childhood Lead Poisoning Screening and Management Guidelines", issued by the New Hampshire Department of Health and Human Services, 2009 or subsequent revisions.

b) All children enrolled in either Healthy Kids-Gold or the Women, Infant, and Children (WIC) Program and/or who are ≤ 185% poverty, regardless of town of residence, are required to have a blood lead test at ages one and two years. All children ages three to six years who have not been previously tested shall have a capillary or venous blood lead test performed.

c) All children shall be screened for iron deficiency anemia as outlined in the Centers for Disease Control and Prevention document "Recommendations to Prevent and Control Iron Deficiency in the United States (4/2/98)".

d) Age-appropriate anticipatory guidance, dietary guidance, and *feeding practice counseling* for optimal oral health shall be provided at each well child visit according to the American Academy of Pediatrics' periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent edition. Starting at age 6 months, it is recommended that all children receive an oral health assessment at every well child visit.

e) Supplemental fluoride shall be prescribed as needed based upon the fluoride levels in the child's *drinking* water supply. The fluoride dosage regimen accepted by the American Academy of Pediatrics shall be followed. No fluoride shall be prescribed without obtaining water from private wells or noting the presence or absence of fluoride in the public water supply. *Supplemental fluoride may include bottled water containing fluoride and topical applications such as varnishes.*

f) *For infants enrolled in the WIC Nutrition Program, parents shall be referred to WIC for breastfeeding support and referral to the WIC Nutrition Program peer counselors.*

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5. Sexually Transmitted Infections

Primary Care Services shall provide age appropriate screening and treatment of sexually transmitted infections.

a) Treatment for sexually transmitted infections shall be provided according to the United States Centers for Disease Control Sexually Transmitted Diseases Treatment Guidelines, 2010 or subsequent revisions.

b) All clients, including women, shall be offered HIV testing following the most current recommendations of the United States Centers for Disease Control.

c) The contractor shall be responsible for ensuring referral to appropriate treatment services for any woman found to screen positive.

d) Appropriate risk reduction counseling shall be provided based on client needs.

6. Substance Use Services

a) A substance use screening history using a formal, validated screening tool shall be obtained for all clients as soon after entry into care as possible. Substance use counseling *or other substance abuse intervention, treatment, or recovery services* by an appropriately credentialed provider shall be provided on-site, or by referral, to clients with identified needs for these services. ***For these identified clients, ongoing primary care services should include follow up monitoring relative to substance abuse.***

b) All clients, including pregnant women, identified as smokers shall receive counseling *using the 5A's (ask, advise, assess, assist, and arrange) treatment available through the NH Tobacco Helpline* as cited in the US Public Health Services report "Tobacco Use and Dependence", 2008, or "Smoking Cessation During Pregnancy: *A Clinician's Guide to Helping Pregnant Women Quit Smoking*", American College of Obstetricians and Gynecologists, 2011. ***With prior approval, agencies may also opt to participate in the DPHS best practice initiative of the 2A's and R (ask, advise and refer).***

7. Immunizations

a) The Contractor shall adhere to the most current version of the "Recommended Adult Immunization Schedule United States", approved by the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

b) The Contractor shall administer vaccines according to the most current version of the *"Recommended Immunization Schedule for Persons Aged 0 Through 6 Years - United States", and "Recommended Immunization Schedule for Persons Aged 7 Through 18 Years – United States"* approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians, based upon availability of vaccine from the New Hampshire Immunization Program.

8. Prenatal Genetic Screening

a) A genetic screening history shall be obtained on all prenatal clients as soon after entry into care as possible.

b) All pregnant women should be offered voluntary genetic screening for fetal chromosomal abnormalities at the appropriate time following recommendations found in the American College of Obstetricians and Gynecologists' "Screening for Fetal Chromosomal

Abnormalities (2007)" or more recent guidelines. The Contractor shall be responsible for ensuring referral to appropriate genetic testing and counseling for any woman found to have a positive screening test.

9. Additional Requirements

a) The Contractor's Medical Director shall participate in the development and approval of specific guidelines for medical care that supplement minimal clinical standards. Supplemental guidelines should be reviewed, signed, and dated annually, and updated as indicated.

b) Contractors considering clinical or sociological research using clients as subjects must adhere to the legal requirements governing human subjects research. Contractors must inform the DPHS, MCHS prior to initiating any research related to this contract.

c) *The Contractor shall provide information to all employees annually about the Medical Reserve Corps Unit within their Public Health Region to enhance recruitment.*

d) *The Contractor shall provide information to all employees annually regarding the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) managed by the NH Department of Health and Human Services' Emergency Services Unit, to enhance recruitment.*

B) Staffing Provisions

The Contractor shall have, at minimum, the following staff positions:

a) executive director

b) fiscal director

c) registered nurse

d) clinical coordinator

e) medical service director

f) nutritionist *(on site or by referral)*

g) social worker

Staff positions required to provide direct services on-site include:

a) registered nurse

b) clinical coordinator

c) social worker

1. Qualifications

All health and allied health professionals shall have the appropriate New Hampshire licenses whether directly employed, contracted, or subcontracted.

In addition the following minimum qualifications shall be met for:

a) Registered Nurse

a. A registered nurse licensed in the state of New Hampshire, Bachelor's degree preferred. Minimum of one-year experience in a community health setting.

b) Nutritionists:

a. A Bachelor's degree in nutritional sciences or dietetics, or a Master's degree in nutritional sciences, nutrition education, or public health nutrition or current Registered Dietitian status in accordance with the Commission on dietetic Registration of the American Dietetic Association.

b. Individuals who perform functions similar to a nutritionist but do not meet the above qualifications shall not use the title of nutritionist.

c) Social Workers shall have:

a. A Bachelor's or Master's degree in social work or Bachelor's or Master's degree in a related social science or human behavior field. A minimum of one year of experience in a community health or social services setting is preferred.

b. Individuals who perform functions similar to a social worker but do not meet the above qualifications shall not use the title of social worker.

d) Clinical Coordinators shall be:

a. A registered nurse (RN), physician, physician assistant, or nurse practitioner with a license to practice in New Hampshire.

b. The coordinator is a clinical position that oversees and takes responsibility for the clinical and administrative functions of each program.

c. The coordinator may be responsible for more than one MCH funded program.

2. New Hires

The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing within one month of hire when a new administrator, clinical coordinator, or any staff person essential to carrying out contracted services is hired to work in the program. A resume of the employee shall accompany the aforesaid notification.

3. Vacancies

a) The Contractor must notify the MCHS in writing if any critical position is vacant for more than one month, or if at any time funded under this contract does not have adequate staffing to perform all required services for more than one month. This may be done through a budget revision.

b) Before an agency hires new program personnel that do not meet the required staff qualifications, the agency shall notify the MCHS in writing requesting a waiver of the applicable staffing requirements. The Section may grant waivers based on the need of the program, individuals' experience, and additional training.

C) **Coordination of Services**

1. The Contractor shall coordinate, where possible, with other service providers within the contractor's community. At a minimum, such collaboration shall include interagency referrals and coordination of care.

2. The Contractor shall participate in activities *in the Public Health Region in which they provide services* as appropriate. These activities enhance the integration of community-based public health

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prevention and health care initiatives that are being implemented by the contractor and may include community needs assessments, public health performance assessments, and/or the development of regional health improvement plans.

3. The Contractor agrees to *participate* in and coordinate public health activities as requested by the Division of Public Health Services during any *disease outbreak* and/or *emergency*, natural or man made, affecting the public's health.

4. The Contractor is responsible for case management of the client enrolled in the program and for program follow-up activities. Case management services shall promote effective and efficient organization and utilization of resources to assure access to necessary comprehensive medical, nutritional, and social services for clients.

5. The Contractor shall assure that *appropriate, responsive, and timely* referrals and linkages for other needed services are made, carried through, and documented. Such services shall include, but not be limited to: dental services, genetic counseling, high risk prenatal services, mental health, social services, including domestic violence crisis centers, substance abuse services; and family planning services, Early Supports and Services Program, local WIC/CSF Program, Home Visiting New Hampshire Programs and health and social service agencies which serve children and families in need of those services.

D) Meetings and Trainings

The contractor will be responsible for sending staff to meetings and training required by the MCHS program, including but not limited to:

1. MCHS Agency Directors' meetings

2. Prenatal and Child Health Coordinators' meetings

3. MCHS Agency Medical Services Directors' meetings

III. Quality or Performance Improvement (QI/PI)

A) Workplans

1. Performance Workplans are required for this program and are used to monitor achievement of standard measures of performance of the services provided under this contract. The workplans are a key component of the RHPCS and the MCHS performance-based contracting system and of this contract. Outcomes shall be reported by clinical site.

2. Submit Performance Workplans and Workplan Outcome reports according to the schedule and instructions provided by the MCHS. The MCHS shall notify the Contractor at least 30 days in advance of any changes in the submission schedule.

3. The Contractor shall incorporate required and developmental performance measures, defined by the MCHS into the agency's Performance Workplan. Reports on Workplan Progress/Outcomes shall detail the Performance Workplan and activities that monitor and evaluate the agency's progress toward performance measure targets.

4. The Contractor shall comply with modifications and/or additions to the workplan and annual report format as requested by RHPCS and MCHS. MCHS will provide the contractor with reasonable notice of such changes.

5. Agencies contracting for Primary Care Services must submit the workplans for Primary Care *Clinical and Financial*, Child Health, and Prenatal Care.

B) Additional Reporting requirements

In addition to Performance Workplans, the Contractor shall submit to MCHS the following data and information listed below which are used to monitor program performance:

1. In years when contracts or amendments are not required, the DPHS Budget Form, Budget Justification, Sources of Revenue and Program Staff list forms must be completed according to the relevant instructions and submitted as requested by DPHS and, at minimum, by April 30 of each year.

2. The Sources of Revenue report must be resubmitted at any point when changes in revenue threaten the ability of the agency to carry out the planned program.

3. Completed Uniform Data Set (UDS) tables reflecting program performance in the previous calendar year, by March 31 of each year.

4. The Perinatal Client Data Form (PCDF) shall be submitted electronically according to the instructions set forth by the MCHS.

5. A copy of the agency's updated Sliding Fee Scale including the amount(s) of any client fees and the schedule of discounts must be submitted by March 31st of each year. The agency's sliding fee scale must be updated annually based on the US DHHS Poverty guidelines as published in the Federal Register.

6. An annual summary of program-specific patient satisfaction results obtained during the prior contract period and the method by which the results were obtained shall be submitted annually as an addendum to the Workplan Outcome/Progress reports.

C) **On-site reviews**

1. The contractor shall allow a team or person authorized by the Division of Public Health Services to periodically review the contractor's systems of governance, administration, data collection and submission, clinical and financial management, and delivery of education services in order to assure systems are adequate to provide the contracted services.
2. Reviews shall include client record reviews to measure compliance with this exhibit.
3. The contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.
4. On-Site reviews may be waived or abbreviated at the discretion of MCHS, upon submission of satisfactory reports of reviews such as Health Services Resources Administration (HRSA): Office of Performance Review (OPR), or reviews from nationally accreditation organizations such as the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), Medicare, the Community Health Accreditation Program (CHAP), Accreditation Association for Ambulatory Healthcare (AAAHC), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey. Abbreviated reviews will focus on any deficiencies found in previous reviews, issues of compliance with this exhibit, and actions to strengthen performance as outlined in the agency Performance Workplan.

State of New Hampshire
Department of Health and Human Services
Amendment #1 to the
Concord Hospital, Inc.

This 1st Amendment to the Concord Hospital, Inc., contract (hereinafter referred to as "Amendment One") dated this 7th day of March, 2014, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Concord Hospital, Inc., (hereinafter referred to as "the Contractor"), a corporation with a place of business at 250 Pleasant Street, Concord, New Hampshire 03301.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on June 20, 2012, 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, the State and the Contractor have agreed to make changes to the scope of work, payment schedules and terms and conditions of the contract; and

WHEREAS, pursuant to the General Provisions, Paragraph 18, the State may modify the scope of work and the payment schedule of the contract by written agreement of the parties;

WHEREAS, the Department desires to provide additional primary health care services for preventive and episodic health care for acute and chronic health conditions for people of all ages.

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 as follows:

To amend as follows:

- Form P-37, to change:
  Block 1.7 to read: June 30, 2015
  Block 1.8 to read: $992,198

- Exhibit A, Scope of Services to add:
  Exhibit A – Amendment 1

- Exhibit B, Purchase of Services, Contract Price, to add:

  Paragraph 1.1 to Paragraph 1:
  The contract price shall increase by $64,413 for SFY 2014 and $376,377 for SFY 2015.

  Paragraph 1.2 to Paragraph 1:
  Funding is available as follows:
- $64,413 from 05-95-90-902010-5190-102-500731, 100% General Funds;
- $322,992 from 05-95-90-902010-5190-102-500731, 6.7% Federal Funds from the US Department of Health and Human Services Administration, Maternal and Child Health Bureau, CFDA #93.994 and 93.3% General Funds;

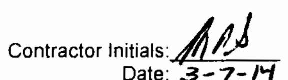
Contractor Initials: [initials]
Date: 3-7-14

- $53,385 from 05-95-90-902010-5659-102-500731, 100% Federal Funds from the US Department of Health and Human Services, Centers for Disease Control and Prevention, CFDA #93.283;

  Add Paragraph 8
  8. Notwithstanding paragraph 18 of the General Provisions P-37, an amendment limited to adjustments to amounts between and among account numbers, within the price limitation, may be made by written agreement of both parties and may be made without obtaining approval of the Governor and Executive Council.

- Budget, to add:
  Exhibit B-1 (2014) - Amendment 1,
  Exhibit B-1 (2015) - Amendment 1

This amendment shall be in effect July 1, 2013, effective upon the date of Governor and Executive Council approval.

Contractor Initials: 
Date: 3-7-14

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

3/28/14
Date

Brook Dupee
Bureau Chief

Concord Hospital, Inc.

March 7, 2014
Date

Name: Robert P. Steigmeyer
Title: President & CEO

Acknowledgement:

State of New Hampshire, County of Merrimack on March 7, 2014, before the undersigned officer, personally appeared the person identified above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.

Signature of Notary Public or Justice of the Peace

CHRISTINA DECATO MY COMMISSION EXPIRES APRIL 18, 2017 NOTARY PUBLIC NEW HAMPSHIRE

Christina Decato
Name and Title of Notary or Justice of the Peace

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

OFFICE OF THE ATTORNEY GENERAL

4-2-14
Date

Name: Rosemary Wiant
Title: Assistant Attorney General

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:

Contractor Initials: [illegible]
Date: 2-7-14

EXHIBIT A – AMENDMENT 1

Scope of Services

The Department desires to continue the relationship with the primary care agencies to provide additional primary health care services for preventive and episodic health care for acute and chronic health conditions for people of all ages.

I. General Provisions

A) Eligibility and Income Determination

1. Office-based primary care services will be provided to low-income individuals and families (defined as ≤ 185% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), in the State of New Hampshire.

2. Breast and Cervical Cancer screening services will be provided to low-income (defined as ≤ 250% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), New Hampshire women age 21– 64, uninsured or underinsured. BCCP changes.

3. The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing if, at any time, the practice is closed to new patients, or maintains a wait list for new patients, or any other mechanism is used that limits access for new patients for more than a one month period.

4. The Contractor shall document annually, for each client enrolled in the program, family income and family size, and calculate percentage of the federal poverty level. If calculations indicate that the client may be eligible for enrollment in Medicaid, the Contractor shall complete with the client the most recent version of the 800P form.

5. The Contractor shall implement, and post in a public and conspicuous location, a sliding fee payment schedule, approved in advance by the Division of Public Health Services (DPHS), for low-income patients. Signage must state that no client will be denied services for inability to pay.

   a. As an alternative, the contractor may post, in a public and conspicuous location, a notice to clients that a sliding fee scale is available and that no client will be denied services for inability to pay. The sliding fee scale must be updated annually based on USDHHS Poverty guidelines as published in the Federal Register, submitted to and approved by DPHS prior to implementation.

6. The primary care contract entered into here shall be the payer of last resort. The contractor shall make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid, for all reimbursable services rendered.

EXHIBIT A – AMENDMENT 1

B) Numbers Served

1. The contract funds shall be expended to provide the above services to a minimum of 13,000 users annually with 42,000 medical encounters, as defined in the Data and Reporting Requirements. Breast and Cervical Cancer Screening for eligible women, as defined by the Breast and Cervical Cancer Program (BCCP), shall be provided to 300 women annually and billed directly to the BCCP. Clinical service reimbursements shall not exceed the Medicare rate.

C) Culturally and Linguistically Appropriate Standards of Care

The Department of Health and Human Services (DHHS) recognizes that culture and language have considerable impact on how consumers access and respond to public health services. Culturally and linguistically diverse populations experience barriers in efforts to access health services. To ensure equal access to quality health services, the Division of Public Health Services (DPHS) expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.

2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.

3. Provide clients of limited English proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.

4. Offer consumers a forum through which clients have the opportunity to provide feedback to providers and organizations regarding cultural and linguistic issues that may deserve response.

5. The contractor shall maintain a program policy that sets forth compliance with Title VI, Language Efficiency and Proficiency Citation 45 CFR 80.3(b) (2). The policy shall describe the way in which the items listed above were addressed and shall indicate the circumstances in which interpretation services are provided and the method of providing service (e.g. trained interpreter, staff person who speaks the language of the client, language line).

D) State and Federal Laws

The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. The Contractor shall report all cases of communicable diseases according to New Hampshire RSA 141-C and He-P 301, adopted 6/3/08.

2. Persons employed by the contractor shall comply with the reporting requirements of New Hampshire RSA 169:C, Child Protection Act; RSA 161:F46, Protective Services to Adults, RSA 631:6, Assault and Related Offences and RSA 130:A, Lead Paint Poisoning and Control.

3. Immunizations shall be conducted in accordance with RSA 141-C and the Immunization Rules promulgated hereunder.

E) Relevant Policies and Guidelines

1. The Contractor shall design and provide the services described above to meet the unique and identified health needs of the populations within the contracted service area.

2. Primary Care funds shall be targeted to populations in need. Populations in need are defined as follows:

   a) uninsured;

   b) under-insured;

   c) families and individuals with significant psychosocial and economic risk, including low income status;

   d) all life cycles including perinatal, child, adolescent, adult, and elderly who meet one or more of the above criteria.

3. The Contractor shall design and implement systems of governance, administration, financial management, information management, and clinical services which are adequate to assure the provision of contracted services, and to meet the data and reporting requirements. These systems shall meet the most current minimum standards described in at least one of the following: Health Resources and Services Administration (HRSA) Office of Performance Review protocols, Joint Commission on Accreditation of Health Care Organizations (JCAHO), Accreditation Association for Ambulatory Healthcare (AAAHC), Community Health Accreditation Program (CHAP), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey.

4. The Contractor shall have an agency emergency preparedness and response plan in accordance with HRSA Health Center Emergency Management Program Expectations, Document #2007-15 or most recent version. Such plan shall also include a Continuity of Operations plan.

5. The Contractor shall carry out the work as described in the performance Workplan submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

6. No Workplan is required by the Breast and Cervical Cancer Program (BCCP). The contractor shall be required to respond to the Quality Improvement Feedback Report twice a year.

7. The Contractor shall carry out the work as described in the Supplemental Funding Form submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

F) Publications Funded Under Contract

1. The DHHS and/or its funders will retain COPYRIGHT ownership for any and all original materials produced with DHHS contract funding, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports.

2. All documents (written, video, audio, electronic) produced, reproduced, or purchased under the contract shall have prior approval from DPHS before printing, production, distribution, or use.

3. The Contractor shall credit DHHS on all materials produced under this contract following the instructions outlined in Exhibit C (14).

G) Subcontractors

If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing and approve the subcontractual agreement, prior to initiation of the subcontract.

1. If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing and approve the subcontractual agreement, prior to initiation of the subcontract.

2. In addition, the original DPHS contractor will remain liable for all requirements included in this Exhibit and carried out by subcontractors.

II. <u>Minimal Standards of Core Services</u>

A. Service Requirements

1. Medical Home

The Contractor shall provide a Medical Home that:

a) Facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family.

b) Provides care facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

2. Primary Care Services

The Contractor shall provide office-based primary care services to populations in need who reside in the contractor's service area. Primary care services shall include:

a) Health care provided by a New Hampshire licensed MD, DO, APRN, or PA, including diagnosis and treatment of acute and chronic illnesses within the scope of family practice; preventive services, screenings, and health education according to established, documented state or national guidelines; assessment of need for social and nutrition services, and appropriate referrals to health, oral health, and behavioral health specialty providers.

b) Referral to the WIC Nutrition Program for all eligible pregnant women, infants and children.

c) In-hospital care for conditions within the scope of family practice must be provided at a hospital, within the agency service area, through a staff clinician with full hospital privileges, or in the alternative, through a formal referral and admissions procedure available to clients on a 24 hour/7 day a week basis.

d) Access to a healthcare provider, directly or by referral or subcontract, by telephone twenty-four hours per day, seven days per week.

e) Assessment of psychosocial risk for all clients at least annually and for children at scheduled preventive care visits, including, at a minimum, age appropriate assessment of safety in the home, domestic violence, adequacy of food and housing, care and welfare of children, transportation needs, and provision of necessary social services to address the priority needs and safety issues of clients and families.

f) Falls prevention screening for patients 65 years and older using the algorithm and guidelines of the American Geriatrics Society.

g) Behavioral health care directly or by referral to an agency or provider with a sliding fee scale.

h) Nutrition assessment for all clients as part of the health maintenance visit. Therapeutic nutrition services shall be provided as indicated directly or by referral to an agency or provider with a sliding fee scale. These services shall be recorded in the medical record.

i) Formal arrangements with a local hospital for emergency care must be in place and reviewed annually.

j) Home health care directly or by referral to an agency or provider with a sliding fee scale.

k) Assisted living and skilled nursing facility care by referral.

l) Oral screening annually for all clients 21 years and older to note obvious dental decay and soft tissue abnormalities with a reminder to the patient that poor oral health impacts total health.

m) Diagnosis and management of pediatric and adult patients with asthma provided according to National Heart Lung Blood Institute, National Asthma Education and Prevention Program, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, 2007.

3. Breast and Cervical Cancer Screening

a) Women age 21 to 64 who are eligible for Breast and Cervical Cancer Program (BCCP) services according to income (equal to or under 250% of poverty, underinsured/uninsured) and insurance status criteria shall be provided the following services, following USPSTF screening recommendations:

i. cervical cancer screening including a pelvic examination and Pap smear;
ii. breast cancer screening including a clinical breast exam, mammogram and,
iii. referrals for diagnostic and treatment services based on screening results,
iv. case management services.

b) All referrals under this provision shall be to approved certified laboratory, pathology, radiology, and surgical services. Mammography units shall be accredited by the American College of Radiology, and must be FDA certified under MQSA. Laboratories shall be CLIA certified.

c) All services shall be provided in accordance with the Breast and Cervical Cancer Program (BCCP) Policy and Procedure Manual.

d) Follow-up and tracking of all tests done, and referrals made shall be provided in accordance with the minimum standards outlined in the Breast and Cervical Cancer Program Policy and Procedure Manual.

e) All services for women enrolled in the Breast and Cervical Cancer Program (BCCP) shall be billed directly to the BCCP in accordance with protocols established by the Breast and Cervical Cancer Program.

f) The Contractor shall provide the NH Breast and Cervical Cancer Program with breast and cervical cancer screening rates for all women served by the practice as requested, but not more than twice per SFY.

g) The contractor shall work with the NH Breast and Cervical Cancer Program staff to increase the breast and cervical cancer screening rates among all women serviced by the practice.

4. Reproductive Health Services

The Contractor shall provide prenatal, interconceptional and preconception medical care, social services, nutrition services, education, and nursing care to all women of childbearing age. Preconceptional care includes the preconception, interconceptional, and postpartum periods in women's health. It is recommended that preconceptional and interconceptional care visits focus on maintaining or achieving the optimal health of the mother, lowering the risk of future adverse pregnancy outcomes, the family's future plans, and how additional children fit into that plan. Preconceptional counseling may be done during an office, group or home visit.

a) In the event prenatal care is not provided directly by the Contractor a formal Memorandum/a of Agreement for coordinated referral to an appropriately qualified provider must be maintained.

b) Prenatal care shall, at minimum, be provided in accordance with the Guidelines for Perinatal Care, sixth or most current edition, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and /or the Centers for Disease Control.

c) Age appropriate reproductive health care shall, at a minimum, be provided in accordance with the American College of Obstetricians and Gynecologists, or the USDHHS Centers for Disease Control (CDC) current guidelines.

d) Pregnant women enrolled in the WIC Nutrition Program shall be referred to WIC for breastfeeding education and referral to the WIC Nutrition Program peer counselors.

e. Family planning counseling for prevention of subsequent pregnancy following an infant's birth shall be discussed with the infant's mother at the first postpartum visit and at the infant's 2-month visit and other visits as appropriate. Rationale for birth intervals of 18-24 months shall be presented.

f) A referral to a Title X Family Planning Clinic or other reproductive health care provider shall be made as appropriate.

5. Services for Children and Adolescents

The Contractor shall provide as a minimum, comprehensive and age-appropriate health care, screenings, and health education according to the American Academy of Pediatrics' most recent periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent. Children and adolescent visits shall include:

EXHIBIT A – AMENDMENT 1

a) The World Health Organization (WHO) growth charts shall be used to monitor growth for infants and children birth up to age 2 years. The Centers for Disease Control and Prevention (CDC) growth charts shall be used for children age 2 years and older.

b) Blood lead testing shall be performed in accordance with "New Hampshire Childhood Lead Poisoning Screening and Management Guidelines", issued by the New Hampshire Department of Health and Human Services, 2009 or subsequent revisions.

c) All children enrolled in either Medicaid, Head Start, or the Women, Infant, and Children (WIC) Program and/or who are ≤ 185%_poverty, regardless of town of residence, are required to have a blood lead test at ages one and two years. All children ages three to six years who have not been previously tested shall have a blood lead test performed.

d) All children shall be screened for iron deficiency anemia as outlined in the Centers for Disease Control and Prevention document "Recommendations to Prevent and Control Iron Deficiency in the United States (4/2/98)".

e) Age-appropriate anticipatory guidance, dietary guidance, and *feeding practice counseling* for optimal oral health shall be provided at each well child visit according to the American Academy of Pediatrics' periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent edition. Starting at age 6 months, it is recommended that all children receive an oral health assessment at every well child visit, and a referral for the child's first visit to the dentist by age one as recommended by the American Academy of Pediatrics and the American Academy of Pediatric Dentistry.

f) Supplemental fluoride shall be prescribed as needed based upon the fluoride levels in the child's drinking water supply. The fluoride dosage regimen accepted by the American Academy of Pediatrics shall be followed. No fluoride shall be prescribed without obtaining water from private wells or noting the presence or absence of fluoride in the public water supply. Supplemental fluoride may include bottled water containing fluoride and topical applications such as varnishes.

g) For infants enrolled in the WIC Nutrition Program, parents shall be referred to WIC for breastfeeding support and referral to the WIC Nutrition Program peer counselors.

6. Sexually Transmitted Infections

   Primary Care Services shall provide age appropriate screening and treatment of sexually transmitted infections.

a) Treatment for sexually transmitted infections shall be provided according to the United States Centers for Disease Control Sexually Transmitted Diseases Treatment Guidelines, 2010 or subsequent revisions.

b) All clients, including women, shall be offered HIV testing following the most current recommendations of the United States Centers for Disease Control.

c) The contractor shall be responsible for ensuring referral to appropriate treatment services for any woman found to screen positive.

d) Appropriate risk reduction counseling shall be provided based on client needs.

7. Substance Use Services

   a) A substance use screening history using a formal, validated screening tool shall be obtained for all clients as soon after entry into care as possible. Substance use counseling or other substance abuse intervention, treatment, or recovery services by an appropriately credentialed provider shall be provided on-site, or by referral, to clients with identified needs for these services. For these identified clients, ongoing primary care services should include follow up monitoring relative to substance abuse.

   b) All clients, including pregnant women, identified as smokers shall receive counseling using the 5A's (ask, advise, assess, assist, and arrange) treatment available through the NH Tobacco Helpline as cited in the US Public Health Services report "Tobacco Use and Dependence", 2008, or "Smoking Cessation During Pregnancy: A Clinician's Guide to Helping Pregnant Women Quit Smoking", American College of Obstetricians and Gynecologists, 2011. With prior approval, agencies may also opt to participate in the DPHS best practice initiative of the 2A's and R (ask, advise and refer).

8. Immunizations

   a) The Contractor shall adhere to the most current version of the "Recommended Adult Immunization Schedule for Adults (19 years and older) by Age and Medical Condition - United States", approved by the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

   b) The Contractor shall administer vaccines according to the most current version of the "Recommended Immunization Schedule for Persons Aged 0 Through 6 Years - United States", and "Recommended Immunization Schedule for Persons Aged 7 Through 18 Years – United States" approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians, based upon availability of vaccine from the New Hampshire Immunization Program.

9. Prenatal Genetic Screening

a) A genetic screening history shall be obtained on all prenatal clients as soon after entry into care as possible.

b) All pregnant women should be offered voluntary genetic screening for fetal chromosomal abnormalities at the appropriate time following recommendations found in the American College of Obstetricians and Gynecologists' "Screening for Fetal Chromosomal Abnormalities (2007)" or more recent guidelines. The Contractor shall be responsible for ensuring referral to appropriate genetic testing and counseling for any woman found to have a positive screening test.

10. Additional Requirements

a) The Contractor's Medical Director shall participate in the development and approval of specific guidelines for medical care that supplement minimal clinical standards. Supplemental guidelines should be reviewed, signed, and dated annually, and updated as indicated.

b) Contractors considering clinical or sociological research using clients as subjects must adhere to the legal requirements governing human subjects research. Contractors must inform the DPHS, MCHS prior to initiating any research related to this contract.

c) The Contractor shall provide information to all employees annually about the Medical Reserve Corps Unit within their Public Health Region to enhance recruitment.

d) The Contractor shall provide information to all employees annually regarding the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) managed by the NH Department of Health and Human Services' Emergency Services Unit, to enhance recruitment.

B) Staffing Provisions

The Contractor shall have, at minimum, the following staff positions:

a) executive director

b) fiscal director

c) registered nurse

d) clinical coordinator

e) medical service director

f) nutritionist (on site or by referral)

g) social worker

EXHIBIT A – AMENDMENT 1

Staff positions required to provide direct services on-site include:

a) registered nurse

b) clinical coordinator

c) social worker

1. Qualifications

All health and allied health professionals shall have the appropriate New Hampshire licenses whether directly employed, contracted, or subcontracted.

In addition the following minimum qualifications shall be met for:

a) Registered Nurse
   a. A registered nurse licensed in the state of New Hampshire, Bachelor's degree preferred. Minimum of one-year experience in a community health setting.

b) Nutritionists:
   a. A Bachelor's degree in nutritional sciences or dietetics, or a Master's degree in nutritional sciences, nutrition education, or public health nutrition or current Registered Dietitian status in accordance with the Commission on dietetic Registration of the American Dietetic Association.
   b. Individuals who perform functions similar to a nutritionist but do not meet the above qualifications shall not use the title of nutritionist.

c) Social Workers shall have:
   a. A Bachelor's or Master's degree in social work or Bachelor's or Master's degree in a related social science or human behavior field. A minimum of one year of experience in a community health or social services setting is preferred.
   b. Individuals who perform functions similar to a social worker but do not meet the above qualifications shall not use the title of social worker.

d) Clinical Coordinators shall be:
   a. A registered nurse (RN), physician, physician assistant, or nurse practitioner with a license to practice in New Hampshire.
   b. The coordinator is a clinical position that oversees and takes responsibility for the clinical and administrative functions of each program.
   c. The coordinator may be responsible for more than one MCH funded program.

2. New Hires

The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing within one month of hire when a new administrator, clinical coordinator, or any staff person essential to carrying out contracted services is hired to work in the program. A resume of the employee shall accompany the aforesaid notification.

3. Vacancies

   a) The Contractor must notify the MCHS in writing if any critical position is vacant for more than one month, or if at any time funded under this contract does not have adequate staffing to perform all required services for more than one month. This may be done through a budget revision.

   b) Before an agency hires new program personnel that do not meet the required staff qualifications, the agency shall notify the MCHS in writing requesting a waiver of the applicable staffing requirements. The Section may grant waivers based on the need of the program, individuals' experience, and additional training.

C) Coordination of Services

1. The Contractor shall coordinate, where possible, with other service providers within the contractor's community. At a minimum, such collaboration shall include interagency referrals and coordination of care.

2. The Contractor shall participate in activities in the Public Health Region in which they provide services as appropriate. These activities enhance the integration of community-based public health prevention and health care initiatives that are being implemented by the contractor and may include community needs assessments, public health performance assessments, and/or the development of regional health improvement plans.

3. The Contractor agrees to participate in and coordinate public health activities as requested by the Division of Public Health Services during any disease outbreak and/or emergency, natural or man-made, affecting the public's health.

4. The Contractor is responsible for case management of the client enrolled in the program and for program follow-up activities. Case management services shall promote effective and efficient organization and utilization
   of resources to assure access to necessary comprehensive medical, nutritional, and social services for clients.

5. The Contractor shall assure that appropriate, responsive, and timely referrals and linkages for other needed services are made, carried through, and documented. Such services shall include, but not be limited to: dental services, genetic counseling, high risk prenatal services, mental health, social services, including domestic violence crisis centers, substance abuse services; and family planning services, Early Supports and Services Program, local WIC/CSF Program, Home Visiting New Hampshire Programs and health and social service agencies which serve children and families in need of those services.

D) Meetings and Trainings

The contractor will be responsible for sending staff to meetings and training required by the MCHS program, including but not limited to:

1. MCHS Agency Directors' meetings
2. Prenatal and Child Health Coordinators' meetings
3. MCHS Agency Medical Services Directors' meetings

III. Quality or Performance Improvement (QI/PI)

A) Workplans

1. Performance Workplans are required for this program and are used to monitor achievement of standard measures of performance of the services provided under this contract. The workplans are a key component of the RHPCS and the MCHS performance-based contracting system and of this contract. Outcomes shall be reported by clinical site.
2. Performance Workplans and Workplan Outcome reports according to the schedule and instructions provided by the MCHS. The MCHS shall notify the Contractor at least 30 days in advance of any changes in the submission schedule.
3. The Contractor shall incorporate required and developmental performance measures, defined by the MCHS into the agency's Performance Workplan. Reports on Workplan Progress/Outcomes shall detail the Performance Workplan plans and activities that monitor and evaluate the agency's progress toward performance measure targets.
4. The Contractor shall comply with modifications and/or additions to the workplan and annual report format as requested by RHPCS and MCHS. MCHS will provide the contractor with reasonable notice of such changes.
5. Agencies contracting for Primary Care Services must submit the workplans for Primary Care Clinical and Financial, Child Health, and Prenatal Care.

B) Additional Reporting requirements

In addition to Performance Workplans, the Contractor shall submit to MCHS the following data and information listed below which are used to monitor program performance:

1. In years when contracts or amendments are not required, the DPHS Budget Form, Budget Justification, Sources of Revenue and Program Staff list forms must be

completed according to the relevant instructions and submitted as requested by DPHS and, at minimum, by April 30 of each year.

2. The Sources of Revenue report must be resubmitted at any point when changes in revenue threaten the ability of the agency to carry out the planned program.

3. Completed Uniform Data Set (UDS) tables reflecting program performance in the previous calendar year, by March 31 of each year.

4. The Perinatal Client Data Form (PCDF) shall be submitted electronically according to the instructions set forth by the MCHS.

5. A copy of the agency's updated Sliding Fee Scale including the amount(s) of any client fees and the schedule of discounts must be submitted by March 31st of each year. The agency's sliding fee scale must be updated annually based on the US DHHS Poverty guidelines as published in the Federal Register.

6. An annual summary of program-specific patient satisfaction results obtained during the prior contract period and the method by which the results were obtained shall be submitted annually as an addendum to the Workplan Outcome/Progress reports.

C) On-site reviews

1. The contractor shall allow a team or person authorized by the Division of Public Health Services to periodically review the contractor's systems of governance, administration, data collection and submission, clinical and financial management, and delivery of education services in order to assure systems are adequate to provide the contracted services.

2. Reviews shall include client record reviews to measure compliance with this exhibit.

3. The contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.

4. On-Site reviews may be waived or abbreviated at the discretion of MCHS, upon submission of satisfactory reports of reviews such as Health Services Resources Administration (HRSA): Office of Performance Review (OPR), or reviews from nationally accreditation organizations such as the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), Medicare, the Community Health Accreditation Program (CHAP), Accreditation Association for Ambulatory Healthcare (AAAHC), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey. Abbreviated reviews will focus on any deficiencies found in previous reviews, issues of compliance with this exhibit, and actions to strengthen performance as outlined in the agency Performance Workplan.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE CHILD HEALTH DIRECT CARE SERVICES
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Please note, for all measures, the following should be used **unless otherwise indicated:**

- Less than 19 years of age
- Served within the scope of this MCH contract during State Fiscal Year 2015 (July 1, 2014 – June 30, 2015)
- Each client can only be counted once (unduplicated)

Child Health Direct (CH – D) Performance Measure #1

Measure: 92%* of eligible children will be enrolled in Medicaid

Goal: To increase access to health care for children through the provision of health insurance

Definition: **Numerator-**
Of those in the denominator, the number of children enrolled in Medicaid.

Denominator-
Number of children who meet all of the following criteria:

- Less than 19 years of age
- Had 3 or more visits/encounters** during the reporting period
- As of the last visit during the reporting period were eligible for Medicaid

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**An encounter is face to face contact between a user and a provider who exercises independent judgment in the provision of services to the individual (UDS Table Definition).

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #2

Measure: 85%* of at-risk** children who were screened for blood lead between 18 and 30 months of age

Goal: To prevent childhood lead poisoning through early identification of lead exposure

Definition: **Numerator-**
Of those in the denominator, number of children screened for blood lead by capillary or venous on or after their 18-month birthday and prior to their 30-month birthday.

Denominator-
Number of at-risk** children who reached age 30 months during the reporting period. If discharged prior to 30 months, do not include in denominator.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**At risk = During the reporting period, the children were 18-29 months of age, and fit at least one of the following criteria:

- "Low income" (less than 185% poverty guidelines)
- Over 185% and resided in a town considered needing "Universal" screening per NH Childhood Lead Poisoning Prevention Program
- Over 185%, resided in a town considered "Target" and had a positive response to the risk questionnaire
- Refugee children -A refugee is defined as a person outside of his or her country of nationality who is unable or unwilling to return because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion (U.S. Citizenship and Immigration Services definition).

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #3

Measure: 71%* of children age two to nineteen years receiving primary care preventive health services with a Body Mass Index (BMI) percentile greater than or equal to the 85%ile with documented discussion of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Goal: To increase the percent of children receiving primary care preventive health services who have an elevated BMI percentile who receive guidance about promoting a healthier lifestyle.

Definition: **Numerator-**
Of those in the denominator, the number of children who had documentation in their medical record of there being discussion at least once during the reporting period of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Denominator-
Number of children who turned twenty-four months during or before the reporting period, up to the age of nineteen years, with one or more well child visit after their twenty-fourth month of age within the reporting year, and had an age and gender appropriate BMI percentile greater than or equal to the 85 % percentile at least once during the reporting period.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

Rationale: Children between the 85th – 94th percentiles BMI are encouraged to have 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks. (Discussion of the importance of family meal time, limiting eating out, consuming a healthy breakfast, preparing own foods, and promotion of breastfeeding is also encouraged.) American Academy of Pediatrics' guidance for Prevention and Treatment of Childhood Overweight and Obesity, (http://www.aap.org/obesity/health_professionals.html), from AAP Policy Statement: *Prevention of Pediatric Overweight and Obesity* and the AAP endorsed Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Children and Adolescent Overweight and Obesity, 2007.

*Target based on 2012 & 2013 Data Trend Table averages.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) #4

Measure: 75%* of eligible** infants and children with client record documentation of enrollment in WIC

Goal: To increase access to nutrition education, breastfeeding support, and healthy food through enrollment in the WIC Nutrition Program

Definition: **Numerator** -
Of those in the denominator, the number of infants and children who, as of the last well child visit during the reporting period, had client record documentation that infant or child was enrolled in WIC.

Denominator -
Unduplicated number of infants and children less than 5 years of age, enrolled in the agency, during the reporting period, who were eligible** for WIC.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**WIC Eligibility Requirements:

- Infants, and children up to their fifth birthday
- Must be income eligible (income guidelines are up to 185% of federal gross income, and are based on family size)

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #5

Measure: 23%* of infants who were exclusively** breastfed for the first three months, at their four month well baby visit

Goal: To provide optimum nutrition to infants in their first three months of life

Definition: **Numerator -**
Of those in the denominator, the number of infants who had client record documentation that the infant had been exclusively breastfed for their first three months when checked at their four month well baby visit.

Denominator -
Number of infants who received one or more visits during or before the reporting period and were seen for a four-month well baby visit during the reporting period.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

Benmarks: 2011 PedNSS (WIC) exclusive at 3 months: NH 22.9%, National (2010) 10.7%
2013 CDC Report Card (NIS, provisional 2010 births): NH 49.5%, National 37.7%
Healthy People 2020 goal: 44%

Rationale: The AAP recommends exclusive breastfeeding for about 6 months, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant, a recommendation concurred to by the World Health Organization and the Institute of Medicine. (American Academy of Pediatrics Policy Statement on Breastfeeding and the Use of Human Milk, 2012)

*Target based on 2012 & 2013 Data Trend Table averages.
**Exclusive means breast milk only, no supplemental formula, cereal/baby food, or water/fluids.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE: ADULT

PERFORMANCE MEASURES DEFINITIONS

State Fiscal Year 2015

Primary Care: Adult Performance Measure #1

Measure:* 58%** of adult patients 18 – 85 years of age diagnosed with hypertension will have a blood pressure measurement less than 140/90*** mm at the time of their last measurement.

Goal: To ensure patients diagnosed with hypertension are adequately controlled.

Definition: **Numerator-** Number of patients from the denominator with blood pressure measurement less than 140/90 mm at the time of their last measurement.

Denominator- Number of patients age 18 – 85 with diagnosed hypertension must have been diagnosed with hypertension 6 or more months before the measurement date. (Excludes pregnant women and patients with End Stage Renal Disease.)

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

*Measure based on the National Quality Forum 0018

**Health People 2020 National Target is 61.2%

***Both the numerator and denominator must be less that 140/90 mm

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE CLINICAL
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Primary Care Clinical Adolescent (PC-C) Performance Measure #1

Measure: 61%* of adolescents aged 11-21 years received an annual health maintenance visits in the past 12 months.

Goal: To enhance adolescent health by assuring annual, recommended, adolescent well -visits.

Definition:

Numerator-
Number of adolescents in the denominator who received an annual health maintenance "well" visit during the reporting year.

Denominator-
Total number of adolescents aged 11-21 years who were enrolled in the primary care clinic as primary care clients during the reporting year period.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

***Target based on 2012 & 2013 Data Trend Table averages.**

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Primary Care Clinical Prenatal (PC-C) Performance Measure #2

Measure: 31%* of women and adolescent girls aged 15-44 take multi-vitamins with folic acid.

Goal: To enhance pregnancy outcomes by reducing neural tube defects.

Definition:

Numerator-
The number of women and adolescent girls aged 15-44 who take a multi-vitamin with folic acid.

Denominator-
The number of women and adolescent girls aged 15-44 who were seen in primary care for a well visit in the past year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

***Target based on 2012 & 2013 Data Trend Table averages.**

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE - FINANCIAL
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Primary Care (PC) Performance Measure #1

Measure: Patient Payor Mix

Goal: To allow monitoring of payment method trends at State funded primary care sites.

Definition: Patients enrolled in Medicare, Medicaid, Commercial insurance, or uninsured.

Data Source: Provided by agency

Primary Care (PC) Performance Measure #2

Measure: Accounts Receivables (AR) Days

Goal: To allow monitoring of financial sustainability trends at State funded primary care sites.

Definition: AR Days: Net Patient Accounts Receivable **multiplied by** 365 **divided by** Net Patient Revenue

Data Source: Provided by agency

Primary Care (PC) Performance Measure #3

Measure: Current Ratio

Goal: To allow monitoring of financial sustainability trends at State funded primary care sites.

Definition: Current Ratio = Current Assets **divided by** Current Liabilities

Data Source: Provided by agency

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRENATAL
PERFORMANCE MEASURES DEFINITIONS
State Fiscal Year 2015

Prenatal (PN) Performance Measure #1

Measure: 85%* of pregnant women who are enrolled in the agency's prenatal program will begin prenatal care during the first trimester of pregnancy.

Goal: To enhance pregnancy outcomes by assuring early entrance into prenatal care.

Definition:

Numerator-
Number of women in the denominator who had a documented prenatal visit during the first trimester (on or before 13.6 weeks gestation).

Denominator-
Number of women enrolled in the agency prenatal program who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

* Target based on 2012 & 2013 Data Trend Table averages.

Prenatal (PN) Performance Measure #2

Measure: 20%* of pregnant women who are identified as cigarette smokers will be referred to QuitWorks-New Hampshire.

Goal: To reduce tobacco use during pregnancy through focused tobacco use cessation activities at public health prenatal clinics.

Definition:

Numerator-
Number of women in the denominator who received at least one referral to QuitWorks-New Hampshire during pregnancy.

A referral is defined as signing the patient up for QuitWorks-NH via phone, fax, or EMR. It is not defined as discussing QuitWorks-NH with the patient and encouraging her to sign up.

Denominator-
Number of women enrolled in the agency prenatal program and identified as tobacco users who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

*Target set in consultation with the NH Tobacco Program & FY13 Data Trend Table average.

Prenatal (PN) Performance Measure #3

Measure: 79%* of pregnant women will be screened, using a formal valid screening tool, for alcohol and other substance use during every trimester they are enrolled in the prenatal program.

Goal: To reduce prenatal substance use through systematic screening and identification.

Definition: **Numerator-** Number of women in the denominator who were screened for substance and alcohol use, using a formal and valid screening tool, during each trimester that they were enrolled in the prenatal program.

Denominator- Number of women enrolled in the agency prenatal program and who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

* Target based on 2012 & 2013 Data Trend Table averages.

Exhibit B-1 (2014) -Amendment 1
Budget

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: Concord Hospital, Inc.

Budget Request for: MCH Primary Care
(Name of RFP)

Budget Period: SFY 2014

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages	$ 64,413.00	$ -	$ 64,413.00	
2. Employee Benefits	$ -	$ -	$ -	
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	$ -	$ -	$ -	
13. Other (specific details mandatory):	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
TOTAL	**$ 64,413.00**	**$ -**	**$ 64,413.00**	

Indirect As A Percent of Direct 0.0%

Contractor Initials: MD

Date: 3-7-14

Exhibit B-1 (2015) -Amendment 1
Budget

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: Concord Hospital, Inc.

Budget Request for: MCH Primary Care
(Name of RFP)

Budget Period: SFY 2015

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages	$ 343,392.00	$ -	$ 343,392.00	0
2. Employee Benefits	$ -	$ -	$ -	0
3. Consultants	$ -	$ -	$ -	0
4. Equipment:	$ -	$ -	$ -	0
Rental	$ -	$ -	$ -	0
Repair and Maintenance	$ -	$ -	$ -	0
Purchase/Depreciation	$ -	$ -	$ -	0
5. Supplies:	$ -	$ -	$ -	0
Educational	$ -	$ -	$ -	0
Lab	$ -	$ -	$ -	0
Pharmacy	$ -	$ -	$ -	0
Medical	$ -	$ -	$ -	0
Office	$ -	$ -	$ -	0
6. Travel	$ -	$ -	$ -	0
7. Occupancy	$ -	$ -	$ -	0
8. Current Expenses	$ -	$ -	$ -	0
Telephone	$ -	$ -	$ -	0
Postage	$ -	$ -	$ -	0
Subscriptions	$ -	$ -	$ -	0
Audit and Legal	$ -	$ -	$ -	0
Insurance	$ -	$ -	$ -	0
Board Expenses	$ -	$ -	$ -	0
9. Software	$ -	$ -	$ -	0
10. Marketing/Communications	$ -	$ -	$ -	0
11. Staff Education and Training	$ -	$ -	$ -	0
12. Subcontracts/Agreements	$ -	$ -	$ -	0
13. Other (specific details mandatory):		$ -	$ -	0
300 visits at 109.95	$ 32,985.00	$ -	$ 32,985.00	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
	$ -	$ -	$ -	0
TOTAL	**$ 376,377.00**	**$ -**	**$ 376,377.00**	0

Indirect As A Percent of Direct 0.0%

Contractor Initials: [signature]

Date: 3-7-14

State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that Concord Hospital, Inc. is a New Hampshire nonprofit corporation formed January 29, 1985. I further certify that it is in good standing as far as this office is concerned, having filed the return(s) and paid the fees required by law.

In TESTIMONY WHEREOF, I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 4th day of April A.D. 2013

Wm Gardner

William M. Gardner
Secretary of State

CERTIFICATE

I, Mary Boucher, Secretary of Concord Hospital, Inc. do hereby certify:

1) I maintain and have custody of and am familiar with the seal and minute books of the corporation;
2) I am authorized to issue certificates with respect to the contents of such books and to affix such seal to such certificates;
3) The following is a true and complete copy of the resolution adopted by the board of trustees of the corporation at a meeting of that board on March 21, 2005 which meeting was held in accordance with the law of the state of incorporation and the bylaws of the corporation:

   The motion was made, seconded and the Board unanimously voted that the powers and duties of the President shall include the execution of all contracts and other legal documents on behalf of the corporation, unless some other person is specifically so designated by the Board, by law, or pursuant to the administrative policy addressing contract and expenditure approval levels.

4) the foregoing resolution is in full force and effect, unamended, as of the date hereof; and
5) the following persons lawfully occupy the offices indicated below:

   Robert P. Steigmeyer, President
   Bruce R. Burns, Chief Financial Officer

IN WITNESS WHEREOF, I have hereunto set my hand as the Secretary of the Corporation this 7 day of Mar, 2014.

(Corporate seal)

Mary Boucher
Secretary

State of New Hampshire, County of Merrimack

On this the 7th day of March, 2014, before me, Mary Boucher, the undersigned officer, personally appeared Mary Boucher, who acknowledged her/himself to be the Secretary of Concord Hospital inc, a corporation, and that such Secretary being authorized to do so, executed the foregoing instrument for the purposes therein contained, by signing the name of the corporation by her/himself as Mary Boucher.

IN WITNETSS WHEREOF I hereunto set my hand and official seal.

(Seal)

CHRISTINA DEPATO
MY COMMISSION EXPIRES APRIL 18, 2017
NOTARY PUBLIC
NEW HAMPSHIRE

Notary Public/Justice of the Peace

My Commission expires: April 18, 2017

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 03/03/2014

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 be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
MARSH USA, INC.
99 HIGH STREET
BOSTON, MA 02110
Attn: Boston.certrequest@marsh.com

319078-CHS-gener-14-15

CONTACT NAME:
PHONE (A/C, No, Ext): | FAX (A/C, No):
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Granite Shield Insurance Exchange	
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
CAPITAL REGION HEALTHCARE CORPORATION
& CONCORD HOSPITAL, INC.
ATTN: JESSICA FANJOY
250 PLEASANT STREET
CONCORD, NH 03301

COVERAGES **CERTIFICATE NUMBER:** NYC-006813023-01 **REVISION NUMBER:** 5

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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT LOC			GSIE-PRIM-2014-101	01/01/2014	01/01/2015	EACH OCCURRENCE	$ 2,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
							GENERAL AGGREGATE	$ 12,000,000
							PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS / SCHEDULED AUTOS HIRED AUTOS / NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident)	$
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB / OCCUR EXCESS LIAB / CLAIMS-MADE DED RETENTION $						EACH OCCURRENCE	$
							AGGREGATE	$
								$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A					WC STATU-TORY LIMITS / OTH-ER	
							E.L. EACH ACCIDENT	$
							E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Professional Liability			GSIE-PRIM-2014-101	01/01/2014	01/01/2015		SEE ABOVE

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
EVIDENCE OF CURRENT LIABILITY COVERAGE.

GENERAL LIABILITY AND PROFESSIONAL LIABILITY SHARE A COMBINED LIMIT OF 2,000,000/12,000,000. HOSPITAL PROFESSIONAL LIABILITY RETRO ACTIVE-DATE 6/24/1985. EACH OCCURRENCE AND AGGREGATE LIMITS ARE SHARED AMONGST THE GRANITE SHIELD EXCHANGE HOSPITALS.

CERTIFICATE HOLDER

DEPARTMENT OF HEALTH & HUMAN SERVICES
CONTRACTS AND PROCUREMENT UNIT
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
of Marsh USA Inc.
Susan Molloy
Susan Molloy

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Client#: 243089 CAPITALREG

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 03/06/2014

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PRODUCER
HUB Healthcare Solutions
HUB International New England, LLC
136 Turnpike Road, Suite 105
Southborough, MA 01772

CONTACT NAME: Amanda Keaveney
PHONE (A/C, No, Ext): 508-303-9471 FAX (A/C, No): 866-388-8907
E-MAIL ADDRESS: amanda.keaveney@hubinternational.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Safety National Casualty Corp	
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Capital Region Healthcare Corporation
Concord Hospital
250 Pleasant Street
Concord, NH 03301

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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	GENERAL LIABILITY COMMERCIAL GENERAL LIABILITY CLAIMS-MADE / OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY / PRO-JECT / LOC						EACH OCCURRENCE	$
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
							GENERAL AGGREGATE	$
							PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS / SCHEDULED AUTOS HIRED AUTOS / NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident)	$
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB / OCCUR EXCESS LIAB / CLAIMS-MADE DED / RETENTION $						EACH OCCURRENCE	$
							AGGREGATE	$
								$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		SP4049733 SIR $450,000	10/01/13	10/01/14	X WC STATU-TORY LIMITS / OTH-ER	
							E.L. EACH ACCIDENT	$1,000,000
							E.L. DISEASE - EA EMPLOYEE	$1,000,000
							E.L. DISEASE - POLICY LIMIT	$1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
For Record Purposes

CERTIFICATE HOLDER

DHHS
Contracts and Procurement Unit
129 Pleasant Street
Concord, NH 03301

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

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INDEPENDENT AUDITORS' REPORT

The Board of Trustees
Concord Hospital, Inc.

We have audited the accompanying consolidated financial statements of Concord Hospital, Inc. and Subsidiaries (the System), which comprise the consolidated balance sheets as of September 30, 2013 and 2012, and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these 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 these 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 of 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 the auditors' 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, the auditor considers internal control relevant to the entity'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 entity'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 the System as of September 30, 2013 and 2012, and the results of its operations, changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Baker Newman & Noyes
Limited Liability Company

Manchester, New Hampshire
December 9, 2013

CONCORD HOSPITAL, INC. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS

September 30, 2013 and 2012

ASSETS
(In thousands)

	2013	2012
Current assets:		
Cash and cash equivalents	$ 24,006	$ 32,720
Investments	2,384	14,382
Accounts receivable, less allowance for doubtful accounts of $19,695 in 2013 and $17,995 in 2012	46,061	41,614
Due from affiliates	584	240
Supplies	1,153	740
Prepaid expenses and other current assets	5,983	4,452
Total current assets	80,171	94,148
Assets whose use is limited or restricted:		
Board designated	230,143	174,864
Funds held by trustee:		
Workers' compensation reserves and self-insurance escrows	9,212	7,966
Construction fund	10,398	–
Donor-restricted	32,367	29,642
Total assets whose use is limited or restricted	282,120	212,472
Other noncurrent assets:		
Due from affiliates, net of current portion	2,779	3,167
Bond issuance costs and other assets	18,651	10,311
Total other noncurrent assets	21,430	13,478
Property and equipment:		
Land and land improvements	5,394	5,383
Buildings	166,951	157,893
Equipment	205,283	192,633
Construction in progress	9,286	14,000
	386,914	369,909
Less accumulated depreciation	(230,767)	(212,808)
Net property and equipment	156,147	157,101
	$ 539,868	$ 477,199

LIABILITIES AND NET ASSETS
(In thousands)

	2013	2012
Current liabilities:		
Short-term notes payable	$ 1,027	$ 701
Accounts payable and accrued expenses	21,822	22,236
Accrued compensation and related expenses	23,293	22,222
Accrual for estimated third-party payor settlements	14,599	11,342
Current portion of long-term debt	7,931	9,721
Total current liabilities	68,672	66,222
Long-term debt, net of current portion	111,781	97,512
Accrued pension and other long-term liabilities	64,102	83,000
Total liabilities	244,555	246,734
Net assets:		
Unrestricted	262,946	200,823
Temporarily restricted	14,127	12,890
Permanently restricted	18,240	16,752
Total net assets	295,313	230,465
	$ 539,868	$ 477,199

See accompanying notes.

CONCORD HOSPITAL, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF OPERATIONS

Years Ended September 30, 2013 and 2012
(In thousands)

	2013	2012
Unrestricted revenue and other support:		
Net patient service revenue, net of contractual allowances and discounts	$432,232	$409,261
Provision for doubtful accounts	(31,493)	(26,251)
Net patient service revenue less provision for doubtful accounts	400,739	383,010
Other revenue	24,140	25,413
Net assets released from restrictions for operations	1,886	1,973
Total unrestricted revenue and other support	426,765	410,396
Expenses:		
Salaries and wages	180,716	173,024
Employee benefits	45,644	43,943
Supplies and other	76,347	71,989
Purchased services	59,783	59,057
Professional fees	3,170	2,629
Depreciation and amortization	25,047	24,595
Medicaid enhancement tax	16,541	16,175
Interest expense	4,720	4,918
Total expenses	411,968	396,330
Income from operations	14,797	14,066
Nonoperating (loss) income:		
Unrestricted gifts and bequests	159	3,984
Investment income and other	92	2,079
Loss on extinguishment of debt	(3,169)	–
Total nonoperating (loss) income	(2,918)	6,063
Excess of revenues and gains over expenses	$ 11,879	$ 20,129

See accompanying notes.

CONCORD HOSPITAL, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CHANGES IN NET ASSETS

Years Ended September 30, 2013 and 2012
(In thousands)

	2013	2012
Unrestricted net assets:		
Excess of revenues and gains over expenses	$ 11,879	$ 20,129
Net unrealized gains on investments	22,870	16,891
Net transfers from affiliates	295	258
Net assets released from restrictions used for purchases of property and equipment	112	503
Pension adjustment	26,967	(15,369)
Increase in unrestricted net assets	62,123	22,412
Temporarily restricted net assets:		
Restricted contributions and pledges	1,285	1,346
Restricted investment income	66	336
Contributions to affiliates and other community organizations	(135)	(123)
Net unrealized gains on investments	2,019	1,715
Net assets released from restrictions for operations	(1,886)	(1,973)
Net assets released from restrictions used for purchases of property and equipment	(112)	(503)
Increase in temporarily restricted net assets	1,237	798
Permanently restricted net assets:		
Restricted contributions and pledges	1,022	129
Unrealized gains on trusts administered by others	466	898
Increase in permanently restricted net assets	1,488	1,027
Increase in net assets	64,848	24,237
Net assets, beginning of year	230,465	206,228
Net assets, end of year	$295,313	$230,465

See accompanying notes.

CONCORD HOSPITAL, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS

Years Ended September 30, 2013 and 2012
(In thousands)

	2013	2012
Cash flows from operating activities:		
Increase in net assets	$ 64,848	$ 24,237
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Restricted contributions and pledges	(2,307)	(1,475)
Depreciation and amortization	25,047	24,595
Net realized and unrealized gains on investments	(23,589)	(20,623)
Bond discount/premium amortization	(202)	(209)
Loss on extinguishment of debt	3,169	–
Provision for doubtful accounts	31,493	26,251
Equity in earnings of affiliates, net	(5,835)	(5,987)
Loss on disposal of property and equipment	56	321
Pension adjustment	(26,967)	15,369
Changes in operating assets and liabilities:		
Accounts receivable	(35,940)	(24,721)
Supplies and prepaid expenses	(1,944)	(179)
Other assets	(11,973)	(3,339)
Due from affiliates	44	515
Accounts payable and accrued expenses	(414)	(538)
Accrued compensation and related expenses	1,071	1,773
Accrual for estimated third-party payor settlements	3,257	2,831
Accrued pension and other long-term liabilities	8,069	(1,137)
Net cash provided by operating activities	27,883	37,684
Cash flows from investing activities:		
Increase in property and equipment, net	(23,961)	(23,559)
Purchases of investments	(161,265)	(84,651)
Proceeds from sales of investments	127,222	96,910
Equity distributions from affiliates	6,152	6,456
Net cash used by investing activities	(51,852)	(4,844)
Cash flows from financing activities:		
Proceeds from long-term debt	81,052	–
Payments on long-term debt	(67,646)	(9,755)
Change in short-term notes payable	326	(243)
Bond issuance costs	(766)	–
Restricted contributions and pledges	2,289	1,429
Net cash provided (used) by financing activities	15,255	(8,569)
Net (decrease) increase in cash and cash equivalents	(8,714)	24,271
Cash and cash equivalents at beginning of year	32,720	8,449
Cash and cash equivalents at end of year	$ 24,006	$ 32,720

See accompanying notes.

CONCORD HOSPITAL
TRUSTEES BY TERM

		Became CH Bd Member	Term Limit 4 consecutive 3 yr tms
Terms Expiring January, 2015:	C. Thomas Brown	2003	2015
	William L. Chapman, Esq.	2011	2024
	Jeffrey S. Kipperman	2003	2015
	Muriel D. Schadee **CHAIR**	2007	2021
	David A. Stevenson, MD	2008	2021
	Jeffrey K. Towle	2012	2024
Terms Expiring January, 2016:	D. Thomas Akey, MD	2004	2016
	Philip Boulter, MD **VICE CHAIR**	2007	2019
	Christian Hallowell, MD	2002	2016
	David Ruedig	2007	2019
	Hon. Michael Sullivan	2004	2016
Terms Expiring January, 2017:	Sol Asmar	2010	2023
	Mary Boucher **SECRETARY**	2005	2017
	Michelle Chicoine	2008	2020
	Claudia Walker	2005	2017

Ex-officio: Diane E. Wood Allen, RN, Concord Hospital CNO – 2009 -
Douglas Ewing, MD, President, Concord Hospital Medical Staff – 2014 –
Robert Steigmeyer, President & CEO, CRHC & CH – 2014 –

TREASURER – Bruce Burns (non-trustee)

1/14

Mission Statement

Concord Hospital is a charitable organization which exists to meet the health needs of individuals within the communities it serves.

It is the established policy of Concord Hospital to provide services on the sole basis of the medical necessity of such services as determined by the medical staff without reference to race, color, ethnicity, national origin, sexual orientation, marital status, religion, age, gender, disability or inability to pay for such services.

Revised and approved, Board of Trustees 9-24-12

Vision Statement

We exist only to serve patients and their families.

We enthusiastically and collectively engage with all those seeking and providing services to achieve an optimal healing environment.

We aggressively identify and apply new proven or promising technologies and therapies.

We manage the resources entrusted to us to assure a successful hospital for future generations.

We actively involve and participate with our community.

KEY ADMINISTRATIVE PERSONNEL

NH Department of Health and Human Services

Contractor Name: Concord Hospital

Name of Bureau/Section: MCH Primary Care

BUDGET PERIOD: SFY 14

Program Area: MCH Primary Care

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Marie Wawrzyniak	Director	$102,810	0.00%	$0.00
Travis Harker	Medical Director	$170,000	37.89%	$64,413.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$64,413.00**

KEY ADMINISTRATIVE PERSONNEL

NH Department of Health and Human Services

Contractor Name: **Concord Hospital**

Name of Bureau/Section: **MCH Primary Care & BCCP**

BUDGET PERIOD: **SFY 15**

Program Area: **MCH Primary Care Services**

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Marie Wawrzyniak	Director	$104,866	0.00%	$0.00
Travis Harker	Medical Director	$170,000	54.06%	$91,895.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$91,895.00**

Program Area: **Breast and Cervical Cancer Program Services**

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Marie Wawrzyniak	Director	$104,866	0.00%	$0
Travis Harker	Medical Director	$170,000	0.00%	$0
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$0**

Marie N. Wawrzyniak, MS, RN

Professional Experience

Director, Family Health Centers, Concord Hospital, Concord NH, July 2006-current. Accountable for leadership and direction of the Concord Hospital Family Health Centers-Concord and Hillsboro-Deering in order to advance the position of the hospital's and health centers' mission and goals. Oversee the health centers' clinical, fiscal and administrative operations to insure quality patient care, production efficiency, needed services, cost-effective management of resources, and effective, high-quality family medicine resident education.

Community Health Services Director, Concord Hospital, Capital Region Family Health Center, Concord NH, September 1998 to July 2006. Responsible for assessing and assuring health needs of the community are met through the health center's programs and services. Director of nurse care coordination for at risk populations, community care management, school based services, community clinics, social services, public health network, prescription assistance and dental clinic. Assure systems are in place to address contract and grant requirements. Mentor of family practice residents' community projects. Participate in overall management and administration of the center and residency as a member of the strategic team. Resigned ARNP license when no longer active in advanced practice.

Public Health Nurse Practitioner Consultant, N.H. Department of Health and Human Services, Bureau of Maternal and Child Health, July 1994 – September 1998. Contracted consultant. Provided clinical consultation, education, and technical assistance to primary care, family planning, and prenatal agencies and health professionals in these settings. Monitored and evaluated the quality of health care provided by agencies that contract with the Bureau. Developed policies, procedures, standards, and guidelines to assure program excellence and agency compliance with regulators. Wrote grants, developed and monitored contracts. Liaison to Bureau of Health Facilities Administration and Board of Pharmacy.

Family Nurse Practitioner, Belknap/Merrimack CAP, Franklin and Laconia, NH, 1996 – 1998. Nurse Practitioner in women's health program, per diem basis.

Family Nurse Practitioner, Concord Regional Visiting Nurse Association, Concord, NH, part time, June 1993 - July 1994, per diem basis 1985-1994. Nurse Practitioner in family planning, STD clinic, prenatal, adult, and child health programs.

Quality Assurance Nurse Coordinator, Concord Regional Visiting Nurse Association, Concord, NH, November 1991 - June 1993. Developed and implemented an agency wide quality assessment and improvement plan. Coordinated all quality monitoring and evaluation activities for home health, hospice, family planning, and child health programs. Responsible for maintaining compliance with regulatory bodies e.g. Medicare certification, NH licensure, State contracts, JCAHO accreditation.

Vice President and Director of Home Care, Concord Regional Visiting Nurse Association, Concord, NH, October 1989 - October 1991. Directed a home health care department including 100+ staff. Assumed the responsibilities of agency president in her absence. Collaborated with the president and assumed a leadership role with agency directors to plan, implement, and evaluate all agency operations. Resigned position to parent a newborn.

Director of Family Planning and Women's Health, Concord Regional Visiting Nurse Association, Concord, NH October 1988 - October 1989. Managed a program providing well woman health care and contraceptive services. Supervised nurse practitioners, nurses, and clerical staff. Coordinated all clinical services and medical follow up. Provided direct client care in nurse practitioner role. Promoted to Vice President.

Faculty, Parent and Child Nursing Coordinator, Concord Hospital School of Nursing, Concord NH, October 1984 - September 1988. Course instructor and coordinator of parent and child nursing course (maternity and pediatric nursing) for second year students. Participated in curriculum revision and preparation for NLN accreditation.

P. TRAVIS HARKER, MD, MPH

Positions & Employment

Concord Hospital, Concord, New Hampshire December 2006—Present
Medical Director, CH Family Health Centers, Concord and Hillsboro-Deering
Member, Accountable Care Organization Steering Committee 2011-present
Chair, Clinical Practice and Quality Improvement Committee, Concord Hospital Medical Group, 2010-present

- Activities include Strep algorithm, advance directives, ER utilization, readmission prevention.

Chair, Quality Improvement Committee of Family Health Center, 2006-present

- Oversee all quality improvement activities, prepare QI Annual Report, coordinate residency QI curriculum.

Clinical Leader, Family Health Center, 2006-2012

- Enact QI initiatives in the clinical setting, and coordinate resident outpatient curriculum.

Faculty, New Hampshire Dartmouth Family Medicine Residency Program, Leadership Preventive Medicine Residency Program

Dartmouth Leadership and Preventive Medicine Residency Program, Lebanon/Concord, New Hampshire June 2006—Present
Faculty

- Core faculty responsible for teaching leadership and improvement science, assessing the quality and importance of resident projects, and coaching residents through a yearlong longitudinal quality improvement experience.

Dartmouth Medical School, Hanover, New Hampshire June 2009—Present
Adjunct Assistant Professor of Community and Family Medicine

Concord Hospital, Concord, New Hampshire June 2002—December 2006
Family Medicine Intern & Resident, New Hampshire Dartmouth Family Practice Residency Program
Paul W. Ambrose Fellow in Leadership and Preventive Medicine, Dartmouth Leadership and Preventive Medicine Residency Program

Office of Disease Prevention and Health Promotion, Department of Health and Human Services, Washington DC June, 2001-June 2002
Research Fellow

- Prepared a patient-oriented, guide to healthy living focusing on the ten leading health indicators.
- Developed budget initiative to improve diabetes care.

Paul W. Ambrose Resident Physician Leadership Symposium, Koop Institute, Dartmouth Medical School, Hanover, New Hampshire September 2001 - April 2002
Founder/Director

- Coordinated and led a four-day workshop for resident leaders on leadership, advocacy, and creating change

Community and Public Health Institute, Washington DC September 2000 - April 2001
Founder Director

- Coordinated and led a weekend workshop for medical student leaders on community needs assessment, policy development, and implementation of health initiatives.

Office of Disease Prevention and Health Promotion, Department of Health and Human Services, Washington DC October – November 2000
Student Intern

- Presentation on Healthy People 2010 and the leading health indicators for medical students.
- Coordinated a rural health breakout session for the Healthy People Consortium meeting.

American Medical Student Association, Reston, Virginia May 1998-May 1999
Legislative Affairs Director

- Represented 30,000 medical students on Capitol Hill and in other policy arenas.
- Education on pertinent health policy issues such as physician workforce issues, and managed care reform.
- Developed projects to increase physician-in-training activism and advocacy, including national voter registration drive, health policy internships, and letter writing campaigns.
- Managed National Primary Care Week grant
- Supervised health policy interns
- Planed 1999 AMSA National Convention.

Washington Health Policy Fellowship Program, Washington D.C Summer 1997
Intern, American Public Health Association, Office of Government Relations

Education

Dartmouth Medical School Center for the Evaluative Clinical Sciences, Hanover, New Hampshire September 2002—June 2006
MPH conferred, June 2006

The Ohio State University College of Medicine and Public Health, Columbus, Ohio September 1996—June 2001
MD conferred, June 2001

The Ohio State University College of Arts and Sciences, Columbus, Ohio September 1992—June 1996
BS Biology, with minor in Spanish, June 1996. Graduated Magna Cum Laude with Honors in the Liberal Arts.

Honors

- 40 Under 40 New Hampshire 2011, The New Hampshire Union Leader
- William F. Ashe Public Health Award 2001, The Ohio State University College of Medicine and Public Health
- Phi Beta Kappa 1996, The Ohio State University College of Arts and Sciences
- The Mortar Board National Senior Honor Society Ruth Weimer Mount Award 1996, The Ohio State University College of Arts and Sciences

Licensure & Certification

- Licensed Physician, New Hampshire Board of Medicine November 2006—Present
- Diplomate, American Board of Family Medicine August 2007—Present
- Federal Drug Enforcement Administration Registration November 2006—Present

Leadership Positions

- New Hampshire Medical Society, President 2012-Present
- New Hampshire Medical Society, Vice President/President Elect 2010-2012
- New Hampshire Medical Society, Executive Council. Young physician board member 2008 – 2010
- Concord YMCA, Board member 2007-2008

Professional Society Affiliations

- American Academy of Family Physicians
- American College of Preventive Medicine
- New Hampshire Medical Society
- Society of Teachers of Family Medicine

Invited Presentations & Posters

- "Improving colon cancer screening rates at a community health center for economically disadvantaged individuals" 2009 New England Regional Minority Health Conference. Providence, RI, October 15, 2009
- "Integrating Behavioral Health into Leadership of the Clinical Microsystem to Improve Care and Team Function" The Collaborative Family Health Care Association Annual Conference, Asheville, NC, November 10, 2007
- "Improving Mood, Levels of Pain and Weight Loss through Collaborative Care Group Visits" The Collaborative Family Health Care Association Annual Conference, Asheville, NC, November 10, 2007
- "Improving Screening and Treatment Rates for Overweight and Obesity at the Capital Region Family Health Center " Cutting-Edge Research and Science in Preventive Medicine: Submitted Abstracts Session. Preventive Medicine 2007, American College of Preventive Medicine Annual Meeting, Miami, FL, February 23, 2007
- "Improving Weight Management Systems of Care at a Community Health Center" Poster presentation, North American Primary Care Research Group, Tucson, AZ, October 16, 2006
- "The Diagnosis and Treatment Patterns of Overweight and Obesity at the Capital Region Family Health Center" Poster presentation, American College of Preventive Medicine, Reno, NV, February 23, 2006
- "Motivating Achievement of Self-management Goals" Diabetes Prevention Showcase, New Hampshire Diabetes Education Program, Bretton Woods, NH, November 3, 2005
- "Obesity Treatment: Beyond Diet and Exercise" New Hampshire Academy of Family Physicians Annual Meeting, Waterville Valley, NH, October 8, 2005
- "Addressing Obesity In Primary Care" Rural Health Symposium, Northern NH and Northeastern VT AHEC, Whitefield, NH, May 4, 2005
- "Addressing Obesity: An Evidence Based Approach" Grand Rounds, Concord Hospital, Concord, NH, May 4, 2005
- "Obesity: A Physician's Perspective" CME presentation, Franklin Regional Hospital. Laconia, NH, October 4, 2004
- "An Introduction To Understanding Obesity In The Clinical Setting" CME presentation, Southern NH AHEC, Manchester NH, March 23, 2004
- "Challenges Facing Medicine: Can I Make A Difference?" University of Pennsylvania, Health Policy and Activism Class, Hershey, PA, April 19, 2001
- "Integration of Healthy People 2010 into Academic Curriculum" APHA 2000 National Convention, Boston, MA, November 13, 2000
- "Healthy People 2010: Changing The Way We Think About Health Care" Seattle, October 7, 2000; Baltimore, October 28, 2000; Ann Arbor, December 2, 2000; Columbus, February 8, 2001.
- "Uniting Physicians, Students, And Patients For Universal Health Care" Harvard Medical School, Boston, MA, September 11, 1999
- "Medical Student, Resident and Physician Activism: Join the team!" Health Policy & Legislative Awareness Initiative at Penn State College of Medicine, Philadelphia, PA, October 6, 1998
- "How To Make A Difference In The Legislative Process" Women in Medicine 2nd Annual Lobby Day, Washington, DC, October 2, 1998

Publications

- Kessel, W; Jarros, J; Harker, P. *The Social Security Act and Maternal and Child Health Services: Securing a Bright Future.* Health and Welfare for Families in the 21st Century, 2nd edition, 2003
- Harker P. *Diary of a student-activist.* The New Physician. October 2000. p.13
- Harker P. *Buying prescription drugs in bulk could save lives.* The Columbus Dispatch. August 9, 2000
- Harker P. *Collective bargaining would cut price of drugs.* The Columbus Dispatch. July 2, 1999
- Harker P. *Legislative Corner.* The New Physician. Monthly contributor, May 1998 – May 1999
- Harker P. *Tax issue takes toll on NHSC Scholars.* Clinicians and Community. Summer 1998. p. 1

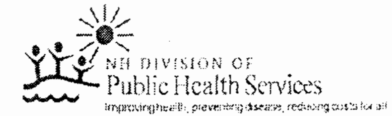
Testimonies

- "Toward a healthier learning environment." Liaison Committee on Medical Education hearing on medical student abuse. February 10, 1999.
- "Moving the Corps through reauthorization and into the 21st Century." National Health Service Corps Advisory Council. September 12, 1998.

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

29 HAZEN DRIVE, CONCORD, NH 03301-6527
603-271-4517 1-800-852-3345 Ext. 4517
Fax: 603-271-4519 TDD Access: 1-800-735-2964



Nicholas A. Toumpas
Commissioner

José Thier Montero
Director

May 1, 2012

APPROVED G/C ______
DATE ______
APPROVED G&C #133
DATE 6/20/12
NOT APPROVED ______

His Excellency, Governor John H. Lynch
and the Honorable Executive Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Public Health Services, Bureau of Population Health and Community Services, Maternal and Child Health Section to enter into an agreement with Concord Hospital, Inc., (Vendor #177653-B011), 250 Pleasant Street, Concord, New Hampshire 03301, in an amount not to exceed $551,408.00, to provide primary care services and breast and cervical cancer screening, to be effective July 1, 2012 or date of Governor and Executive Council approval, whichever is later, through June 30, 2014. Funds are available in the following accounts for SFY 2013, and are anticipated to be available in SFY 2014 upon the availability and continued appropriation of funds in the future operating budgets.

05-95-90-902010-5190 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES, MATERNAL AND CHILD HEALTH

Fiscal Year	Class/Object	Class Title	Job Number	Total Amount
SFY 2013	102-500731	Contracts for Program Services	90080000	$215,637
SFY 2014	102-500731	Contracts for Program Services	90080000	$215,637
			Sub-Total	$431,274

05-95-90-902010-5659 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES, COMPREHENSIVE CANCER

Fiscal Year	Class/Object	Class Title	Job Number	Total Amount
SFY 2013	102-500731	Contracts for Program Services	90080081	$60,067
SFY 2014	102-500731	Contracts for Program Services	90080081	$60,067
			Sub-Total	$120,134
			Total	$551,408

EXPLANATION

Funds in this agreement will be used to provide breast and cervical cancer screening and office-based primary care services for low-income and uninsured families. This agreement provides funds for services as a last resort; contractor is required to make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid.

Primary health care services include preventive and episodic health care for acute and chronic health conditions for people of all ages, including pregnant women, children, adolescents, adults, and the elderly. Community health agencies that receive support through the Division of Public Health Services deliver primary and preventive health care services to underserved people who face barriers to accessing health care, due to issues such as a lack of insurance, inability to pay, language barriers, and geographic isolation. In addition to medical care, community health centers are unique among primary care providers for the array of patient-centered services they offer, including care coordination, translation, transportation, outreach, eligibility assistance, and health education. These services help individuals overcome barriers to getting the care they need and achieving their optimal health. One area of particular success has been in ensuring that eligible families maintain consistent enrollment in Medicaid for their children. Community health centers provide support for families in filling out applications and ensuring that children have continuity of care.

Community health agencies throughout New Hampshire have demonstrated success in meeting the health care needs of the uninsured and under-insured citizens of the state. Division of Public Health Services funded primary care providers participate in rigorous quality improvement efforts utilizing standard performance measures that focus attention on improving health outcomes for patients. For example, in State Fiscal Year 2011:

- 88% of eligible children served were enrolled in Medicaid/Healthy Kids Gold.
- 86% of children 24-35 months, served received the appropriate schedule of immunizations.
- 82% of infants born to women served received prenatal care beginning in the first trimester of pregnancy.

In addition, breast and cervical cancers continue to be ongoing public health issues for New Hampshire. The Division of Public Health Services, Breast and Cervical Cancer Screening Program provides support for breast and cervical cancer screening services that include clinical examinations, pap smears and referral for mammography. Through this program, women found to have abnormal screening results, following their testing, receive additional coverage for diagnostic work-up and, if necessary, have their care coordinated through the initiation of treatment.

Should Governor and Executive Council not authorize this Request, a minimum of 15,300 low-income individuals from the Concord area may not have access to primary care services, and eligible women may not receive recommended breast and cervical cancer screenings. A strong primary care infrastructure reduces costs for uncompensated care, improves health outcomes, and reduces health disparities. Additionally women that receive recommended breast and cervical cancer screenings are at lower risk of late diagnosis of breast and cervical cancers.

Concord Hospital, Inc. was selected for this project through a competitive bid process. A Request for Proposals was posted on the Department of Health and Human Services' web site from January 10, 2012 through February 16, 2012. In addition, a bidder's conference, conference call, and web conference were held on January 19, 2012 to alert agencies to this bid.

Thirteen proposals were received in response to the posting. Each proposal was scored by three professionals, who work internal and external to the Department of Health and Human Services. All reviewers have between three to twenty years experience either in clinical settings, providing community-based family support services, and or managing agreements with vendors for various public health programs. Areas of specific expertise include maternal and child health; quality assurance and performance improvement; chronic and communicable diseases and public health infrastructure. The reviewers used a standardized form to score agencies' relevant experience and capacity to carry out the activities outlined in the proposal. Reviewers look for realistic targets when scoring performance measures in addition to detailed workplans including evaluation components. Budgets were reviewed to be reasonable, justified and consistent with the intent of the program goals and outcomes. There were no competing applications within each of the separate service areas. Scores were averaged and all proposals were recommended for funding. In those instances where scores were less than ideal, agency specific remedial actions were recommended and completed. The Bid Summary is attached.

As referenced in the Request for Proposals, Renewals Section, this competitively procured Agreement has the option to renew for two additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties and approval of the Governor and Executive Council. These services were contracted previously with this agency in SFY 2011 and SFY 2012 in the amount of $921,062. This represents a decrease of $369,654. The decrease is due to budget reductions.

The performance measures used to measure the effectiveness of the agreement are attached.

Area served: Merrimack and Hillsborough Counties.

Source of Funds: 37.39% Federal Funds from US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau and 62.61% General Funds.

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

Respectfully submitted,

José Thier Montero, MD
Director

Approved by:
Nicholas A. Toumpas
Commissioner

JTM/PMT/sc

Primary Care Performance Measures

State Fiscal Year 2013

Primary Care Prenatal (PN) Performance Measure #1

Measure: Percent of infants born to women receiving prenatal care beginning in the first trimester of pregnancy.

Primary Care Prenatal (PN) Performance Measure #2

Measure: Percent of pregnant women identified as cigarette smokers that are referred to QuitWorks-New Hampshire.

Primary Care Prenatal (PN) Performance Measure #3

Measure: Percent of pregnant women who were screened, using a formal valid screening tool, for alcohol and other drug use during every trimester the patient was enrolled.

Primary Care Child Health Direct (CH – D) Performance Measure #1

Measure: Percent of eligible children enrolled in Medicaid

Primary Care Child Health Direct (CH – D) Performance Measure #2

Measure: Percent of at-risk children who were screened for blood lead between 18 and 30 months of age

Primary Care Child Health Direct (CH – D) Performance Measure #3

Measure: Percent of children age two to nineteen years receiving primary care preventive health services with a Body Mass Index (BMI) percentile greater than or equal to the 85th percentile with documented discussion of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Primary Care Child Health Direct (CH – D) Performance Measure #4

Measure: Percent of eligible infants and children with client record documentation of enrollment in Women Infant Children Program.

Primary Care Child Health Direct (CH – D) Performance Measure #5

Measure: Percent of infants who were exclusively breastfed for the first three months, at their four month well baby visit.

Primary Care Financial (PC) Performance Measure #1

Measure: Patient Payor Mix

Primary Care Financial (PC) Performance Measure #2

Measure: Accounts Receivables (AR) Days

Primary Care Financial (PC) Performance Measure #3

Measure: Current Ratio

Primary Care Performance Measures

State Fiscal Year 2013

Primary Care Clinical Adolescent (PC-C) Performance Measure #1

Measure: Percent of adolescents aged 10-21 years who received annual health maintenance visits in the past 12 months.

Primary Care Clinical Prenatal (PC-C) Performance Measure #2

Measure: Percent of women and adolescent girls aged 15-44 who take a multi-vitamin with folic acid.

Subject: Primary Care Services

AGREEMENT

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

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name NH Department of Health and Human Services Division of Public Health Services		**1.2 State Agency Address** 29 Hazen Drive Concord, NH 03301-6504	
1.3 Contractor Name Concord Hospital, Inc.		**1.4 Contractor Address** 250 Pleasant Street Concord, New Hampshire 03301	
1.5 Contractor Phone Number 603-227-7000	**1.6 Account Number** 010-090-5190-102-500731 010-090-5659-102-500731	**1.7 Completion Date** June 30, 2014	**1.8 Price Limitation** $551,408
1.9 Contracting Officer for State Agency Joan H. Ascheim, Bureau Chief		**1.10 State Agency Telephone Number** 603-271-4501	
1.11 Contractor Signature [signature]		**1.12 Name and Title of Contractor Signatory** Michael B. Green President + CEO	
1.13 Acknowledgement: State of NH **, County of** Merrimack On 4/16/12, before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.			
1.13.1 Signature of Notary Public or Justice of the Peace Rebecca G. Webster [Seal]			
1.13.2 Name and Title of Notary or Justice of the Peace Rebecca G. Webster, Notary			
1.14 State Agency Signature [signature]		**1.15 Name and Title of State Agency Signatory** Joan H. Ascheim, Bureau Chief	
1.16 Approval by the N.H. Department of Administration, Division of Personnel ***(if applicable)*** By:		Director, On:	
1.17 Approval by the Attorney General (Form, Substance and Execution) By: [signature] Jeanne P. Herrick, Attorney		On: 4 May 2012	
1.18 Approval by the Governor and Executive Council By:		On:	

NH Department of Health and Human Services

Exhibit A

Scope of Services

Primary Care Services

CONTRACT PERIOD: July 1, 2012 or date of G&C approval, whichever is later, through June 30, 2014

CONTRACTOR NAME: Concord Hospital, Inc.

ADDRESS: 250 Pleasant Street
Concord, New Hampshire 03301
Director: Marie Wawrzyniak
TELEPHONE: 603-227-7000

The Contractor shall:

I. General Provisions

A) Eligibility and Income Determination

1. Office-based primary care services will be provided to low-income individuals and families (defined as ≤ 185% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), in the State of New Hampshire.

2. Breast and Cervical Cancer screening services will be provided to low-income (defined as ≤ 250% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), New Hampshire women age 18 – 64, *uninsured or underinsured*.

3. The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing if, at any time, the practice is closed to new patients, or maintains a wait list for new patients, or any other mechanism is used that limits access for new patients for more than a one month period.

4. The Contractor shall document annually, for each client enrolled in the program, family income and family size, and calculate percentage of the federal poverty level. If calculations indicate that the client may be eligible for enrollment in Medicaid, the Contractor shall complete with the client the most recent version of the 800P form.

5. The Contractor shall implement, and post in a public and conspicuous location, a sliding fee payment schedule, approved in advance by the Division of Public Health Services (DPHS), for low-income patients. Signage must state that no client will be denied services for inability to pay.

   a. As an alternative, the contractor may post, in a public and conspicuous location, a notice to clients that a sliding fee scale is available and that no client will be denied services for inability to pay. The sliding fee scale must be updated annually based on USDHHS Poverty guidelines as published in the Federal Register, submitted to and approved by DPHS *prior to implementation.*

6. The primary care contract entered into here shall be the payer of last resort. The contractor shall make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid, for all reimbursable services rendered.

Contractor Initials: MGS

Date: Apr 16, 2012

B) Numbers Served

1. The contract funds shall be expended to provide the above services to a minimum of 15,300 users annually with 44,950 medical encounters, as defined in the Data and Reporting Requirements. Breast and Cervical Cancer Screening for eligible women, as defined by the Breast and Cervical Cancer Program (BCCP), shall be provided to 350 women annually and billed directly to the BCCP. Clinical service reimbursements shall not exceed the Medicare rate.

C) **Culturally and Linguistically Appropriate Standards of Care**

The Department of Health and Human Services (DHHS) recognizes that culture and language have considerable impact on how consumers access and respond to public health services. Culturally and linguistically diverse populations experience barriers in efforts to access health services. To ensure equal access to quality health services, the Division of Public Health Services (DPHS) expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.

2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.

3. *Provide* clients of limited English proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.

4. Offer consumers a forum through which clients have the opportunity to provide feedback to providers and organizations regarding cultural and linguistic issues that may deserve response.

5. The contractor shall maintain a program policy that sets forth compliance with Title VI, Language Efficiency and Proficiency Citation 45 CFR 80.3(b) (2). The policy shall describe the way in which the items listed above were addressed and shall indicate the circumstances in which interpretation services are provided and the method of providing service (e.g. trained interpreter, staff person who speaks the language of the client, language line).

D) **State and Federal Laws**

The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. The Contractor shall report all cases of communicable diseases according to New Hampshire RSA 141-C and He-P 301, adopted 6/3/08.

2. Persons employed by the contractor shall comply with the reporting requirements of New Hampshire RSA 169:C, Child Protection Act; RSA 161:F46, Protective Services to Adults, RSA 631:6, Assault and Related Offences and RSA 130:A, Lead Paint Poisoning and Control.

3. Immunizations shall be conducted in accordance with RSA 141-C and the Immunization Rules promulgated hereunder.

E) **Relevant Policies and Guidelines**

1. The Contractor shall design and provide the services described above to meet the unique and identified health needs of the populations within the contracted service area.

Contractor Initials: MGS

Date: Apr 16, 2012

2. Primary Care funds shall be targeted to populations in need. Populations in need are defined as follows:

   a) uninsured;

   b) under-insured;

   c) families and individuals with significant psychosocial and economic risk, including low income status;

   d) all life cycles including perinatal, child, adolescent, adult, and elderly who meet one or more of the above criteria.

3. The Contractor shall design and implement systems of governance, administration, financial management, information management, and clinical services which are adequate to assure the provision of contracted services, and to meet the data and reporting requirements. These systems shall meet the most current minimum standards described in at least one of the following: Health Resources and Services Administration (HRSA) Office of Performance Review protocols, Joint Commission on Accreditation of Health Care Organizations (JCAHO), Accreditation Association for Ambulatory Healthcare (AAAHC), Community Health Accreditation Program (CHAP), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey.

4. *The Contractor shall have an agency emergency preparedness and response plan in accordance with HRSA Health Center Emergency Management Program Expectations, Document #2007-15 or most recent version. Such plan shall also include a Continuity of Operations plan.*

5. The Contractor shall carry out the work as described in the performance Workplan submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

6. No Workplan is required by the Breast and Cervical Cancer Program (BCCP). The contractor shall be required to respond to the Quality Improvement Feedback Report twice a year.

7. The Contractor shall carry out the work as described in the Supplemental Funding Form submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

F) Publications Funded Under Contract

1. The DHHS and/or its funders will retain COPYRIGHT ownership for any and all original materials produced with DHHS contract funding, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports.

2. All documents (written, video, audio, *electronic*) produced, reproduced, or purchased under the contract shall have prior approval from DPHS before printing, production, distribution, or use.

3. The Contractor shall credit DHHS on all materials produced under this contract following the instructions outlined in Exhibit C (14).

G) Subcontractors

1. If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing *and approve the subcontractual agreement,* prior to initiation of the subcontract.

Contractor Initials: MAS
Date: Apr 11, 2012

2. In addition, the original DPHS contractor will remain liable for all requirements included in this Exhibit and carried out by subcontractors.

II. Minimal Standards of Core Services

A) Service Requirements

1. *Medical Home*

   The Contractor shall provide a Medical Home that:

   a) *Facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family.*

   b) *Provides care facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.*

2. Primary Care Services

   The Contractor shall provide office-based primary care services to populations in need who reside in the contractor's service area. Primary care services shall include:

   a) Health care provided by a New Hampshire licensed MD, DO, APRN, or PA, including diagnosis and treatment of acute and chronic illnesses within the scope of family practice; preventive services, screenings, and health education according to established, documented state or national guidelines; assessment of need for social and nutrition services, and appropriate referrals to health, *oral health*, and behavioral health specialty providers.

   b) *Referral to the WIC Nutrition Program for all eligible pregnant women, infants and children.*

   c) In-hospital care for conditions within the scope of family practice must be provided at a hospital, within the agency service area, through a staff clinician with full hospital privileges, or in the alternative, through a formal referral and admissions procedure available to clients on a 24 hour/7 day a week basis.

   d) Access to a healthcare provider, directly or by referral or subcontract, by telephone twenty-four hours per day, seven days per week.

   e) Assessment of psychosocial risk for all clients at least annually and for children at scheduled preventive care visits, including, at a minimum, age appropriate assessment of safety in the home, domestic violence, adequacy of food and housing, care and welfare of children, transportation needs, and provision of necessary social services to address the priority needs and safety issues of clients and families.

   f) Falls prevention screening for patients 65 years and older using the algorithm and guidelines of the American Geriatrics Society.

   g) Behavioral health care directly or by referral to an agency or provider with a sliding fee scale.

   h) *Nutrition assessment for all clients as part of the health maintenance visit.* Therapeutic nutrition services shall be provided *as indicated* directly or by referral to an agency or provider with a sliding fee scale. These services shall be recorded in the medical record.

   i) Formal arrangements with a local hospital for emergency care must be in place and reviewed annually.

Contractor Initials: [signature]
Date: Apr 16, 2012

j) Home health care directly or by referral to an agency or provider with a sliding fee scale.

k) Assisted living and skilled nursing facility care by referral.

l) *Oral screening annually for all clients 19 years and older to note obvious dental decay and soft tissue abnormalities with a reminder to the patient that poor oral health impacts total health.*

m) *Diagnosis and management of pediatric and adult patients with asthma provided according to National Heart Lung Blood Institute, National Asthma Education and Prevention Program, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, 2007.*

2. Breast and Cervical Cancer Screening

a) Women age 18 to 64 who are eligible for Breast and Cervical Cancer Program (BCCP) services according to income (equal to or under 250% of poverty, underinsured/uninsured) *and insurance status* criteria shall be provided the following services:

   i. cervical cancer screening including a pelvic examination and Pap smear;
   ii. annual breast cancer screening including a clinical breast exam, mammogram and,
   iii. referrals for diagnostic and treatment services based on screening results,
   iv. case management services.

b) All referrals under this provision shall be to approved certified laboratory, pathology, radiology, and surgical services. Mammography units shall be accredited by the American College of Radiology, and must be FDA certified under MQSA. Laboratories shall be CLIA certified.

c) All services shall be provided in accordance with the Breast and Cervical Cancer Program (BCCP) Policy and Procedure Manual.

d) Follow-up and tracking of all tests done, and referrals made shall be provided in accordance with the minimum standards outlined in the Breast and Cervical Cancer Program Policy and Procedure Manual.

e) All services for women enrolled in the Breast and Cervical Cancer Program (BCCP) shall be billed directly to the BCCP in accordance with protocols established by the Breast and Cervical Cancer Program.

3. Reproductive Health Services

The Contractor shall provide prenatal, interconceptional and preconception medical care, social services, nutrition services, education, and nursing care to all women of childbearing age. Preconceptional care includes the preconception, interconceptional, and postpartum periods in women's health. It is recommended that preconceptional and interconceptional care visits focus on maintaining or achieving the optimal health of the mother, lowering the risk of future adverse pregnancy outcomes, the family's future plans, and how additional children fit into that plan. Preconceptional counseling may be done during an office, group or home visit.

a) In the event prenatal care is not provided directly by the Contractor a formal Memorandum/a of Agreement for coordinated referral to an appropriately qualified provider must be maintained.

b) Prenatal care shall, at minimum, be provided in accordance with the Guidelines for Perinatal Care, sixth or most current edition, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and /or the Centers for Disease Control.

Contractor Initials: [signature]

Date: Apr 16, 2012

c) Age appropriate reproductive health care shall, at a minimum, be provided in accordance with the American College of Obstetricians and Gynecologists, or the USDHHS Centers for Disease Control (CDC) current guidelines.

d) *Pregnant women enrolled in the WIC Nutrition Program shall be referred to WIC for breastfeeding education and referral to the WIC Nutrition Program peer counselors.*

e. Family planning counseling for prevention of subsequent pregnancy following an infant's birth shall be discussed with the infant's mother *at the first postpartum visit and at the infant's 2-month visit and other visits as appropriate.* Rationale for birth intervals of 18-24 months shall be presented.

f) A referral to a Title X Family Planning Clinic or other reproductive health care provider shall be made as appropriate.

4. Services for Children and Adolescents

The Contractor shall provide as a minimum, comprehensive and age-appropriate health care, screenings, and health education according to the American Academy of Pediatrics' most recent periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent. Children and adolescent visits shall include:

a) Blood lead testing shall be performed in accordance with "New Hampshire Childhood Lead Poisoning Screening and Management Guidelines", issued by the New Hampshire Department of Health and Human Services, 2009 or subsequent revisions.

b) All children enrolled in either Healthy Kids-Gold or the Women, Infant, and Children (WIC) Program and/or who are ≤ 185% poverty, regardless of town of residence, are required to have a blood lead test at ages one and two years. All children ages three to six years who have not been previously tested shall have a capillary or venous blood lead test performed.

c) All children shall be screened for iron deficiency anemia as outlined in the Centers for Disease Control and Prevention document "Recommendations to Prevent and Control Iron Deficiency in the United States (4/2/98)".

d) Age-appropriate anticipatory guidance, dietary guidance, and *feeding practice counseling* for optimal oral health shall be provided at each well child visit according to the American Academy of Pediatrics' periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent edition. Starting at age 6 months, it is recommended that all children receive an oral health assessment at every well child visit.

e) Supplemental fluoride shall be prescribed as needed based upon the fluoride levels in the child's *drinking* water supply. The fluoride dosage regimen accepted by the American Academy of Pediatrics shall be followed. No fluoride shall be prescribed without obtaining water from private wells or noting the presence or absence of fluoride in the public water supply. *Supplemental fluoride may include bottled water containing fluoride and topical applications such as varnishes.*

f) *For infants enrolled in the WIC Nutrition Program, parents shall be referred to WIC for breastfeeding support and referral to the WIC Nutrition Program peer counselors.*

Contractor Initials: [signature]

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5. Sexually Transmitted Infections

Primary Care Services shall provide age appropriate screening and treatment of sexually transmitted infections.

a) Treatment for sexually transmitted infections shall be provided according to the United States Centers for Disease Control Sexually Transmitted Diseases Treatment Guidelines, 2010 or subsequent revisions.

b) All clients, including women, shall be offered HIV testing following the most current recommendations of the United States Centers for Disease Control.

c) The contractor shall be responsible for ensuring referral to appropriate treatment services for any woman found to screen positive.

d) Appropriate risk reduction counseling shall be provided based on client needs.

6. Substance Use Services

a) A substance use screening history using a formal, validated screening tool shall be obtained for all clients as soon after entry into care as possible. Substance use counseling *or other substance abuse intervention, treatment, or recovery services* by an appropriately credentialed provider shall be provided on-site, or by referral, to clients with identified needs for these services. ***For these identified clients, ongoing primary care services should include follow up monitoring relative to substance abuse.***

b) All clients, including pregnant women, identified as smokers shall receive counseling *using the 5A's (ask, advise, assess, assist, and arrange) treatment available through the NH Tobacco Helpline* as cited in the US Public Health Services report "Tobacco Use and Dependence", 2008, or "Smoking Cessation During Pregnancy: *A Clinician's Guide to Helping Pregnant Women Quit Smoking*", American College of Obstetricians and Gynecologists, 2011. ***With prior approval, agencies may also opt to participate in the DPHS best practice initiative of the 2A's and R (ask, advise and refer).***

7. Immunizations

a) The Contractor shall adhere to the most current version of the "Recommended Adult Immunization Schedule United States", approved by the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

b) The Contractor shall administer vaccines according to the most current version of the *"Recommended Immunization Schedule for Persons Aged 0 Through 6 Years - United States", and "Recommended Immunization Schedule for Persons Aged 7 Through 18 Years – United States"* approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians, based upon availability of vaccine from the New Hampshire Immunization Program.

8. Prenatal Genetic Screening

a) A genetic screening history shall be obtained on all prenatal clients as soon after entry into care as possible.

b) All pregnant women should be offered voluntary genetic screening for fetal chromosomal abnormalities at the appropriate time following recommendations found in the American College of Obstetricians and Gynecologists' "Screening for Fetal Chromosomal

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Abnormalities (2007)" or more recent guidelines. The Contractor shall be responsible for ensuring referral to appropriate genetic testing and counseling for any woman found to have a positive screening test.

9. Additional Requirements

a) The Contractor's Medical Director shall participate in the development and approval of specific guidelines for medical care that supplement minimal clinical standards. Supplemental guidelines should be reviewed, signed, and dated annually, and updated as indicated.

b) Contractors considering clinical or sociological research using clients as subjects must adhere to the legal requirements governing human subjects research. Contractors must inform the DPHS, MCHS prior to initiating any research related to this contract.

c) *The Contractor shall provide information to all employees annually about the Medical Reserve Corps Unit within their Public Health Region to enhance recruitment.*

d) *The Contractor shall provide information to all employees annually regarding the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) managed by the NH Department of Health and Human Services' Emergency Services Unit, to enhance recruitment.*

B) Staffing Provisions

The Contractor shall have, at minimum, the following staff positions:

a) executive director

b) fiscal director

c) registered nurse

d) clinical coordinator

e) medical service director

f) nutritionist *(on site or by referral)*

g) social worker

Staff positions required to provide direct services on-site include:

a) registered nurse

b) clinical coordinator

c) social worker

1. Qualifications

All health and allied health professionals shall have the appropriate New Hampshire licenses whether directly employed, contracted, or subcontracted.

In addition the following minimum qualifications shall be met for:

a) Registered Nurse

a. A registered nurse licensed in the state of New Hampshire, Bachelor's degree preferred. Minimum of one-year experience in a community health setting.

b) Nutritionists:

   a. A Bachelor's degree in nutritional sciences or dietetics, or a Master's degree in nutritional sciences, nutrition education, or public health nutrition or current Registered Dietitian status in accordance with the Commission on dietetic Registration of the American Dietetic Association.

   b. Individuals who perform functions similar to a nutritionist but do not meet the above qualifications shall not use the title of nutritionist.

c) Social Workers shall have:

   a. A Bachelor's or Master's degree in social work or Bachelor's or Master's degree in a related social science or human behavior field. A minimum of one year of experience in a community health or social services setting is preferred.

   b. Individuals who perform functions similar to a social worker but do not meet the above qualifications shall not use the title of social worker.

d) Clinical Coordinators shall be:

   a. A registered nurse (RN), physician, physician assistant, or nurse practitioner with a license to practice in New Hampshire.

   b. The coordinator is a clinical position that oversees and takes responsibility for the clinical and administrative functions of each program.

   c. The coordinator may be responsible for more than one MCH funded program.

2. New Hires

The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing within one month of hire when a new administrator, clinical coordinator, or any staff person essential to carrying out contracted services is hired to work in the program. A resume of the employee shall accompany the aforesaid notification.

3. Vacancies

   a) The Contractor must notify the MCHS in writing if any critical position is vacant for more than one month, or if at any time funded under this contract does not have adequate staffing to perform all required services for more than one month. This may be done through a budget revision.

   b) Before an agency hires new program personnel that do not meet the required staff qualifications, the agency shall notify the MCHS in writing requesting a waiver of the applicable staffing requirements. The Section may grant waivers based on the need of the program, individuals' experience, and additional training.

C) Coordination of Services

1. The Contractor shall coordinate, where possible, with other service providers within the contractor's community. At a minimum, such collaboration shall include interagency referrals and coordination of care.

2. The Contractor shall participate in activities *in the Public Health Region in which they provide services* as appropriate. These activities enhance the integration of community-based public health prevention and health care initiatives that are being implemented by the contractor and may include community needs assessments, public health performance assessments, and/or the development of regional health improvement plans.

Contractor Initials MAS
Date Apr. 12, 2012

3. The Contractor agrees to *participate* in and coordinate public health activities as requested by the Division of Public Health Services during any *disease outbreak* and/or *emergency*, natural or man made, affecting the public's health.

4. The Contractor is responsible for case management of the client enrolled in the program and for program follow-up activities. Case management services shall promote effective and efficient organization and utilization of resources to assure access to necessary comprehensive medical, nutritional, and social services for clients.

5. The Contractor shall assure that *appropriate, responsive, and timely* referrals and linkages for other needed services are made, carried through, and documented. Such services shall include, but not be limited to: dental services, genetic counseling, high risk prenatal services, mental health, social services, including domestic violence crisis centers, substance abuse services; and family planning services, Early Supports and Services Program, local WIC/CSF Program, Home Visiting New Hampshire Programs and health and social service agencies which serve children and families in need of those services.

D) Meetings and Trainings

The contractor will be responsible for sending staff to meetings and training required by the MCHS program, including but not limited to:

1. MCHS Agency Directors' meetings
2. Prenatal and Child Health Coordinators' meetings
3. MCHS Agency Medical Services Directors' meetings

III. Quality or Performance Improvement (QI/PI)

A) Workplans

1. Performance Workplans are required for this program and are used to monitor achievement of standard measures of performance of the services provided under this contract. The workplans are a key component of the RHPCS and the MCHS performance-based contracting system and of this contract. Outcomes shall be reported by clinical site.

2. Submit Performance Workplans and Workplan Outcome reports according to the schedule and instructions provided by the MCHS. The MCHS shall notify the Contractor at least 30 days in advance of any changes in the submission schedule.

3. The Contractor shall incorporate required and developmental performance measures, defined by the MCHS into the agency's Performance Workplan. Reports on Workplan Progress/Outcomes shall detail the Performance Workplan and activities that monitor and evaluate the agency's progress toward performance measure targets.

4. The Contractor shall comply with modifications and/or additions to the workplan and annual report format as requested by RHPCS and MCHS. MCHS will provide the contractor with reasonable notice of such changes.

5. Agencies contracting for Primary Care Services must submit the workplans for Primary Care *Clinical and Financial*, Child Health, and Prenatal Care.

Contractor Initials MBG
Date Apr. 16, 2012

B) Additional Reporting requirements

In addition to Performance Workplans, the Contractor shall submit to MCHS the following data and information listed below which are used to monitor program performance:

1. In years when contracts or amendments are not required, the DPHS Budget Form, Budget Justification, Sources of Revenue and Program Staff list forms must be completed according to the relevant instructions and submitted as requested by DPHS and, at minimum, by April 30 of each year.

2. The Sources of Revenue report must be resubmitted at any point when changes in revenue threaten the ability of the agency to carry out the planned program.

3. Completed Uniform Data Set (UDS) tables reflecting program performance in the previous calendar year, by March 31 of each year.

4. The Perinatal Client Data Form (PCDF) shall be submitted electronically according to the instructions set forth by the MCHS.

5. A copy of the agency's updated Sliding Fee Scale including the amount(s) of any client fees and the schedule of discounts must be submitted by March 31st of each year. The agency's sliding fee scale must be updated annually based on the US DHHS Poverty guidelines as published in the Federal Register.

6. An annual summary of program-specific patient satisfaction results obtained during the prior contract period and the method by which the results were obtained shall be submitted annually as an addendum to the Workplan Outcome/Progress reports.

C) On-site reviews

1. The contractor shall allow a team or person authorized by the Division of Public Health Services to periodically review the contractor's systems of governance, administration, data collection and submission, clinical and financial management, and delivery of education services in order to assure systems are adequate to provide the contracted services.

2. Reviews shall include client record reviews to measure compliance with this exhibit.

3. The contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.

4. On-Site reviews may be waived or abbreviated at the discretion of MCHS, upon submission of satisfactory reports of reviews such as Health Services Resources Administration (HRSA): Office of Performance Review (OPR), or reviews from nationally accreditation organizations such as the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), Medicare, the Community Health Accreditation Program (CHAP), Accreditation Association for Ambulatory Healthcare (AAAHC), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey. Abbreviated reviews will focus on any deficiencies found in previous reviews, issues of compliance with this exhibit, and actions to strengthen performance as outlined in the agency Performance Workplan.

Contractor Initials: [signature]
Date: Apr 16, 2012

State of New Hampshire
Department of Health and Human Services
Amendment #1 to the
Coos County Family Health Services, Inc.

This 1st Amendment to the Coos County Family Health Services, Inc., contract (hereinafter referred to as "Amendment One") dated this 6th day of March, 2014, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Coos County Family Health Services, Inc., (hereinafter referred to as "the Contractor"), a corporation with a place of business at 54 Willow Street, Berlin, New Hampshire 03570.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on June 20, 2012, 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, the State and the Contractor have agreed to make changes to the scope of work, payment schedules and terms and conditions of the contract; and

WHEREAS, pursuant to the General Provisions, Paragraph 18, the State may modify the scope of work and the payment schedule of the contract by written agreement of the parties;

WHEREAS, the Department desires to provide additional primary health care services for preventive and episodic health care for acute and chronic health conditions for people of all ages.

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 as follows:

To amend as follows:

- Form P-37, to change:
  Block 1.7 to read: June 30, 2015
  Block 1.8 to read: $427,142

- Exhibit A, Scope of Services to add:
  Exhibit A – Amendment 1

- Exhibit B, Purchase of Services, Contract Price, to add:

  Paragraph 1.1 to Paragraph 1:
  The contract price shall increase by $24,351 for SFY 2014 and $159,685 for SFY 2015.

  Paragraph 1.2 to Paragraph 1:
  Funding is available as follows:
- $24,351 from 05-95-90-902010-5190-102-500731, 100% General Funds;
- $122,103 from 05-95-90-902010-5190-102-500731, 6.7% Federal Funds from the US Department of Health and Human Services Administration, Maternal and Child Health Bureau, CFDA #93.994 and 93.3% General Funds;

Contractor Initials: adw
Date: 3/6/14

- $27,582 from 05-95-90-902010-5659-102-500731, 100% Federal Funds from the US Department of Health and Human Services, Centers for Disease Control and Prevention, CFDA #93.283;

- $10,000 from 05-95-90-901010-7965-102-500731, 100% General Funds.

  Add Paragraph 8
  8. Notwithstanding paragraph 18 of the General Provisions P-37, an amendment limited to adjustments to amounts between and among account numbers, within the price limitation, may be made by written agreement of both parties and may be made without obtaining approval of the Governor and Executive Council.

- Budget, to add:
  Exhibit B-1 (2014) - Amendment 1,
  Exhibit B-1 (2015) - Amendment 1

This amendment shall be in effect July 1, 2013, effective upon the date of Governor and Executive Council approval.

Contractor Initials: adw
Date: 3/6/14

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

3/28/2014
Date

Brook Dupee
Bureau Chief

Coos County Family Health Services, Inc.

3/6/14
Date

Name: Adele D. Woods
Title: Chief Executive Officer

Acknowledgement:

State of New Hampshire, County of Coos on March 6, 2014, before the undersigned officer, personally appeared the person identified above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.

Signature of Notary Public or Justice of the Peace
LINDA BLANCHETTE, Notary Public
My Commission Expires September 18, 2018

Name and Title of Notary or Justice of the Peace

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

OFFICE OF THE ATTORNEY GENERAL

4-2-14
Date

Name: Rosemary Wiant
Title: Assistant Attorney General

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:

Contractor Initials: adw
Date: 3/6/14

EXHIBIT A – AMENDMENT 1

Scope of Services

The Department desires to continue the relationship with the primary care agencies to provide additional primary health care services for preventive and episodic health care for acute and chronic health conditions for people of all ages.

I. General Provisions

A) Eligibility and Income Determination

1. Office-based primary care services will be provided to low-income individuals and families (defined as ≤ 185% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), in the State of New Hampshire.

2. Breast and Cervical Cancer screening services will be provided to low-income (defined as ≤ 250% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), New Hampshire women age 21– 64, uninsured or underinsured. BCCP changes.

3. The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing if, at any time, the practice is closed to new patients, or maintains a wait list for new patients, or any other mechanism is used that limits access for new patients for more than a one month period.

4. The Contractor shall document annually, for each client enrolled in the program, family income and family size, and calculate percentage of the federal poverty level. If calculations indicate that the client may be eligible for enrollment in Medicaid, the Contractor shall complete with the client the most recent version of the 800P form.

5. The Contractor shall implement, and post in a public and conspicuous location, a sliding fee payment schedule, approved in advance by the Division of Public Health Services (DPHS), for low-income patients. Signage must state that no client will be denied services for inability to pay.

   a. As an alternative, the contractor may post, in a public and conspicuous location, a notice to clients that a sliding fee scale is available and that no client will be denied services for inability to pay. The sliding fee scale must be updated annually based on USDHHS Poverty guidelines as published in the Federal Register, submitted to and approved by DPHS prior to implementation.

6. The primary care contract entered into here shall be the payer of last resort. The contractor shall make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid, for all reimbursable services rendered.

B) Numbers Served

1. The contract funds shall be expended to provide the above services to a minimum of 4,000 users annually with 12,000 medical encounters, as defined in the Data and Reporting Requirements. Breast and Cervical Cancer Screening for eligible women, as defined by the Breast and Cervical Cancer Program (BCCP), shall be provided to 155 women annually and billed directly to the BCCP. Clinical service reimbursements shall not exceed the Medicare rate.

C) Culturally and Linguistically Appropriate Standards of Care

The Department of Health and Human Services (DHHS) recognizes that culture and language have considerable impact on how consumers access and respond to public health services. Culturally and linguistically diverse populations experience barriers in efforts to access health services. To ensure equal access to quality health services, the Division of Public Health Services (DPHS) expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.

2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.

3. Provide clients of limited English proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.

4. Offer consumers a forum through which clients have the opportunity to provide feedback to providers and organizations regarding cultural and linguistic issues that may deserve response.

5. The contractor shall maintain a program policy that sets forth compliance with Title VI, Language Efficiency and Proficiency Citation 45 CFR 80.3(b) (2). The policy shall describe the way in which the items listed above were addressed and shall indicate the circumstances in which interpretation services are provided and the method of providing service (e.g. trained interpreter, staff person who speaks the language of the client, language line).

D) State and Federal Laws

The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. The Contractor shall report all cases of communicable diseases according to New Hampshire RSA 141-C and He-P 301, adopted 6/3/08.

2. Persons employed by the contractor shall comply with the reporting requirements of New Hampshire RSA 169:C, Child Protection Act; RSA 161:F46, Protective Services to Adults, RSA 631:6, Assault and Related Offences and RSA 130:A, Lead Paint Poisoning and Control.

3. Immunizations shall be conducted in accordance with RSA 141-C and the Immunization Rules promulgated hereunder.

E) Relevant Policies and Guidelines

1. The Contractor shall design and provide the services described above to meet the unique and identified health needs of the populations within the contracted service area.

2. Primary Care funds shall be targeted to populations in need. Populations in need are defined as follows:

   a) uninsured;

   b) under-insured;

   c) families and individuals with significant psychosocial and economic risk, including low income status;

   d) all life cycles including perinatal, child, adolescent, adult, and elderly who meet one or more of the above criteria.

3. The Contractor shall design and implement systems of governance, administration, financial management, information management, and clinical services which are adequate to assure the provision of contracted services, and to meet the data and reporting requirements. These systems shall meet the most current minimum standards described in at least one of the following: Health Resources and Services Administration (HRSA) Office of Performance Review protocols, Joint Commission on Accreditation of Health Care Organizations (JCAHO), Accreditation Association for Ambulatory Healthcare (AAAHC), Community Health Accreditation Program (CHAP), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey.

4. The Contractor shall have an agency emergency preparedness and response plan in accordance with HRSA Health Center Emergency Management Program Expectations, Document #2007-15 or most recent version. Such plan shall also include a Continuity of Operations plan.

5. The Contractor shall carry out the work as described in the performance Workplan submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

6. No Workplan is required by the Breast and Cervical Cancer Program (BCCP). The contractor shall be required to respond to the Quality Improvement Feedback Report twice a year.

7. The Contractor shall carry out the work as described in the Supplemental Funding Form submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

F) Publications Funded Under Contract

1. The DHHS and/or its funders will retain COPYRIGHT ownership for any and all original materials produced with DHHS contract funding, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports.

2. All documents (written, video, audio, electronic) produced, reproduced, or purchased under the contract shall have prior approval from DPHS before printing, production, distribution, or use.

3. The Contractor shall credit DHHS on all materials produced under this contract following the instructions outlined in Exhibit C (14).

G) Subcontractors

If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing and approve the subcontractual agreement, prior to initiation of the subcontract.

1. If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing and approve the subcontractual agreement, prior to initiation of the subcontract.

2. In addition, the original DPHS contractor will remain liable for all requirements included in this Exhibit and carried out by subcontractors.

II. Minimal Standards of Core Services

A. Service Requirements

1. Medical Home

The Contractor shall provide a Medical Home that:

a) Facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family.

b) Provides care facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

2. Primary Care Services

The Contractor shall provide office-based primary care services to populations in need who reside in the contractor's service area. Primary care services shall include:

a) Health care provided by a New Hampshire licensed MD, DO, APRN, or PA, including diagnosis and treatment of acute and chronic illnesses within the scope of family practice; preventive services, screenings, and health education according to established, documented state or national guidelines; assessment of need for social and nutrition services, and appropriate referrals to health, oral health, and behavioral health specialty providers.

b) Referral to the WIC Nutrition Program for all eligible pregnant women, infants and children.

c) In-hospital care for conditions within the scope of family practice must be provided at a hospital, within the agency service area, through a staff clinician with full hospital privileges, or in the alternative, through a formal referral and admissions procedure available to clients on a 24 hour/7 day a week basis.

d) Access to a healthcare provider, directly or by referral or subcontract, by telephone twenty-four hours per day, seven days per week.

e) Assessment of psychosocial risk for all clients at least annually and for children at scheduled preventive care visits, including, at a minimum, age appropriate assessment of safety in the home, domestic violence, adequacy of food and housing, care and welfare of children, transportation needs, and provision of necessary social services to address the priority needs and safety issues of clients and families.

f) Falls prevention screening for patients 65 years and older using the algorithm and guidelines of the American Geriatrics Society.

g) Behavioral health care directly or by referral to an agency or provider with a sliding fee scale.

h) Nutrition assessment for all clients as part of the health maintenance visit. Therapeutic nutrition services shall be provided as indicated directly or by referral to an agency or provider with a sliding fee scale. These services shall be recorded in the medical record.

i) Formal arrangements with a local hospital for emergency care must be in place and reviewed annually.

j) Home health care directly or by referral to an agency or provider with a sliding fee scale.

k) Assisted living and skilled nursing facility care by referral.

l) Oral screening annually for all clients 21 years and older to note obvious dental decay and soft tissue abnormalities with a reminder to the patient that poor oral health impacts total health.

m) Diagnosis and management of pediatric and adult patients with asthma provided according to National Heart Lung Blood Institute, National Asthma Education and Prevention Program, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, 2007.

3. Breast and Cervical Cancer Screening

a) Women age 21 to 64 who are eligible for Breast and Cervical Cancer Program (BCCP) services according to income (equal to or under 250% of poverty, underinsured/uninsured) and insurance status criteria shall be provided the following services, following USPSTF screening recommendations:

i. cervical cancer screening including a pelvic examination and Pap smear;
ii. breast cancer screening including a clinical breast exam, mammogram and,
iii. referrals for diagnostic and treatment services based on screening results,
iv. case management services.

b) All referrals under this provision shall be to approved certified laboratory, pathology, radiology, and surgical services. Mammography units shall be accredited by the American College of Radiology, and must be FDA certified under MQSA. Laboratories shall be CLIA certified.

c) All services shall be provided in accordance with the Breast and Cervical Cancer Program (BCCP) Policy and Procedure Manual.

d) Follow-up and tracking of all tests done, and referrals made shall be provided in accordance with the minimum standards outlined in the Breast and Cervical Cancer Program Policy and Procedure Manual.

e) All services for women enrolled in the Breast and Cervical Cancer Program (BCCP) shall be billed directly to the BCCP in accordance with protocols established by the Breast and Cervical Cancer Program.

f) The Contractor shall provide the NH Breast and Cervical Cancer Program with breast and cervical cancer screening rates for all women served by the practice as requested, but not more than twice per SFY.

g) The contractor shall work with the NH Breast and Cervical Cancer Program staff to increase the breast and cervical cancer screening rates among all women serviced by the practice.

4. Reproductive Health Services

The Contractor shall provide prenatal, interconceptional and preconception medical care, social services, nutrition services, education, and nursing care to all women of childbearing age. Preconceptional care includes the preconception, interconceptional, and postpartum periods in women's health. It is recommended that preconceptional and interconceptional care visits focus on maintaining or achieving the optimal health of the mother, lowering the risk of future adverse pregnancy outcomes, the family's future plans, and how additional children fit into that plan. Preconceptional counseling may be done during an office, group or home visit.

a) In the event prenatal care is not provided directly by the Contractor a formal Memorandum/a of Agreement for coordinated referral to an appropriately qualified provider must be maintained.

b) Prenatal care shall, at minimum, be provided in accordance with the Guidelines for Perinatal Care, sixth or most current edition, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and /or the Centers for Disease Control.

c) Age appropriate reproductive health care shall, at a minimum, be provided in accordance with the American College of Obstetricians and Gynecologists, or the USDHHS Centers for Disease Control (CDC) current guidelines.

d) Pregnant women enrolled in the WIC Nutrition Program shall be referred to WIC for breastfeeding education and referral to the WIC Nutrition Program peer counselors.

e. Family planning counseling for prevention of subsequent pregnancy following an infant's birth shall be discussed with the infant's mother at the first postpartum visit and at the infant's 2-month visit and other visits as appropriate. Rationale for birth intervals of 18-24 months shall be presented.

f) A referral to a Title X Family Planning Clinic or other reproductive health care provider shall be made as appropriate.

5. Services for Children and Adolescents

The Contractor shall provide as a minimum, comprehensive and age-appropriate health care, screenings, and health education according to the American Academy of Pediatrics' most recent periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent. Children and adolescent visits shall include:

EXHIBIT A – AMENDMENT 1

a) The World Health Organization (WHO) growth charts shall be used to monitor growth for infants and children birth up to age 2 years. The Centers for Disease Control and Prevention (CDC) growth charts shall be used for children age 2 years and older.

b) Blood lead testing shall be performed in accordance with "New Hampshire Childhood Lead Poisoning Screening and Management Guidelines", issued by the New Hampshire Department of Health and Human Services, 2009 or subsequent revisions.

c) All children enrolled in either Medicaid, Head Start, or the Women, Infant, and Children (WIC) Program and/or who are $\leq$ 185%_poverty, regardless of town of residence, are required to have a blood lead test at ages one and two years. All children ages three to six years who have not been previously tested shall have a blood lead test performed.

d) All children shall be screened for iron deficiency anemia as outlined in the Centers for Disease Control and Prevention document "Recommendations to Prevent and Control Iron Deficiency in the United States (4/2/98)".

e) Age-appropriate anticipatory guidance, dietary guidance, and *feeding practice counseling* for optimal oral health shall be provided at each well child visit according to the American Academy of Pediatrics' periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent edition. Starting at age 6 months, it is recommended that all children receive an oral health assessment at every well child visit, and a referral for the child's first visit to the dentist by age one as recommended by the American Academy of Pediatrics and the American Academy of Pediatric Dentistry.

f) Supplemental fluoride shall be prescribed as needed based upon the fluoride levels in the child's drinking water supply. The fluoride dosage regimen accepted by the American Academy of Pediatrics shall be followed. No fluoride shall be prescribed without obtaining water from private wells or noting the presence or absence of fluoride in the public water supply. Supplemental fluoride may include bottled water containing fluoride and topical applications such as varnishes.

g) For infants enrolled in the WIC Nutrition Program, parents shall be referred to WIC for breastfeeding support and referral to the WIC Nutrition Program peer counselors.

6. Sexually Transmitted Infections

Primary Care Services shall provide age appropriate screening and treatment of sexually transmitted infections.

a) Treatment for sexually transmitted infections shall be provided according to the United States Centers for Disease Control Sexually Transmitted Diseases Treatment Guidelines, 2010 or subsequent revisions.

b) All clients, including women, shall be offered HIV testing following the most current recommendations of the United States Centers for Disease Control.

c) The contractor shall be responsible for ensuring referral to appropriate treatment services for any woman found to screen positive.

d) Appropriate risk reduction counseling shall be provided based on client needs.

7. Substance Use Services

a) A substance use screening history using a formal, validated screening tool shall be obtained for all clients as soon after entry into care as possible. Substance use counseling or other substance abuse intervention, treatment, or recovery services by an appropriately credentialed provider shall be provided on-site, or by referral, to clients with identified needs for these services. For these identified clients, ongoing primary care services should include follow up monitoring relative to substance abuse.

b) All clients, including pregnant women, identified as smokers shall receive counseling using the 5A's (ask, advise, assess, assist, and arrange) treatment available through the NH Tobacco Helpline as cited in the US Public Health Services report "Tobacco Use and Dependence", 2008, or "Smoking Cessation During Pregnancy: A Clinician's Guide to Helping Pregnant Women Quit Smoking", American College of Obstetricians and Gynecologists, 2011. With prior approval, agencies may also opt to participate in the DPHS best practice initiative of the 2A's and R (ask, advise and refer).

8. Immunizations

a) The Contractor shall adhere to the most current version of the "Recommended Adult Immunization Schedule for Adults (19 years and older) by Age and Medical Condition - United States", approved by the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

b) The Contractor shall administer vaccines according to the most current version of the "Recommended Immunization Schedule for Persons Aged 0 Through 6 Years - United States", and "Recommended Immunization Schedule for Persons Aged 7 Through 18 Years – United States" approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians, based upon availability of vaccine from the New Hampshire Immunization Program.

9. Prenatal Genetic Screening

a) A genetic screening history shall be obtained on all prenatal clients as soon after entry into care as possible.

b) All pregnant women should be offered voluntary genetic screening for fetal chromosomal abnormalities at the appropriate time following recommendations found in the American College of Obstetricians and Gynecologists' "Screening for Fetal Chromosomal Abnormalities (2007)" or more recent guidelines. The Contractor shall be responsible for ensuring referral to appropriate genetic testing and counseling for any woman found to have a positive screening test.

10. Additional Requirements

a) The Contractor's Medical Director shall participate in the development and approval of specific guidelines for medical care that supplement minimal clinical standards. Supplemental guidelines should be reviewed, signed, and dated annually, and updated as indicated.

b) Contractors considering clinical or sociological research using clients as subjects must adhere to the legal requirements governing human subjects research. Contractors must inform the DPHS, MCHS prior to initiating any research related to this contract.

c) The Contractor shall provide information to all employees annually about the Medical Reserve Corps Unit within their Public Health Region to enhance recruitment.

d) The Contractor shall provide information to all employees annually regarding the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) managed by the NH Department of Health and Human Services' Emergency Services Unit, to enhance recruitment.

B) Staffing Provisions

The Contractor shall have, at minimum, the following staff positions:

a) executive director

b) fiscal director

c) registered nurse

d) clinical coordinator

e) medical service director

f) nutritionist (on site or by referral)

g) social worker

EXHIBIT A – AMENDMENT 1

Staff positions required to provide direct services on-site include:

a) registered nurse

b) clinical coordinator

c) social worker

1. Qualifications

All health and allied health professionals shall have the appropriate New Hampshire licenses whether directly employed, contracted, or subcontracted.

In addition the following minimum qualifications shall be met for:

a) Registered Nurse
   a. A registered nurse licensed in the state of New Hampshire, Bachelor's degree preferred. Minimum of one-year experience in a community health setting.

b) Nutritionists:
   a. A Bachelor's degree in nutritional sciences or dietetics, or a Master's degree in nutritional sciences, nutrition education, or public health nutrition or current Registered Dietitian status in accordance with the Commission on dietetic Registration of the American Dietetic Association.
   b. Individuals who perform functions similar to a nutritionist but do not meet the above qualifications shall not use the title of nutritionist.

c) Social Workers shall have:
   a. A Bachelor's or Master's degree in social work or Bachelor's or Master's degree in a related social science or human behavior field. A minimum of one year of experience in a community health or social services setting is preferred.
   b. Individuals who perform functions similar to a social worker but do not meet the above qualifications shall not use the title of social worker.

d) Clinical Coordinators shall be:
   a. A registered nurse (RN), physician, physician assistant, or nurse practitioner with a license to practice in New Hampshire.
   b. The coordinator is a clinical position that oversees and takes responsibility for the clinical and administrative functions of each program.
   c. The coordinator may be responsible for more than one MCH funded program.

2. New Hires

The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing within one month of hire when a new administrator, clinical coordinator, or any staff person essential to carrying out contracted services is hired to work in the program. A resume of the employee shall accompany the aforesaid notification.

3. Vacancies

   a) The Contractor must notify the MCHS in writing if any critical position is vacant for more than one month, or if at any time funded under this contract does not have adequate staffing to perform all required services for more than one month. This may be done through a budget revision.

   b) Before an agency hires new program personnel that do not meet the required staff qualifications, the agency shall notify the MCHS in writing requesting a waiver of the applicable staffing requirements. The Section may grant waivers based on the need of the program, individuals' experience, and additional training.

C) Coordination of Services

1. The Contractor shall coordinate, where possible, with other service providers within the contractor's community. At a minimum, such collaboration shall include interagency referrals and coordination of care.

2. The Contractor shall participate in activities in the Public Health Region in which they provide services as appropriate. These activities enhance the integration of community-based public health prevention and health care initiatives that are being implemented by the contractor and may include community needs assessments, public health performance assessments, and/or the development of regional health improvement plans.

3. The Contractor agrees to participate in and coordinate public health activities as requested by the Division of Public Health Services during any disease outbreak and/or emergency, natural or man-made, affecting the public's health.

4. The Contractor is responsible for case management of the client enrolled in the program and for program follow-up activities. Case management services shall promote effective and efficient organization and utilization
   of resources to assure access to necessary comprehensive medical, nutritional, and social services for clients.

5. The Contractor shall assure that appropriate, responsive, and timely referrals and linkages for other needed services are made, carried through, and documented. Such services shall include, but not be limited to: dental services, genetic counseling, high risk prenatal services, mental health, social services, including domestic violence crisis centers, substance abuse services; and family planning services, Early Supports and Services Program, local WIC/CSF Program, Home Visiting New Hampshire Programs and health and social service agencies which serve children and families in need of those services.

D) Meetings and Trainings

The contractor will be responsible for sending staff to meetings and training required by the MCHS program, including but not limited to:

1. MCHS Agency Directors' meetings
2. Prenatal and Child Health Coordinators' meetings
3. MCHS Agency Medical Services Directors' meetings

III. Quality or Performance Improvement (QI/PI)

A) Workplans

1. Performance Workplans are required for this program and are used to monitor achievement of standard measures of performance of the services provided under this contract. The workplans are a key component of the RHPCS and the MCHS performance-based contracting system and of this contract. Outcomes shall be reported by clinical site.
2. Performance Workplans and Workplan Outcome reports according to the schedule and instructions provided by the MCHS. The MCHS shall notify the Contractor at least 30 days in advance of any changes in the submission schedule.
3. The Contractor shall incorporate required and developmental performance measures, defined by the MCHS into the agency's Performance Workplan. Reports on Workplan Progress/Outcomes shall detail the Performance Workplan plans and activities that monitor and evaluate the agency's progress toward performance measure targets.
4. The Contractor shall comply with modifications and/or additions to the workplan and annual report format as requested by RHPCS and MCHS. MCHS will provide the contractor with reasonable notice of such changes.
5. Agencies contracting for Primary Care Services must submit the workplans for Primary Care Clinical and Financial, Child Health, and Prenatal Care.

B) Additional Reporting requirements

In addition to Performance Workplans, the Contractor shall submit to MCHS the following data and information listed below which are used to monitor program performance:

1. In years when contracts or amendments are not required, the DPHS Budget Form, Budget Justification, Sources of Revenue and Program Staff list forms must be

completed according to the relevant instructions and submitted as requested by DPHS and, at minimum, by April 30 of each year.

2. The Sources of Revenue report must be resubmitted at any point when changes in revenue threaten the ability of the agency to carry out the planned program.

3. Completed Uniform Data Set (UDS) tables reflecting program performance in the previous calendar year, by March 31 of each year.

4. The Perinatal Client Data Form (PCDF) shall be submitted electronically according to the instructions set forth by the MCHS.

5. A copy of the agency's updated Sliding Fee Scale including the amount(s) of any client fees and the schedule of discounts must be submitted by March 31st of each year. The agency's sliding fee scale must be updated annually based on the US DHHS Poverty guidelines as published in the Federal Register.

6. An annual summary of program-specific patient satisfaction results obtained during the prior contract period and the method by which the results were obtained shall be submitted annually as an addendum to the Workplan Outcome/Progress reports.

C) On-site reviews

1. The contractor shall allow a team or person authorized by the Division of Public Health Services to periodically review the contractor's systems of governance, administration, data collection and submission, clinical and financial management, and delivery of education services in order to assure systems are adequate to provide the contracted services.

2. Reviews shall include client record reviews to measure compliance with this exhibit.

3. The contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.

4. On-Site reviews may be waived or abbreviated at the discretion of MCHS, upon submission of satisfactory reports of reviews such as Health Services Resources Administration (HRSA): Office of Performance Review (OPR), or reviews from nationally accreditation organizations such as the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), Medicare, the Community Health Accreditation Program (CHAP), Accreditation Association for Ambulatory Healthcare (AAAHC), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey. Abbreviated reviews will focus on any deficiencies found in previous reviews, issues of compliance with this exhibit, and actions to strengthen performance as outlined in the agency Performance Workplan.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE CHILD HEALTH DIRECT CARE SERVICES
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Please note, for all measures, the following should be used **unless otherwise indicated:**

- Less than 19 years of age
- Served within the scope of this MCH contract during State Fiscal Year 2015 (July 1, 2014 – June 30, 2015)
- Each client can only be counted once (unduplicated)

Child Health Direct (CH – D) Performance Measure #1

Measure: 92%* of eligible children will be enrolled in Medicaid

Goal: To increase access to health care for children through the provision of health insurance

Definition: **Numerator-**
Of those in the denominator, the number of children enrolled in Medicaid.

Denominator-
Number of children who meet all of the following criteria:

- Less than 19 years of age
- Had 3 or more visits/encounters** during the reporting period
- As of the last visit during the reporting period were eligible for Medicaid

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**An encounter is face to face contact between a user and a provider who exercises independent judgment in the provision of services to the individual (UDS Table Definition).

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #2

Measure: 85%* of at-risk** children who were screened for blood lead between 18 and 30 months of age

Goal: To prevent childhood lead poisoning through early identification of lead exposure

Definition: **Numerator-**
Of those in the denominator, number of children screened for blood lead by capillary or venous on or after their 18-month birthday and prior to their 30-month birthday.

Denominator-
Number of at-risk** children who reached age 30 months during the reporting period. If discharged prior to 30 months, do not include in denominator.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**At risk = During the reporting period, the children were 18-29 months of age, and fit at least one of the following criteria:

- "Low income" (less than 185% poverty guidelines)
- Over 185% and resided in a town considered needing "Universal" screening per NH Childhood Lead Poisoning Prevention Program
- Over 185%, resided in a town considered "Target" and had a positive response to the risk questionnaire
- Refugee children -A refugee is defined as a person outside of his or her country of nationality who is unable or unwilling to return because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion (U.S. Citizenship and Immigration Services definition).

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #3

Measure: 71%* of children age two to nineteen years receiving primary care preventive health services with a Body Mass Index (BMI) percentile greater than or equal to the 85%ile with documented discussion of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Goal: To increase the percent of children receiving primary care preventive health services who have an elevated BMI percentile who receive guidance about promoting a healthier lifestyle.

Definition: **Numerator-**
Of those in the denominator, the number of children who had documentation in their medical record of there being discussion at least once during the reporting period of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Denominator-
Number of children who turned twenty-four months during or before the reporting period, up to the age of nineteen years, with one or more well child visit after their twenty-fourth month of age within the reporting year, and had an age and gender appropriate BMI percentile greater than or equal to the 85 % percentile at least once during the reporting period.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

Rationale: Children between the 85th – 94th percentiles BMI are encouraged to have 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks. (Discussion of the importance of family meal time, limiting eating out, consuming a healthy breakfast, preparing own foods, and promotion of breastfeeding is also encouraged.) American Academy of Pediatrics' guidance for Prevention and Treatment of Childhood Overweight and Obesity, (http://www.aap.org/obesity/health_professionals.html), from AAP Policy Statement: *Prevention of Pediatric Overweight and Obesity* and the AAP endorsed Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Children and Adolescent Overweight and Obesity, 2007.

*Target based on 2012 & 2013 Data Trend Table averages.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) #4

Measure: 75%* of eligible** infants and children with client record documentation of enrollment in WIC

Goal: To increase access to nutrition education, breastfeeding support, and healthy food through enrollment in the WIC Nutrition Program

Definition: **Numerator -**
Of those in the denominator, the number of infants and children who, as of the last well child visit during the reporting period, had client record documentation that infant or child was enrolled in WIC.

Denominator -
Unduplicated number of infants and children less than 5 years of age, enrolled in the agency, during the reporting period, who were eligible** for WIC.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**WIC Eligibility Requirements:

- Infants, and children up to their fifth birthday
- Must be income eligible (income guidelines are up to 185% of federal gross income, and are based on family size)

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #5

Measure: 23%* of infants who were exclusively** breastfed for the first three months, at their four month well baby visit

Goal: To provide optimum nutrition to infants in their first three months of life

Definition: **Numerator -**
Of those in the denominator, the number of infants who had client record documentation that the infant had been exclusively breastfed for their first three months when checked at their four month well baby visit.

Denominator -
Number of infants who received one or more visits during or before the reporting period and were seen for a four-month well baby visit during the reporting period.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

Benmarks: 2011 PedNSS (WIC) exclusive at 3 months: NH 22.9%, National (2010) 10.7%
2013 CDC Report Card (NIS, provisional 2010 births): NH 49.5%, National 37.7%
Healthy People 2020 goal: 44%

Rationale: The AAP recommends exclusive breastfeeding for about 6 months, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant, a recommendation concurred to by the World Health Organization and the Institute of Medicine. (American Academy of Pediatrics Policy Statement on Breastfeeding and the Use of Human Milk, 2012)

*Target based on 2012 & 2013 Data Trend Table averages.
**Exclusive means breast milk only, no supplemental formula, cereal/baby food, or water/fluids.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE: ADULT

PERFORMANCE MEASURES DEFINITIONS

State Fiscal Year 2015

Primary Care: Adult Performance Measure #1

Measure:* 58%** of adult patients 18 – 85 years of age diagnosed with hypertension will have a blood pressure measurement less than 140/90*** mm at the time of their last measurement.

Goal: To ensure patients diagnosed with hypertension are adequately controlled.

Definition: **Numerator-** Number of patients from the denominator with blood pressure measurement less than 140/90 mm at the time of their last measurement.

Denominator- Number of patients age 18 – 85 with diagnosed hypertension must have been diagnosed with hypertension 6 or more months before the measurement date. (Excludes pregnant women and patients with End Stage Renal Disease.)

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

*Measure based on the National Quality Forum 0018

**Health People 2020 National Target is 61.2%

***Both the numerator and denominator must be less that 140/90 mm

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE CLINICAL PERFORMANCE MEASURE DEFINITIONS Fiscal Year 2015

Primary Care Clinical Adolescent (PC-C) Performance Measure #1

Measure: 61%* of adolescents aged 11-21 years received an annual health maintenance visits in the past 12 months.

Goal: To enhance adolescent health by assuring annual, recommended, adolescent well -visits.

Definition: **Numerator-**
Number of adolescents in the denominator who received an annual health maintenance "well" visit during the reporting year.

Denominator-
Total number of adolescents aged 11-21 years who were enrolled in the primary care clinic as primary care clients during the reporting year period.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

***Target based on 2012 & 2013 Data Trend Table averages.**

Primary Care Clinical Prenatal (PC-C) Performance Measure #2

Measure: 31%* of women and adolescent girls aged 15-44 take multi-vitamins with folic acid.

Goal: To enhance pregnancy outcomes by reducing neural tube defects.

Definition:

Numerator-
The number of women and adolescent girls aged 15-44 who take a multi-vitamin with folic acid.

Denominator-
The number of women and adolescent girls aged 15-44 who were seen in primary care for a well visit in the past year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

***Target based on 2012 & 2013 Data Trend Table averages.**

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE - FINANCIAL
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Primary Care (PC) Performance Measure #1

Measure: Patient Payor Mix

Goal: To allow monitoring of payment method trends at State funded primary care sites.

Definition: Patients enrolled in Medicare, Medicaid, Commercial insurance, or uninsured.

Data Source: Provided by agency

Primary Care (PC) Performance Measure #2

Measure: Accounts Receivables (AR) Days

Goal: To allow monitoring of financial sustainability trends at State funded primary care sites.

Definition: AR Days: Net Patient Accounts Receivable **multiplied by** 365 **divided by** Net Patient Revenue

Data Source: Provided by agency

Primary Care (PC) Performance Measure #3

Measure: Current Ratio

Goal: To allow monitoring of financial sustainability trends at State funded primary care sites.

Definition: Current Ratio = Current Assets **divided by** Current Liabilities

Data Source: Provided by agency

PRENATAL
PERFORMANCE MEASURES DEFINITIONS
State Fiscal Year 2015

Prenatal (PN) Performance Measure #1

Measure: 85%* of pregnant women who are enrolled in the agency's prenatal program will begin prenatal care during the first trimester of pregnancy.

Goal: To enhance pregnancy outcomes by assuring early entrance into prenatal care.

Definition:

Numerator-
Number of women in the denominator who had a documented prenatal visit during the first trimester (on or before 13.6 weeks gestation).

Denominator-
Number of women enrolled in the agency prenatal program who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

* Target based on 2012 & 2013 Data Trend Table averages.

Prenatal (PN) Performance Measure #2

Measure: 20%* of pregnant women who are identified as cigarette smokers will be referred to QuitWorks-New Hampshire.

Goal: To reduce tobacco use during pregnancy through focused tobacco use cessation activities at public health prenatal clinics.

Definition:

Numerator-
Number of women in the denominator who received at least one referral to QuitWorks-New Hampshire during pregnancy.

A referral is defined as signing the patient up for QuitWorks-NH via phone, fax, or EMR. It is not defined as discussing QuitWorks-NH with the patient and encouraging her to sign up.

Denominator-
Number of women enrolled in the agency prenatal program and identified as tobacco users who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

*Target set in consultation with the NH Tobacco Program & FY13 Data Trend Table average.

Prenatal (PN) Performance Measure #3

Measure: 79%* of pregnant women will be screened, using a formal valid screening tool, for alcohol and other substance use during every trimester they are enrolled in the prenatal program.

Goal: To reduce prenatal substance use through systematic screening and identification.

Definition: **Numerator-** Number of women in the denominator who were screened for substance and alcohol use, using a formal and valid screening tool, during each trimester that they were enrolled in the prenatal program.

Denominator- Number of women enrolled in the agency prenatal program and who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

* Target based on 2012 & 2013 Data Trend Table averages.

Exhibit B-1 (2014) -Amendment 1

Budget

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: Coos County Family Health Services, Inc.

Budget Request for: MCH Primary Care
(Name of RFP)

Budget Period: SFY 2014

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages	$ 18,309.00	$ -	$ 18,309.00	
2. Employee Benefits	$ 6,042.00	$ -	$ 6,042.00	
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	$ -	$ -	$ -	
13. Other (specific details mandatory):	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
TOTAL	**$ 24,351.00**	**$ -**	**$ 24,351.00**	

Indirect As A Percent of Direct 0.0%

Contractor Initials: adw

Date: 3/6/14

Exhibit B-1 (2015) -Amendment 1

Budget

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: Coos County Family Health Services, Inc.

Budget Request for: MCH Primary Care
(Name of RFP)

Budget Period: SFY 2015

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages	$ 99,348.00	$ -	$ 99,348.00	0
2. Employee Benefits	$ 31,792.00	$ -	$ 31,792.00	0
3. Consultants	$ -	$ -	$ -	0
4. Equipment:	$ -	$ -	$ -	0
Rental	$ -	$ -	$ -	0
Repair and Maintenance	$ -	$ -	$ -	0
Purchase/Depreciation	$ -	$ -	$ -	0
5. Supplies:	$ -	$ -	$ -	0
Educational	$ -	$ -	$ -	0
Lab	$ -	$ -	$ -	0
Pharmacy	$ -	$ -	$ -	0
Medical	$ -	$ -	$ -	0
Office	$ -	$ -	$ -	0
6. Travel	$ -	$ -	$ -	0
7. Occupancy	$ -	$ -	$ -	0
8. Current Expenses	$ -	$ -	$ -	0
Telephone	$ -	$ -	$ -	0
Postage	$ -	$ -	$ -	0
Subscriptions	$ -	$ -	$ -	0
Audit and Legal	$ -	$ -	$ -	0
Insurance	$ -	$ -	$ -	0
Board Expenses	$ -	$ -	$ -	0
9. Software	$ -	$ -	$ -	0
10. Marketing/Communications	$ -	$ -	$ -	0
11. Staff Education and Training	$ -	$ -	$ -	0
12. Subcontracts/Agreements	$ 28,545.00	$ -	$ 28,545.00	0
13. Other (specific details mandatory):	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0		$ -	$ -	0
0		$ -	$ -	0
0	$ -	$ -	$ -	0
TOTAL	**$ 159,685.00**	**$ -**	**$ 159,685.00**	0

Indirect As A Percent of Direct 0.0%

Contractor Initials: adw

Date: 3/6/14

State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that COOS COUNTY FAMILY HEALTH SERVICES, INC. is a New Hampshire nonprofit corporation formed December 14, 1979. I further certify that it is in good standing as far as this office is concerned, having filed the return(s) and paid the fees required by law.

In TESTIMONY WHEREOF, I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 5th day of April A.D. 2013

William M. Gardner
Secretary of State

CERTIFICATE OF VOTE/AUTHORITY

I, Betty A. Gosselin, of, Coos County Family Health Services do hereby certify that:

1. I am the duly elected Secretary of Coos County Family Health Services Inc.

2. The following are true copies of two resolutions duly adopted at a meeting of the Board of Directors of the Coos County Family Health Services corporation, duly held on February 21, 2013;

RESOLVED: That this corporation may enter into any and all contracts, amendments, renewals, revisions or modifications thereto, with the State of New Hampshire, acting through its Department of Health and Human Services.

RESOLVED: That the President, Vice-President, Treasurer, or Chief Executive Officer is hereby authorized on behalf of this corporation to enter into said contracts with the State and to execute any and all documents, agreements, and other instruments; and any amendments, revisions, or modifications thereto, as he/she may deem necessary, desirable, or appropriate.

Adele D. Woods is the duly appointed Chief Executive Officer of the corporation.

3. The foregoing resolutions have not been amended or revoked and remain in full force and effect as of March 6, 2014.

IN WITNESS WHEREOF, I have hereunto set my hand as the Secretary of the corporation this 6th day of March, 2014.

Betty A. Gosselin

STATE OF New Hampshire
COUNTY OF Coos

The foregoing instrument was acknowledged before me this 6th day of March, 2014 by Betty A. Gosselin.

Linda Blanchette
Notary Public/Justice of the Peace

My Commission Expires:
LINDA BLANCHETTE, Notary Public
My Commission Expires September 18, 2018

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 2/28/2014

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 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
FIAI/Cross Insurance
1100 Elm Street
Manchester NH 03101

CONTACT NAME: Vivian Vaudreuil
PHONE (A/C, No, Ext): (603) 669-3218 FAX (A/C, No): (603) 645-4331
E-MAIL ADDRESS: vvaudreuil@crossagency.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: Philadelphia Indemnity Ins Co	18058
INSURER B: Philadelphia Ins Co	
INSURER C: MEMIC Indemnity Company	11030
INSURER D:	
INSURER E:	
INSURER F:	

INSURED
Coos County Family Health Services, Inc
133 Pleasant Street
Berlin NH 03570-2006

COVERAGES CERTIFICATE NUMBER: 13-14 All lines 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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY; X COMMERCIAL GENERAL LIABILITY; CLAIMS-MADE; X OCCUR; GEN'L AGGREGATE LIMIT APPLIES PER: POLICY; PRO-JECT; X LOC			PHPK1043047	7/1/2013	7/1/2014	EACH OCCURRENCE	$ 1,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 1,000,000
							MED EXP (Any one person)	$ 20,000
							PERSONAL & ADV INJURY	$ 1,000,000
							GENERAL AGGREGATE	$ 2,000,000
							PRODUCTS - COMP/OP AGG	$ 2,000,000
								$
A	AUTOMOBILE LIABILITY; X ANY AUTO; ALL OWNED AUTOS; SCHEDULED AUTOS; HIRED AUTOS; NON-OWNED AUTOS			PHPK1043047	7/1/2013	7/1/2014	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
							Uninsured motorist BI-single	$ 1,000,000
B	X UMBRELLA LIAB; X OCCUR; EXCESS LIAB; CLAIMS-MADE; DED; X RETENTION $ 10,000			PHUB426898	7/1/2013	7/1/2014	EACH OCCURRENCE	$ 2,000,000
							AGGREGATE	$ 2,000,000
								$
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N; ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) N; If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		3102802240 (3a.) NH All officers included	7/1/2013	7/1/2014	X WC STATU-TORY LIMITS; OTH-ER	
							E.L. EACH ACCIDENT	$ 1,000,000
							E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000
B	Employee Dishonesty			PHSD843661	7/1/2013	7/1/2014	Limit	1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
The certificate holder is included as additional insured with respects to the CGL as per written contract. Refer to policy for exclusionary endorsements and special provisions.

CERTIFICATE HOLDER

NH DHHS
Contracts and Procurement Unit
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
Dwayne Davis/JSC

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COOS COUNTY FAMILY HEALTH SERVICES, INC.

AUDITED FINANCIAL STATEMENTS

JUNE 30, 2013 AND 2012

BRAD BORBIDGE, P.A.
CERTIFIED PUBLIC ACCOUNTANTS
197 LOUDON ROAD, SUITE 350
CONCORD, NEW HAMPSHIRE 03301

TELEPHONE 603/224-0849
FAX 603/224-2397

Independent Auditor's Report on Financial Statements

Board of Directors
Coos County Family Health Services, Inc.
Berlin, New Hampshire

We have audited the accompanying financial statements of Coos County Family Health Services, Inc. as of June 30, 2013 and 2012 , the related statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the 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 entity'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 financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of of Coos County Family Health Services, Inc. as of June 30, 2013 and 2012, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The accompanying schedule of expenditures of federal awards is presented for purposes of additional analysis as required by U.S. Office of Management and Budget Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations, and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the schedule of expenditures of federal awards is fairly stated in all material respects in relation to the financial statements as a whole.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards,* we have also issued our report dated August 15, 2013, on our consideration of the Association's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and important for assessing the results of our audit.

Concord, New Hampshire
August 15, 2013

COOS COUNTY FAMILY HEALTH SERVICES, INC.

BALANCE SHEETS

JUNE 30, 2013 AND 2012

ASSETS

	2013	2012
Current Assets		
Cash and cash equivalents	$ 310,353	$ 905,538
Patient accounts receivable, net of allowances of for uncollectible accounts of $195,000 and $187,000 at June 30, 2013 and 2012, respectively	435,123	376,734
Grants receivable	242,150	247,547
Due from third party payers	31,737	41,000
Prepaid expenses	102,267	62,585
Total Current Assets	1,121,630	1,633,404
Assets Limited As To Use	625,069	632,742
Beneficial Interest In Perpetual Trust Held By Others	18,274	-
Property And Equipment, Net	2,100,494	2,236,926
TOTAL ASSETS	$ 3,865,467	$ 4,503,072

LIABILITIES AND NET ASSETS

	2013	2012
Current Liabilities		
Accounts payable and accrued expenses	$ 83,220	$ 63,477
Accrued payroll and related expenses	680,503	653,282
Due to third party payers	21,057	-
Deferred revenue	60,282	793,834
Current maturities of long-term debt	79,892	83,683
Total Current Liabilities	924,954	1,594,276
Long-term Debt, Less Current Maturities	902,002	983,580
Total Liabilities	1,826,956	2,577,856
Net Assets		
Unrestricted	1,153,541	871,052
Temporarily restricted	864,280	1,035,587
Permanently restricted	20,690	18,577
Total Net Assets	2,038,511	1,925,216
TOTAL LIABILITIES AND NET ASSETS	$ 3,865,467	$ 4,503,072

(See accompanying notes to these financial statements)

COOS COUNTY FAMILY HEALTH SERVICES, INC.

STATEMENTS OF OPERATIONS

FOR THE YEARS ENDED JUNE 30, 2013 AND 2012

	2013	2012
Operating Revenue		
Patient service revenue	$ 5,817,776	$ 5,442,467
Provision for bad debts	(269,804)	(286,208)
Net patient service revenue	5,547,972	5,156,259
Grants, contracts, and contributions	2,712,601	2,717,539
Other operating revenue	466,133	245,330
Interest income	3,134	4,054
Net assets released from restrictions for operations	219,146	216,967
Total Operating Revenue	8,948,986	8,340,149
Operating Expenses		
Salaries and benefits	6,688,068	6,443,676
Other operating expenses	1,707,879	1,560,124
Depreciation	227,921	237,004
Interest expense	42,629	41,447
Total Operating Expenses	8,666,497	8,282,251
EXCESS OF REVENUE OVER EXPENSES AND INCREASE IN UNRESTRICTED NET ASSETS	$ 282,489	$ 57,898

(See accompanying notes to these financial statements)

COOS COUNTY FAMILY HEALTH SERVICES, INC.

STATEMENTS OF CHANGES IN NET ASSETS

FOR THE YEARS ENDED JUNE 30, 2013 AND 2012

	2013	2012
Unrestricted Net Assets:		
Excess of revenue over expenses and increase in unrestricted net assets	$ 282,489	$ 57,898
Temporarily Restricted Net Assets:		
Grants, contracts, and contributions	47,035	66,026
Net assets released from restrictions for operations	(219,146)	(216,967)
Capital appreciation (depreciation) on endowment funds	530	(173)
Change in fair value of beneficial interest in perpetual trust held by others	274	-
Change in Temporarily Restricted Net Assets	(171,307)	(151,114)
Permanently Restricted Net Assets:		
Contributions	2,113	1,657
Change in Permanently Restricted Net Assets	2,113	1,657
Change in Net Assets	113,295	(91,559)
Net Assets, Beginning of Year	1,925,216	2,016,775
NET ASSETS, END OF YEAR	$ 2,038,511	$ 1,925,216

(See accompanying notes to these financial statements)

COOS COUNTY FAMILY HEALTH SERVICES, INC.

STATEMENTS OF CASH FLOWS

FOR THE YEARS ENDED JUNE 30, 2013 AND 2012

	2013	2012
Cash Flows From Operating Activities		
Change in net assets	$ 113,295	$ (91,559)
Adjustments to reconcile change in net assets to net cash (used) provided by operating activities		
Bad debt expense	269,804	286,208
Depreciation	227,921	237,004
Restricted grants, contracts, and contributions	(49,148)	(67,683)
Capital (appreciation) depreciation on endowment funds	(530)	173
Change in fair value of beneficial interest in perpetual trust held by others	(274)	-
(Increase) decrease in the following assets:		
Patient accounts receivable	(328,193)	(245,272)
Grants receivable	5,397	(118,087)
Due from third party payers	9,263	407
Prepaid expenses	(39,682)	22,184
Increase (decrease) in the following liabilities:		
Accounts payable and accrued expenses	19,743	(67,482)
Accrued payroll and related expenses	27,221	(174)
Due to third party payers	21,057	-
Deferred revenue	(733,552)	793,834
Net Cash (Used) Provided by Operating Activities	(457,678)	749,553
Cash Flows From Investing Activities		
Decrease in assets limited as to use	57,351	46,990
Increase in beneficial interest in perpetual trust held by others	(18,000)	-
Capital acquisitions	(91,489)	(373,763)
Net Cash Used by Investing Activities	(52,138)	(326,773)
Cash Flows From Financing Activities		
Proceeds from issuance of long-term debt	-	290,000
Payments on long-term debt	(85,369)	(97,475)
Net Cash (Used) Provided by Financing Activities	(85,369)	192,525

COOS COUNTY FAMILY HEALTH SERVICES, INC.
STATEMENTS OF CASH FLOWS (CONTINUED)
FOR THE YEARS ENDED JUNE 30, 2013 AND 2012

	2013	2012
Net (Decrease) Increase in Cash and Cash Equivalents	(595,185)	615,305
Cash and Cash Equivalents, Beginning of Year	905,538	290,233
CASH AND CASH EQUIVALENTS, END OF YEAR	$ 310,353	$ 905,538
Supplemental Disclosures of Cash Flow Information:		
Cash paid for interest	$ 42,629	$ 41,447

(See accompanying notes to these financial statements)

54 Willow Street
Berlin, NH 03570-1800
Ph: 1-603-752-3669
Fax: 1-603-752-3027

2 Broadway Street
Gorham, NH 03581-1597
Ph: 1-603-466-2741
Fax: 1-603-466-2953

133 Pleasant Street
Berlin, NH 03570-2006
Ph: 1-603-752-2040
Fax 1-603-752-7797

59 Page Hill Road
Berlin, NH 03570-3568
Ph: 1-603-752-2900
Fax: 1-603-752-3727

BOARD OF DIRECTORS

Robert Pelchat, 2014 (4th)
PRESIDENT

Roland Olivier, (1st)

Joan Merrill, 2016 (2nd)
VICE-PRESIDENT

Aline Boucher, 2014 (2nd)
TREASURER
Chair, Finance/Development Committee

Betty A. Gosselin, MSW, 2016 (3rd)
SECRETARY

Marge McClellan, 2014 (4th)
Chair, Governance Committee
Chair, Quality Improvement Committee

Åsa Brosnan, 2015 (4th)

H. Guyford Stever, Jr., 2016 (2nd)
Chair, Personnel Committee

Linda Sjostrom, 2015 (1st)

Jeffrey D. Smith, 2015 (1st)
Chair, Corporate Compliance Committee

Andrea Gagne, 2016 (1st)

Charles Greenhalgh, (1st)

(Board List) 2/14

MISSION OF
COÖS COUNTY FAMILY HEALTH SERVICES

Coös County Family Health Services is a community-based organization providing innovative, personalized, comprehensive health care and social services of the highest quality to everyone, regardless of economic status.

VISION OF
COÖS COUNTY FAMILY HEALTH SERVICES

We envision CCFHS as

1) providing high quality medical, dental, and social services to area residents without discrimination;
2) meeting the growing needs of our community by appropriately expanding and developing programs, staff and facilities;
3) an organization with highly committed staff working together as a team to realize our goals;
4) meeting the growing needs of our team by providing optimum staffing levels, training and compensation;
5) a financially stable organization having the ability to thrive in an era of technological and economic changes in the health care industry; and
6) a vital member of the community network providing comprehensive health care including prevention, education and social services.

(Mission/Vision Statement)
Board Approved 1/16/14

KEY ADMINISTRATIVE PERSONNEL

NH Department of Health and Human Services

Contractor Name: Coos County Family Health Services, Inc.

Name of Bureau/Section: MCH Primary Care

BUDGET PERIOD: SFY 14

Program Area: MCH Primary Care

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Adele Woods	CEO	$130,000	0.00%	$0.00
Patricia Couture	COO	$95,000	0.00%	$0.00
Melissa Frenette	CFO	$90,000	0.00%	$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$0.00**

KEY ADMINISTRATIVE PERSONNEL

NH Department of Health and Human Services

Contractor Name: Coos County Family Health Services, Inc.

Name of Bureau/Section: MCH Primary Care & BCCP

BUDGET PERIOD: SFY 15

Program Area: MCH Primary Care Services

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Adele Woods	CEO	$140,000	0.00%	$0.00
Patricia Couture	COO	$105,000	0.00%	$0.00
Melissa Frenette	CFO	$100,000	0.00%	$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$0.00**

Program Area: Breast and Cervical Cancer Program Services

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Adele Woods	CEO	$140,000	0.00%	$0.00
Patricia Couture	COO	$105,000	0.00%	$0.00
Melissa Frenette	CFO	$100,000	0.00%	$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$0.00**

Program Area: Rural Health and Primary Care Services

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Adele Woods	CEO	$140,000	0.00%	$0.00
Patricia Couture	COO	$105,000	0.00%	$0.00
Melissa Frenette	CFO	$100,000	0.00%	$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$0.00**

ADELE D. WOODS

PROFESSIONAL HISTORY

1981–Present Coos County Family Health Services, 54 Willow Street, Berlin, NH 03570
(603)752-3669 ext. 4018 awoods@ccfhs.org

Chief Executive Officer (1989 – Present)
Responsible for the successful administration and overall direction of a $9.2M Community Health Center, including 6 sites and 10 programs. Major administrative responsibilities include: oversight of budget preparation and fiscal management, development and implementation of long and short-term planning, personnel management, grantsmanship and public relations. Includes extensive contact with the public and government officials as well as ongoing communications with 15 member volunteer Board of Directors, 120 paid staff and numerous volunteers.

Coordinator: Prenatal, Child Health and Family Planning Programs (4/1987 – 4/1989)
Health Educator – Child Health Program (12/1986 – 4/1989)
Director of Programs (10/1983 – 4/1987)
Coordinator, WIC Program (8/1981 – 10/1983)

1979–1981 *Fiscal Manager,* White Mountains Center for the Arts, Bretton Woods, NH 03575
Supervised 2-10 employees. Responsible for all accounting and bookkeeping functions for $300,000 annual budget non-profit organization. Performed all functions necessary for the procurement of grant monies from public and private sources. Oversaw public relations and advertising campaigns.

1972–1974 *Credit Manager*, Littleton Hospital, Littleton, NH 03561

EDUCATION

1996-1997 Springfield College, Human Services Administration, MS
1981-Present Workshops and conferences at the local, State and National level pertinent to work at CCFHS, including Supervision, Provider Recruitment, Legislative Updates, Grants Management, Corporate Compliance
1970-1971 Graduate Studies, University of Delaware, American Studies
1967-1970 University of Delaware, American Studies, BA/Honors

MEMBERSHIPS AND AFFILIATIONS

2007-Present Assistant Coach, White Mountains Regional High School Golf Team
2005-Present President, Waumbek Dollars for Scholars
2000-2010 Advisory Council, Endowment for Health
1999-Present Member, Androscoggin Valley Community Partners (Currently Chair)
1998-Present Member Bi-State Primary Care Association (Past President)
1998-2009 Advisory Council, Child and Family Services
1998-Present Member, National Association of Community Health Centers (Committee Memberships: Rural Health and Elderly)
1998-Present Member, Jefferson Historical Society (Treasurer since 2000)
1997-Present Board Member, North County Health Consortium (5 years as President)
1995-Present Volunteer, RESPONSE to Sexual and Domestic Violence
2011-Present Advisory Board, NH Charitable Foundation, Northern Region
2012-Present Advisory Board, White Mountains Community College
1980-2004 Trustee, Town of Jefferson Public Library

HONORS AND AWARDS

2007 – NH Governor's Citation for work with Coos County Family Health Services
2004 – Androscoggin Valley Economic Recovery Corporation "Citizen of the Year"
2002 – United Way "Community Champion"
1996 – RESPONSE to Sexual and Domestic Violence "Volunteer of the Year"
1996 – New England Community Health Center Association "Outstanding Executive Director"
1994 – Walter J. Dunfey "Excellence in Management" Corporate Fund Award

Patricia A. Couture
pcouture@ccfhs.org

Work History

1983- Present Coos County Family Health Services, Berlin, NH.

1991- Present: Chief Operating Officer/RN: Responsible for the day-to-day administration and overall activities of the clinical services in conjunction with the Medical Director and Chief Executive Officer. Major administrative responsibilities include: implement and monitor quality improvement programs; hire, train, supervise and evaluate employees; assist Chief Executive Officer with grant proposals; assist Medical Director with clinical policies and guidelines; perform medical record audits; implement all clinical schedules, and be familiar with all outpatient nursing functions. Responsible for the overall direction, coordination and evaluation of Nursing, Medical Records, Pharmacy, Medical Support, Laboratory and Maintenance Services.

2011- Present: Corporate Compliance Officer: Responsible for the operation and management of the Compliance Program and reports to the CEO and Board of Directors.

1986-1991 Site Coordinator: Responsible for the coordination and evaluation of three programs: Family Planning/Women's Health, Sexually Transmitted Diseases, and HIV Counseling and Testing in three communities - Berlin, Lancaster and Colebrook. Administrative responsibilities included: trained, supervised and evaluated employees; assisted Executive Director with agency policies, procedure and protocols; and provided community education. Clinical responsibilities included: patient counseling, education, follow-up, documentation, laboratory services, referrals and nursing functions/procedures.

1983-1986 Clinical Nurse/Counselor: Responsible for outpatient clinical services and Family Planning/Women's Health counseling services.

1976-1983 St. Vincent de Paul Nursing Home, Berlin, NH.
LPN Charge Nurse: Nursing responsibilities included: responsible for 29 residents, supervised nurse's aides, prepared verbal/written reports, administration of medication, complete nursing care, transcribed physician orders, and documentation; nursing process, assessment, nursing diagnosis, care plan, outpatient goals, outcomes and nursing interventions.

1976-1977 Androscoggin Valley Hospital Berlin, NH
Private Duty Nurse: Complete nursing care.

Education:

Granite State College
Bachelor of Science in Healthcare Administration, 2007 December
Member of Alpha Sigma Lambda National Honor Society
New Hampshire Technical College, Berlin, NH
Associate Nursing Degree, 1989 (May)
Member of Phi Theta Kappa Honor Society
New Hampshire Vocational Technical College, Berlin, NH
Practical Nursing Diploma, 1976 (June) - Graduated with Honors
Berlin High School, Berlin, NH - Graduated 1975

License:

New Hampshire Board of Nursing, Concord, NH
Registered Nurse License, 1990 (July)
Practical Nurse License, 1976 (October)

Continued Education:

Nursing and Management Workshops, Seminars, National Conferences and Lectures.

MELISSA M FRENETTE, CPA

FUNCTIONAL SUMMARY

Certified Public Accountant with over twelve years of experience in public accounting. Experienced in training and supervising staff, managing multiple on-going engagements and facilitating timely income tax filing and reporting for firm clients.

EMPLOYMENT

2007-Present Coos County Family Health Services Berlin, NH
Chief Financial Officer

Oversee the general operation of the Finance and Purchasing Departments
Analyzes available data and suggests way to improve agency's self sufficiency
Prepares budgets, reports and studies for CCFHS and all funding sources
Takes a leadership role in the annual financial audit
Performs employee evaluations and assigns tasks as appropriate
Attends applicable board and committee meetings
Possesses a through working knowledge of cost reporting requirements

2004-2007 Malone, Dirubbo & Company/Phillips & AssociatesLincoln, NH
Senior Staff Accountant

Conducted financial statement audits for multiple entities
Prepared audited, reviewed, and compiled financial statements
Compiled and prepared loan package information
Consulted in business entity choices
Prepared personal and business income tax returns
Prepared personal and business income tax projections
Prepared projected financial statements and cash flows
Consulted in inventory cost methods
Trained clients in use of accounting software

1995-2004 Driscoll & Company, PLLC Berlin, NH
Senior Staff Accountant/ Office Manager

Supervised and trained office staff members
Managed work flow for deadline achievement
Installed and maintained accounting and tax software
Prepared audited, reviewed, and compiled financial statements
Prepared payroll tax returns
Conducted 401(K) plan audits and financial statements

EDUCATION

1992-1995 Plymouth State University Plymouth, NH
B.S. Accounting, minor Mathematics
Graduated cum laude

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

29 HAZEN DRIVE, CONCORD, NH 03301-6527
603-271-4517 1-800-852-3345 Ext. 4517
Fax: 603-271-4519 TDD Access: 1-800-735-2964

Nicholas A. Toumpas
Commissioner

José Thier Montero
Director

May 1, 2012

His Excellency, Governor John H. Lynch
and the Honorable Executive Council
State House
Concord, New Hampshire 03301

APPROVED F/C
DATE
APPROVED G&C #130
DATE 6/20/12
NOT APPROVED

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Public Health Services, Bureau of Population Health and Community Services, Maternal and Child Health Section, to enter into an agreement with Coos County Family Health Services, Inc. (Vendor #155327-B001), 54 Willow Street, Berlin, New Hampshire 03570, in an amount not to exceed $243,106.00, to provide primary care services and breast and cervical cancer screening, to be effective July 1, 2012 or date of Governor and Executive Council approval, whichever is later, through June 30, 2014. Funds are available in the following accounts for SFY 2013, and are anticipated to be available in SFY 2014 upon the availability and continued appropriation of funds in the future operating budgets.

05-95-90-902010-5190 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES, MATERNAL AND CHILD HEALTH

Fiscal Year	Class/Object	Class Title	Job Number	Total Amount
SFY 2013	102-500731	Contracts for Program Services	90080000	$81,519
SFY 2014	102-500731	Contracts for Program Services	90080000	$81,519
			Sub-Total	$163,038

05-95-90-901010-5149 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF PUBLIC HEALTH SYSTEMS, POLICY AND PERFORMANCE, RURAL HEALTH AND PRIMARY CARE

Fiscal Year	Class/Object	Class Title	Job Number	Total Amount
SFY 2013	102-500731	Contracts for Program Services	90073001	$10,000
SFY 2014	102-500731	Contracts for Program Services	90073001	$10,000
			Sub-Total	$20,000

05-95-90-902010-5659 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES, COMPREHENSIVE CANCER

Fiscal Year	Class/Object	Class Title	Job Number	Total Amount
SFY 2013	102-500731	Contracts for Program Services	90080081	$30,034
SFY 2014	102-500731	Contracts for Program Services	90080081	$30,034
			Sub-Total	$60,068
			Total	$243,106

EXPLANATION

Funds in this agreement will be used to provide breast and cervical cancer screening and office-based primary care services for low-income and uninsured families. This agreement provides funds for services as a last resort; contractor is required to make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid.

Primary health care services include preventive and episodic health care for acute and chronic health conditions for people of all ages, including pregnant women, children, adolescents, adults, and the elderly. Community health agencies that receive support through the Division of Public Health Services deliver primary and preventive health care services to underserved people who face barriers to accessing health care, due to issues such as a lack of insurance, inability to pay, language barriers, and geographic isolation. In addition to medical care, community health centers are unique among primary care providers for the array of patient-centered services they offer, including care coordination, translation, transportation, outreach, eligibility assistance, and health education. These services help individuals overcome barriers to getting the care they need and achieving their optimal health. One area of particular success has been in ensuring that eligible families maintain consistent enrollment in Medicaid for their children. Community health centers provide support for families in filling out applications and ensuring that children have continuity of care.

Community health agencies throughout New Hampshire have demonstrated success in meeting the health care needs of the uninsured and under-insured citizens of the state. Division of Public Health Services funded primary care providers participate in rigorous quality improvement efforts utilizing standard performance measures that focus attention on improving health outcomes for patients. For example, in State Fiscal Year 2011:

- 88% of eligible children served were enrolled in Medicaid/Healthy Kids Gold.
- 86% of children 24-35 months, served received the appropriate schedule of immunizations.
- 82% of infants born to women served received prenatal care beginning in the first trimester of pregnancy.

In addition, breast and cervical cancers continue to be ongoing public health issues for New Hampshire. The Division of Public Health Services, Breast and Cervical Cancer Screening Program provides support for breast and cervical cancer screening services that include clinical examinations, pap smears and referral for mammography. Through this program, women found to have abnormal screening results, following their testing,

receive additional coverage for diagnostic work-up and, if necessary, have their care coordinated through the initiation of treatment.

Should Governor and Executive Council not authorize this Request, a minimum of 8,350 low-income individuals from the Coos area may not have access to primary care services, and eligible women may not receive recommended breast and cervical cancer screenings. A strong primary care infrastructure reduces costs for uncompensated care, improves health outcomes, and reduces health disparities. Additionally women that receive recommended breast and cervical cancer screenings are at lower risk of late diagnosis of breast and cervical cancers.

Coos County Family Health Services, Inc. was selected for this project through a competitive bid process. A Request for Proposals was posted on the Department of Health and Human Services' web site from January 10, 2012 through February 16, 2012. In addition, a bidder's conference, conference call, and web conference were held on January 19, 2012 to alert agencies to this bid.

Thirteen proposals were received in response to the posting. Each proposal was scored by three professionals, who work internal and external to the Department of Health and Human Services. All reviewers have between three to twenty years experience either in clinical settings, providing community-based family support services, and managing agreements with vendors for various public health programs. Areas of specific expertise include maternal and child health; quality assurance and performance improvement; chronic and communicable diseases and public health infrastructure. The reviewers used a standardized form to score agencies' relevant experience and capacity to carry out the activities outlined in the proposal. Reviewers look for realistic targets when scoring performance measures in addition to detailed workplans including evaluation components. Budgets were reviewed to be reasonable, justified and consistent with the intent of the program goals and outcomes. There were no competing applications within each of the separate service areas. Scores were averaged and all proposals were recommended for funding. In those instances where scores were less than ideal, agency specific remedial actions were recommended and completed. Some primary care agencies are being funded at levels higher than they requested. Agencies were instructed to develop budgets based on previous allocations. While some proposed budgets higher than what was available for funding, others proposed budgets lower than what was available. There was an increase in breast and cervical cancer screening that bidders were unaware of when they drafted budgets. Adjustments were made accordingly for those agencies that proposed budgets at levels lower than available funds. This is a contract where that situation occurred. The Bid Summary is attached.

As referenced in the Request for Proposals, Renewals Section, this competitively procured Agreement has the option to renew for two additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties and approval of the Governor and Executive Council. These services were contracted previously with this agency in SFY 2011 and SFY 2012 in the amount of $360,016. This represents a decrease of $116,910. The decrease is due to budget reductions.

The performance measures used to measure the effectiveness of the agreement are attached.

Area served: Berlin, Dummer, Errol, Gorham, Milan, Randolph and Shelburne.

Source of Funds: 39.72% Federal Funds from US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau and 60.28% General Funds.

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

Respectfully submitted,

José Thier Montero, MD
Director

Approved by:
Nicholas A. Toumpas
Commissioner

JTM/PMT/sc

Primary Care Performance Measures

State Fiscal Year 2013

Primary Care Prenatal (PN) Performance Measure #1

Measure: Percent of infants born to women receiving prenatal care beginning in the first trimester of pregnancy.

Primary Care Prenatal (PN) Performance Measure #2

Measure: Percent of pregnant women identified as cigarette smokers that are referred to QuitWorks-New Hampshire.

Primary Care Prenatal (PN) Performance Measure #3

Measure: Percent of pregnant women who were screened, using a formal valid screening tool, for alcohol and other drug use during every trimester the patient was enrolled.

Primary Care Child Health Direct (CH – D) Performance Measure #1

Measure: Percent of eligible children enrolled in Medicaid

Primary Care Child Health Direct (CH – D) Performance Measure #2

Measure: Percent of at-risk children who were screened for blood lead between 18 and 30 months of age

Primary Care Child Health Direct (CH – D) Performance Measure #3

Measure: Percent of children age two to nineteen years receiving primary care preventive health services with a Body Mass Index (BMI) percentile greater than or equal to the 85th percentile with documented discussion of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Primary Care Child Health Direct (CH – D) Performance Measure #4

Measure: Percent of eligible infants and children with client record documentation of enrollment in Women Infant Children Program.

Primary Care Child Health Direct (CH – D) Performance Measure #5

Measure: Percent of infants who were exclusively breastfed for the first three months, at their four month well baby visit.

Primary Care Financial (PC) Performance Measure #1

Measure: Patient Payor Mix

Primary Care Financial (PC) Performance Measure #2

Measure: Accounts Receivables (AR) Days

Primary Care Financial (PC) Performance Measure #3

Measure: Current Ratio

Primary Care Performance Measures

State Fiscal Year 2013

Primary Care Clinical Adolescent (PC-C) Performance Measure #1

Measure: Percent of adolescents aged 10-21 years who received annual health maintenance visits in the past 12 months.

Primary Care Clinical Prenatal (PC-C) Performance Measure #2

Measure: Percent of women and adolescent girls aged 15-44 who take a multi-vitamin with folic acid.

FORM NUMBER P-37 (version 1/09)

Subject: Primary Care Services

AGREEMENT

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

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name NH Department of Health and Human Services Division of Public Health Services		**1.2 State Agency Address** 29 Hazen Drive Concord, NH 03301-6504	
1.3 Contractor Name Coos County Family Health Services, Inc.		**1.4 Contractor Address** 54 Willow Street Berlin, New Hampshire 03570	
1.5 Contractor Phone Number 603-752-3669	**1.6 Account Number** 010-090-5190-102-500731 010-090-5149-102-500731 010-090-5659-102-500731	**1.7 Completion Date** June 30, 2014	**1.8 Price Limitation** $243,106
1.9 Contracting Officer for State Agency Joan H. Ascheim, Bureau Chief		**1.10 State Agency Telephone Number** 603-271-4501	
1.11 Contractor Signature Adele Woods		**1.12 Name and Title of Contractor Signatory** Adele Woods, Chief Executive Officer	
1.13 Acknowledgement: State of NH, **County of** Coos On 3/26/12 before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.			
1.13.1 Signature of Notary Public or Justice of the Peace [Seal] Linda Blanchette LINDA BLANCHETTE, Notary Public My Commission Expires September 17, 2013			
1.13.2 Name and Title of Notary or Justice of the Peace Linda Blanchette, Notary Public			
1.14 State Agency Signature [signature]		**1.15 Name and Title of State Agency Signatory** Joan H. Ascheim, Bureau Chief	
1.16 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)* By:		Director, On:	
1.17 Approval by the Attorney General (Form, Substance and Execution) By: Jeanne P. Herrick, Attorney		On: 8 May 2012	
1.18 Approval by the Governor and Executive Council By:		On:	

NH Department of Health and Human Services

Exhibit A

Scope of Services

Primary Care Services

CONTRACT PERIOD: July 1, 2012 or date of G&C approval, whichever is later, through June 30, 2014

CONTRACTOR NAME: Coos County Family Health Services, Inc.

ADDRESS: 54 Willow Street
Berlin, New Hampshire 03570
Chief Executive Officer: Adele Woods
TELEPHONE: 603-752-3669

<u>The Contractor shall:</u>

I. <u>General Provisions</u>

A) Eligibility and Income Determination

1. Office-based primary care services will be provided to low-income individuals and families (defined as ≤ 185% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), in the State of New Hampshire.

2. Breast and Cervical Cancer screening services will be provided to low-income (defined as ≤ 250% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), New Hampshire women age 18 – 64, *<u>uninsured or underinsured</u>*.

3. The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing if, at any time, the practice is closed to new patients, or maintains a wait list for new patients, or any other mechanism is used that limits access for new patients for more than a one month period.

4. The Contractor shall document annually, for each client enrolled in the program, family income and family size, and calculate percentage of the federal poverty level. If calculations indicate that the client may be eligible for enrollment in Medicaid, the Contractor shall complete with the client the most recent version of the 800P form.

5. The Contractor shall implement, and post in a public and conspicuous location, a sliding fee payment schedule, approved in advance by the Division of Public Health Services (DPHS), for low-income patients. Signage must state that no client will be denied services for inability to pay.

   a. As an alternative, the contractor may post, in a public and conspicuous location, a notice to clients that a sliding fee scale is available and that no client will be denied services for inability to pay. The sliding fee scale must be updated annually based on USDHHS Poverty guidelines as published in the Federal Register, submitted to and approved by DPHS *<u>prior to implementation.</u>*

6. The primary care contract entered into here shall be the payer of last resort. The contractor shall make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid, for all reimbursable services rendered.

Contractor Initials: [signature]
Date: 3/26/12

B) Numbers Served

1. The contract funds shall be expended to provide the above services to a minimum of 4,000 users annually with 12,000 medical encounters, as defined in the Data and Reporting Requirements. Breast and Cervical Cancer Screening for eligible women, as defined by the Breast and Cervical Cancer Program (BCCP), shall be provided to 175 women annually and billed directly to the BCCP. Clinical service reimbursements shall not exceed the Medicare rate.

C) **Culturally and Linguistically Appropriate Standards of Care**

The Department of Health and Human Services (DHHS) recognizes that culture and language have considerable impact on how consumers access and respond to public health services. Culturally and linguistically diverse populations experience barriers in efforts to access health services. To ensure equal access to quality health services, the Division of Public Health Services (DPHS) expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.

2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.

3. *Provide* clients of limited English proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.

4. Offer consumers a forum through which clients have the opportunity to provide feedback to providers and organizations regarding cultural and linguistic issues that may deserve response.

5. The contractor shall maintain a program policy that sets forth compliance with Title VI, Language Efficiency and Proficiency Citation 45 CFR 80.3(b) (2). The policy shall describe the way in which the items listed above were addressed and shall indicate the circumstances in which interpretation services are provided and the method of providing service (e.g. trained interpreter, staff person who speaks the language of the client, language line).

D) **State and Federal Laws**

The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. The Contractor shall report all cases of communicable diseases according to New Hampshire RSA 141-C and He-P 301, adopted 6/3/08.

2. Persons employed by the contractor shall comply with the reporting requirements of New Hampshire RSA 169:C, Child Protection Act; RSA 161:F46, Protective Services to Adults, RSA 631:6, Assault and Related Offences and RSA 130:A, Lead Paint Poisoning and Control.

3. Immunizations shall be conducted in accordance with RSA 141-C and the Immunization Rules promulgated hereunder.

E) **Relevant Policies and Guidelines**

1. The Contractor shall design and provide the services described above to meet the unique and identified health needs of the populations within the contracted service area.

Contractor Initials: CLW
Date: 2/26/12

2. Primary Care funds shall be targeted to populations in need. Populations in need are defined as follows:

   a) uninsured;

   b) under-insured;

   c) families and individuals with significant psychosocial and economic risk, including low income status;

   d) all life cycles including perinatal, child, adolescent, adult, and elderly who meet one or more of the above criteria.

3. The Contractor shall design and implement systems of governance, administration, financial management, information management, and clinical services which are adequate to assure the provision of contracted services, and to meet the data and reporting requirements. These systems shall meet the most current minimum standards described in at least one of the following: Health Resources and Services Administration (HRSA) Office of Performance Review protocols, Joint Commission on Accreditation of Health Care Organizations (JCAHO), Accreditation Association for Ambulatory Healthcare (AAAHC), Community Health Accreditation Program (CHAP), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey.

4. *The Contractor shall have an agency emergency preparedness and response plan in accordance with HRSA Health Center Emergency Management Program Expectations, Document #2007-15 or most recent version. Such plan shall also include a Continuity of Operations plan.*

5. The Contractor shall carry out the work as described in the performance Workplan submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

6. No Workplan is required by the Breast and Cervical Cancer Program (BCCP). The contractor shall be required to respond to the Quality Improvement Feedback Report twice a year.

7. The Contractor shall carry out the work as described in the Supplemental Funding Form submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

F) Publications Funded Under Contract

1. The DHHS and/or its funders will retain COPYRIGHT ownership for any and all original materials produced with DHHS contract funding, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports.

2. All documents (written, video, audio, *electronic*) produced, reproduced, or purchased under the contract shall have prior approval from DPHS before printing, production, distribution, or use.

3. The Contractor shall credit DHHS on all materials produced under this contract following the instructions outlined in Exhibit C (14).

G) Subcontractors

1. If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing *and approve the subcontractual agreement,* prior to initiation of the subcontract.

Contractor Initials: [illegible]
Date: 3/26/12

2. In addition, the original DPHS contractor will remain liable for all requirements included in this Exhibit and carried out by subcontractors.

II. Minimal Standards of Core Services

A) Service Requirements

1. *Medical Home*

The Contractor shall provide a Medical Home that:

a) *Facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family.*

b) ***Provides care facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.***

2. Primary Care Services

The Contractor shall provide office-based primary care services to populations in need who reside in the contractor's service area. Primary care services shall include:

a) Health care provided by a New Hampshire licensed MD, DO, APRN, or PA, including diagnosis and treatment of acute and chronic illnesses within the scope of family practice; preventive services, screenings, and health education according to established, documented state or national guidelines; assessment of need for social and nutrition services, and appropriate referrals to health, *oral health*, and behavioral health specialty providers.

b) ***Referral to the WIC Nutrition Program for all eligible pregnant women, infants and children.***

c) In-hospital care for conditions within the scope of family practice must be provided at a hospital, within the agency service area, through a staff clinician with full hospital privileges, or in the alternative, through a formal referral and admissions procedure available to clients on a 24 hour/7 day a week basis.

d) Access to a healthcare provider, directly or by referral or subcontract, by telephone twenty-four hours per day, seven days per week.

e) Assessment of psychosocial risk for all clients at least annually and for children at scheduled preventive care visits, including, at a minimum, age appropriate assessment of safety in the home, domestic violence, adequacy of food and housing, care and welfare of children, transportation needs, and provision of necessary social services to address the priority needs and safety issues of clients and families.

f) Falls prevention screening for patients 65 years and older using the algorithm and guidelines of the American Geriatrics Society.

g) Behavioral health care directly or by referral to an agency or provider with a sliding fee scale.

h) *Nutrition assessment for all clients as part of the health maintenance visit.* Therapeutic nutrition services shall be provided *as indicated* directly or by referral to an agency or provider with a sliding fee scale. These services shall be recorded in the medical record.

i) Formal arrangements with a local hospital for emergency care must be in place and reviewed annually.

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j) Home health care directly or by referral to an agency or provider with a sliding fee scale.

k) Assisted living and skilled nursing facility care by referral.

l) *Oral screening annually for all clients 19 years and older to note obvious dental decay and soft tissue abnormalities with a reminder to the patient that poor oral health impacts total health.*

m) *Diagnosis and management of pediatric and adult patients with asthma provided according to National Heart Lung Blood Institute, National Asthma Education and Prevention Program, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, 2007.*

2. Breast and Cervical Cancer Screening

a) Women age 18 to 64 who are eligible for Breast and Cervical Cancer Program (BCCP) services according to income (equal to or under 250% of poverty, underinsured/uninsured) *and insurance status* criteria shall be provided the following services:

   i. cervical cancer screening including a pelvic examination and Pap smear;
   ii. annual breast cancer screening including a clinical breast exam, mammogram and,
   iii. referrals for diagnostic and treatment services based on screening results,
   iv. case management services.

b) All referrals under this provision shall be to approved certified laboratory, pathology, radiology, and surgical services. Mammography units shall be accredited by the American College of Radiology, and must be FDA certified under MQSA. Laboratories shall be CLIA certified.

c) All services shall be provided in accordance with the Breast and Cervical Cancer Program (BCCP) Policy and Procedure Manual.

d) Follow-up and tracking of all tests done, and referrals made shall be provided in accordance with the minimum standards outlined in the Breast and Cervical Cancer Program Policy and Procedure Manual.

e) All services for women enrolled in the Breast and Cervical Cancer Program (BCCP) shall be billed directly to the BCCP in accordance with protocols established by the Breast and Cervical Cancer Program.

3. Reproductive Health Services

The Contractor shall provide prenatal, interconceptional and preconception medical care, social services, nutrition services, education, and nursing care to all women of childbearing age. Preconceptional care includes the preconception, interconceptional, and postpartum periods in women's health. It is recommended that preconceptional and interconceptional care visits focus on maintaining or achieving the optimal health of the mother, lowering the risk of future adverse pregnancy outcomes, the family's future plans, and how additional children fit into that plan. Preconceptional counseling may be done during an office, group or home visit.

a) In the event prenatal care is not provided directly by the Contractor a formal Memorandum/a of Agreement for coordinated referral to an appropriately qualified provider must be maintained.

b) Prenatal care shall, at minimum, be provided in accordance with the Guidelines for Perinatal Care, sixth or most current edition, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and /or the Centers for Disease Control.

Contractor Initials: [signature]
Date: 3/26/12

c) Age appropriate reproductive health care shall, at a minimum, be provided in accordance with the American College of Obstetricians and Gynecologists, or the USDHHS Centers for Disease Control (CDC) current guidelines.

d) *Pregnant women enrolled in the WIC Nutrition Program shall be referred to WIC for breastfeeding education and referral to the WIC Nutrition Program peer counselors.*

e. Family planning counseling for prevention of subsequent pregnancy following an infant's birth shall be discussed with the infant's mother *at the first postpartum visit and at the infant's 2-month visit and other visits as appropriate.* Rationale for birth intervals of 18-24 months shall be presented.

f) A referral to a Title X Family Planning Clinic or other reproductive health care provider shall be made as appropriate.

4. Services for Children and Adolescents

The Contractor shall provide as a minimum, comprehensive and age-appropriate health care, screenings, and health education according to the American Academy of Pediatrics' most recent periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent. Children and adolescent visits shall include:

a) Blood lead testing shall be performed in accordance with "New Hampshire Childhood Lead Poisoning Screening and Management Guidelines", issued by the New Hampshire Department of Health and Human Services, 2009 or subsequent revisions.

b) All children enrolled in either Healthy Kids-Gold or the Women, Infant, and Children (WIC) Program and/or who are ≤ 185% poverty, regardless of town of residence, are required to have a blood lead test at ages one and two years. All children ages three to six years who have not been previously tested shall have a capillary or venous blood lead test performed.

c) All children shall be screened for iron deficiency anemia as outlined in the Centers for Disease Control and Prevention document "Recommendations to Prevent and Control Iron Deficiency in the United States (4/2/98)".

d) Age-appropriate anticipatory guidance, dietary guidance, and *feeding practice counseling* for optimal oral health shall be provided at each well child visit according to the American Academy of Pediatrics' periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent edition. Starting at age 6 months, it is recommended that all children receive an oral health assessment at every well child visit.

e) Supplemental fluoride shall be prescribed as needed based upon the fluoride levels in the child's *drinking* water supply. The fluoride dosage regimen accepted by the American Academy of Pediatrics shall be followed. No fluoride shall be prescribed without obtaining water from private wells or noting the presence or absence of fluoride in the public water supply. *Supplemental fluoride may include bottled water containing fluoride and topical applications such as varnishes.*

f) *For infants enrolled in the WIC Nutrition Program, parents shall be referred to WIC for breastfeeding support and referral to the WIC Nutrition Program peer counselors.*

Contractor Initials: [illegible]
Date: 7/26/12

5. Sexually Transmitted Infections

Primary Care Services shall provide age appropriate screening and treatment of sexually transmitted infections.

a) Treatment for sexually transmitted infections shall be provided according to the United States Centers for Disease Control Sexually Transmitted Diseases Treatment Guidelines, 2010 or subsequent revisions.

b) All clients, including women, shall be offered HIV testing following the most current recommendations of the United States Centers for Disease Control.

c) The contractor shall be responsible for ensuring referral to appropriate treatment services for any woman found to screen positive.

d) Appropriate risk reduction counseling shall be provided based on client needs.

6. Substance Use Services

a) A substance use screening history using a formal, validated screening tool shall be obtained for all clients as soon after entry into care as possible. Substance use counseling *or other substance abuse intervention, treatment, or recovery services* by an appropriately credentialed provider shall be provided on-site, or by referral, to clients with identified needs for these services. ***For these identified clients, ongoing primary care services should include follow up monitoring relative to substance abuse.***

b) All clients, including pregnant women, identified as smokers shall receive counseling *using the 5A's (ask, advise, assess, assist, and arrange) treatment available through the NH Tobacco Helpline* as cited in the US Public Health Services report "Tobacco Use and Dependence", 2008, or "Smoking Cessation During Pregnancy: *A Clinician's Guide to Helping Pregnant Women Quit Smoking*", American College of Obstetricians and Gynecologists, 2011. *With prior approval, agencies may also opt to participate in the DPHS best practice initiative of the 2A's and R (ask, advise and refer).*

7. Immunizations

a) The Contractor shall adhere to the most current version of the "Recommended Adult Immunization Schedule United States", approved by the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

b) The Contractor shall administer vaccines according to the most current version of the *"Recommended Immunization Schedule for Persons Aged 0 Through 6 Years - United States", and "Recommended Immunization Schedule for Persons Aged 7 Through 18 Years – United States"* approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians, based upon availability of vaccine from the New Hampshire Immunization Program.

8. Prenatal Genetic Screening

a) A genetic screening history shall be obtained on all prenatal clients as soon after entry into care as possible.

b) All pregnant women should be offered voluntary genetic screening for fetal chromosomal abnormalities at the appropriate time following recommendations found in the American College of Obstetricians and Gynecologists' "Screening for Fetal Chromosomal

Abnormalities (2007)" or more recent guidelines. The Contractor shall be responsible for ensuring referral to appropriate genetic testing and counseling for any woman found to have a positive screening test.

9. Additional Requirements

   a) The Contractor's Medical Director shall participate in the development and approval of specific guidelines for medical care that supplement minimal clinical standards. Supplemental guidelines should be reviewed, signed, and dated annually, and updated as indicated.

   b) Contractors considering clinical or sociological research using clients as subjects must adhere to the legal requirements governing human subjects research. Contractors must inform the DPHS, MCHS prior to initiating any research related to this contract.

   c) *The Contractor shall provide information to all employees annually about the Medical Reserve Corps Unit within their Public Health Region to enhance recruitment.*

   d) *The Contractor shall provide information to all employees annually regarding the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) managed by the NH Department of Health and Human Services' Emergency Services Unit, to enhance recruitment.*

B) Staffing Provisions

The Contractor shall have, at minimum, the following staff positions:

a) executive director

b) fiscal director

c) registered nurse

d) clinical coordinator

e) medical service director

f) nutritionist *(on site or by referral)*

g) social worker

Staff positions required to provide direct services on-site include:

a) registered nurse

b) clinical coordinator

c) social worker

1. Qualifications

   All health and allied health professionals shall have the appropriate New Hampshire licenses whether directly employed, contracted, or subcontracted.

   In addition the following minimum qualifications shall be met for:

   a) Registered Nurse
      a. A registered nurse licensed in the state of New Hampshire, Bachelor's degree preferred. Minimum of one-year experience in a community health setting.

Contractor Initials: [signature]
Date: 3/26/12

b) Nutritionists:

a. A Bachelor's degree in nutritional sciences or dietetics, or a Master's degree in nutritional sciences, nutrition education, or public health nutrition or current Registered Dietitian status in accordance with the Commission on dietetic Registration of the American Dietetic Association.

b. Individuals who perform functions similar to a nutritionist but do not meet the above qualifications shall not use the title of nutritionist.

c) Social Workers shall have:

a. A Bachelor's or Master's degree in social work or Bachelor's or Master's degree in a related social science or human behavior field. A minimum of one year of experience in a community health or social services setting is preferred.

b. Individuals who perform functions similar to a social worker but do not meet the above qualifications shall not use the title of social worker.

d) Clinical Coordinators shall be:

a. A registered nurse (RN), physician, physician assistant, or nurse practitioner with a license to practice in New Hampshire.

b. The coordinator is a clinical position that oversees and takes responsibility for the clinical and administrative functions of each program.

c. The coordinator may be responsible for more than one MCH funded program.

2. New Hires

The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing within one month of hire when a new administrator, clinical coordinator, or any staff person essential to carrying out contracted services is hired to work in the program. A resume of the employee shall accompany the aforesaid notification.

3. Vacancies

a) The Contractor must notify the MCHS in writing if any critical position is vacant for more than one month, or if at any time funded under this contract does not have adequate staffing to perform all required services for more than one month. This may be done through a budget revision.

b) Before an agency hires new program personnel that do not meet the required staff qualifications, the agency shall notify the MCHS in writing requesting a waiver of the applicable staffing requirements. The Section may grant waivers based on the need of the program, individuals' experience, and additional training.

C) Coordination of Services

1. The Contractor shall coordinate, where possible, with other service providers within the contractor's community. At a minimum, such collaboration shall include interagency referrals and coordination of care.

2. The Contractor shall participate in activities *in the Public Health Region in which they provide services* as appropriate. These activities enhance the integration of community-based public health prevention and health care initiatives that are being implemented by the contractor and may include community needs assessments, public health performance assessments, and/or the development of regional health improvement plans.

Contractor Initials: [signature]
Date: 3/24/12

3. The Contractor agrees to *participate* in and coordinate public health activities as requested by the Division of Public Health Services during any *disease outbreak* and/or *emergency*, natural or man made, affecting the public's health.

4. The Contractor is responsible for case management of the client enrolled in the program and for program follow-up activities. Case management services shall promote effective and efficient organization and utilization of resources to assure access to necessary comprehensive medical, nutritional, and social services for clients.

5. The Contractor shall assure that *appropriate, responsive, and timely* referrals and linkages for other needed services are made, carried through, and documented. Such services shall include, but not be limited to: dental services, genetic counseling, high risk prenatal services, mental health, social services, including domestic violence crisis centers, substance abuse services; and family planning services, Early Supports and Services Program, local WIC/CSF Program, Home Visiting New Hampshire Programs and health and social service agencies which serve children and families in need of those services.

D) Meetings and Trainings

The contractor will be responsible for sending staff to meetings and training required by the MCHS program, including but not limited to:

1. MCHS Agency Directors' meetings
2. Prenatal and Child Health Coordinators' meetings
3. MCHS Agency Medical Services Directors' meetings

III. Quality or Performance Improvement (QI/PI)

A) Workplans

1. Performance Workplans are required for this program and are used to monitor achievement of standard measures of performance of the services provided under this contract. The workplans are a key component of the RHPCS and the MCHS performance-based contracting system and of this contract. Outcomes shall be reported by clinical site.

2. Submit Performance Workplans and Workplan Outcome reports according to the schedule and instructions provided by the MCHS. The MCHS shall notify the Contractor at least 30 days in advance of any changes in the submission schedule.

3. The Contractor shall incorporate required and developmental performance measures, defined by the MCHS into the agency's Performance Workplan. Reports on Workplan Progress/Outcomes shall detail the Performance Workplan and activities that monitor and evaluate the agency's progress toward performance measure targets.

4. The Contractor shall comply with modifications and/or additions to the workplan and annual report format as requested by RHPCS and MCHS. MCHS will provide the contractor with reasonable notice of such changes.

5. Agencies contracting for Primary Care Services must submit the workplans for Primary Care *Clinical and Financial*, Child Health, and Prenatal Care.

Contractor Initials: *[initials]*
Date: 3/26/12

B) **Additional Reporting requirements**

In addition to Performance Workplans, the Contractor shall submit to MCHS the following data and information listed below which are used to monitor program performance:

1. In years when contracts or amendments are not required, the DPHS Budget Form, Budget Justification, Sources of Revenue and Program Staff list forms must be completed according to the relevant instructions and submitted as requested by DPHS and, at minimum, by April 30 of each year.

2. The Sources of Revenue report must be resubmitted at any point when changes in revenue threaten the ability of the agency to carry out the planned program.

3. Completed Uniform Data Set (UDS) tables reflecting program performance in the previous calendar year, by March 31 of each year.

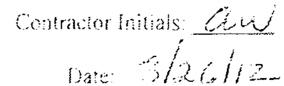
4. The Perinatal Client Data Form (PCDF) shall be submitted electronically according to the instructions set forth by the MCHS.

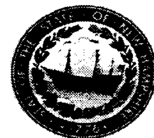
5. A copy of the agency's updated Sliding Fee Scale including the amount(s) of any client fees and the schedule of discounts must be submitted by March 31st of each year. The agency's sliding fee scale must be updated annually based on the US DHHS Poverty guidelines as published in the Federal Register.

6. An annual summary of <u>program-specific</u> patient satisfaction results obtained during the prior contract period and the method by which the results were obtained shall be submitted annually as an addendum to the Workplan Outcome/Progress reports.

C) **On-site reviews**

1. The contractor shall allow a team or person authorized by the Division of Public Health Services to periodically review the contractor's systems of governance, administration, data collection and submission, clinical and financial management, and delivery of education services in order to assure systems are adequate to provide the contracted services.
2. Reviews shall include client record reviews to measure compliance with this exhibit.
3. The contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.
4. On-Site reviews may be waived or abbreviated at the discretion of MCHS, upon submission of satisfactory reports of reviews such as Health Services Resources Administration (HRSA): Office of Performance Review (OPR), or reviews from nationally accreditation organizations such as the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), Medicare, the Community Health Accreditation Program (CHAP), Accreditation Association for Ambulatory Healthcare (AAAHC), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey. Abbreviated reviews will focus on any deficiencies found in previous reviews, issues of compliance with this exhibit, and actions to strengthen performance as outlined in the agency Performance Workplan.

Contractor Initials: 
Date:



State of New Hampshire
Department of Health and Human Services
Amendment #1 to the
Families First of the Greater Seacoast

This 1st Amendment to the Families First of the Greater Seacoast, contract (hereinafter referred to as "Amendment One") dated this 6th day of March, 2014, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Families First of the Greater Seacoast, (hereinafter referred to as "the Contractor"), a corporation with a place of business at 100 Campus Drive, Suite 12, Portsmouth, New Hampshire 03801.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on June 20, 2012, 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, the State and the Contractor have agreed to make changes to the scope of work, payment schedules and terms and conditions of the contract; and

WHEREAS, pursuant to the General Provisions, Paragraph 18, the State may modify the scope of work and the payment schedule of the contract by written agreement of the parties;

WHEREAS, the Department desires to provide additional primary health care services for preventive and episodic health care for acute and chronic health conditions for people of all ages.

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 as follows:

To amend as follows:

- Form P-37, to change:
  Block 1.7 to read: June 30, 2015
  Block 1.8 to read: $624,540

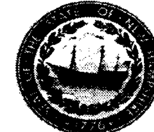
- Exhibit A, Scope of Services to add:
  Exhibit A – Amendment 1

- Exhibit B, Purchase of Services, Contract Price, to add:

  Paragraph 1.1 to Paragraph 1:
  The contract price shall increase by $41,892 for SFY 2014 and $242,094 for SFY 2015.

  Paragraph 1.2 to Paragraph 1:
  Funding is available as follows:
- $41,892 from 05-95-90-902010-5190-102-500731, 100% General Funds;
- $210,063 from 05-95-90-902010-5190-102-500731, 6.7% Federal Funds from the US Department of Health and Human Services Administration, Maternal and Child Health Bureau, CFDA #93.994 and 93.3% General Funds;

Contractor Initials: [handwritten initials]
Date: 3/6/14



- $32,031 from 05-95-90-902010-5659-102-500731, 100% Federal Funds from the US Department of Health and Human Services, Centers for Disease Control and Prevention, CFDA #93.283;

  Add Paragraph 8
  8. Notwithstanding paragraph 18 of the General Provisions P-37, an amendment limited to adjustments to amounts between and among account numbers, within the price limitation, may be made by written agreement of both parties and may be made without obtaining approval of the Governor and Executive Council.

- Budget, to add:
  Exhibit B-1 (2014) - Amendment 1,
  Exhibit B-1 (2015) - Amendment 1

This amendment shall be in effect July 1, 2013, effective upon the date of Governor and Executive Council approval.

Contractor Initials: [illegible]
Date: 3/6/14

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

3/28/14
Date

Brook Dupee
Bureau Chief

Families First of the Greater Seacoast

3/6/14
Date

Name: Helen B. Taft
Title: Executive Director / President

Acknowledgement:

State of NH, County of Rockingham on March 6, 2014, before the undersigned officer, personally appeared the person identified above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.

Signature of Notary Public or Justice of the Peace

Nancy Casko Notary
Name and Title of Notary or Justice of the Peace

My Commission Expires March 7, 2017

Contractor Initials: HBT
Date: 3/6/14

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

OFFICE OF THE ATTORNEY GENERAL

4-2-14
Date

Name: Rosemary Wiant
Title: Assistant Attorney General

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

OFFICE OF THE SECRETARY OF STATE

Date

Name:
Title:

EXHIBIT A – AMENDMENT 1

Scope of Services

The Department desires to continue the relationship with the primary care agencies to provide additional primary health care services for preventive and episodic health care for acute and chronic health conditions for people of all ages.

I. General Provisions

A) Eligibility and Income Determination

1. Office-based primary care services will be provided to low-income individuals and families (defined as ≤ 185% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), in the State of New Hampshire.

2. Breast and Cervical Cancer screening services will be provided to low-income (defined as ≤ 250% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), New Hampshire women age 21– 64, uninsured or underinsured. BCCP changes.

3. The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing if, at any time, the practice is closed to new patients, or maintains a wait list for new patients, or any other mechanism is used that limits access for new patients for more than a one month period.

4. The Contractor shall document annually, for each client enrolled in the program, family income and family size, and calculate percentage of the federal poverty level. If calculations indicate that the client may be eligible for enrollment in Medicaid, the Contractor shall complete with the client the most recent version of the 800P form.

5. The Contractor shall implement, and post in a public and conspicuous location, a sliding fee payment schedule, approved in advance by the Division of Public Health Services (DPHS), for low-income patients. Signage must state that no client will be denied services for inability to pay.

   a. As an alternative, the contractor may post, in a public and conspicuous location, a notice to clients that a sliding fee scale is available and that no client will be denied services for inability to pay. The sliding fee scale must be updated annually based on USDHHS Poverty guidelines as published in the Federal Register, submitted to and approved by DPHS prior to implementation.

6. The primary care contract entered into here shall be the payer of last resort. The contractor shall make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid, for all reimbursable services rendered.

EXHIBIT A – AMENDMENT 1

B) Numbers Served

1. The contract funds shall be expended to provide the above services to a minimum of 4,150 users annually with 13,549 medical encounters, as defined in the Data and Reporting Requirements. Breast and Cervical Cancer Screening for eligible women, as defined by the Breast and Cervical Cancer Program (BCCP), shall be provided to 180 women annually and billed directly to the BCCP. Clinical service reimbursements shall not exceed the Medicare rate.

C) Culturally and Linguistically Appropriate Standards of Care

The Department of Health and Human Services (DHHS) recognizes that culture and language have considerable impact on how consumers access and respond to public health services. Culturally and linguistically diverse populations experience barriers in efforts to access health services. To ensure equal access to quality health services, the Division of Public Health Services (DPHS) expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.
2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.
3. Provide clients of limited English proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.
4. Offer consumers a forum through which clients have the opportunity to provide feedback to providers and organizations regarding cultural and linguistic issues that may deserve response.
5. The contractor shall maintain a program policy that sets forth compliance with Title VI, Language Efficiency and Proficiency Citation 45 CFR 80.3(b) (2). The policy shall describe the way in which the items listed above were addressed and shall indicate the circumstances in which interpretation services are provided and the method of providing service (e.g. trained interpreter, staff person who speaks the language of the client, language line).

D) State and Federal Laws

The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. The Contractor shall report all cases of communicable diseases according to New Hampshire RSA 141-C and He-P 301, adopted 6/3/08.

2. Persons employed by the contractor shall comply with the reporting requirements of New Hampshire RSA 169:C, Child Protection Act; RSA 161:F46, Protective Services to Adults, RSA 631:6, Assault and Related Offences and RSA 130:A, Lead Paint Poisoning and Control.

3. Immunizations shall be conducted in accordance with RSA 141-C and the Immunization Rules promulgated hereunder.

E) Relevant Policies and Guidelines

1. The Contractor shall design and provide the services described above to meet the unique and identified health needs of the populations within the contracted service area.

2. Primary Care funds shall be targeted to populations in need. Populations in need are defined as follows:

   a) uninsured;

   b) under-insured;

   c) families and individuals with significant psychosocial and economic risk, including low income status;

   d) all life cycles including perinatal, child, adolescent, adult, and elderly who meet one or more of the above criteria.

3. The Contractor shall design and implement systems of governance, administration, financial management, information management, and clinical services which are adequate to assure the provision of contracted services, and to meet the data and reporting requirements. These systems shall meet the most current minimum standards described in at least one of the following: Health Resources and Services Administration (HRSA) Office of Performance Review protocols, Joint Commission on Accreditation of Health Care Organizations (JCAHO), Accreditation Association for Ambulatory Healthcare (AAAHC), Community Health Accreditation Program (CHAP), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey.

4. The Contractor shall have an agency emergency preparedness and response plan in accordance with HRSA Health Center Emergency Management Program Expectations, Document #2007-15 or most recent version. Such plan shall also include a Continuity of Operations plan.

5. The Contractor shall carry out the work as described in the performance Workplan submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

6. No Workplan is required by the Breast and Cervical Cancer Program (BCCP). The contractor shall be required to respond to the Quality Improvement Feedback Report twice a year.

7. The Contractor shall carry out the work as described in the Supplemental Funding Form submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

F) Publications Funded Under Contract

1. The DHHS and/or its funders will retain COPYRIGHT ownership for any and all original materials produced with DHHS contract funding, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports.

2. All documents (written, video, audio, electronic) produced, reproduced, or purchased under the contract shall have prior approval from DPHS before printing, production, distribution, or use.

3. The Contractor shall credit DHHS on all materials produced under this contract following the instructions outlined in Exhibit C (14).

G) Subcontractors

If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing and approve the subcontractual agreement, prior to initiation of the subcontract.

1. If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing and approve the subcontractual agreement, prior to initiation of the subcontract.

2. In addition, the original DPHS contractor will remain liable for all requirements included in this Exhibit and carried out by subcontractors.

II. <u>Minimal Standards of Core Services</u>

A. Service Requirements

1. Medical Home

The Contractor shall provide a Medical Home that:

a) Facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family.

b) Provides care facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

2. Primary Care Services

The Contractor shall provide office-based primary care services to populations in need who reside in the contractor's service area. Primary care services shall include:

a) Health care provided by a New Hampshire licensed MD, DO, APRN, or PA, including diagnosis and treatment of acute and chronic illnesses within the scope of family practice; preventive services, screenings, and health education according to established, documented state or national guidelines; assessment of need for social and nutrition services, and appropriate referrals to health, oral health, and behavioral health specialty providers.

b) Referral to the WIC Nutrition Program for all eligible pregnant women, infants and children.

c) In-hospital care for conditions within the scope of family practice must be provided at a hospital, within the agency service area, through a staff clinician with full hospital privileges, or in the alternative, through a formal referral and admissions procedure available to clients on a 24 hour/7 day a week basis.

d) Access to a healthcare provider, directly or by referral or subcontract, by telephone twenty-four hours per day, seven days per week.

e) Assessment of psychosocial risk for all clients at least annually and for children at scheduled preventive care visits, including, at a minimum, age appropriate assessment of safety in the home, domestic violence, adequacy of food and housing, care and welfare of children, transportation needs, and provision of necessary social services to address the priority needs and safety issues of clients and families.

f) Falls prevention screening for patients 65 years and older using the algorithm and guidelines of the American Geriatrics Society.

g) Behavioral health care directly or by referral to an agency or provider with a sliding fee scale.

h) Nutrition assessment for all clients as part of the health maintenance visit. Therapeutic nutrition services shall be provided as indicated directly or by referral to an agency or provider with a sliding fee scale. These services shall be recorded in the medical record.

i) Formal arrangements with a local hospital for emergency care must be in place and reviewed annually.

j) Home health care directly or by referral to an agency or provider with a sliding fee scale.

k) Assisted living and skilled nursing facility care by referral.

l) Oral screening annually for all clients 21 years and older to note obvious dental decay and soft tissue abnormalities with a reminder to the patient that poor oral health impacts total health.

m) Diagnosis and management of pediatric and adult patients with asthma provided according to National Heart Lung Blood Institute, National Asthma Education and Prevention Program, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, 2007.

3. Breast and Cervical Cancer Screening

a) Women age 21 to 64 who are eligible for Breast and Cervical Cancer Program (BCCP) services according to income (equal to or under 250% of poverty, underinsured/uninsured) and insurance status criteria shall be provided the following services, following USPSTF screening recommendations:

i. cervical cancer screening including a pelvic examination and Pap smear;
ii. breast cancer screening including a clinical breast exam, mammogram and,
iii. referrals for diagnostic and treatment services based on screening results,
iv. case management services.

b) All referrals under this provision shall be to approved certified laboratory, pathology, radiology, and surgical services. Mammography units shall be accredited by the American College of Radiology, and must be FDA certified under MQSA. Laboratories shall be CLIA certified.

c) All services shall be provided in accordance with the Breast and Cervical Cancer Program (BCCP) Policy and Procedure Manual.

d) Follow-up and tracking of all tests done, and referrals made shall be provided in accordance with the minimum standards outlined in the Breast and Cervical Cancer Program Policy and Procedure Manual.

e) All services for women enrolled in the Breast and Cervical Cancer Program (BCCP) shall be billed directly to the BCCP in accordance with protocols established by the Breast and Cervical Cancer Program.

f) The Contractor shall provide the NH Breast and Cervical Cancer Program with breast and cervical cancer screening rates for all women served by the practice as requested, but not more than twice per SFY.

g) The contractor shall work with the NH Breast and Cervical Cancer Program staff to increase the breast and cervical cancer screening rates among all women serviced by the practice.

4. Reproductive Health Services

The Contractor shall provide prenatal, interconceptional and preconception medical care, social services, nutrition services, education, and nursing care to all women of childbearing age. Preconceptional care includes the preconception, interconceptional, and postpartum periods in women's health. It is recommended that preconceptional and interconceptional care visits focus on maintaining or achieving the optimal health of the mother, lowering the risk of future adverse pregnancy outcomes, the family's future plans, and how additional children fit into that plan. Preconceptional counseling may be done during an office, group or home visit.

a) In the event prenatal care is not provided directly by the Contractor a formal Memorandum/a of Agreement for coordinated referral to an appropriately qualified provider must be maintained.

b) Prenatal care shall, at minimum, be provided in accordance with the Guidelines for Perinatal Care, sixth or most current edition, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and /or the Centers for Disease Control.

c) Age appropriate reproductive health care shall, at a minimum, be provided in accordance with the American College of Obstetricians and Gynecologists, or the USDHHS Centers for Disease Control (CDC) current guidelines.

d) Pregnant women enrolled in the WIC Nutrition Program shall be referred to WIC for breastfeeding education and referral to the WIC Nutrition Program peer counselors.

e. Family planning counseling for prevention of subsequent pregnancy following an infant's birth shall be discussed with the infant's mother at the first postpartum visit and at the infant's 2-month visit and other visits as appropriate. Rationale for birth intervals of 18-24 months shall be presented.

f) A referral to a Title X Family Planning Clinic or other reproductive health care provider shall be made as appropriate.

5. Services for Children and Adolescents

The Contractor shall provide as a minimum, comprehensive and age-appropriate health care, screenings, and health education according to the American Academy of Pediatrics' most recent periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent. Children and adolescent visits shall include:

EXHIBIT A – AMENDMENT 1

a) The World Health Organization (WHO) growth charts shall be used to monitor growth for infants and children birth up to age 2 years. The Centers for Disease Control and Prevention (CDC) growth charts shall be used for children age 2 years and older.

b) Blood lead testing shall be performed in accordance with "New Hampshire Childhood Lead Poisoning Screening and Management Guidelines", issued by the New Hampshire Department of Health and Human Services, 2009 or subsequent revisions.

c) All children enrolled in either Medicaid, Head Start, or the Women, Infant, and Children (WIC) Program and/or who are ≤ 185%_poverty, regardless of town of residence, are required to have a blood lead test at ages one and two years. All children ages three to six years who have not been previously tested shall have a blood lead test performed.

d) All children shall be screened for iron deficiency anemia as outlined in the Centers for Disease Control and Prevention document "Recommendations to Prevent and Control Iron Deficiency in the United States (4/2/98)".

e) Age-appropriate anticipatory guidance, dietary guidance, and *feeding practice counseling* for optimal oral health shall be provided at each well child visit according to the American Academy of Pediatrics' periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent edition. Starting at age 6 months, it is recommended that all children receive an oral health assessment at every well child visit, and a referral for the child's first visit to the dentist by age one as recommended by the American Academy of Pediatrics and the American Academy of Pediatric Dentistry.

f) Supplemental fluoride shall be prescribed as needed based upon the fluoride levels in the child's drinking water supply. The fluoride dosage regimen accepted by the American Academy of Pediatrics shall be followed. No fluoride shall be prescribed without obtaining water from private wells or noting the presence or absence of fluoride in the public water supply. Supplemental fluoride may include bottled water containing fluoride and topical applications such as varnishes.

g) For infants enrolled in the WIC Nutrition Program, parents shall be referred to WIC for breastfeeding support and referral to the WIC Nutrition Program peer counselors.

6. Sexually Transmitted Infections

Primary Care Services shall provide age appropriate screening and treatment of sexually transmitted infections.

EXHIBIT A – AMENDMENT 1

a) Treatment for sexually transmitted infections shall be provided according to the United States Centers for Disease Control Sexually Transmitted Diseases Treatment Guidelines, 2010 or subsequent revisions.

b) All clients, including women, shall be offered HIV testing following the most current recommendations of the United States Centers for Disease Control.

c) The contractor shall be responsible for ensuring referral to appropriate treatment services for any woman found to screen positive.

d) Appropriate risk reduction counseling shall be provided based on client needs.

7. Substance Use Services

a) A substance use screening history using a formal, validated screening tool shall be obtained for all clients as soon after entry into care as possible. Substance use counseling or other substance abuse intervention, treatment, or recovery services by an appropriately credentialed provider shall be provided on-site, or by referral, to clients with identified needs for these services. For these identified clients, ongoing primary care services should include follow up monitoring relative to substance abuse.

b) All clients, including pregnant women, identified as smokers shall receive counseling using the 5A's (ask, advise, assess, assist, and arrange) treatment available through the NH Tobacco Helpline as cited in the US Public Health Services report "Tobacco Use and Dependence", 2008, or "Smoking Cessation During Pregnancy: A Clinician's Guide to Helping Pregnant Women Quit Smoking", American College of Obstetricians and Gynecologists, 2011. With prior approval, agencies may also opt to participate in the DPHS best practice initiative of the 2A's and R (ask, advise and refer).

8. Immunizations

a) The Contractor shall adhere to the most current version of the "Recommended Adult Immunization Schedule for Adults (19 years and older) by Age and Medical Condition - United States", approved by the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

b) The Contractor shall administer vaccines according to the most current version of the "Recommended Immunization Schedule for Persons Aged 0 Through 6 Years - United States", and "Recommended Immunization Schedule for Persons Aged 7 Through 18 Years – United States" approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians, based upon availability of vaccine from the New Hampshire Immunization Program.

9. Prenatal Genetic Screening

a) A genetic screening history shall be obtained on all prenatal clients as soon after entry into care as possible.

b) All pregnant women should be offered voluntary genetic screening for fetal chromosomal abnormalities at the appropriate time following recommendations found in the American College of Obstetricians and Gynecologists' "Screening for Fetal Chromosomal Abnormalities (2007)" or more recent guidelines. The Contractor shall be responsible for ensuring referral to appropriate genetic testing and counseling for any woman found to have a positive screening test.

10. Additional Requirements

a) The Contractor's Medical Director shall participate in the development and approval of specific guidelines for medical care that supplement minimal clinical standards. Supplemental guidelines should be reviewed, signed, and dated annually, and updated as indicated.

b) Contractors considering clinical or sociological research using clients as subjects must adhere to the legal requirements governing human subjects research. Contractors must inform the DPHS, MCHS prior to initiating any research related to this contract.

c) The Contractor shall provide information to all employees annually about the Medical Reserve Corps Unit within their Public Health Region to enhance recruitment.

d) The Contractor shall provide information to all employees annually regarding the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) managed by the NH Department of Health and Human Services' Emergency Services Unit, to enhance recruitment.

B) Staffing Provisions

The Contractor shall have, at minimum, the following staff positions:

a) executive director

b) fiscal director

c) registered nurse

d) clinical coordinator

e) medical service director

f) nutritionist (on site or by referral)

g) social worker

EXHIBIT A – AMENDMENT 1

Staff positions required to provide direct services on-site include:

a) registered nurse

b) clinical coordinator

c) social worker

1. Qualifications

All health and allied health professionals shall have the appropriate New Hampshire licenses whether directly employed, contracted, or subcontracted.

In addition the following minimum qualifications shall be met for:

a) Registered Nurse
   a. A registered nurse licensed in the state of New Hampshire, Bachelor's degree preferred. Minimum of one-year experience in a community health setting.

b) Nutritionists:
   a. A Bachelor's degree in nutritional sciences or dietetics, or a Master's degree in nutritional sciences, nutrition education, or public health nutrition or current Registered Dietitian status in accordance with the Commission on dietetic Registration of the American Dietetic Association.
   b. Individuals who perform functions similar to a nutritionist but do not meet the above qualifications shall not use the title of nutritionist.

c) Social Workers shall have:
   a. A Bachelor's or Master's degree in social work or Bachelor's or Master's degree in a related social science or human behavior field. A minimum of one year of experience in a community health or social services setting is preferred.
   b. Individuals who perform functions similar to a social worker but do not meet the above qualifications shall not use the title of social worker.

d) Clinical Coordinators shall be:
   a. A registered nurse (RN), physician, physician assistant, or nurse practitioner with a license to practice in New Hampshire.
   b. The coordinator is a clinical position that oversees and takes responsibility for the clinical and administrative functions of each program.
   c. The coordinator may be responsible for more than one MCH funded program.

2. New Hires

The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing within one month of hire when a new administrator, clinical coordinator, or any staff person essential to carrying out contracted services is hired to work in the program. A resume of the employee shall accompany the aforesaid notification.

3. Vacancies

   a) The Contractor must notify the MCHS in writing if any critical position is vacant for more than one month, or if at any time funded under this contract does not have adequate staffing to perform all required services for more than one month. This may be done through a budget revision.

   b) Before an agency hires new program personnel that do not meet the required staff qualifications, the agency shall notify the MCHS in writing requesting a waiver of the applicable staffing requirements. The Section may grant waivers based on the need of the program, individuals' experience, and additional training.

C) Coordination of Services

1. The Contractor shall coordinate, where possible, with other service providers within the contractor's community. At a minimum, such collaboration shall include interagency referrals and coordination of care.

2. The Contractor shall participate in activities in the Public Health Region in which they provide services as appropriate. These activities enhance the integration of community-based public health prevention and health care initiatives that are being implemented by the contractor and may include community needs assessments, public health performance assessments, and/or the development of regional health improvement plans.

3. The Contractor agrees to participate in and coordinate public health activities as requested by the Division of Public Health Services during any disease outbreak and/or emergency, natural or man-made, affecting the public's health.

4. The Contractor is responsible for case management of the client enrolled in the program and for program follow-up activities. Case management services shall promote effective and efficient organization and utilization
   of resources to assure access to necessary comprehensive medical, nutritional, and social services for clients.

5. The Contractor shall assure that appropriate, responsive, and timely referrals and linkages for other needed services are made, carried through, and documented. Such services shall include, but not be limited to: dental services, genetic counseling, high risk prenatal services, mental health, social services, including domestic violence crisis centers, substance abuse services; and family planning services, Early Supports and Services Program, local WIC/CSF Program, Home Visiting New Hampshire Programs and health and social service agencies which serve children and families in need of those services.

D) Meetings and Trainings

The contractor will be responsible for sending staff to meetings and training required by the MCHS program, including but not limited to:

1. MCHS Agency Directors' meetings
2. Prenatal and Child Health Coordinators' meetings
3. MCHS Agency Medical Services Directors' meetings

III. Quality or Performance Improvement (QI/PI)

A) Workplans

1. Performance Workplans are required for this program and are used to monitor achievement of standard measures of performance of the services provided under this contract. The workplans are a key component of the RHPCS and the MCHS performance-based contracting system and of this contract. Outcomes shall be reported by clinical site.
2. Performance Workplans and Workplan Outcome reports according to the schedule and instructions provided by the MCHS. The MCHS shall notify the Contractor at least 30 days in advance of any changes in the submission schedule.
3. The Contractor shall incorporate required and developmental performance measures, defined by the MCHS into the agency's Performance Workplan. Reports on Workplan Progress/Outcomes shall detail the Performance Workplan plans and activities that monitor and evaluate the agency's progress toward performance measure targets.
4. The Contractor shall comply with modifications and/or additions to the workplan and annual report format as requested by RHPCS and MCHS. MCHS will provide the contractor with reasonable notice of such changes.
5. Agencies contracting for Primary Care Services must submit the workplans for Primary Care Clinical and Financial, Child Health, and Prenatal Care.

B) Additional Reporting requirements

In addition to Performance Workplans, the Contractor shall submit to MCHS the following data and information listed below which are used to monitor program performance:

1. In years when contracts or amendments are not required, the DPHS Budget Form, Budget Justification, Sources of Revenue and Program Staff list forms must be

completed according to the relevant instructions and submitted as requested by DPHS and, at minimum, by April 30 of each year.

2. The Sources of Revenue report must be resubmitted at any point when changes in revenue threaten the ability of the agency to carry out the planned program.

3. Completed Uniform Data Set (UDS) tables reflecting program performance in the previous calendar year, by March 31 of each year.

4. The Perinatal Client Data Form (PCDF) shall be submitted electronically according to the instructions set forth by the MCHS.

5. A copy of the agency's updated Sliding Fee Scale including the amount(s) of any client fees and the schedule of discounts must be submitted by March 31st of each year. The agency's sliding fee scale must be updated annually based on the US DHHS Poverty guidelines as published in the Federal Register.

6. An annual summary of program-specific patient satisfaction results obtained during the prior contract period and the method by which the results were obtained shall be submitted annually as an addendum to the Workplan Outcome/Progress reports.

C) On-site reviews

1. The contractor shall allow a team or person authorized by the Division of Public Health Services to periodically review the contractor's systems of governance, administration, data collection and submission, clinical and financial management, and delivery of education services in order to assure systems are adequate to provide the contracted services.

2. Reviews shall include client record reviews to measure compliance with this exhibit.

3. The contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.

4. On-Site reviews may be waived or abbreviated at the discretion of MCHS, upon submission of satisfactory reports of reviews such as Health Services Resources Administration (HRSA): Office of Performance Review (OPR), or reviews from nationally accreditation organizations such as the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), Medicare, the Community Health Accreditation Program (CHAP), Accreditation Association for Ambulatory Healthcare (AAAHC), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey. Abbreviated reviews will focus on any deficiencies found in previous reviews, issues of compliance with this exhibit, and actions to strengthen performance as outlined in the agency Performance Workplan.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE CHILD HEALTH DIRECT CARE SERVICES
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Please note, for all measures, the following should be used **unless otherwise indicated:**

- Less than 19 years of age
- Served within the scope of this MCH contract during State Fiscal Year 2015 (July 1, 2014 – June 30, 2015)
- Each client can only be counted once (unduplicated)

Child Health Direct (CH – D) Performance Measure #1

Measure: 92%* of eligible children will be enrolled in Medicaid

Goal: To increase access to health care for children through the provision of health insurance

Definition: **Numerator-**
Of those in the denominator, the number of children enrolled in Medicaid.

Denominator-
Number of children who meet all of the following criteria:

- Less than 19 years of age
- Had 3 or more visits/encounters** during the reporting period
- As of the last visit during the reporting period were eligible for Medicaid

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**An encounter is face to face contact between a user and a provider who exercises independent judgment in the provision of services to the individual (UDS Table Definition).

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #2

Measure: 85%* of at-risk** children who were screened for blood lead between 18 and 30 months of age

Goal: To prevent childhood lead poisoning through early identification of lead exposure

Definition: **Numerator-**
Of those in the denominator, number of children screened for blood lead by capillary or venous on or after their 18-month birthday and prior to their 30-month birthday.

Denominator-
Number of at-risk** children who reached age 30 months during the reporting period. If discharged prior to 30 months, do not include in denominator.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**At risk = During the reporting period, the children were 18-29 months of age, and fit at least one of the following criteria:

- "Low income" (less than 185% poverty guidelines)
- Over 185% and resided in a town considered needing "Universal" screening per NH Childhood Lead Poisoning Prevention Program
- Over 185%, resided in a town considered "Target" and had a positive response to the risk questionnaire
- Refugee children -A refugee is defined as a person outside of his or her country of nationality who is unable or unwilling to return because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion (U.S. Citizenship and Immigration Services definition).

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #3

Measure: 71%* of children age two to nineteen years receiving primary care preventive health services with a Body Mass Index (BMI) percentile greater than or equal to the 85%ile with documented discussion of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Goal: To increase the percent of children receiving primary care preventive health services who have an elevated BMI percentile who receive guidance about promoting a healthier lifestyle.

Definition: **Numerator-**
Of those in the denominator, the number of children who had documentation in their medical record of there being discussion at least once during the reporting period of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Denominator-
Number of children who turned twenty-four months during or before the reporting period, up to the age of nineteen years, with one or more well child visit after their twenty-fourth month of age within the reporting year, and had an age and gender appropriate BMI percentile greater than or equal to the 85 % percentile at least once during the reporting period.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

Rationale: Children between the 85th – 94th percentiles BMI are encouraged to have 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks. (Discussion of the importance of family meal time, limiting eating out, consuming a healthy breakfast, preparing own foods, and promotion of breastfeeding is also encouraged.) American Academy of Pediatrics' guidance for Prevention and Treatment of Childhood Overweight and Obesity, (http://www.aap.org/obesity/health_professionals.html), from AAP Policy Statement: *Prevention of Pediatric Overweight and Obesity* and the AAP endorsed Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Children and Adolescent Overweight and Obesity, 2007.

*Target based on 2012 & 2013 Data Trend Table averages.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) #4

Measure: 75%* of eligible** infants and children with client record documentation of enrollment in WIC

Goal: To increase access to nutrition education, breastfeeding support, and healthy food through enrollment in the WIC Nutrition Program

Definition: **Numerator** -
Of those in the denominator, the number of infants and children who, as of the last well child visit during the reporting period, had client record documentation that infant or child was enrolled in WIC.

Denominator -
Unduplicated number of infants and children less than 5 years of age, enrolled in the agency, during the reporting period, who were eligible** for WIC.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**WIC Eligibility Requirements:

- Infants, and children up to their fifth birthday
- Must be income eligible (income guidelines are up to 185% of federal gross income, and are based on family size)

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #5

Measure: 23%* of infants who were exclusively** breastfed for the first three months, at their four month well baby visit

Goal: To provide optimum nutrition to infants in their first three months of life

Definition: **Numerator -**
Of those in the denominator, the number of infants who had client record documentation that the infant had been exclusively breastfed for their first three months when checked at their four month well baby visit.

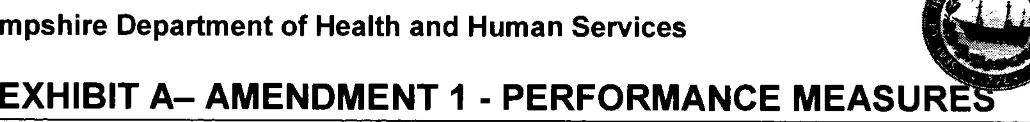
Denominator -
Number of infants who received one or more visits during or before the reporting period and were seen for a four-month well baby visit during the reporting period.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

Benmarks: 2011 PedNSS (WIC) exclusive at 3 months: NH 22.9%, National (2010) 10.7%
2013 CDC Report Card (NIS, provisional 2010 births): NH 49.5%, National 37.7%
Healthy People 2020 goal: 44%

Rationale: The AAP recommends exclusive breastfeeding for about 6 months, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant, a recommendation concurred to by the World Health Organization and the Institute of Medicine. (American Academy of Pediatrics Policy Statement on Breastfeeding and the Use of Human Milk, 2012)

*Target based on 2012 & 2013 Data Trend Table averages.
**Exclusive means breast milk only, no supplemental formula, cereal/baby food, or water/fluids.



PRIMARY CARE: ADULT

PERFORMANCE MEASURES DEFINITIONS

State Fiscal Year 2015

Primary Care: Adult Performance Measure #1

Measure:* 58%** of adult patients 18 – 85 years of age diagnosed with hypertension will have a blood pressure measurement less than 140/90*** mm at the time of their last measurement.

Goal: To ensure patients diagnosed with hypertension are adequately controlled.

Definition: **Numerator-** Number of patients from the denominator with blood pressure measurement less than 140/90 mm at the time of their last measurement.

Denominator- Number of patients age 18 – 85 with diagnosed hypertension must have been diagnosed with hypertension 6 or more months before the measurement date. (Excludes pregnant women and patients with End Stage Renal Disease.)

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

*Measure based on the National Quality Forum 0018

**Health People 2020 National Target is 61.2%

***Both the numerator and denominator must be less that 140/90 mm

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE CLINICAL
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Primary Care Clinical Adolescent (PC-C) Performance Measure #1

Measure: 61%* of adolescents aged 11-21 years received an annual health maintenance visits in the past 12 months.

Goal: To enhance adolescent health by assuring annual, recommended, adolescent well -visits.

Definition:

Numerator-
Number of adolescents in the denominator who received an annual health maintenance "well" visit during the reporting year.

Denominator-
Total number of adolescents aged 11-21 years who were enrolled in the primary care clinic as primary care clients during the reporting year period.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

***Target based on 2012 & 2013 Data Trend Table averages.**

Primary Care Clinical Prenatal (PC-C) Performance Measure #2

Measure: 31%* of women and adolescent girls aged 15-44 take multi-vitamins with folic acid.

Goal: To enhance pregnancy outcomes by reducing neural tube defects.

Definition:

Numerator-
The number of women and adolescent girls aged 15-44 who take a multi-vitamin with folic acid.

Denominator-
The number of women and adolescent girls aged 15-44 who were seen in primary care for a well visit in the past year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

***Target based on 2012 & 2013 Data Trend Table averages.**

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE - FINANCIAL
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Primary Care (PC) Performance Measure #1

Measure: Patient Payor Mix

Goal: To allow monitoring of payment method trends at State funded primary care sites.

Definition: Patients enrolled in Medicare, Medicaid, Commercial insurance, or uninsured.

Data Source: Provided by agency

Primary Care (PC) Performance Measure #2

Measure: Accounts Receivables (AR) Days

Goal: To allow monitoring of financial sustainability trends at State funded primary care sites.

Definition: AR Days: Net Patient Accounts Receivable **multiplied by** 365 **divided by** Net Patient Revenue

Data Source: Provided by agency

Primary Care (PC) Performance Measure #3

Measure: Current Ratio

Goal: To allow monitoring of financial sustainability trends at State funded primary care sites.

Definition: Current Ratio = Current Assets **divided by** Current Liabilities

Data Source: Provided by agency

PRENATAL
PERFORMANCE MEASURES DEFINITIONS
State Fiscal Year 2015

Prenatal (PN) Performance Measure #1

Measure: 85%* of pregnant women who are enrolled in the agency's prenatal program will begin prenatal care during the first trimester of pregnancy.

Goal: To enhance pregnancy outcomes by assuring early entrance into prenatal care.

Definition:

Numerator-
Number of women in the denominator who had a documented prenatal visit during the first trimester (on or before 13.6 weeks gestation).

Denominator-
Number of women enrolled in the agency prenatal program who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

* Target based on 2012 & 2013 Data Trend Table averages.

Prenatal (PN) Performance Measure #2

Measure: 20%* of pregnant women who are identified as cigarette smokers will be referred to QuitWorks-New Hampshire.

Goal: To reduce tobacco use during pregnancy through focused tobacco use cessation activities at public health prenatal clinics.

Definition:

Numerator-
Number of women in the denominator who received at least one referral to QuitWorks-New Hampshire during pregnancy.

A referral is defined as signing the patient up for QuitWorks-NH via phone, fax, or EMR. It is not defined as discussing QuitWorks-NH with the patient and encouraging her to sign up.

Denominator-
Number of women enrolled in the agency prenatal program and identified as tobacco users who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

*Target set in consultation with the NH Tobacco Program & FY13 Data Trend Table average.

Prenatal (PN) Performance Measure #3

Measure: 79%* of pregnant women will be screened, using a formal valid screening tool, for alcohol and other substance use during every trimester they are enrolled in the prenatal program.

Goal: To reduce prenatal substance use through systematic screening and identification.

Definition: **Numerator-** Number of women in the denominator who were screened for substance and alcohol use, using a formal and valid screening tool, during each trimester that they were enrolled in the prenatal program.

Denominator- Number of women enrolled in the agency prenatal program and who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

* Target based on 2012 & 2013 Data Trend Table averages.

Exhibit B-1 (2014) -Amendment 1
Budget

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: Families First of the Greater Seacoast

2/21/2014

Budget Request for: MCH Primary Care
(Name of RFP)

Budget Period: SFY 2014

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages	$ 41,892.00	$ -	$ 41,892.00	
2. Employee Benefits	$ -	$ -	$ -	
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	$ -	$ -	$ -	
13. Other (specific details mandatory):	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
TOTAL	**$ 41,892.00**	**$ -**	**$ 41,892.00**	

Indirect As A Percent of Direct 0.0%

Contractor Initials: [handwritten initials]

Date: 3/6/14

Exhibit B-1 (2015) -Amendment 1
Budget

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: Families First of the Greater Seacoast

Budget Request for: MCH Primary Care
(Name of RFP)

Budget Period: SFY 2015

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages	$ 227,919.00	$ -	$ 227,919.00	0
2. Employee Benefits	$ 1,395.00	$ -	$ 1,395.00	0
3. Consultants	$ -	$ -	$ -	0
4. Equipment:	$ -	$ -	$ -	0
Rental	$ -	$ -	$ -	0
Repair and Maintenance	$ -	$ -	$ -	0
Purchase/Depreciation	$ -	$ -	$ -	0
5. Supplies:	$ -	$ -	$ -	0
Educational	$ -	$ -	$ -	0
Lab	$ -	$ -	$ -	0
Pharmacy	$ -	$ -	$ -	0
Medical	$ -	$ -	$ -	0
Office	$ -	$ -	$ -	0
6. Travel	$ -	$ -	$ -	0
7. Occupancy	$ -	$ -	$ -	0
8. Current Expenses	$ -	$ -	$ -	0
Telephone	$ -	$ -	$ -	0
Postage	$ -	$ -	$ -	0
Subscriptions	$ -	$ -	$ -	0
Audit and Legal	$ -	$ -	$ -	0
Insurance	$ -	$ -	$ -	0
Board Expenses	$ -	$ -	$ -	0
9. Software	$ -	$ -	$ -	0
10. Marketing/Communications	$ -	$ -	$ -	0
11. Staff Education and Training	$ -	$ -	$ -	0
12. Subcontracts/Agreements	$ -	$ -	$ -	0
13. Other (Clinical Services):	$ 12,780.00	$ -	$ 12,780.00	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
TOTAL	**$ 242,094.00**	**$ -**	**$ 242,094.00**	0

Indirect As A Percent of Direct 0.0%

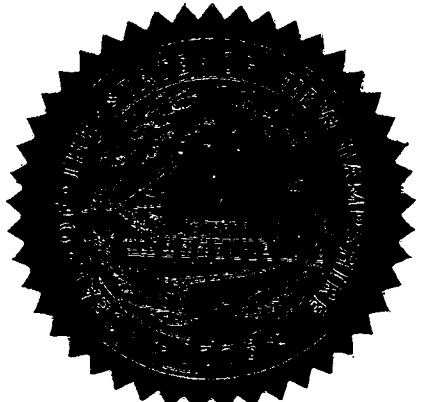
Contractor Initials: HR

Date: 3/6/14

State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that FAMILIES FIRST OF THE GREATER SEACOAST is a New Hampshire nonprofit corporation formed August 28, 1986. I further certify that it is in good standing as far as this office is concerned, having filed the return(s) and paid the fees required by law.



In TESTIMONY WHEREOF, I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 1st day of April A.D. 2013

William M. Gardner
Secretary of State

CERTIFICATE OF VOTE

I, Linda Sanborn, do hereby certify that:

1. I am the duly elected Treasurer of Families First of the Greater Seacoast;

2. The following are true copies of two resolutions duly adopted at a meeting by the Board of Directors of the Corporation duly held on March 6, 2014.

   RESOLVED: That this Corporation enter into a contract with the State of New Hampshire, acting through its Department of Health and Human Services, for the provision of Primary Health Care Services.

   RESOLVED: That the Director of Families First of the Greater Seacoast is hereby authorized to execute any and all documents, agreements, and other instruments, and any amendments, revisions, or modifications thereto, as he/she may deem necessary, desirable or appropriate.

3. The forgoing resolutions have not been amended or revoked, and remain in full force and effect as of the 6th day of March, 2014.

4. Helen B. Taft is the duly elected Director of the Corporation.

Linda Sanborn, Treasurer

STATE OF NEW HAMPSHIRE
COUNTY OF ROCKINGHAM

The foregoing instrument was acknowledged before me this 6th day of March, 2014 by Linda Sanborn.

Notary Public/Justice of the Peace

My Commission Expires: My Commission Expires March 7, 2017

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 2/27/2014

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 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	
Tobey & Merrill Insurance 20 High Street Hampton NH 03842-2214	CONTACT NAME: Jennifer Reckmeyer PHONE (A/C, No, Ext): (603) 926-7655 FAX (A/C, No): (603) 926-2135 E-MAIL ADDRESS: jennifer@tobeymerrill.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: Peerless Indemnity	18333
INSURER B: Peerless Insurance Company	24198
INSURER C:	
INSURER D:	
INSURER E:	
INSURER F:	

INSURED

Families First of the Greater Seacoast
100 Campus Dr Ste 12
Suite 12
Portsmouth NH 03801

COVERAGES CERTIFICATE NUMBER: CL141302577 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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY / PRO-JECT / LOC			BOP8358757	12/29/2013	12/29/2014	EACH OCCURRENCE	$ 2,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 50,000
							MED EXP (Any one person)	$ 5,000
							PERSONAL & ADV INJURY	$ 2,000,000
							GENERAL AGGREGATE	$ 4,000,000
							PRODUCTS - COMP/OP AGG	$ 4,000,000
								$
B	AUTOMOBILE LIABILITY X ANY AUTO ALL OWNED AUTOS / SCHEDULED AUTOS HIRED AUTOS / NON-OWNED AUTOS			BA5375202	12/29/2013	12/29/2014	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
							Underinsured motorist	$ 1,000,000
B	X UMBRELLA LIAB / OCCUR EXCESS LIAB / CLAIMS-MADE DED X RETENTION $ 10,000			CU8353458	12/29/2013	12/29/2014	EACH OCCURRENCE	$ 1,000,000
							AGGREGATE	$ 1,000,000
								$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		WC5055429	12/29/2013	12/29/2014	WC STATU-TORY LIMITS / OTH-ER	
							E.L. EACH ACCIDENT	$ 1,000,000
							E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

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

CERTIFICATE HOLDER

DHHS
Contracts and Procurement Unit
129 Pleasant St
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

B Lizotte CIC/DEB [signature] Barbara R Lizotte CIC

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Families First of the Greater Seacoast

Financial Report

June 30, 2013

Independent Auditors' Report

To the Board of Directors
Families First of the Greater Seacoast
Portsmouth, New Hampshire

Report on the Financial Statements

We have audited the accompanying financial statements of Families First of the Greater Seacoast (a nonprofit organization) which comprise the statements of financial position as of June 30, 2013 and 2012, and the related statements of activities, functional expenses, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

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

Auditors' Responsibility

Our responsibility is to express an opinion on these 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 audits to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the 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 entity'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 financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Macpage LLC
[illegible] Creek Drive, South Portland, ME 04106-2437 | 207-774-5701 | 207-774-7835 fax | cpa@macpage.com
[illegible] Market Square, Augusta, ME 04330-4637 | 207-622-4766 | 207-622-6545 fax
macpage.com
An Independently Owned Member, McGladrey Alliance

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Families First of the Greater Seacoast as of June 30, 2013 and 2012, and the changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Macpage

Augusta, Maine
November 5, 2013

Statements of Financial Position

June 30,

	2013	2012
ASSETS		
Current Assets		
Cash (note 2)	$ 74,547	$ 401,496
Cash, fiscal agent (note 9)	195	3,195
Grants receivable (note 3)	67,300	60,265
Accounts receivable, net (notes 1 and 4)	131,560	134,102
Current portion of pledges receivable (notes 1 and 5)	336,748	199,012
Other receivables (note 6)	26,620	52,998
Prepaid expenses	15,133	20,149
Total Current Assets	652,103	871,217
Non-Current Assets		
Pledges receivable, net of current (notes 1 and 5)		108,301
Property and Equipment, Net (Notes 1 and 7)	247,992	336,726
Investments		
Endowment (notes 8 and 19)	1,392,530	1,267,448
Board designated	66,360	62,409
Total Investments	1,458,890	1,329,857
Total Assets	$ 2,358,985	$ 2,646,101
LIABILITIES AND NET ASSETS		
Current Liabilities		
Accounts payable	$ 85,519	$ 63,918
Accrued expenses	287,904	224,664
Amount due, fiscal agent (note 9)	195	3,195
Deferred revenue	24,476	113,574
Total Current Liabilities	398,094	405,351
Net Assets		
Unrestricted	177,628	622,628
Temporarily restricted (notes 8 and 12)	583,076	417,935
Permanently restricted (notes 8 and 13)	1,200,187	1,200,187
Total Net Assets	1,960,891	2,240,750
Total Liabilities and Net Assets	$ 2,358,985	$ 2,646,101

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

Statements of Activities

Year ended June 30,

	2013			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
PUBLIC SUPPORT AND REVENUES:				
Public Support				
Contributions	$ 1,404,161	$ 640,797		$ 2,044,958
Grants and contracts	940,575			940,575
Total public support	2,344,736	640,797		2,985,533
Revenues				
Patient service revenue (note 11)	1,577,353			1,577,353
Provision for bad debt	(43,860)			(43,860)
Net patient service revenue	1,533,493			1,533,493
Investment income - endowment (note 8)		42,953		42,953
Investment income - board designated	2,322			2,322
Unrealized gain on investments - endowment (note 8)		135,824		135,824
Unrealized gain on investments - board designated	1,630			1,630
Miscellaneous	82,505			82,505
Total revenue	1,619,950	178,777		1,798,727
Public support and revenues	3,964,686	819,574		4,784,260
Net Assets Released from Restrictions	654,433	(654,433)		
TOTAL PUBLIC SUPPORT AND REVENUES	4,619,119	165,141		4,784,260
EXPENSES				
Program services	4,365,565			4,365,565
Management and general	540,959			540,959
Fundraising	157,595			157,595
Total expenses	5,064,119			5,064,119
CHANGE IN NET ASSETS	(445,000)	165,141		(279,859)
NET ASSETS, BEGINNING OF YEAR	622,628	417,935	$ 1,200,187	2,240,750
NET ASSETS, END OF YEAR	$ 177,628	$ 583,076	$ 1,200,187	$ 1,960,891

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

Statements of Activities - Continued

Year ended June 30,

	2012			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
PUBLIC SUPPORT AND REVENUES:				
Public Support				
Contributions	$ 1,216,970	$ 713,725		$ 1,930,695
Grants and contracts	1,012,307			1,012,307
Total public support	2,229,277	713,725		2,943,002
Revenues				
Patient service revenue (note 11)	1,656,550			1,656,550
Provision for bad debt	(46,017)			(46,017)
Net patient service revenue	1,610,533			1,610,533
Investment income - endowment (note 8)		36,260		36,260
Investment income - board designated	2,046			2,046
Unrealized gain on investments - endowment (note 8)		(56,885)		(56,885)
Unrealized gain on investments - board designated	174			174
Miscellaneous	54,135			54,135
Total revenue	1,666,888	(20,625)		1,646,263
Public support and revenues	3,896,165	693,100		4,589,265
Net Assets Released from Restrictions	707,148	(707,148)		
TOTAL PUBLIC SUPPORT AND REVENUES	4,603,313	(14,048)		4,589,265
EXPENSES				
Program services	3,944,736			3,944,736
Management and general	518,091			518,091
Fundraising	157,111			157,111
Total expenses	4,619,938			4,619,938
CHANGE IN NET ASSETS	(16,625)	(14,048)		(30,673)
NET ASSETS, BEGINNING OF YEAR	639,253	431,983	$ 1,200,187	2,271,423
NET ASSETS, END OF YEAR	$ 622,628	$ 417,935	$ 1,200,187	$ 2,240,750

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

Statements of Cash Flows

Years ended June 30,

	2013	2012
Cash flows from operating activities		
Change in net assets	$ (279,859)	$ (30,673)
Adjustments to reconcile change in net assets to net cash flows from operating activities:		
Depreciation expense	98,920	108,863
Unrealized (gain) loss on investments	(137,454)	56,711
Provision for bad debt	43,860	46,017
(Increase) decrease in operating assets:		
Cash, fiscal agent	3,000	850
Grants receivable	(7,035)	22,587
Accounts receivable	(41,318)	(29,206)
Pledges receivable	(29,435)	(28,379)
Other receivable	26,378	(48,074)
Prepaid expenses	5,016	17,957
Increase (decrease) in operating liabilities:		
Accounts payable	21,602	17,103
Accrued expenses	63,240	6,714
Amount due, fiscal agent	(3,000)	(850)
Deferred revenue	(89,098)	63,574
Total adjustments	(45,324)	233,867
Net cash flows from operating activities	(325,183)	203,194
Cash flows from investing activities:		
Purchase of property and equipment	(10,186)	(72,899)
Net (purchase) proceeds from sale of investments	8,420	(6)
Net cash flows from investing activities	(1,766)	(72,905)
Net change in cash and cash equivalents	(326,949)	130,289
Cash and cash equivalents at beginning of year	401,496	271,207
Cash and cash equivalents at end of year	$ 74,547	$ 401,496

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

Statements of Functional Expenses

Year ended June 30, 2013

	Health Services		
	Primary Care	Dental	Homeless
Salaries	$ 1,443,761	$ 482,291	$ 405,383
Payroll taxes/benefits	261,220	83,963	53,403
Professional fees/contract labor	223,716	17,482	73,160
Medical/laboratory costs	25,630	70,854	15,655
Physicians/dentists	170,970	28,710	33,538
Office	15,862	8,210	55,195
Miscellaneous	10,242	1,979	272
Travel	3,107	608	21,655
Conferences	10,587	924	883
Dues/publications	5,322	2,370	1,605
Depreciation	8,458	25,453	17,212
Rent (note 15)	63,613	9,424	3,534
Telephone	4,456	650	811
Postage	436	6	3
Insurance	38,883	8,058	5,665
Printing	3,274	480	405
Computer operations	58,889	14,049	14,701
Flexible funds			
Program expenses	49,054	5,949	6,361
	$ 2,397,480	$ 761,460	$ 709,441

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

Statements of Functional Expenses - Continued

Year ended June 30, 2013

	Family Services	Total Program	Management & General	Fundraising	Total
Salaries	$ 278,483	$ 2,609,918	$ 318,984	$ 121,609	$ 3,050,511
Payroll taxes/benefits	51,340	449,926	52,532	17,925	520,383
Professional fees/contract labor	40,185	354,543	33,968		388,511
Medical/laboratory costs		112,139			112,139
Physicians/dentists		233,218			233,218
Office	14,135	93,402	20,110	2,641	116,153
Miscellaneous	505	12,998	25,577	638	39,213
Travel	14,135	39,505	2,394	316	42,215
Conferences	1,607	14,001	994	2,893	17,888
Dues/publications	380	9,677	8,556	1,065	19,298
Depreciation	436	51,559	47,361		98,920
Rent (note 15)	41,231	117,802			117,802
Telephone	3,363	9,280	766		10,046
Postage	11	456	18,126	1,138	19,720
Insurance	6,523	59,129	7,099		66,228
Printing	860	5,019	1,206	7,639	13,864
Computer operations	13,109	100,748	2,907	727	104,382
Flexible funds	25,756	25,756			25,756
Program expenses	5,125	66,489	379	1,004	67,872
	$ 497,184	$ 4,365,565	$ 540,959	$ 157,595	$ 5,064,119

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

Statements of Functional Expenses

Year ended June 30, 2012

	Health Services		
	Primary Care	Dental	Homeless
Salaries	$ 1,167,150	$ 442,369	$ 403,576
Payroll taxes/benefits	155,715	53,062	57,001
Professional fees/contract labor	194,149	22,420	66,153
Medical/laboratory costs	22,614	72,576	17,014
Physicians/dentists	292,487	27,903	26,198
Office	16,215	9,342	42,946
Miscellaneous	34,499	6,385	296
Travel	3,441	949	16,110
Conferences	9,177	2,398	3,341
Dues/publications	4,350	990	635
Depreciation	14,243	24,246	16,582
Rent (note 15)	60,456	8,956	3,359
Telephone	5,874	901	7,204
Postage	158	7	4
Insurance	22,173	6,252	2,988
Printing	2,519	380	178
Computer operations	54,442	10,873	4,975
Flexible funds			
Program expenses	32,676	6,310	3,964
	$ 2,092,338	$ 696,319	$ 672,524

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

Statements of Functional Expenses - Continued

Year ended June 30, 2012

	Family Services	Total Program	Management & General	Fundraising	Total
Salaries	$ 279,155	$ 2,292,250	$ 301,477	$ 118,836	$ 2,712,563
Payroll taxes/benefits	37,820	303,598	46,117	20,836	370,551
Professional fees/contract labor	54,367	337,089	29,750	2,665	369,504
Medical/laboratory costs		112,204			112,204
Physicians/dentists		346,588			346,588
Office	9,177	77,680	21,034	2,592	101,306
Miscellaneous	626	41,806	22,952	3,091	67,849
Travel	13,441	33,941	2,629	233	36,803
Conferences	1,990	16,906	693		17,599
Dues/publications	24	5,999	8,201	10	14,210
Depreciation	436	55,507	53,356		108,863
Rent (note 15)	39,185	111,956			111,956
Telephone	4,207	18,186	1,873		20,059
Postage	13	182	18,585	814	19,581
Insurance	4,164	35,577	6,189		41,766
Printing	721	3,798	415	7,103	11,316
Computer operations	11,393	81,683	2,990	498	85,171
Flexible funds	22,936	22,936			22,936
Program expenses	3,900	46,850	1,830	433	49,113
	$ 483,555	$ 3,944,736	$ 518,091	$ 157,111	$ 4,619,938

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

Families First

support for families...health care for all

Mission Statement

Families First Health and Support Center contributes to the health and well-being of the Seacoast community by providing a broad range of health and family services to all, regardless of ability to pay.

Vision Statement

We envision a strong community that provides fully for the health and well-being of all its members.

Guiding Principles

Families First will:

- offer a broad array of health and family services to meet evolving community needs;
- meet a standard of excellence in all services;
- ensure that no one is turned away due to inability to pay;
- treat clients respectfully and with concern for dignity;
- integrate services wherever possible;
- partner with other organizations to help realize our vision.

Families First

support for families...health care for all

Board of Directors

Director	Term Ending
Patricia Locuratolo, MD, **Chair**	2014
Mary Schleyer, **Vice Chair**	2015
Kristen Hanley, **Secretary**	2016
Linda Sanborn, **Treasurer**	2015
Karin Barndollar, **Director**	2015
Mike Burke, **Director**	2016
Marsha Filion **Director**	2015
Barbara Henry, **Director**	2015
Jack Jamison, **Director**	2015
Sarah Knowlton, **Director**	2016
Josephine Lamprey, **Director**	2014
Kathleen MacLeod, **Director**	2014
Ronda MacLeod, **Director**	2016
David McNicholas, **Director**	2016
Edna Mosher, **Director**	2016
Tom Newbold, **Director**	2016
John Pelletier, **Director**	2015
Donna Ryan, **Director**	2014
Daniel Schwarz, **Director**	2014
Richard Senger, **Director Emeritus**	

KEY ADMINISTRATIVE PERSONNEL

NH Department of Health and Human Services

Contractor Name: Families First of the Greater Seacoast

2/20/2014

Name of Bureau/Section: MCH Primary Care

BUDGET PERIOD: SFY 14

Program Area: MCH Primary Care

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Helen B. Taft	Executive Director	$103,189	0.00%	$0.00
David C. Choate	Finance Director	$68,216	0.00%	$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$0.00**

KEY ADMINISTRATIVE PERSONNEL

NH Department of Health and Human Services

Contractor Name: Families First of the Greater Seacoast

2/21/2014

Name of Bureau/Section: MCH Primary Care & BCCP

BUDGET PERIOD: SFY 15

Program Area: MCH Primary Care Services

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Helen B. Taft	Executive Director	$103,189	0.00%	$0.00
David C. Choate	Finance Director	$68,216	0.00%	$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$0**

Program Area: Breast and Cervical Cancer Program Services

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Helen B. Taft	Executive Director	$103,189	0.00%	$0.00
David C. Choate	Finance Director	$68,216	0.00%	$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$0.00**

HELEN B. TAFT

Families First of the Greater Seacoast
100 Campus Drive, Suite 12
Portsmouth, NH 03801
603-422-8208
Email: htaft@familiesfirstseacoast.org

OBJECTIVE: A position as Administrator in the human services or health care fields.

PROFILE:

- Highly developed research and writing skills with emphasis on analysis and evaluation
- Excellent academic record
- Strong verbal communication and group discussion skills
- Experienced interpersonal skills
- Long-term commitment to community service

EDUCATION: University of New Hampshire
Masters of Public Administration, 1989
Certificate of Paralegal Studies, 1982
Smith College
B.A. (Government) 1966

PROFESSIONAL EXPERIENCE:

FAMILIES FIRST OF THE GREATER SEACOAST, Portsmouth, NH
Executive Director Dec.1989 – Present
FOUNDATION FOR SEACOAST HEALTH, Portsmouth, N.H
Administrative Intern Jan. -June 1989
HARVEY AND MAHONEY LAW OFFICES, Manchester, NH
Paralegal 1982 -1988

VOLUNTEER LEADERSHIP EXPERIENCE:

CHILD AND FAMILY SERVICES OF NEW HAMPSHIRE 1972 –1992
President; First Vice-President; Board of Directors; Chair, Long ,Range Planning Committee; Chair, Advocacy Committee; President, Manchester Regional Executive Committee
UNITED WAY OF MANCHESTER 1985 -1988
Board of Directors; Chair, Campaign Phonothon; Venture Grant Committee
MANCHESTER LEAGUE OF WOMEN VOTERS 1973 -1978
President; Board of Directors
GREATER SEACOAST UNITED WAY 1997 -1999
Board of Directors

REFERENCES: Furnished upon request.

David C. Choate
Families First of the Greater Seacoast
100 Campus Drive, Suite 12
Portsmouth, NH 03801
603-422-8208
Email: dchoate@familiesfirstseacoast.org

PROFESSIONAL OBJECTIVE

A position in **Senior Financial Management** providing the opportunity to make a strong contribution to organizational goals though continued development of professional management and financial skills.

QUALIFICATIONS PROFILE

Experience/ Skills:

Chief Financial Officer: Assure the financial integrity of the agency.
Related skills and practices include:

- Preparing and monitoring required financial statements and reports
- Developing and revising comprehensive annual agency budgets
- Developing and updating the Administrative and Fiscal Internal Control Policies and Procedures Manual
- Supervising support staff which includes: payroll, accounts payable, accounts receivable, finance clerk, network administrator, receptionist and building maintenance
- Advising agency management and the Board of Directors in regards to fiscal planning, cost analysis auditing systems and financial reporting requirements
- Acting as the lead administrative staff for banking and investment functions, grant management and auditing functions; i.e. external and funding sources
- Reviewing and analyzing plant and equipment needs and negotiating the purchase of major equipment and financing

Computers:

- Windows-based PC's with various accounting software including Microsoft Great Plains Solomon
- Equation Solvers: Microsoft Office: Word, Excel and Outlook

Administration:

- Ensuring compliance with all applicable laws, standards, and reporting requirements of funding sources
- Preparing grant financial reports and documentations

Education:

Master Degree in Business Administration, 1989
Southern New Hampshire University – Manchester, New Hampshire

Bachelor of Science Degree in Business Administration-Accounting, 1974
Thomas College – Waterville, Maine

Accomplishments/Strengths:

- Extensive accounting, auditing and management consulting skills
- Excellent troubleshooting and analytical skills
- Well organized and proficient with details
- Excellent interpersonal and team skills

PROFESSIONAL EXPERIENCE

January 2008 to present

FAMILIES FIRST OF THE GREATER SEACOAST, Portsmouth, NH

Finance Director

July 2000 to June 2007

INDEPENDENCE ASSOCIATION, INC, Brunswick, Maine

Director of Finance & Administration

An agency that provides residential housing and day programs to adults and children with disabilities.

Accomplishments:

- Streamlined and updated audit procedures to assure successful audits
- Responsible for smooth computer conversion to Great Plains Solomon accounting software
- Maintained and increased profits from services

November 1995 to July 2000

METHODIST CONFERENCE HOME, INC, Rockland, Maine

Finance Manager

A senior housing agency with programs such as housing services, housing management, senior citizen meals and regional transportation.

Accomplishments:

- Involved in obtaining finance and operating funds to build an upscale senior housing facility
- Instituted financial administrative policies
- Obtained line of credit for operations.
- Computerized the accounting systems

May 1988 to November 1995

PROFESSIONAL MANAGEMENT ASSOCIATES, Portland, Maine

Partner and Management Consultant

A business offering a wide range of management and accounting services to professionals and small to medium-sized business, both non-profit and for profit.

Clientele:

- Small to mid-size business, i.e. food industry and pharmacies
- Health care providers; i.e. physicians, dentists, chiropractors, hospitals and veterinarians.

Accomplishments:

- Increased profits for companies through new financial management policies and procedures.

— Excellent references are available upon request —

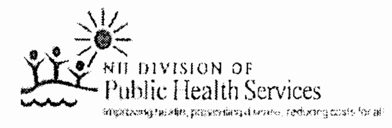
Nicholas A. Toumpas
Commissioner

José Thier Montero
Director

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

29 HAZEN DRIVE, CONCORD, NH 03301-6527
603-271-4517 1-800-852-3345 Ext. 4517
Fax: 603-271-4519 TDD Access: 1-800-735-2964



May 1, 2012

APPROVED G&C # 134
DATE 6|20|12
NOT APPROVED

His Excellency, Governor John H. Lynch
and the Honorable Executive Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Public Health Services, Bureau of Population Health and Community Services, Maternal and Child Health Section, to enter into an agreement with Families First of the Greater Seacoast (Vendor #166629-B001), 100 Campus Drive, Suite 12, Portsmouth, New Hampshire 03801, in an amount not to exceed $340,554.00, to provide primary care services and breast and cervical cancer screening, to be effective July 1, 2012 or date of Governor and Executive Council approval, whichever is later, through June 30, 2014. Funds are available in the following accounts for SFY 2013, and are anticipated to be available in SFY 2014 upon the availability and continued appropriation of funds in the future operating budgets.

05-95-90-902010-5190 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES, MATERNAL AND CHILD HEALTH

Fiscal Year	Class/Object	Class Title	Job Number	Total Amount
SFY 2013	102-500731	Contracts for Program Services	90080000	$140,243
SFY 2014	102-500731	Contracts for Program Services	90080000	$140,243
			Sub-Total	$280,486

05-95-90-902010-5659 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES, COMPREHENSIVE CANCER

Fiscal Year	Class/Object	Class Title	Job Number	Total Amount
SFY 2013	102-500731	Contracts for Program Services	90080081	$30,034
SFY 2014	102-500731	Contracts for Program Services	90080081	$30,034
			Sub-Total	$60,068
			Total	$340,554

EXPLANATION

Funds in this agreement will be used to provide breast and cervical cancer screening and office-based primary care services for low-income and uninsured families. This agreement provides funds for services as a last resort; contractor is required to make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid.

Primary health care services include preventive and episodic health care for acute and chronic health conditions for people of all ages, including pregnant women, children, adolescents, adults, and the elderly. Community health agencies that receive support through the Division of Public Health Services deliver primary and preventive health care services to underserved people who face barriers to accessing health care, due to issues such as a lack of insurance, inability to pay, language barriers, and geographic isolation. In addition to medical care, community health centers are unique among primary care providers for the array of patient-centered services they offer, including care coordination, translation, transportation, outreach, eligibility assistance, and health education. These services help individuals overcome barriers to getting the care they need and achieving their optimal health. One area of particular success has been in ensuring that eligible families maintain consistent enrollment in Medicaid for their children. Community health centers provide support for families in filling out applications and ensuring that children have continuity of care.

Community health agencies throughout New Hampshire have demonstrated success in meeting the health care needs of the uninsured and under-insured citizens of the state. Division of Public Health Services funded primary care providers participate in rigorous quality improvement efforts utilizing standard performance measures that focus attention on improving health outcomes for patients. For example, in State Fiscal Year 2011:

- 88% of eligible children served were enrolled in Medicaid/Healthy Kids Gold.
- 86% of children 24-35 months, served received the appropriate schedule of immunizations.
- 82% of infants born to women served received prenatal care beginning in the first trimester of pregnancy.

In addition, breast and cervical cancers continue to be ongoing public health issues for New Hampshire. The Division of Public Health Services, Breast and Cervical Cancer Screening Program provides support for breast and cervical cancer screening services that include clinical examinations, pap smears and referral for mammography. Through this program, women found to have abnormal screening results, following their testing, receive additional coverage for diagnostic work-up and, if necessary, have their care coordinated through the initiation of treatment.

Should Governor and Executive Council not authorize this Request, a minimum of 8,907 low-income individuals from the Seacoast area may not have access to primary care services, and eligible women may not receive recommended breast and cervical cancer screenings. A strong primary care infrastructure reduces costs for uncompensated care, improves health outcomes, and reduces health disparities. Additionally women that receive recommended breast and cervical cancer screenings are at lower risk of late diagnosis of breast and cervical cancers.

Families First of the Greater Seacoast was selected for this project through a competitive bid process. A Request for Proposals was posted on the Department of Health and Human Services' web site from January 10, 2012 through February 16, 2012. In addition, a bidder's conference, conference call, and web conference were held on January 19, 2012 to alert agencies to this bid.

Thirteen proposals were received in response to the posting. Each proposal was scored by three professionals, who work internal and external to the Department of Health and Human Services. All reviewers have between three to twenty years experience either in clinical settings, providing community-based family support services, and managing agreements with vendors for various public health programs. Areas of specific expertise include maternal and child health; quality assurance and performance improvement; chronic and communicable diseases and public health infrastructure. The reviewers used a standardized form to score agencies' relevant experience and capacity to carry out the activities outlined in the proposal. Reviewers look for realistic targets when scoring performance measures in addition to detailed workplans including evaluation components. Budgets were reviewed to be reasonable, justified and consistent with the intent of the program goals and outcomes. There were no competing applications within each of the separate service areas. Scores were averaged and all proposals were recommended for funding. In those instances where scores were less than ideal, agency specific remedial actions were recommended and completed. Some primary care agencies are being funded at levels higher than they requested. Agencies were instructed to develop budgets based on previous allocations. While some proposed budgets higher than what was available for funding, others proposed budgets lower than what was available. There was an increase in breast and cervical cancer screening funds that bidders were unaware of when they drafted budgets. Adjustments were made accordingly for those agencies that proposed budgets at levels lower than available funds. This is a contract where that situation occurred. The Bid Summary is attached.

As referenced in the Request for Proposals, Renewals Section, this competitively procured Agreement has the option to renew for two additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties and approval of the Governor and Executive Council. These services were contracted previously with this agency in SFY 2011 and SFY 2012 in the amount of $535,658. This represents a decrease of $195,104. The decrease is due to budget reductions.

The performance measures used to measure the effectiveness of the agreement are attached.

Area served: Seacoast.

Source of Funds: 34.07% Federal Funds from US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau and 65.93% General Funds.

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

Respectfully submitted,

José Thier Montero, MD
Director

Approved by: Nicholas A. Toumpas
Commissioner

JTM/PMT/sc

Primary Care Performance Measures

State Fiscal Year 2013

Primary Care Prenatal (PN) Performance Measure #1

Measure: Percent of infants born to women receiving prenatal care beginning in the first trimester of pregnancy.

Primary Care Prenatal (PN) Performance Measure #2

Measure: Percent of pregnant women identified as cigarette smokers that are referred to QuitWorks-New Hampshire.

Primary Care Prenatal (PN) Performance Measure #3

Measure: Percent of pregnant women who were screened, using a formal valid screening tool, for alcohol and other drug use during every trimester the patient was enrolled.

Primary Care Child Health Direct (CH – D) Performance Measure #1

Measure: Percent of eligible children enrolled in Medicaid

Primary Care Child Health Direct (CH – D) Performance Measure #2

Measure: Percent of at-risk children who were screened for blood lead between 18 and 30 months of age

Primary Care Child Health Direct (CH – D) Performance Measure #3

Measure: Percent of children age two to nineteen years receiving primary care preventive health services with a Body Mass Index (BMI) percentile greater than or equal to the 85th percentile with documented discussion of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Primary Care Child Health Direct (CH – D) Performance Measure #4

Measure: Percent of eligible infants and children with client record documentation of enrollment in Women Infant Children Program.

Primary Care Child Health Direct (CH – D) Performance Measure #5

Measure: Percent of infants who were exclusively breastfed for the first three months, at their four month well baby visit.

Primary Care Financial (PC) Performance Measure #1

Measure: Patient Payor Mix

Primary Care Financial (PC) Performance Measure #2

Measure: Accounts Receivables (AR) Days

Primary Care Financial (PC) Performance Measure #3

Measure: Current Ratio

Primary Care Performance Measures

State Fiscal Year 2013

Primary Care Clinical Adolescent (PC-C) Performance Measure #1

Measure: Percent of adolescents aged 10-21 years who received annual health maintenance visits in the past 12 months.

Primary Care Clinical Prenatal (PC-C) Performance Measure #2

Measure: Percent of women and adolescent girls aged 15-44 who take a multi-vitamin with folic acid.

FORM NUMBER P-37 (version 1/09)

Subject: Primary Care Services

AGREEMENT

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

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name NH Department of Health and Human Services Division of Public Health Services		**1.2 State Agency Address** 29 Hazen Drive Concord, NH 03301-6504	
1.3 Contractor Name Families First of the Greater Seacoast		**1.4 Contractor Address** 100 Campus Drive, Suite 12 Portsmouth, New Hampshire 03801	
1.5 Contractor Phone Number 603-422-8208	**1.6 Account Number** 010-090-5190-102-500731 010-090-5659-102-500731	**1.7 Completion Date** June 30, 2014	**1.8 Price Limitation** $340,554
1.9 Contracting Officer for State Agency Joan H. Ascheim, Bureau Chief		**1.10 State Agency Telephone Number** 603-271-4501	
1.11 Contractor Signature Helen B. Taft		**1.12 Name and Title of Contractor Signatory** Helen B. Taft, Executive Director/President	

1.13 Acknowledgement: State of NH, County of Rockingham

On 3/27/12, before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.

1.13.1 Signature of Notary Public or Justice of the Peace

[Seal] Nancy Casko — My Commission Expires March 7, 2017

1.13.2 Name and Title of Notary or Justice of the Peace

NANCY CASKO, NOTARY

1.14 State Agency Signature [signature]	**1.15 Name and Title of State Agency Signatory** Joan H. Ascheim, Bureau Chief

1.16 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)*

By: Director, On:

1.17 Approval by the Attorney General (Form, Substance and Execution)

By: Jeanne P. Herrick, Attorney On: 10 May 2012

1.18 Approval by the Governor and Executive Council

By: On:

NH Department of Health and Human Services

Exhibit A

Scope of Services

Primary Care Services

CONTRACT PERIOD: July 1, 2012 or date of G&C approval, whichever is later, through June 30, 2014

CONTRACTOR NAME: Families First of the Greater Seacoast

ADDRESS: 100 Campus Drive, Suite 12
Portsmouth, New Hampshire 03801
Executive Director: Helen Taft
TELEPHONE: 603-422-8208

The Contractor shall:

I. General Provisions

A) Eligibility and Income Determination

1. Office-based primary care services will be provided to low-income individuals and families (defined as ≤ 185% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), in the State of New Hampshire.

2. Breast and Cervical Cancer screening services will be provided to low-income (defined as ≤ 250% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), New Hampshire women age 18 – 64, *uninsured or underinsured*.

3. The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing if, at any time, the practice is closed to new patients, or maintains a wait list for new patients, or any other mechanism is used that limits access for new patients for more than a one month period.

4. The Contractor shall document annually, for each client enrolled in the program, family income and family size, and calculate percentage of the federal poverty level. If calculations indicate that the client may be eligible for enrollment in Medicaid, the Contractor shall complete with the client the most recent version of the 800P form.

5. The Contractor shall implement, and post in a public and conspicuous location, a sliding fee payment schedule, approved in advance by the Division of Public Health Services (DPHS), for low-income patients. Signage must state that no client will be denied services for inability to pay.

   a. As an alternative, the contractor may post, in a public and conspicuous location, a notice to clients that a sliding fee scale is available and that no client will be denied services for inability to pay. The sliding fee scale must be updated annually based on USDHHS Poverty guidelines as published in the Federal Register, submitted to and approved by DPHS *prior to implementation.*

6. The primary care contract entered into here shall be the payer of last resort. The contractor shall make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid, for all reimbursable services rendered.

B) Numbers Served

1. The contract funds shall be expended to provide the above services to a minimum of 4,156 users annually with 3,549 medical encounters, as defined in the Data and Reporting Requirements. Breast and Cervical Cancer Screening for eligible women, as defined by the Breast and Cervical Cancer Program (BCCP), shall be provided to 200 women annually and billed directly to the BCCP. Clinical service reimbursements shall not exceed the Medicare rate.

C) Culturally and Linguistically Appropriate Standards of Care

The Department of Health and Human Services (DHHS) recognizes that culture and language have considerable impact on how consumers access and respond to public health services. Culturally and linguistically diverse populations experience barriers in efforts to access health services. To ensure equal access to quality health services, the Division of Public Health Services (DPHS) expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.

2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.

3. *Provide* clients of limited English proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.

4. Offer consumers a forum through which clients have the opportunity to provide feedback to providers and organizations regarding cultural and linguistic issues that may deserve response.

5. The contractor shall maintain a program policy that sets forth compliance with Title VI, Language Efficiency and Proficiency Citation 45 CFR 80.3(b) (2). The policy shall describe the way in which the items listed above were addressed and shall indicate the circumstances in which interpretation services are provided and the method of providing service (e.g. trained interpreter, staff person who speaks the language of the client, language line).

D) State and Federal Laws

The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. The Contractor shall report all cases of communicable diseases according to New Hampshire RSA 141-C and He-P 301, adopted 6/3/08.

2. Persons employed by the contractor shall comply with the reporting requirements of New Hampshire RSA 169:C, Child Protection Act; RSA 161:F46, Protective Services to Adults, RSA 631:6, Assault and Related Offences and RSA 130:A, Lead Paint Poisoning and Control.

3. Immunizations shall be conducted in accordance with RSA 141-C and the Immunization Rules promulgated hereunder.

E) Relevant Policies and Guidelines

1. The Contractor shall design and provide the services described above to meet the unique and identified health needs of the populations within the contracted service area.

2. Primary Care funds shall be targeted to populations in need. Populations in need are defined as follows:

   a) uninsured;

   b) under-insured;

   c) families and individuals with significant psychosocial and economic risk, including low income status;

   d) all life cycles including perinatal, child, adolescent, adult, and elderly who meet one or more of the above criteria.

3. The Contractor shall design and implement systems of governance, administration, financial management, information management, and clinical services which are adequate to assure the provision of contracted services; and to meet the data and reporting requirements. These systems shall meet the most current minimum standards described in at least one of the following: Health Resources and Services Administration (HRSA) Office of Performance Review protocols, Joint Commission on Accreditation of Health Care Organizations (JCAHO), Accreditation Association for Ambulatory Healthcare (AAAHC), Community Health Accreditation Program (CHAP), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey.

4. *The Contractor shall have an agency emergency preparedness and response plan in accordance with HRSA Health Center Emergency Management Program Expectations, Document #2007-15 or most recent version. Such plan shall also include a Continuity of Operations plan.*

5. The Contractor shall carry out the work as described in the performance Workplan submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

6. No Workplan is required by the Breast and Cervical Cancer Program (BCCP). The contractor shall be required to respond to the Quality Improvement Feedback Report twice a year.

7. The Contractor shall carry out the work as described in the Supplemental Funding Form submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

F) Publications Funded Under Contract

1. The DHHS and/or its funders will retain COPYRIGHT ownership for any and all original materials produced with DHHS contract funding, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports.

2. All documents (written, video, audio, *electronic*) produced, reproduced, or purchased under the contract shall have prior approval from DPHS before printing, production, distribution, or use.

4. The Contractor shall credit DHHS on all materials produced under this contract following the instructions outlined in Exhibit C (14).

G) Subcontractors

1. If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing *and approve the subcontractual agreement,* prior to initiation of the subcontract.

Contractor Initials: [handwritten initials]
Date: [handwritten date]

2. In addition, the original DPHS contractor will remain liable for all requirements included in this Exhibit and carried out by subcontractors.

II. Minimal Standards of Core Services

A) Service Requirements

1. *Medical Home*

The Contractor shall provide a Medical Home that:

a) *Facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family.*

b) ***Provides care facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.***

2. Primary Care Services

The Contractor shall provide office-based primary care services to populations in need who reside in the contractor's service area. Primary care services shall include:

a) Health care provided by a New Hampshire licensed MD, DO, APRN, or PA, including diagnosis and treatment of acute and chronic illnesses within the scope of family practice; preventive services, screenings, and health education according to established, documented state or national guidelines; assessment of need for social and nutrition services, and appropriate referrals to health, *oral health*, and behavioral health specialty providers.

b) ***Referral to the WIC Nutrition Program for all eligible pregnant women, infants and children.***

c) In-hospital care for conditions within the scope of family practice must be provided at a hospital, within the agency service area, through a staff clinician with full hospital privileges, or in the alternative, through a formal referral and admissions procedure available to clients on a 24 hour/7 day a week basis.

d) Access to a healthcare provider, directly or by referral or subcontract, by telephone twenty-four hours per day, seven days per week.

e) Assessment of psychosocial risk for all clients at least annually and for children at scheduled preventive care visits, including, at a minimum, age appropriate assessment of safety in the home, domestic violence, adequacy of food and housing, care and welfare of children, transportation needs, and provision of necessary social services to address the priority needs and safety issues of clients and families.

f) Falls prevention screening for patients 65 years and older using the algorithm and guidelines of the American Geriatrics Society.

g) Behavioral health care directly or by referral to an agency or provider with a sliding fee scale.

h) *Nutrition assessment for all clients as part of the health maintenance visit.* Therapeutic nutrition services shall be provided *as indicated* directly or by referral to an agency or provider with a sliding fee scale. These services shall be recorded in the medical record.

i) Formal arrangements with a local hospital for emergency care must be in place and reviewed annually.

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Date: 3/21/12

j) Home health care directly or by referral to an agency or provider with a sliding fee scale.

k) Assisted living and skilled nursing facility care by referral.

l) *Oral screening annually for all clients 19 years and older to note obvious dental decay and soft tissue abnormalities with a reminder to the patient that poor oral health impacts total health.*

m) *Diagnosis and management of pediatric and adult patients with asthma provided according to National Heart Lung Blood Institute, National Asthma Education and Prevention Program, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, 2007.*

2. Breast and Cervical Cancer Screening

a) Women age 18 to 64 who are eligible for Breast and Cervical Cancer Program (BCCP) services according to income (equal to or under 250% of poverty, underinsured/uninsured) *and insurance status* criteria shall be provided the following services:

i. cervical cancer screening including a pelvic examination and Pap smear;
ii. annual breast cancer screening including a clinical breast exam, mammogram and,
iii. referrals for diagnostic and treatment services based on screening results,
iv. case management services.

b) All referrals under this provision shall be to approved certified laboratory, pathology, radiology, and surgical services. Mammography units shall be accredited by the American College of Radiology, and must be FDA certified under MQSA. Laboratories shall be CLIA certified.

c) All services shall be provided in accordance with the Breast and Cervical Cancer Program (BCCP) Policy and Procedure Manual.

d) Follow-up and tracking of all tests done, and referrals made shall be provided in accordance with the minimum standards outlined in the Breast and Cervical Cancer Program Policy and Procedure Manual.

e) All services for women enrolled in the Breast and Cervical Cancer Program (BCCP) shall be billed directly to the BCCP in accordance with protocols established by the Breast and Cervical Cancer Program.

3. Reproductive Health Services

The Contractor shall provide prenatal, interconceptional and preconception medical care, social services, nutrition services, education, and nursing care to all women of childbearing age. Preconceptional care includes the preconception, interconceptional, and postpartum periods in women's health. It is recommended that preconceptional and interconceptional care visits focus on maintaining or achieving the optimal health of the mother, lowering the risk of future adverse pregnancy outcomes, the family's future plans, and how additional children fit into that plan. Preconceptional counseling may be done during an office, group or home visit.

a) In the event prenatal care is not provided directly by the Contractor a formal Memorandum/a of Agreement for coordinated referral to an appropriately qualified provider must be maintained.

b) Prenatal care shall, at minimum, be provided in accordance with the Guidelines for Perinatal Care, sixth or most current edition, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and /or the Centers for Disease Control.

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c) Age appropriate reproductive health care shall, at a minimum, be provided in accordance with the American College of Obstetricians and Gynecologists, or the USDHHS Centers for Disease Control (CDC) current guidelines.

d) *Pregnant women enrolled in the WIC Nutrition Program shall be referred to WIC for breastfeeding education and referral to the WIC Nutrition Program peer counselors.*

e. Family planning counseling for prevention of subsequent pregnancy following an infant's birth shall be discussed with the infant's mother *at the first postpartum visit and at the infant's 2-month visit and other visits as appropriate.* Rationale for birth intervals of 18-24 months shall be presented.

f) A referral to a Title X Family Planning Clinic or other reproductive health care provider shall be made as appropriate.

4. Services for Children and Adolescents

The Contractor shall provide as a minimum, comprehensive and age-appropriate health care, screenings, and health education according to the American Academy of Pediatrics' most recent periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent. Children and adolescent visits shall include:

a) Blood lead testing shall be performed in accordance with "New Hampshire Childhood Lead Poisoning Screening and Management Guidelines", issued by the New Hampshire Department of Health and Human Services, 2009 or subsequent revisions.

b) All children enrolled in either Healthy Kids-Gold or the Women, Infant, and Children (WIC) Program and/or who are ≤ 185% poverty, regardless of town of residence, are required to have a blood lead test at ages one and two years. All children ages three to six years who have not been previously tested shall have a capillary or venous blood lead test performed.

c) All children shall be screened for iron deficiency anemia as outlined in the Centers for Disease Control and Prevention document "Recommendations to Prevent and Control Iron Deficiency in the United States (4/2/98)".

d) Age-appropriate anticipatory guidance, dietary guidance, and *feeding practice counseling* for optimal oral health shall be provided at each well child visit according to the American Academy of Pediatrics' periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent edition. Starting at age 6 months, it is recommended that all children receive an oral health assessment at every well child visit.

e) Supplemental fluoride shall be prescribed as needed based upon the fluoride levels in the child's *drinking* water supply. The fluoride dosage regimen accepted by the American Academy of Pediatrics shall be followed. No fluoride shall be prescribed without obtaining water from private wells or noting the presence or absence of fluoride in the public water supply. *Supplemental fluoride may include bottled water containing fluoride and topical applications such as varnishes.*

f) *For infants enrolled in the WIC Nutrition Program, parents shall be referred to WIC for breastfeeding support and referral to the WIC Nutrition Program peer counselors.*

Contractor Initials: [handwritten initials]

Date: [handwritten date]

5. Sexually Transmitted Infections

Primary Care Services shall provide age appropriate screening and treatment of sexually transmitted infections.

a) Treatment for sexually transmitted infections shall be provided according to the United States Centers for Disease Control Sexually Transmitted Diseases Treatment Guidelines, 2010 or subsequent revisions.

b) All clients, including women, shall be offered HIV testing following the most current recommendations of the United States Centers for Disease Control.

c) The contractor shall be responsible for ensuring referral to appropriate treatment services for any woman found to screen positive.

d) Appropriate risk reduction counseling shall be provided based on client needs.

6. Substance Use Services

a) A substance use screening history using a formal, validated screening tool shall be obtained for all clients as soon after entry into care as possible. Substance use counseling *or other substance abuse intervention, treatment, or recovery services* by an appropriately credentialed provider shall be provided on-site, or by referral, to clients with identified needs for these services. *For these identified clients, ongoing primary care services should include follow up monitoring relative to substance abuse.*

b) All clients, including pregnant women, identified as smokers shall receive counseling *using the 5A's (ask, advise, assess, assist, and arrange) treatment available through the NH Tobacco Helpline* as cited in the US Public Health Services report "Tobacco Use and Dependence", 2008, or "Smoking Cessation During Pregnancy: *A Clinician's Guide to Helping Pregnant Women Quit Smoking*", American College of Obstetricians and Gynecologists, 2011. *With prior approval, agencies may also opt to participate in the DPHS best practice initiative of the 2A's and R (ask, advise and refer).*

7. Immunizations

a) The Contractor shall adhere to the most current version of the "Recommended Adult Immunization Schedule United States", approved by the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

b) The Contractor shall administer vaccines according to the most current version of the *"Recommended Immunization Schedule for Persons Aged 0 Through 6 Years - United States", and "Recommended Immunization Schedule for Persons Aged 7 Through 18 Years – United States"* approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians, based upon availability of vaccine from the New Hampshire Immunization Program.

8. Prenatal Genetic Screening

a) A genetic screening history shall be obtained on all prenatal clients as soon after entry into care as possible.

b) All pregnant women should be offered voluntary genetic screening for fetal chromosomal abnormalities at the appropriate time following recommendations found in the American College of Obstetricians and Gynecologists' "Screening for Fetal Chromosomal

Abnormalities (2007)" or more recent guidelines. The Contractor shall be responsible for ensuring referral to appropriate genetic testing and counseling for any woman found to have a positive screening test.

9. Additional Requirements

a) The Contractor's Medical Director shall participate in the development and approval of specific guidelines for medical care that supplement minimal clinical standards. Supplemental guidelines should be reviewed, signed, and dated annually, and updated as indicated.

b) Contractors considering clinical or sociological research using clients as subjects must adhere to the legal requirements governing human subjects research. Contractors must inform the DPHS, MCHS prior to initiating any research related to this contract.

c) *The Contractor shall provide information to all employees annually about the Medical Reserve Corps Unit within their Public Health Region to enhance recruitment.*

d) *The Contractor shall provide information to all employees annually regarding the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) managed by the NH Department of Health and Human Services' Emergency Services Unit, to enhance recruitment.*

B) Staffing Provisions

The Contractor shall have, at minimum, the following staff positions:

a) executive director

b) fiscal director

c) registered nurse

d) clinical coordinator

e) medical service director

f) nutritionist *(on site or by referral)*

g) social worker

Staff positions required to provide direct services on-site include:

a) registered nurse

b) clinical coordinator

c) social worker

1. Qualifications

All health and allied health professionals shall have the appropriate New Hampshire licenses whether directly employed, contracted, or subcontracted.

In addition the following minimum qualifications shall be met for:

a) Registered Nurse

Contractor Initials: [illegible]
Date: [illegible]

a. A registered nurse licensed in the state of New Hampshire, Bachelor's degree preferred. Minimum of one-year experience in a community health setting.

b) Nutritionists:

a. A Bachelor's degree in nutritional sciences or dietetics, or a Master's degree in nutritional sciences, nutrition education, or public health nutrition or current Registered Dietitian status in accordance with the Commission on dietetic Registration of the American Dietetic Association.

b. Individuals who perform functions similar to a nutritionist but do not meet the above qualifications shall not use the title of nutritionist.

c) Social Workers shall have:

a. A Bachelor's or Master's degree in social work or Bachelor's or Master's degree in a related social science or human behavior field. A minimum of one year of experience in a community health or social services setting is preferred.

b. Individuals who perform functions similar to a social worker but do not meet the above qualifications shall not use the title of social worker.

d) Clinical Coordinators shall be:

a. A registered nurse (RN), physician, physician assistant, or nurse practitioner with a license to practice in New Hampshire.

b. The coordinator is a clinical position that oversees and takes responsibility for the clinical and administrative functions of each program.

c. The coordinator may be responsible for more than one MCH funded program.

2. New Hires

The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing within one month of hire when a new administrator, clinical coordinator, or any staff person essential to carrying out contracted services is hired to work in the program. A resume of the employee shall accompany the aforesaid notification.

3. Vacancies

a) The Contractor must notify the MCHS in writing if any critical position is vacant for more than one month, or if at any time funded under this contract does not have adequate staffing to perform all required services for more than one month. This may be done through a budget revision.

b) Before an agency hires new program personnel that do not meet the required staff qualifications, the agency shall notify the MCHS in writing requesting a waiver of the applicable staffing requirements. The Section may grant waivers based on the need of the program, individuals' experience, and additional training.

C) Coordination of Services

1. The Contractor shall coordinate, where possible, with other service providers within the contractor's community. At a minimum, such collaboration shall include interagency referrals and coordination of care.

2. The Contractor shall participate in activities *in the Public Health Region in which they provide services* as appropriate. These activities enhance the integration of community-based public health

Contractor Initials: [signature]

Date: 3/27/12

prevention and health care initiatives that are being implemented by the contractor and may include community needs assessments, public health performance assessments, and/or the development of regional health improvement plans.

3. The Contractor agrees to *participate* in and coordinate public health activities as requested by the Division of Public Health Services during any *disease outbreak* and/or *emergency*, natural or man made, affecting the public's health.

4. The Contractor is responsible for case management of the client enrolled in the program and for program follow-up activities. Case management services shall promote effective and efficient organization and utilization of resources to assure access to necessary comprehensive medical, nutritional, and social services for clients.

5. The Contractor shall assure that *appropriate, responsive, and timely* referrals and linkages for other needed services are made, carried through, and documented. Such services shall include, but not be limited to: dental services, genetic counseling, high risk prenatal services, mental health, social services, including domestic violence crisis centers, substance abuse services; and family planning services, Early Supports and Services Program, local WIC/CSF Program, Home Visiting New Hampshire Programs and health and social service agencies which serve children and families in need of those services.

D) Meetings and Trainings

The contractor will be responsible for sending staff to meetings and training required by the MCHS program, including but not limited to:

1. MCHS Agency Directors' meetings
2. Prenatal and Child Health Coordinators' meetings
3. MCHS Agency Medical Services Directors' meetings

III. Quality or Performance Improvement (QI/PI)

A) Workplans

1. Performance Workplans are required for this program and are used to monitor achievement of standard measures of performance of the services provided under this contract. The workplans are a key component of the RHPCS and the MCHS performance-based contracting system and of this contract. Outcomes shall be reported by clinical site.

2. Submit Performance Workplans and Workplan Outcome reports according to the schedule and instructions provided by the MCHS. The MCHS shall notify the Contractor at least 30 days in advance of any changes in the submission schedule.

3. The Contractor shall incorporate required and developmental performance measures, defined by the MCHS into the agency's Performance Workplan. Reports on Workplan Progress/Outcomes shall detail the Performance Workplan and activities that monitor and evaluate the agency's progress toward performance measure targets.

4. The Contractor shall comply with modifications and/or additions to the workplan and annual report format as requested by RHPCS and MCHS. MCHS will provide the contractor with reasonable notice of such changes.

5. Agencies contracting for Primary Care Services must submit the workplans for Primary Care *Clinical and Financial*, Child Health, and Prenatal Care.

Contractor Initials: [illegible]
Date: [illegible]

B) Additional Reporting requirements

In addition to Performance Workplans, the Contractor shall submit to MCHS the following data and information listed below which are used to monitor program performance:

1. In years when contracts or amendments are not required, the DPHS Budget Form, Budget Justification, Sources of Revenue and Program Staff list forms must be completed according to the relevant instructions and submitted as requested by DPHS and, at minimum, by April 30 of each year.

2. The Sources of Revenue report must be resubmitted at any point when changes in revenue threaten the ability of the agency to carry out the planned program.

3. Completed Uniform Data Set (UDS) tables reflecting program performance in the previous calendar year, by March 31 of each year.

4. The Perinatal Client Data Form (PCDF) shall be submitted electronically according to the instructions set forth by the MCHS.

5. A copy of the agency's updated Sliding Fee Scale including the amount(s) of any client fees and the schedule of discounts must be submitted by March 31st of each year. The agency's sliding fee scale must be updated annually based on the US DHHS Poverty guidelines as published in the Federal Register.

6. An annual summary of <u>program-specific</u> patient satisfaction results obtained during the prior contract period and the method by which the results were obtained shall be submitted annually as an addendum to the Workplan Outcome/Progress reports.

C) On-site reviews

1. The contractor shall allow a team or person authorized by the Division of Public Health Services to periodically review the contractor's systems of governance, administration, data collection and submission, clinical and financial management, and delivery of education services in order to assure systems are adequate to provide the contracted services.
2. Reviews shall include client record reviews to measure compliance with this exhibit.
3. The contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.
4. On-Site reviews may be waived or abbreviated at the discretion of MCHS, upon submission of satisfactory reports of reviews such as Health Services Resources Administration (HRSA): Office of Performance Review (OPR), or reviews from nationally accreditation organizations such as the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), Medicare, the Community Health Accreditation Program (CHAP), Accreditation Association for Ambulatory Healthcare (AAAHC), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey. Abbreviated reviews will focus on any deficiencies found in previous reviews, issues of compliance with this exhibit, and actions to strengthen performance as outlined in the agency Performance Workplan.

Contractor Initials: 1Vhs
Date: 3\27\12

State of New Hampshire
Department of Health and Human Services
Amendment #1 to the
Goodwin Community Health

This 1st Amendment to the Goodwin Community Health, contract (hereinafter referred to as "Amendment One") dated this 11 day of March, 2014, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Goodwin Community Health, (hereinafter referred to as "the Contractor"), a corporation with a place of business at 311 Route 108, Somersworth, New Hampshire 03878.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on June 20, 2012, 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, the State and the Contractor have agreed to make changes to the scope of work, payment schedules and terms and conditions of the contract; and

WHEREAS, pursuant to the General Provisions, Paragraph 18, the State may modify the scope of work and the payment schedule of the contract by written agreement of the parties;

WHEREAS, the Department desires to provide additional primary health care services for preventive and episodic health care for acute and chronic health conditions for people of all ages.

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 as follows:

To amend as follows:

- Form P-37, to change:
  Block 1.7 to read: June 30, 2015
  Block 1.8 to read: $1,095,268

- Exhibit A, Scope of Services to add:
  Exhibit A – Amendment 1

- Exhibit B, Purchase of Services, Contract Price, to add:

  Paragraph 1.1 to Paragraph 1:
  The contract price shall increase by $74,293 for SFY 2014 and $420,579 for SFY 2015.

  Paragraph 1.2 to Paragraph 1:
  Funding is available as follows:
- $74,293 from 05-95-90-902010-5190-102-500731, 100% General Funds;
- $372,533 from 05-95-90-902010-5190-102-500731, 6.7% Federal Funds from the US Department of Health and Human Services Administration, Maternal and Child Health Bureau, CFDA #93.994 and 93.3% General Funds;

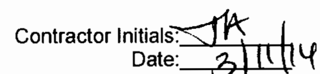
Contractor Initials: JA
Date: 3/11/14

- $48,046 from 05-95-90-902010-5659-102-500731, 100% Federal Funds from the US Department of Health and Human Services, Centers for Disease Control and Prevention, CFDA #93.283;

  Add Paragraph 8
  8. Notwithstanding paragraph 18 of the General Provisions P-37, an amendment limited to adjustments to amounts between and among account numbers, within the price limitation, may be made by written agreement of both parties and may be made without obtaining approval of the Governor and Executive Council.

- Budget, to add:
  Exhibit B-1 (2014) - Amendment 1,
  Exhibit B-1 (2015) - Amendment 1

This amendment shall be in effect July 1, 2013, effective upon the date of Governor and Executive Council approval.

Contractor Initials: 
Date: 3/11/14

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

3/28/14
Date

Brook Dupee
Bureau Chief

Goodwin Community Health

3-11-14
Date

Name: Janet Atkins
Title: Executive Director

Acknowledgement:

State of New Hampshire, County of Strafford on 3-11-14, before the undersigned officer, personally appeared the person identified above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.

Signature of Notary Public or Justice of the Peace

Sherry Trask
Name and Title of Notary or Justice of the Peace
comm exp. 11/6/2018

Contractor Initials: JA
Date: 3/11/14

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

OFFICE OF THE ATTORNEY GENERAL

4-2-14
Date

Name: Rosemary Wiant
Title: Asst Attorney General

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:

Contractor Initials: JA
Date: 3/11/14

EXHIBIT A – AMENDMENT 1

Scope of Services

The Department desires to continue the relationship with the primary care agencies to provide additional primary health care services for preventive and episodic health care for acute and chronic health conditions for people of all ages.

I. General Provisions

A) Eligibility and Income Determination

1. Office-based primary care services will be provided to low-income individuals and families (defined as ≤ 185% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), in the State of New Hampshire.

2. Breast and Cervical Cancer screening services will be provided to low-income (defined as ≤ 250% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), New Hampshire women age 21– 64, uninsured or underinsured. BCCP changes.

3. The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing if, at any time, the practice is closed to new patients, or maintains a wait list for new patients, or any other mechanism is used that limits access for new patients for more than a one month period.

4. The Contractor shall document annually, for each client enrolled in the program, family income and family size, and calculate percentage of the federal poverty level. If calculations indicate that the client may be eligible for enrollment in Medicaid, the Contractor shall complete with the client the most recent version of the 800P form.

5. The Contractor shall implement, and post in a public and conspicuous location, a sliding fee payment schedule, approved in advance by the Division of Public Health Services (DPHS), for low-income patients. Signage must state that no client will be denied services for inability to pay.

   a. As an alternative, the contractor may post, in a public and conspicuous location, a notice to clients that a sliding fee scale is available and that no client will be denied services for inability to pay. The sliding fee scale must be updated annually based on USDHHS Poverty guidelines as published in the Federal Register, submitted to and approved by DPHS prior to implementation.

6. The primary care contract entered into here shall be the payer of last resort. The contractor shall make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid, for all reimbursable services rendered.

EXHIBIT A – AMENDMENT 1

B) Numbers Served

1. The contract funds shall be expended to provide the above services to a minimum of 3000 users annually with 9000 medical encounters, as defined in the Data and Reporting Requirements. Breast and Cervical Cancer Screening for eligible women, as defined by the Breast and Cervical Cancer Program (BCCP), shall be provided to 300 women annually and billed directly to the BCCP. Clinical service reimbursements shall not exceed the Medicare rate.

C) Culturally and Linguistically Appropriate Standards of Care

The Department of Health and Human Services (DHHS) recognizes that culture and language have considerable impact on how consumers access and respond to public health services. Culturally and linguistically diverse populations experience barriers in efforts to access health services. To ensure equal access to quality health services, the Division of Public Health Services (DPHS) expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.

2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.

3. Provide clients of limited English proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.

4. Offer consumers a forum through which clients have the opportunity to provide feedback to providers and organizations regarding cultural and linguistic issues that may deserve response.

5. The contractor shall maintain a program policy that sets forth compliance with Title VI, Language Efficiency and Proficiency Citation 45 CFR 80.3(b) (2). The policy shall describe the way in which the items listed above were addressed and shall indicate the circumstances in which interpretation services are provided and the method of providing service (e.g. trained interpreter, staff person who speaks the language of the client, language line).

D) State and Federal Laws

The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. The Contractor shall report all cases of communicable diseases according to New Hampshire RSA 141-C and He-P 301, adopted 6/3/08.

2. Persons employed by the contractor shall comply with the reporting requirements of New Hampshire RSA 169:C, Child Protection Act; RSA 161:F46, Protective Services to Adults, RSA 631:6, Assault and Related Offences and RSA 130:A, Lead Paint Poisoning and Control.

3. Immunizations shall be conducted in accordance with RSA 141-C and the Immunization Rules promulgated hereunder.

E) Relevant Policies and Guidelines

1. The Contractor shall design and provide the services described above to meet the unique and identified health needs of the populations within the contracted service area.

2. Primary Care funds shall be targeted to populations in need. Populations in need are defined as follows:

   a) uninsured;

   b) under-insured;

   c) families and individuals with significant psychosocial and economic risk, including low income status;

   d) all life cycles including perinatal, child, adolescent, adult, and elderly who meet one or more of the above criteria.

3. The Contractor shall design and implement systems of governance, administration, financial management, information management, and clinical services which are adequate to assure the provision of contracted services, and to meet the data and reporting requirements. These systems shall meet the most current minimum standards described in at least one of the following: Health Resources and Services Administration (HRSA) Office of Performance Review protocols, Joint Commission on Accreditation of Health Care Organizations (JCAHO), Accreditation Association for Ambulatory Healthcare (AAAHC), Community Health Accreditation Program (CHAP), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey.

4. The Contractor shall have an agency emergency preparedness and response plan in accordance with HRSA Health Center Emergency Management Program Expectations, Document #2007-15 or most recent version. Such plan shall also include a Continuity of Operations plan.

5. The Contractor shall carry out the work as described in the performance Workplan submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

6. No Workplan is required by the Breast and Cervical Cancer Program (BCCP). The contractor shall be required to respond to the Quality Improvement Feedback Report twice a year.

7. The Contractor shall carry out the work as described in the Supplemental Funding Form submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

F) Publications Funded Under Contract

1. The DHHS and/or its funders will retain COPYRIGHT ownership for any and all original materials produced with DHHS contract funding, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports.

2. All documents (written, video, audio, electronic) produced, reproduced, or purchased under the contract shall have prior approval from DPHS before printing, production, distribution, or use.

3. The Contractor shall credit DHHS on all materials produced under this contract following the instructions outlined in Exhibit C (14).

G) Subcontractors

If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing and approve the subcontractual agreement, prior to initiation of the subcontract.

1. If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing and approve the subcontractual agreement, prior to initiation of the subcontract.

2. In addition, the original DPHS contractor will remain liable for all requirements included in this Exhibit and carried out by subcontractors.

II. Minimal Standards of Core Services

A. Service Requirements

1. Medical Home

The Contractor shall provide a Medical Home that:

a) Facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family.

b) Provides care facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

2. Primary Care Services

The Contractor shall provide office-based primary care services to populations in need who reside in the contractor's service area. Primary care services shall include:

a) Health care provided by a New Hampshire licensed MD, DO, APRN, or PA, including diagnosis and treatment of acute and chronic illnesses within the scope of family practice; preventive services, screenings, and health education according to established, documented state or national guidelines; assessment of need for social and nutrition services, and appropriate referrals to health, oral health, and behavioral health specialty providers.

b) Referral to the WIC Nutrition Program for all eligible pregnant women, infants and children.

c) In-hospital care for conditions within the scope of family practice must be provided at a hospital, within the agency service area, through a staff clinician with full hospital privileges, or in the alternative, through a formal referral and admissions procedure available to clients on a 24 hour/7 day a week basis.

d) Access to a healthcare provider, directly or by referral or subcontract, by telephone twenty-four hours per day, seven days per week.

e) Assessment of psychosocial risk for all clients at least annually and for children at scheduled preventive care visits, including, at a minimum, age appropriate assessment of safety in the home, domestic violence, adequacy of food and housing, care and welfare of children, transportation needs, and provision of necessary social services to address the priority needs and safety issues of clients and families.

f) Falls prevention screening for patients 65 years and older using the algorithm and guidelines of the American Geriatrics Society.

g) Behavioral health care directly or by referral to an agency or provider with a sliding fee scale.

h) Nutrition assessment for all clients as part of the health maintenance visit. Therapeutic nutrition services shall be provided as indicated directly or by referral to an agency or provider with a sliding fee scale. These services shall be recorded in the medical record.

i) Formal arrangements with a local hospital for emergency care must be in place and reviewed annually.

j) Home health care directly or by referral to an agency or provider with a sliding fee scale.

k) Assisted living and skilled nursing facility care by referral.

l) Oral screening annually for all clients 21 years and older to note obvious dental decay and soft tissue abnormalities with a reminder to the patient that poor oral health impacts total health.

m) Diagnosis and management of pediatric and adult patients with asthma provided according to National Heart Lung Blood Institute, National Asthma Education and Prevention Program, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, 2007.

3. Breast and Cervical Cancer Screening

a) Women age 21 to 64 who are eligible for Breast and Cervical Cancer Program (BCCP) services according to income (equal to or under 250% of poverty, underinsured/uninsured) and insurance status criteria shall be provided the following services, following USPSTF screening recommendations:

i. cervical cancer screening including a pelvic examination and Pap smear;
ii. breast cancer screening including a clinical breast exam, mammogram and,
iii. referrals for diagnostic and treatment services based on screening results,
iv. case management services.

b) All referrals under this provision shall be to approved certified laboratory, pathology, radiology, and surgical services. Mammography units shall be accredited by the American College of Radiology, and must be FDA certified under MQSA. Laboratories shall be CLIA certified.

c) All services shall be provided in accordance with the Breast and Cervical Cancer Program (BCCP) Policy and Procedure Manual.

d) Follow-up and tracking of all tests done, and referrals made shall be provided in accordance with the minimum standards outlined in the Breast and Cervical Cancer Program Policy and Procedure Manual.

e) All services for women enrolled in the Breast and Cervical Cancer Program (BCCP) shall be billed directly to the BCCP in accordance with protocols established by the Breast and Cervical Cancer Program.

f) The Contractor shall provide the NH Breast and Cervical Cancer Program with breast and cervical cancer screening rates for all women served by the practice as requested, but not more than twice per SFY.

EXHIBIT A – AMENDMENT 1

g) The contractor shall work with the NH Breast and Cervical Cancer Program staff to increase the breast and cervical cancer screening rates among all women serviced by the practice.

4. Reproductive Health Services

The Contractor shall provide prenatal, interconceptional and preconception medical care, social services, nutrition services, education, and nursing care to all women of childbearing age. Preconceptional care includes the preconception, interconceptional, and postpartum periods in women's health. It is recommended that preconceptional and interconceptional care visits focus on maintaining or achieving the optimal health of the mother, lowering the risk of future adverse pregnancy outcomes, the family's future plans, and how additional children fit into that plan. Preconceptional counseling may be done during an office, group or home visit.

a) In the event prenatal care is not provided directly by the Contractor a formal Memorandum/a of Agreement for coordinated referral to an appropriately qualified provider must be maintained.

b) Prenatal care shall, at minimum, be provided in accordance with the Guidelines for Perinatal Care, sixth or most current edition, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and /or the Centers for Disease Control.

c) Age appropriate reproductive health care shall, at a minimum, be provided in accordance with the American College of Obstetricians and Gynecologists, or the USDHHS Centers for Disease Control (CDC) current guidelines.

d) Pregnant women enrolled in the WIC Nutrition Program shall be referred to WIC for breastfeeding education and referral to the WIC Nutrition Program peer counselors.

e. Family planning counseling for prevention of subsequent pregnancy following an infant's birth shall be discussed with the infant's mother at the first postpartum visit and at the infant's 2-month visit and other visits as appropriate. Rationale for birth intervals of 18-24 months shall be presented.

f) A referral to a Title X Family Planning Clinic or other reproductive health care provider shall be made as appropriate.

5. Services for Children and Adolescents

The Contractor shall provide as a minimum, comprehensive and age-appropriate health care, screenings, and health education according to the American Academy of Pediatrics' most recent periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent. Children and adolescent visits shall include:

EXHIBIT A – AMENDMENT 1

a) The World Health Organization (WHO) growth charts shall be used to monitor growth for infants and children birth up to age 2 years. The Centers for Disease Control and Prevention (CDC) growth charts shall be used for children age 2 years and older.

b) Blood lead testing shall be performed in accordance with "New Hampshire Childhood Lead Poisoning Screening and Management Guidelines", issued by the New Hampshire Department of Health and Human Services, 2009 or subsequent revisions.

c) All children enrolled in either Medicaid, Head Start, or the Women, Infant, and Children (WIC) Program and/or who are ≤ 185%_poverty, regardless of town of residence, are required to have a blood lead test at ages one and two years. All children ages three to six years who have not been previously tested shall have a blood lead test performed.

d) All children shall be screened for iron deficiency anemia as outlined in the Centers for Disease Control and Prevention document "Recommendations to Prevent and Control Iron Deficiency in the United States (4/2/98)".

e) Age-appropriate anticipatory guidance, dietary guidance, and *feeding practice counseling* for optimal oral health shall be provided at each well child visit according to the American Academy of Pediatrics' periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent edition. Starting at age 6 months, it is recommended that all children receive an oral health assessment at every well child visit, and a referral for the child's first visit to the dentist by age one as recommended by the American Academy of Pediatrics and the American Academy of Pediatric Dentistry.

f) Supplemental fluoride shall be prescribed as needed based upon the fluoride levels in the child's drinking water supply. The fluoride dosage regimen accepted by the American Academy of Pediatrics shall be followed. No fluoride shall be prescribed without obtaining water from private wells or noting the presence or absence of fluoride in the public water supply. Supplemental fluoride may include bottled water containing fluoride and topical applications such as varnishes.

g) For infants enrolled in the WIC Nutrition Program, parents shall be referred to WIC for breastfeeding support and referral to the WIC Nutrition Program peer counselors.

6. Sexually Transmitted Infections

Primary Care Services shall provide age appropriate screening and treatment of sexually transmitted infections.

a) Treatment for sexually transmitted infections shall be provided according to the United States Centers for Disease Control Sexually Transmitted Diseases Treatment Guidelines, 2010 or subsequent revisions.

b) All clients, including women, shall be offered HIV testing following the most current recommendations of the United States Centers for Disease Control.

c) The contractor shall be responsible for ensuring referral to appropriate treatment services for any woman found to screen positive.

d) Appropriate risk reduction counseling shall be provided based on client needs.

7. Substance Use Services

a) A substance use screening history using a formal, validated screening tool shall be obtained for all clients as soon after entry into care as possible. Substance use counseling or other substance abuse intervention, treatment, or recovery services by an appropriately credentialed provider shall be provided on-site, or by referral, to clients with identified needs for these services. For these identified clients, ongoing primary care services should include follow up monitoring relative to substance abuse.

b) All clients, including pregnant women, identified as smokers shall receive counseling using the 5A's (ask, advise, assess, assist, and arrange) treatment available through the NH Tobacco Helpline as cited in the US Public Health Services report "Tobacco Use and Dependence", 2008, or "Smoking Cessation During Pregnancy: A Clinician's Guide to Helping Pregnant Women Quit Smoking", American College of Obstetricians and Gynecologists, 2011. With prior approval, agencies may also opt to participate in the DPHS best practice initiative of the 2A's and R (ask, advise and refer).

8. Immunizations

a) The Contractor shall adhere to the most current version of the "Recommended Adult Immunization Schedule for Adults (19 years and older) by Age and Medical Condition - United States", approved by the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

b) The Contractor shall administer vaccines according to the most current version of the "Recommended Immunization Schedule for Persons Aged 0 Through 6 Years - United States", and "Recommended Immunization Schedule for Persons Aged 7 Through 18 Years – United States" approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians, based upon availability of vaccine from the New Hampshire Immunization Program.

9. Prenatal Genetic Screening

a) A genetic screening history shall be obtained on all prenatal clients as soon after entry into care as possible.

b) All pregnant women should be offered voluntary genetic screening for fetal chromosomal abnormalities at the appropriate time following recommendations found in the American College of Obstetricians and Gynecologists' "Screening for Fetal Chromosomal Abnormalities (2007)" or more recent guidelines. The Contractor shall be responsible for ensuring referral to appropriate genetic testing and counseling for any woman found to have a positive screening test.

10. Additional Requirements

a) The Contractor's Medical Director shall participate in the development and approval of specific guidelines for medical care that supplement minimal clinical standards. Supplemental guidelines should be reviewed, signed, and dated annually, and updated as indicated.

b) Contractors considering clinical or sociological research using clients as subjects must adhere to the legal requirements governing human subjects research. Contractors must inform the DPHS, MCHS prior to initiating any research related to this contract.

c) The Contractor shall provide information to all employees annually about the Medical Reserve Corps Unit within their Public Health Region to enhance recruitment.

d) The Contractor shall provide information to all employees annually regarding the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) managed by the NH Department of Health and Human Services' Emergency Services Unit, to enhance recruitment.

B) Staffing Provisions

The Contractor shall have, at minimum, the following staff positions:

a) executive director

b) fiscal director

c) registered nurse

d) clinical coordinator

e) medical service director

f) nutritionist (on site or by referral)

g) social worker

Staff positions required to provide direct services on-site include:

a) registered nurse

b) clinical coordinator

c) social worker

1. Qualifications

All health and allied health professionals shall have the appropriate New Hampshire licenses whether directly employed, contracted, or subcontracted.

In addition the following minimum qualifications shall be met for:

a) Registered Nurse
   a. A registered nurse licensed in the state of New Hampshire, Bachelor's degree preferred. Minimum of one-year experience in a community health setting.

b) Nutritionists:
   a. A Bachelor's degree in nutritional sciences or dietetics, or a Master's degree in nutritional sciences, nutrition education, or public health nutrition or current Registered Dietitian status in accordance with the Commission on dietetic Registration of the American Dietetic Association.
   b. Individuals who perform functions similar to a nutritionist but do not meet the above qualifications shall not use the title of nutritionist.

c) Social Workers shall have:
   a. A Bachelor's or Master's degree in social work or Bachelor's or Master's degree in a related social science or human behavior field. A minimum of one year of experience in a community health or social services setting is preferred.
   b. Individuals who perform functions similar to a social worker but do not meet the above qualifications shall not use the title of social worker.

d) Clinical Coordinators shall be:
   a. A registered nurse (RN), physician, physician assistant, or nurse practitioner with a license to practice in New Hampshire.
   b. The coordinator is a clinical position that oversees and takes responsibility for the clinical and administrative functions of each program.
   c. The coordinator may be responsible for more than one MCH funded program.

2. New Hires

The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing within one month of hire when a new administrator, clinical coordinator, or any staff person essential to carrying out contracted services is hired to work in the program. A resume of the employee shall accompany the aforesaid notification.

3. Vacancies

 a) The Contractor must notify the MCHS in writing if any critical position is vacant for more than one month, or if at any time funded under this contract does not have adequate staffing to perform all required services for more than one month. This may be done through a budget revision.

 b) Before an agency hires new program personnel that do not meet the required staff qualifications, the agency shall notify the MCHS in writing requesting a waiver of the applicable staffing requirements. The Section may grant waivers based on the need of the program, individuals' experience, and additional training.

C) Coordination of Services

1. The Contractor shall coordinate, where possible, with other service providers within the contractor's community. At a minimum, such collaboration shall include interagency referrals and coordination of care.

2. The Contractor shall participate in activities in the Public Health Region in which they provide services as appropriate. These activities enhance the integration of community-based public health prevention and health care initiatives that are being implemented by the contractor and may include community needs assessments, public health performance assessments, and/or the development of regional health improvement plans.

3. The Contractor agrees to participate in and coordinate public health activities as requested by the Division of Public Health Services during any disease outbreak and/or emergency, natural or man-made, affecting the public's health.

4. The Contractor is responsible for case management of the client enrolled in the program and for program follow-up activities. Case management services shall promote effective and efficient organization and utilization of resources to assure access to necessary comprehensive medical, nutritional, and social services for clients.

5. The Contractor shall assure that appropriate, responsive, and timely referrals and linkages for other needed services are made, carried through, and documented. Such services shall include, but not be limited to: dental services, genetic counseling, high risk prenatal services, mental health, social services, including domestic violence crisis centers, substance abuse services; and family planning services, Early Supports and Services Program, local WIC/CSF Program, Home Visiting New Hampshire Programs and health and social service agencies which serve children and families in need of those services.

D) Meetings and Trainings

The contractor will be responsible for sending staff to meetings and training required by the MCHS program, including but not limited to:

1. MCHS Agency Directors' meetings
2. Prenatal and Child Health Coordinators' meetings
3. MCHS Agency Medical Services Directors' meetings

III. Quality or Performance Improvement (QI/PI)

A) Workplans

1. Performance Workplans are required for this program and are used to monitor achievement of standard measures of performance of the services provided under this contract. The workplans are a key component of the RHPCS and the MCHS performance-based contracting system and of this contract. Outcomes shall be reported by clinical site.
2. Performance Workplans and Workplan Outcome reports according to the schedule and instructions provided by the MCHS. The MCHS shall notify the Contractor at least 30 days in advance of any changes in the submission schedule.
3. The Contractor shall incorporate required and developmental performance measures, defined by the MCHS into the agency's Performance Workplan. Reports on Workplan Progress/Outcomes shall detail the Performance Workplan plans and activities that monitor and evaluate the agency's progress toward performance measure targets.
4. The Contractor shall comply with modifications and/or additions to the workplan and annual report format as requested by RHPCS and MCHS. MCHS will provide the contractor with reasonable notice of such changes.
5. Agencies contracting for Primary Care Services must submit the workplans for Primary Care Clinical and Financial, Child Health, and Prenatal Care.

B) Additional Reporting requirements

In addition to Performance Workplans, the Contractor shall submit to MCHS the following data and information listed below which are used to monitor program performance:

1. In years when contracts or amendments are not required, the DPHS Budget Form, Budget Justification, Sources of Revenue and Program Staff list forms must be

completed according to the relevant instructions and submitted as requested by DPHS and, at minimum, by April 30 of each year.

2. The Sources of Revenue report must be resubmitted at any point when changes in revenue threaten the ability of the agency to carry out the planned program.

3. Completed Uniform Data Set (UDS) tables reflecting program performance in the previous calendar year, by March 31 of each year.

4. The Perinatal Client Data Form (PCDF) shall be submitted electronically according to the instructions set forth by the MCHS.

5. A copy of the agency's updated Sliding Fee Scale including the amount(s) of any client fees and the schedule of discounts must be submitted by March 31st of each year. The agency's sliding fee scale must be updated annually based on the US DHHS Poverty guidelines as published in the Federal Register.

6. An annual summary of program-specific patient satisfaction results obtained during the prior contract period and the method by which the results were obtained shall be submitted annually as an addendum to the Workplan Outcome/Progress reports.

C) On-site reviews

1. The contractor shall allow a team or person authorized by the Division of Public Health Services to periodically review the contractor's systems of governance, administration, data collection and submission, clinical and financial management, and delivery of education services in order to assure systems are adequate to provide the contracted services.

2. Reviews shall include client record reviews to measure compliance with this exhibit.

3. The contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.

4. On-Site reviews may be waived or abbreviated at the discretion of MCHS, upon submission of satisfactory reports of reviews such as Health Services Resources Administration (HRSA): Office of Performance Review (OPR), or reviews from nationally accreditation organizations such as the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), Medicare, the Community Health Accreditation Program (CHAP), Accreditation Association for Ambulatory Healthcare (AAAHC), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey. Abbreviated reviews will focus on any deficiencies found in previous reviews, issues of compliance with this exhibit, and actions to strengthen performance as outlined in the agency Performance Workplan.

PRIMARY CARE CHILD HEALTH DIRECT CARE SERVICES
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Please note, for all measures, the following should be used **unless otherwise indicated:**

- Less than 19 years of age
- Served within the scope of this MCH contract during State Fiscal Year 2015 (July 1, 2014 – June 30, 2015)
- Each client can only be counted once (unduplicated)

Child Health Direct (CH – D) Performance Measure #1

Measure: 92%* of eligible children will be enrolled in Medicaid

Goal: To increase access to health care for children through the provision of health insurance

Definition: **Numerator-**
Of those in the denominator, the number of children enrolled in Medicaid.

Denominator-
Number of children who meet all of the following criteria:

- Less than 19 years of age
- Had 3 or more visits/encounters** during the reporting period
- As of the last visit during the reporting period were eligible for Medicaid

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**An encounter is face to face contact between a user and a provider who exercises independent judgment in the provision of services to the individual (UDS Table Definition).

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #2

Measure: 85%* of at-risk** children who were screened for blood lead between 18 and 30 months of age

Goal: To prevent childhood lead poisoning through early identification of lead exposure

Definition: **Numerator-**
Of those in the denominator, number of children screened for blood lead by capillary or venous on or after their 18-month birthday and prior to their 30-month birthday.

Denominator-
Number of at-risk** children who reached age 30 months during the reporting period. If discharged prior to 30 months, do not include in denominator.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**At risk = During the reporting period, the children were 18-29 months of age, and fit at least one of the following criteria:

- "Low income" (less than 185% poverty guidelines)
- Over 185% and resided in a town considered needing "Universal" screening per NH Childhood Lead Poisoning Prevention Program
- Over 185%, resided in a town considered "Target" and had a positive response to the risk questionnaire
- Refugee children -A refugee is defined as a person outside of his or her country of nationality who is unable or unwilling to return because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion (U.S. Citizenship and Immigration Services definition).

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #3

Measure: 71%* of children age two to nineteen years receiving primary care preventive health services with a Body Mass Index (BMI) percentile greater than or equal to the 85%ile with documented discussion of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Goal: To increase the percent of children receiving primary care preventive health services who have an elevated BMI percentile who receive guidance about promoting a healthier lifestyle.

Definition: **Numerator-**

Of those in the denominator, the number of children who had documentation in their medical record of there being discussion at least once during the reporting period of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Denominator-

Number of children who turned twenty-four months during or before the reporting period, up to the age of nineteen years, with one or more well child visit after their twenty-fourth month of age within the reporting year, and had an age and gender appropriate BMI percentile greater than or equal to the 85 % percentile at least once during the reporting period.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

Rationale: Children between the 85th – 94th percentiles BMI are encouraged to have 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks. (Discussion of the importance of family meal time, limiting eating out, consuming a healthy breakfast, preparing own foods, and promotion of breastfeeding is also encouraged.) American Academy of Pediatrics' guidance for Prevention and Treatment of Childhood Overweight and Obesity, (http://www.aap.org/obesity/health_professionals.html), from AAP Policy Statement: *Prevention of Pediatric Overweight and Obesity* and the AAP endorsed Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Children and Adolescent Overweight and Obesity, 2007.

*Target based on 2012 & 2013 Data Trend Table averages.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) #4

Measure: 75%* of eligible** infants and children with client record documentation of enrollment in WIC

Goal: To increase access to nutrition education, breastfeeding support, and healthy food through enrollment in the WIC Nutrition Program

Definition: **Numerator -**
Of those in the denominator, the number of infants and children who, as of the last well child visit during the reporting period, had client record documentation that infant or child was enrolled in WIC.

Denominator -
Unduplicated number of infants and children less than 5 years of age, enrolled in the agency, during the reporting period, who were eligible** for WIC.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**WIC Eligibility Requirements:

- Infants, and children up to their fifth birthday
- Must be income eligible (income guidelines are up to 185% of federal gross income, and are based on family size)

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #5

Measure: 23%* of infants who were exclusively** breastfed for the first three months, at their four month well baby visit

Goal: To provide optimum nutrition to infants in their first three months of life

Definition: **Numerator -**
Of those in the denominator, the number of infants who had client record documentation that the infant had been exclusively breastfed for their first three months when checked at their four month well baby visit.

Denominator -
Number of infants who received one or more visits during or before the reporting period and were seen for a four-month well baby visit during the reporting period.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

Benmarks: 2011 PedNSS (WIC) exclusive at 3 months: NH 22.9%, National (2010) 10.7%
2013 CDC Report Card (NIS, provisional 2010 births): NH 49.5%, National 37.7%
Healthy People 2020 goal: 44%

Rationale: The AAP recommends exclusive breastfeeding for about 6 months, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant, a recommendation concurred to by the World Health Organization and the Institute of Medicine. (American Academy of Pediatrics Policy Statement on Breastfeeding and the Use of Human Milk, 2012)

*Target based on 2012 & 2013 Data Trend Table averages.
**Exclusive means breast milk only, no supplemental formula, cereal/baby food, or water/fluids.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE: ADULT

PERFORMANCE MEASURES DEFINITIONS

State Fiscal Year 2015

Primary Care: Adult Performance Measure #1

Measure:* 58%** of adult patients 18 – 85 years of age diagnosed with hypertension will have a blood pressure measurement less than 140/90*** mm at the time of their last measurement.

Goal: To ensure patients diagnosed with hypertension are adequately controlled.

Definition: **Numerator-** Number of patients from the denominator with blood pressure measurement less than 140/90 mm at the time of their last measurement.

Denominator- Number of patients age 18 – 85 with diagnosed hypertension must have been diagnosed with hypertension 6 or more months before the measurement date. (Excludes pregnant women and patients with End Stage Renal Disease.)

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

*Measure based on the National Quality Forum 0018

**Health People 2020 National Target is 61.2%

***Both the numerator and denominator must be less that 140/90 mm

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE CLINICAL
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Primary Care Clinical Adolescent (PC-C) Performance Measure #1

Measure: 61%* of adolescents aged 11-21 years received an annual health maintenance visits in the past 12 months.

Goal: To enhance adolescent health by assuring annual, recommended, adolescent well -visits.

Definition: **Numerator-**
Number of adolescents in the denominator who received an annual health maintenance "well" visit during the reporting year.

Denominator-
Total number of adolescents aged 11-21 years who were enrolled in the primary care clinic as primary care clients during the reporting year period.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

***Target based on 2012 & 2013 Data Trend Table averages.**

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Primary Care Clinical Prenatal (PC-C) Performance Measure #2

Measure: 31%* of women and adolescent girls aged 15-44 take multi-vitamins with folic acid.

Goal: To enhance pregnancy outcomes by reducing neural tube defects.

Definition:

Numerator-
The number of women and adolescent girls aged 15-44 who take a multi-vitamin with folic acid.

Denominator-
The number of women and adolescent girls aged 15-44 who were seen in primary care for a well visit in the past year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

***Target based on 2012 & 2013 Data Trend Table averages.**

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE - FINANCIAL
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Primary Care (PC) Performance Measure #1

Measure: Patient Payor Mix

Goal: To allow monitoring of payment method trends at State funded primary care sites.

Definition: Patients enrolled in Medicare, Medicaid, Commercial insurance, or uninsured.

Data Source: Provided by agency

Primary Care (PC) Performance Measure #2

Measure: Accounts Receivables (AR) Days

Goal: To allow monitoring of financial sustainability trends at State funded primary care sites.

Definition: AR Days: Net Patient Accounts Receivable **multiplied by** 365 **divided by** Net Patient Revenue

Data Source: Provided by agency

Primary Care (PC) Performance Measure #3

Measure: Current Ratio

Goal: To allow monitoring of financial sustainability trends at State funded primary care sites.

Definition: Current Ratio = Current Assets **divided by** Current Liabilities

Data Source: Provided by agency

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRENATAL
PERFORMANCE MEASURES DEFINITIONS
State Fiscal Year 2015

Prenatal (PN) Performance Measure #1

Measure: 85%* of pregnant women who are enrolled in the agency's prenatal program will begin prenatal care during the first trimester of pregnancy.

Goal: To enhance pregnancy outcomes by assuring early entrance into prenatal care.

Definition:

Numerator-
Number of women in the denominator who had a documented prenatal visit during the first trimester (on or before 13.6 weeks gestation).

Denominator-
Number of women enrolled in the agency prenatal program who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

* Target based on 2012 & 2013 Data Trend Table averages.

Prenatal (PN) Performance Measure #2

Measure: 20%* of pregnant women who are identified as cigarette smokers will be referred to QuitWorks-New Hampshire.

Goal: To reduce tobacco use during pregnancy through focused tobacco use cessation activities at public health prenatal clinics.

Definition:

Numerator-
Number of women in the denominator who received at least one referral to QuitWorks-New Hampshire during pregnancy.

A referral is defined as signing the patient up for QuitWorks-NH via phone, fax, or EMR. It is not defined as discussing QuitWorks-NH with the patient and encouraging her to sign up.

Denominator-
Number of women enrolled in the agency prenatal program and identified as tobacco users who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

*Target set in consultation with the NH Tobacco Program & FY13 Data Trend Table average.

Prenatal (PN) Performance Measure #3

Measure: 79%* of pregnant women will be screened, using a formal valid screening tool, for alcohol and other substance use during every trimester they are enrolled in the prenatal program.

Goal: To reduce prenatal substance use through systematic screening and identification.

Definition: **Numerator-** Number of women in the denominator who were screened for substance and alcohol use, using a formal and valid screening tool, during each trimester that they were enrolled in the prenatal program.

Denominator- Number of women enrolled in the agency prenatal program and who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

* Target based on 2012 & 2013 Data Trend Table averages.

Exhibit B-1 (2014) -Amendment 1
Budget

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: Goodwin Community Health

Budget Request for: MCH Primary Care
(Name of RFP)

Budget Period: SFY 2014

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages	$ 59,434.40	$ -	$ 59,434.40	
2. Employee Benefits	$ 14,858.60	$ -	$ 14,858.60	
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	$ -	$ -	$ -	
13. Other (specific details mandatory):	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
TOTAL	**$ 74,293.00**	**$ -**	**$ 74,293.00**	

Indirect As A Percent of Direct 0.0%

Contractor Initials: DA

Date: 3-11-14

Exhibit B-1 (2015) -Amendment 1
Budget

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: Goodwin Community Health

Budget Request for: MCH Primary Care & BCCP
(Name of RFP)

Budget Period: SFY 2015

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages	$ 331,123.36	$ -	$ 331,123.36	0
2. Employee Benefits	$ 76,125.64	$ -	$ 76,125.64	0
3. Consultants	$ -	$ -	$ -	0
4. Equipment:	$ -	$ -	$ -	0
Rental	$ -	$ -	$ -	0
Repair and Maintenance	$ -	$ -	$ -	0
Purchase/Depreciation	$ -	$ -	$ -	0
5. Supplies:	$ -	$ -	$ -	0
Educational	$ -	$ -	$ -	0
Lab	$ -	$ -	$ -	0
Pharmacy	$ -	$ -	$ -	0
Medical	$ -	$ -	$ -	0
Office	$ -	$ -	$ -	0
6. Travel	$ -	$ -	$ -	0
7. Occupancy	$ -	$ -	$ -	0
8. Current Expenses	$ -	$ -	$ -	0
Telephone	$ -	$ -	$ -	0
Postage	$ -	$ -	$ -	0
Subscriptions	$ -	$ -	$ -	0
Audit and Legal	$ -	$ -	$ -	0
Insurance	$ -	$ -	$ -	0
Board Expenses	$ -	$ -	$ -	0
9. Software	$ -	$ -	$ -	0
10. Marketing/Communications	$ -	$ -	$ -	0
11. Staff Education and Training	$ -	$ -	$ -	0
12. Subcontracts/Agreements	$ -	$ -	$ -	0
13. Other (specific details mandatory):	$ -	$ -	$ -	0
Clinical Services	$ 13,330.00	$ -	$ 13,330.00	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
	$ -	$ -	$ -	0
TOTAL	**$ 420,579.00**	**$ -**	**$ 420,579.00**	0

Indirect As A Percent of Direct 0.0%

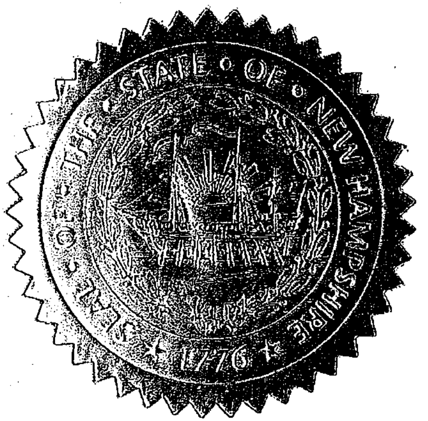
Contractor Initials: JN

Date: 3-11-14

State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that Goodwin Community Health is a New Hampshire nonprofit corporation formed August 18, 1971. I further certify that it is in good standing as far as this office is concerned, having filed the return(s) and paid the fees required by law.



In TESTIMONY WHEREOF, I hereto
set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 6th day of September A.D. 2013

William M. Gardner
Secretary of State

CERTIFICATE OF VOTE

I, David Staples, DDS, of the Goodwin Community Health, do hereby certify that:

1. I am the duly elected Board Chair of the Goodwin Community Health;

2. The following are true copies of two resolutions duly adopted at a meeting of the Board of Directors of Goodwin Community Health, duly held on January 8, 2014;

   Resolved: That this corporation enter into a contract with the State of New Hampshire, acting through its Department of Health and Human Services for the provision of Public Health Services.

   Resolved: That the Executive Director, Janet Atkins, is hereby authorized on behalf of this Corporation to enter into the said contract with the State and to execute any and all documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, as he/she may deem necessary, desirable or appropriate.

3. The foregoing resolutions have not been amended or revoked and remain in full force and effect as of 3 - 11, 2014.

IN WITNESS WHEREOF, I have hereunto set my hand as the Board Chair of the Goodwin Community Health this 11th day of March, 2014.

David Staples, DDS, Board Chair

STATE OF NH

COUNTY OF STRAFFORD

The foregoing instrument was acknowledged before me this 11th day of March 2014 by David Staples, DDS.

Notary Public/Justice of the Peace

My Commission Expires: 11-6-2018

GOODCOM-01 LMICHALS

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 2/27/2014

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 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 # AGR8150
Clark Insurance
80 Canal St
Manchester, NH 03101

CONTACT NAME: Lorraine Michals
PHONE (A/C, No, Ext): (603) 622-2855 FAX (A/C, No): (603) 622-2854
E-MAIL ADDRESS: lmichals@clarkinsurance.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Union Mutual Fire Insurance Companies	25860
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Goodwin Community Health
311 Route 108
Somersworth, NH 03878

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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC			BOP0101921	07/31/2013	07/31/2014	EACH OCCURRENCE	$ 1,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 50,000
							MED EXP (Any one person)	$ 5,000
							PERSONAL & ADV INJURY	$ 1,000,000
							GENERAL AGGREGATE	$ 2,000,000
							PRODUCTS - COMP/OP AGG	$ 2,000,000
								$
A	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS X HIRED AUTOS X NON-OWNED AUTOS			BOP0101921	07/31/2013	07/31/2014	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (PER ACCIDENT)	$
								$
A	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DED RETENTION $			UM 5140748	07/31/2013	07/31/2014	EACH OCCURRENCE	$ 1,000,000
							AGGREGATE	$ 1,000,000
								$ 0
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A					WC STATU-TORY LIMITS OTH-ER	
							E.L. EACH ACCIDENT	$
							E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$

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

CERTIFICATE HOLDER

DHHS
Contracts and Procurement Unit
129 Pleasant Street
Concord, NH 03301

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 02/27/2014

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 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
AUTOMATIC DATA PROCESSING
INSURANCE AGENCY, INC.
1 ADP Boulevard
Roseland, NJ 07068

CONTACT NAME:
PHONE (A/C, No, Ext):
FAX (A/C, No):
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A :	
INSURER B : EastGUARD Insurance Company	14702
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Goodwin Community Health Center

311 Route 108
Somersworth, NH 03878

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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	GENERAL LIABILITY						EACH OCCURRENCE	$ 0
	COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 0
	CLAIMS-MADE / OCCUR						MED EXP (Any one person)	$ 0
							PERSONAL & ADV INJURY	$ 0
							GENERAL AGGREGATE	$ 0
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$ 0
	POLICY / PRO-JECT / LOC							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS / NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB / OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB / CLAIMS-MADE						AGGREGATE	$
	DED / RETENTION $							$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		GOWC435525	07/31/2013	07/31/2014	WC STATU-TORY LIMITS X / OTH-ER	
							E.L. EACH ACCIDENT	$ 500,000
							E.L. DISEASE - EA EMPLOYEE	$ 500,000
							E.L. DISEASE - POLICY LIMIT	$ 500,000

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

CERTIFICATE HOLDER

DHHS Contracts and Procurement Unit
129 Pleasant Street
Concord, NH 03301

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

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Goodwin Community Health and Subsidiary

Financial Report

June 30, 2013

Accessible
Approachable
Accountable

Independent Auditors' Report

Board of Directors
Goodwin Community Health
and Subsidiary
Somersworth, New Hampshire

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Goodwin Community Health and Subsidiary (the Center) which comprise the consolidated statements of financial position as of June 30, 2013 and 2012, and the related consolidated statements of activities, functional expenses, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

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

Auditor's Responsibility

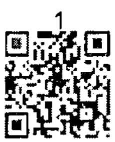
Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable 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 the auditor's 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, the auditor considers internal control relevant to the entity'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 entity'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 consolidated financial position of Goodwin Community Health and Subsidiary as of June 30, 2013 and 2012, and the consolidated changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.



Macpage LLC

30 Long Creek Drive, South Portland, ME 04106-2437 | 207-774-5701 | 207-774-7835 fax | cpa@macpage.com
One Market Square, Augusta, ME 04330-4637 | 207-622-4766 | 207-622-6545 fax

macpage.com

An Independently Owned Member, McGladrey Alliance
McGladrey Alliance is a premier affiliation of independent accounting and consulting firms. McGladrey Alliance member firms maintain their respective names, autonomy and independence and are responsible for their own client fee arrangements, delivery of services and maintenance of client relationships

Other Matter

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating schedules on pages 20 through 22 are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Macpage

Augusta, Maine
November 14, 2013

Consolidated Statements of Financial Position

June 30,

	2013	2012
ASSETS		
Current Assets		
Cash and cash equivalents (Notes 1 and 2)	$ 584,487	$ 299,585
Accounts receivable, net (Notes 1 and 3)	229,940	343,099
Grants receivable (Note 4)	108,182	85,240
Current portion of pledges receivable (Note 5)	25,036	13,999
Cost settlement receivable (Note 6)		38,930
Prepaid expenses	3,637	8,000
Total Current Assets	951,282	788,853
Property and Equipment, Net (Notes 1 and 7)	6,547,866	6,785,398
Other Assets		
Goodwill (Note 1)	17,582	17,582
Pledges receivable, net of current portion (Note 5)	11,494	12,281
Total Other Assets	29,076	29,863
Total Assets	$ 7,528,224	$ 7,604,114
LIABILITIES AND NET ASSETS		
Current Liabilities		
Accounts payable	$ 260,730	$ 385,167
Accrued expenses	320,772	307,764
Lines of credit (Note 8)	327,280	330,280
Current portion of long-term debt (Note 9)	128,157	103,840
Total Current Liabilities	1,036,939	1,127,051
Long-term Liabilities		
Long-term debt, net of current portion (Note 9)	935,100	1,062,605
Total Long-term Liabilities	935,100	1,062,605
Total Liabilities	1,972,039	2,189,656
Net Assets		
Unrestricted (Deficit)	(73,807)	(360,414)
Temporarily restricted (Note 11)	5,629,992	5,774,872
Total Net Assets	5,556,185	5,414,458
TOTAL LIABILITIES AND NET ASSETS	$ 7,528,224	$ 7,604,114

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

Consolidated Statement of Activities

Year ended June 30, 2013

	Unrestricted	Temporarily Restricted	Total
Operating Revenue and Support			
Patient service revenue (Notes 1 and 10)	$ 4,468,027		$ 4,468,027
Provision for bad debts	(275,559)		(275,559)
Net patient service revenue	4,192,468		4,192,468
Grants, contracts and contributions (Notes 1 and 12)	2,135,975	$ 35,416	2,171,391
WIC food vouchers (Note 16)	1,644,806		1,644,806
Other	215,425		215,425
	8,188,674	35,416	8,224,090
Net assets released from restrictions	180,296	(180,296)	
Total Operating Revenue and Support	8,368,970	(144,880)	8,224,090
Functional Expenses			
Program services	6,906,216		6,906,216
Fundraising	140,188		140,188
General and administrative	1,196,207		1,196,207
Total Expenses	8,242,611		8,242,611
Change in Net Assets from Operating Activities	126,359	(144,880)	(18,521)
Non-Operating Revenue and Support			
Rent income	12,182		12,182
Class action settlement	148,066		148,066
Change in Net Assets from Non-Operating Activities	160,248		160,248
Total Change in Net Assets	286,607	(144,880)	141,727
Net Assets (Deficit), Beginning of Year	(360,414)	5,774,872	5,414,458
Net Assets (Deficit), End of Year	$ (73,807)	$ 5,629,992	$ 5,556,185

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

Consolidated Statement of Activities - Continued

Year ended June 30, 2012

	Unrestricted	Temporarily Restricted	Total
Operating Revenue and Support			
Patient service revenue (Notes 1 and 10)	$ 3,613,824		$ 3,613,824
Provision for bad debts	(361,889)		(361,889)
Net patient service revenue	3,251,935		3,251,935
Grants, contracts and contributions (Notes 1 and 12)	2,111,052	$ 15,000	2,126,052
WIC food vouchers (Note 16)	1,458,911		1,458,911
Other	29,042		29,042
	6,850,940	15,000	6,865,940
Net assets released from restrictions	246,366	(246,366)	
Total Operating Revenue and Support	7,097,306	(231,366)	6,865,940
Functional Expenses			
Program services	6,479,198		6,479,198
Fundraising	179,644		179,644
General and administrative	1,266,168		1,266,168
Total Expenses	7,925,010		7,925,010
Change in Net Assets from Operating Activities	(827,704)	(231,366)	(1,059,070)
Non-Operating Revenue and Support			
Gain on sale of property and equipment	86,244		86,244
Rent income	15,675		15,675
Change in Net Assets from Non-Operating Activities	101,919		101,919
Total Change in Net Assets	(725,785)	(231,366)	(957,151)
Net Assets, Beginning of Year	365,371	6,006,238	6,371,609
Net Assets (Deficit), End of Year	$ (360,414)	$ 5,774,872	$ 5,414,458

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

Consolidated Statements of Cash Flows

Years ended June 30,

	2013	2012
Cash flows from operating activities:		
Change in net assets	$ 141,727	$ (957,151)
Adjustments to reconcile change in net assets to net cash flows from operating activities:		
Depreciation	269,624	274,120
Gain on sale of property and equipment		(86,244)
Provision for bad debt	275,559	361,889
(Increase) decrease in operating assets:		
Accounts receivable	(162,400)	552,651
Grants receivable	(22,942)	214,832
Pledges receivable	(10,250)	4,470
Cost settlement receivable	38,930	220,563
Prepaid expenses	4,363	9,720
Security deposits		5,500
Increase (decrease) in operating liabilities:		
Accounts payable	(124,437)	(616,629)
Accrued expenses	13,008	(16,264)
Total adjustments	281,455	924,608
Net cash flows from operating activities	423,182	(32,543)
Cash flows from investing activities:		
Proceeds from sale of property and equipment		311,530
Purchases of equipment	(32,092)	(20,699)
Net cash flows from investing activities	(32,092)	290,831
Cash flows from financing activities:		
Net payments on lines of credit	(3,000)	(37,100)
Principal payments on long-term debt	(103,188)	(215,213)
Net cash flows from financing activities	(106,188)	(252,313)
Net change in cash and cash equivalents	284,902	5,975
Cash and cash equivalents, beginning of year	299,585	293,610
Cash and cash equivalents, end of year	$ 584,487	$ 299,585
Supplemental disclosure of cash flow information:		
Interest paid during year	$ 70,380	$ 73,827

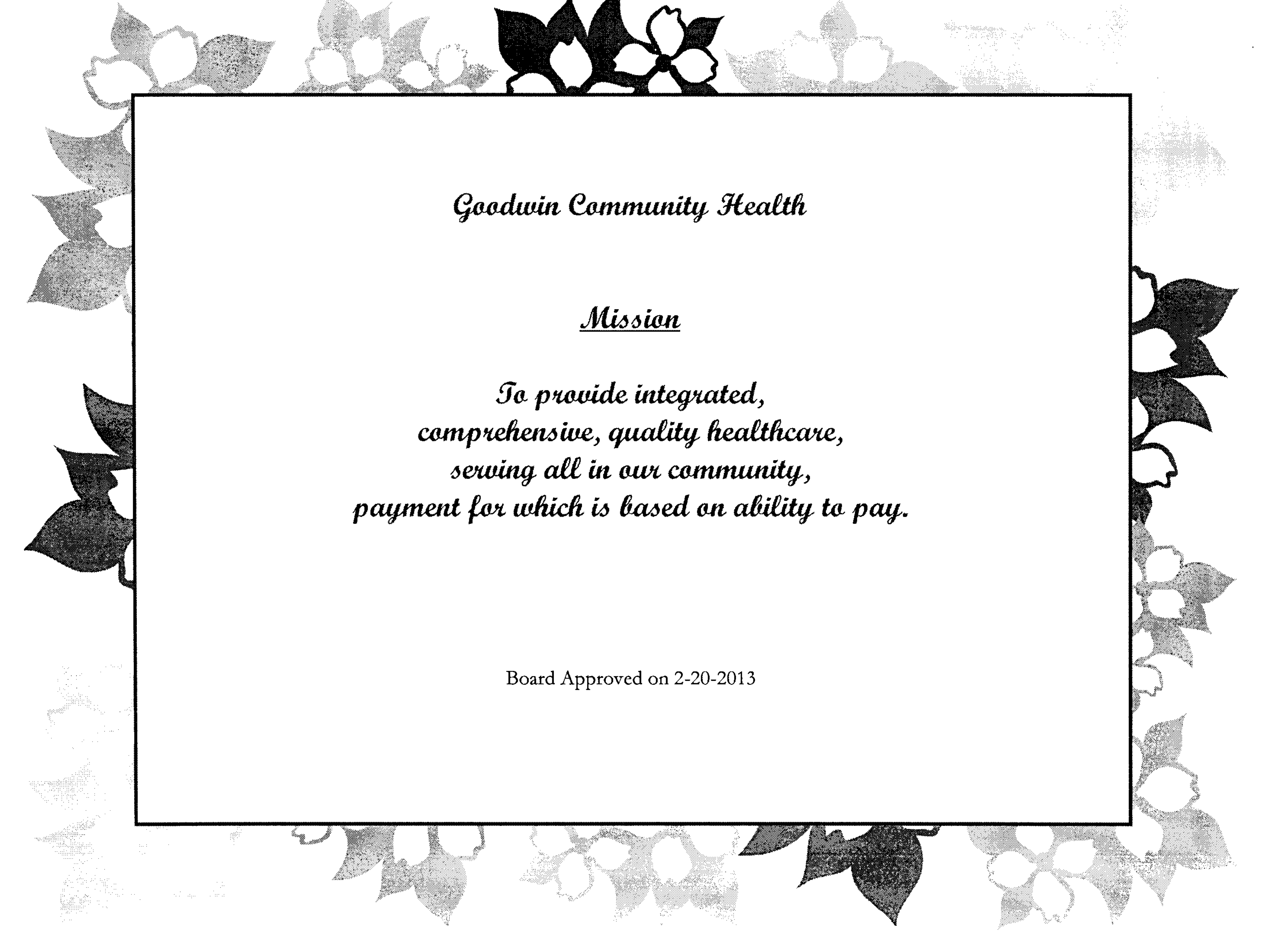
The accompanying notes are an integral part of these consolidated financial statements.

Consolidated Statements of Functional Expenses

Years ended June 30,

	2013				2012			
	Program	Fundraising	General and Administrative	Total	Program	Fundraising	General and Administrative	Total
PERSONNEL								
Salaries and wages	$ 3,522,156	$ 72,307	$ 499,771	$ 4,094,234	$ 3,400,231	$ 123,114	$ 541,048	$ 4,064,393
Payroll taxes and employee benefits (Note 13)	655,824	11,585	324,720	992,129	633,694	27,240	350,633	1,011,567
	4,177,980	83,892	824,491	5,086,363	4,033,925	150,354	891,681	5,075,960
OTHER								
WIC food vouchers (Note 16)	1,644,806			1,644,806	1,458,911			1,458,911
Depreciation (Note 1)	226,148		43,476	269,624	256,283		17,837	274,120
Equipment leases and supplies	180,264	2,336	49,474	232,074	190,878	2,336	17,128	210,342
Professional fees	48,378		89,649	138,027	40,818	1,532	109,190	151,540
Medical supplies	136,372			136,372	100,897			100,897
Physician services	101,997			101,997	52,275			52,275
Repairs and maintenance	63,903	28,721		92,624	49,165	2,834	22,274	74,273
Interest			70,380	70,380			73,827	73,827
Utilities	46,119		22,715	68,834	50,548	3,045	23,706	77,299
Lab and radiology fees	65,438	145	353	65,936	49,795		245	50,040
Insurance	43,560		20,794	64,354	32,156		22,735	54,891
Office materials	44,363	35	14,263	58,661	22,365	627	12,281	35,273
Postage and shipping	26,158	117	12,654	38,929	25,481	342	12,183	38,006
Telephone and communications	27,510		5,369	32,879	33,948		5,540	39,488
Dues and subscriptions	12,378	430	12,131	24,939	12,975	231	11,972	25,178
Advertising and promotion (Note 1)	3,877	22,685	130	26,692	3,287	16,187	188	19,662
Travel	20,449	177	5,741	26,367	16,901	438	3,488	20,827
Education and training	15,933	317	8,162	24,412	13,703	393	3,915	18,011
Rent (Note 14)	6,176		10,860	17,036	14,340		22,846	37,186
Service charges	11,312		4,917	16,229	9,950		10,235	20,185
Printing	3,795	1,333	648	5,776	976	733	308	2,017
Real estate taxes					9,621	592	4,589	14,802
	2,728,936	56,296	371,716	3,156,948	2,445,273	29,290	374,487	2,849,050
	$ 6,906,916	$ 140,188	$ 1,196,207	$ 8,243,311	$ 6,479,198	$ 179,644	$ 1,266,168	$ 7,925,010

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



Goodwin Community Health

Mission

To provide integrated,
comprehensive, quality healthcare,
serving all in our community,
payment for which is based on ability to pay.

Board Approved on 2-20-2013

Goodwin Community Health

Name/Address	Occupation
Chair David B. Staples, DDS	Dentist **Consumer**
Vice Chair Valerie Goodwin	Business
Board Treasurer Mark Boulanger	CPA
Board Secretary: Kelley LaRue	Design Consultant **Consumer**
Board Members	
Jane Wright	Certified Hemodialysis Technician **Consumer**
Pamela Bertram, MD	Physician
Robert F. Kraunz, MD	Retired Physician
Timothy Beaupre, Esq.	Attorney
Laurie A. Biracree	Yoga Instructor **Consumer**
Allison Neal	Education Consultant **Consumer**
Marissa Ruffini	Music Therapist **Consumer**
Hilton Kelly	Financial Advisor **Consumer**
Kirsten Jones	Food Service Industry **Consumer**
Nancy Burgess-Anderson	Retired-Community Non-Profit Agencies **Consumer**

KEY ADMINISTRATIVE PERSONNEL

NH Department of Health and Human Services

Contractor Name: Goodwin Community Health

Name of Bureau/Section: MCH Primary Care

BUDGET PERIOD: SFY 14

Program Area: MCH Primary Care

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Janet Atkins	Executive Director	$130,000	0.00%	$0.00
Erin Ross	Finance Director	$85,176	0.00%	$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$0.00**

KEY ADMINISTRATIVE PERSONNEL

NH Department of Health and Human Services

Contractor Name: Goodwin Community Health

Name of Bureau/Section: MCH Primary Care & BCCP

BUDGET PERIOD: SFY 15

Program Area: MCH Primary Care Services

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Janet Atkins	Executive Director	$130,000	0.00%	$0.00
Erin Ross	Finance Director	$85,176	0.00%	$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$0.00**

Program Area: Breast and Cervical Cancer Program Services

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Janet Atkins	Executive Director	$130,000	0.00%	$0.00
Erin Ross	Finance Director	$85,176	0.00%	$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$0.00**

JANET MARIE ATKINS

Professional Health Care Administrator with years of leadership experience in operations, finance and development.

SUMMARY OF SKILLS

*Budget Development and Management * Financial projections * Grant Writing * Development*
*Strategic Planning * Relationship Building * Patient Satisfaction*
*Quality Improvement * Provider Recruitment and Retention*

PROFESSIONAL EXPERIENCE

Goodwin Community Health, Somersworth, NH –An Innovative Federally Qualified Health Center with an integrated health care model quoted by the Commissioner as the 'model of the future' for NH.

Executive Director — 2005-Present

- Created an innovative, affordable health care program for small-medium businesses
- Created strategic partnerships and collaborative programs with other health care organizations
- Advanced the Health Center by receiving $5.8M in grant funding for a new building
- Merged three locations into one, reduced costs and improved access
- Secured over $25M in grant funding since 2001
- Initiated and integrated behavioral and primary care
- Realized revenue growth through increased collections
- Performed ongoing Board development
- Acquired a for-profit mental health practice
- Successful recruitment and retention of providers
- Submitted and awarded NCQA Medical Home, Level III Certification
- Demonstrated improvements in patient outcomes and satisfaction

CEO Great Bay Mental Health Associates — 2012-Present

- Recruited seven new therapist/prescribers
- Recognized a surplus for the first time in 12 months

Finance Director — 2003-2005

- Awarded Federally Qualified Health Center grant in 2004-$750,000 in perpetuity
- Additional grant award for $150,000 to expand into behavioral health
- Obtained $450,000 in grants to initiate the oral health program
- Ended each year with a surplus
- Successful integration of oral health and primary care

Fund Development — 2001-2003

- 80% success rate for grants
- Successful annual appeals

Grant Writing Services, — 1999-2001
N. Hampton, NH
Sole Proprietor

- Successfully wrote and received grants for health care organizations and education
- Development of a business plan for a local specialist practice.

North Shore Medical Center (Partners Health Care) 1998-1999
Salem, MA
Consultant for North Shore Community Health Center

- Hired for a year to improve cash flow and operations
- Successfully ended up with a surplus
- Recruitment of a Medical Director, and other providers
- Successful obtained state and federal funding to support the Health Center

Director of Nursing for ambulatory and emergency care 1993-1998

- Co-Chair of the Nursing Quality Improvement Committee
- Increased revenue per visit in the emergency room
- Successfully prepared new clinics for licensure and accreditation
- Community Benefit liaison for the hospital
- Co-Chair of the Community Health Network for the North Shore Hospital
- Obtained several awards from Partners Health Care for Community Leadership

Manager of Intermediate Cardiac Care and Telemetry Unit 1991-1993

- Reduction in length of stay by 1.5 days
- Development of a new 24 hour observation unit for patients with chest pain
- Increased skill level of nursing staff to reduce cardiac care length of stay
- Implementation of new patient care models to reduce the cost of care

Registered Nurse- Various positions as a RN including ICU, ER, Boston Visiting Nurse Assoc. 1981-1991

EDUCATION:

University of New Hampshire: M.B.A. Graduated
Durham, N.H. Concentration in Finance 1991

Northern Michigan University: B.S.N.
Marquette, M.I. Minor in Biology 1981

VOLUNTEER ACTIVITIES:
Rochester NH Rotary Member and Past President
Board member Community Health Access Network
Board member for Bi-State Primary Care Association
Past United Way of the Greater Seacoast Board Member

LICENSES:
N.H. Real Estate Broker
N.H. Nursing License

INTERESTS/PERSONAL:
Running, hiking, reading, leadership development

Erin E. Ross

Objective

Obtain a position in Health Care, which will continue to build knowledge and skills from both education and experiences gained.

Qualifications

Mature, energetic individual possessing management experience, organizational skills, multi-tasking abilities, good work initiative and communicates well with internal and external contacts. Proficient in computer skills.

Education

September 1998 – May 2002 **Bachelor of Science in Health Management & Policy**
University of New Hampshire
Durham, New Hampshire 03824

Related Experience

July 2011 – Present **Finance Director**
Goodwin Community Health

- Responsible for financial oversight of center to include supervision of accountant, bookkeeper, billing department and all clinical administrative staff.
- Assist Executive Director in budgeting process each fiscal year for center.
- Generate and assist with financial aspects of all center grants received.
- Complete on an as needed basis finance analysis's of various agency programs.
- Participate in agency fiscal audit at the end of each fiscal year.
- Member of Board of Directors level Finance Committee

August 2009- Present **Chief Executive Officer**
Great Bay Mental Health Associates, Inc

- Responsible for all operations of private, for-profit mental health practice.
- Recruit both professional and administrative staff as needed for practice.
- Develop and implement policies and procedures as needed for practice.

August 2006 – June 2011 **Service Expansion Director**
Avis Goodwin Community Health Center

- Responsible for the overall function of the Winter St location of Avis Goodwin Community Health Center.
- Maintain all clinical equipment and order all necessary supplies.
- Coordinate the scheduling of all clinical and administrative staff in the office.
- Assist with the continued integration of dental services and now mental health services to existing primary care services.
- Assist with the integration of private OB/GYN practice into Avis Goodwin Community Health Center.
- Organize patient outcome data collection and quality improvement measures to monitor multiple aspects and assure sustainability for Avis Goodwin Community Health Center.

January 2005 – August 2006 **Site Manager, Dover Location & Front Office Manager**
Avis Goodwin Community Health Center

- Responsible for the overall function of the Dover location of Avis Goodwin Community Health Center.
- Maintain all clinical equipment and order all necessary supplies.
- Assist with the continued integration of dental services and now mental health services to existing primary care services.
- Coordinate the scheduling of all clinical and administrative staff in the office.
- Organize patient outcome data collection and quality improvement measures to monitor multiple aspects and assure sustainability for Avis Goodwin Community Health Center.
- Supervise, hire and evaluate front office staff of both Avis Goodwin Community Health Center locations.
- Develop and implement policies and procedures for the smooth functioning of the front office.

May 2004 – January 2010 **Dental Coordinator**
Avis Goodwin Community Health Center

- Supervise, hire and evaluate dental staff, including Dental Assistant and Hygienists.
- Acted as general contractor during construction and renovation of existing facility for 4 dental exam rooms.

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

29 HAZEN DRIVE, CONCORD, NH 03301-6527
603-271-4517 1-800-852-3345 Ext. 4517
Fax: 603-271-4519 TDD Access: 1-800-735-2964

Nicholas A. Toumpas
Commissioner

José Thier Montero
Director

May 8, 2012

APPROVED G&C #135
DATE 6/20/12
NOT APPROVED

His Excellency, Governor John H. Lynch
and the Honorable Executive Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Public Health Services, Bureau of Population Health and Community Services, Maternal and Child Health Section, to enter into an agreement with Goodwin Community Health (Vendor #154703-B001), 311 Route 108, Somersworth, New Hampshire 03878, in an amount not to exceed $600,396.00, to provide primary care services and breast and cervical cancer screening, to be effective July 1, 2012 or date of Governor and Executive Council approval, whichever is later, through June 30, 2014. Funds are available in the following accounts for SFY 2013, and are anticipated to be available in SFY 2014 upon the availability and continued appropriation of funds in the future operating budgets.

05-95-90-902010-5190 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES, MATERNAL AND CHILD HEALTH

Fiscal Year	Class/Object	Class Title	Job Number	Total Amount
SFY 2013	102-500731	Contracts for Program Services	90080000	$248,712
SFY 2014	102-500731	Contracts for Program Services	90080000	$248,712
			Sub-Total	$497,424

05-95-90-902010-5659 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES, COMPREHENSIVE CANCER

Fiscal Year	Class/Object	Class Title	Job Number	Total Amount
SFY 2013	102-500731	Contracts for Program Services	90080081	$51,486
SFY 2014	102-500731	Contracts for Program Services	90080081	$51,486
			Sub-Total	$102,972
			Total	$600,396

EXPLANATION

Funds in this agreement will be used to provide breast and cervical cancer screening and office-based primary care services for low-income and uninsured families. This agreement provides funds for services as a last resort; contractor is required to make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid.

Primary health care services include preventive and episodic health care for acute and chronic health conditions for people of all ages, including pregnant women, children, adolescents, adults, and the elderly. Community health agencies that receive support through the Division of Public Health Services deliver primary and preventive health care services to underserved people who face barriers to accessing health care, due to issues such as a lack of insurance, inability to pay, language barriers, and geographic isolation. In addition to medical care, community health centers are unique among primary care providers for the array of patient-centered services they offer, including care coordination, translation, transportation, outreach, eligibility assistance, and health education. These services help individuals overcome barriers to getting the care they need and achieving their optimal health. One area of particular success has been in ensuring that eligible families maintain consistent enrollment in Medicaid for their children. Community health centers provide support for families in filling out applications and ensuring that children have continuity of care.

Community health agencies throughout New Hampshire have demonstrated success in meeting the health care needs of the uninsured and under-insured citizens of the state. Division of Public Health Services funded primary care providers participate in rigorous quality improvement efforts utilizing standard performance measures that focus attention on improving health outcomes for patients. For example, in State Fiscal Year 2011:

- 88% of eligible children served were enrolled in Medicaid/Healthy Kids Gold.
- 86% of children 24-35 months, served received the appropriate schedule of immunizations.
- 82% of infants born to women served received prenatal care beginning in the first trimester of pregnancy.

In addition, breast and cervical cancers continue to be ongoing public health issues for New Hampshire. The Division of Public Health Services, Breast and Cervical Cancer Screening Program provides support for breast and cervical cancer screening services that include clinical examinations, pap smears and referral for mammography. Through this program, women found to have abnormal screening results, following their testing, receive additional coverage for diagnostic work-up and, if necessary, have their care coordinated through the initiation of treatment.

Should Governor and Executive Council not authorize this Request, a minimum of 6,000 low-income individuals from Strafford County may not have access to primary care services, and eligible women may not receive recommended breast and cervical cancer screenings. A strong primary care infrastructure reduces costs for uncompensated care, improves health outcomes, and reduces health disparities. Additionally women that receive recommended breast and cervical cancer screenings are at lower risk of late diagnosis of breast and cervical cancers.

Goodwin Community Health was selected for this project through a competitive bid process. A Request for Proposals was posted on the Department of Health and Human Services' web site from January 10, 2012 through February 16, 2012. In addition, a bidder's conference, conference call, and web conference were held on January 19, 2012 to alert agencies to this bid.

Thirteen proposals were received in response to the posting. Each proposal was scored by three professionals, who work internal and external to the Department of Health and Human Services. All reviewers have between three to twenty years experience either in clinical settings, providing community-based family support services, and managing agreements with vendors for various public health programs. Areas of specific expertise include maternal and child health; quality assurance and performance improvement; chronic and communicable diseases and public health infrastructure. The reviewers used a standardized form to score agencies' relevant experience and capacity to carry out the activities outlined in the proposal. Reviewers look for realistic targets when scoring performance measures in addition to detailed workplans including evaluation components. Budgets were reviewed to be reasonable, justified and consistent with the intent of the program goals and outcomes. There were no competing applications within each of the separate service areas. Scores were averaged and all proposals were recommended for funding. In those instances where scores were less than ideal, agency specific remedial actions were recommended and completed. Some primary care agencies are being funded at levels higher than they requested. Agencies were instructed to develop budgets based on previous allocations. While some proposed budgets higher than what was available for funding, others proposed budgets lower than what was available. There was an increase in breast and cervical cancer screening funds that bidders were unaware of when they drafted budgets. Adjustments were made accordingly for those agencies that proposed budgets at levels lower than available funds. This is a contract where that situation occurred. The Bid Summary is attached.

As referenced in the Request for Proposals, Renewals Section, this competitively procured Agreement has the option to renew for two additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties and approval of the Governor and Executive Council. These services were contracted previously with this agency in SFY 2011 and SFY 2012 in the amount of $983,024. This represents a decrease of $382,628. The decrease is due to budget reductions.

The performance measures used to measure the effectiveness of the agreement are attached.

Area served: Strafford County.

Source of Funds: 33.68% Federal Funds from US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau and 66.32% General Funds.

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

Respectfully submitted,

José Thier Montero, MD
Director

Approved by:
Nicholas A. Toumpas
Commissioner

JTM/PMT/sc

Primary Care Performance Measures

State Fiscal Year 2013

Primary Care Prenatal (PN) Performance Measure #1

Measure: Percent of infants born to women receiving prenatal care beginning in the first trimester of pregnancy.

Primary Care Prenatal (PN) Performance Measure #2

Measure: Percent of pregnant women identified as cigarette smokers that are referred to QuitWorks-New Hampshire.

Primary Care Prenatal (PN) Performance Measure #3

Measure: Percent of pregnant women who were screened, using a formal valid screening tool, for alcohol and other drug use during every trimester the patient was enrolled.

Primary Care Child Health Direct (CH – D) Performance Measure #1

Measure: Percent of eligible children enrolled in Medicaid

Primary Care Child Health Direct (CH – D) Performance Measure #2

Measure: Percent of at-risk children who were screened for blood lead between 18 and 30 months of age

Primary Care Child Health Direct (CH – D) Performance Measure #3

Measure: Percent of children age two to nineteen years receiving primary care preventive health services with a Body Mass Index (BMI) percentile greater than or equal to the 85th percentile with documented discussion of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Primary Care Child Health Direct (CH – D) Performance Measure #4

Measure: Percent of eligible infants and children with client record documentation of enrollment in Women Infant Children Program.

Primary Care Child Health Direct (CH – D) Performance Measure #5

Measure: Percent of infants who were exclusively breastfed for the first three months, at their four month well baby visit.

Primary Care Financial (PC) Performance Measure #1

Measure: Patient Payor Mix

Primary Care Financial (PC) Performance Measure #2

Measure: Accounts Receivables (AR) Days

Primary Care Financial (PC) Performance Measure #3

Measure: Current Ratio

Primary Care Performance Measures

State Fiscal Year 2013

Primary Care Clinical Adolescent (PC-C) Performance Measure #1

Measure: Percent of adolescents aged 10-21 years who received annual health maintenance visits in the past 12 months.

Primary Care Clinical Prenatal (PC-C) Performance Measure #2

Measure: Percent of women and adolescent girls aged 15-44 who take a multi-vitamin with folic acid.

Subject: Primary Care Services

AGREEMENT

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

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name NH Department of Health and Human Services Division of Public Health Services	**1.2 State Agency Address** 29 Hazen Drive Concord, NH 03301-6504
1.3 Contractor Name Goodwin Community Health	**1.4 Contractor Address** 311 Route 108 Somersworth, New Hampshire 03878

1.5 Contractor Phone Number	1.6 Account Number	1.7 Completion Date	1.8 Price Limitation
603-953-0065	010-090-5190-102-500731 010-090-5659-102-500731	June 30, 2014	$600,396

1.9 Contracting Officer for State Agency Joan H. Ascheim, Bureau Chief	**1.10 State Agency Telephone Number** 603-271-4501
1.11 Contractor Signature Janet Atkins	**1.12 Name and Title of Contractor Signatory** Janet Atkins, Executive Director

1.13 Acknowledgement: State of NH, County of Strafford

On 2/24/2012, before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.

1.13.1 Signature of Notary Public or Justice of the Peace

[Seal]

SHERRYLANN TRASK
NOTARY PUBLIC
NEW HAMPSHIRE
MY COMMISSION EXPIRES NOV. 19, 2013

1.13.2 Name and Title of Notary or Justice of the Peace

Sherry Trask, Notary

1.14 State Agency Signature	**1.15 Name and Title of State Agency Signatory** Brook Dupee ~~Joan H. Ascheim~~, Bureau Chief

1.16 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)*

By: Director, On:

1.17 Approval by the Attorney General (Form, Substance and Execution)

By: Jeanne P. Herrick, Attorney On: 15 May 2012

1.18 Approval by the Governor and Executive Council

By: On:

NH Department of Health and Human Services

Exhibit A

Scope of Services

Primary Care Services

CONTRACT PERIOD: July 1, 2012 or date of G&C approval, whichever is later, through June 30, 2014

CONTRACTOR NAME: Goodwin Community Health

ADDRESS: 311 Route 108
Somersworth, New Hampshire 03878
Executive Director: Janet Atkins
TELEPHONE: 603-953-0065

<u>**The Contractor shall:**</u>

I. <u>General Provisions</u>

A) Eligibility and Income Determination

1. Office-based primary care services will be provided to low-income individuals and families (defined as ≤ 185% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), in the State of New Hampshire.

2. Breast and Cervical Cancer screening services will be provided to low-income (defined as ≤ 250% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), New Hampshire women age 18 – 64, *<u>uninsured or underinsured</u>*.

3. The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing if, at any time, the practice is closed to new patients, or maintains a wait list for new patients, or any other mechanism is used that limits access for new patients for more than a one month period.

4. The Contractor shall document annually, for each client enrolled in the program, family income and family size, and calculate percentage of the federal poverty level. If calculations indicate that the client may be eligible for enrollment in Medicaid, the Contractor shall complete with the client the most recent version of the 800P form.

5. The Contractor shall implement, and post in a public and conspicuous location, a sliding fee payment schedule, approved in advance by the Division of Public Health Services (DPHS), for low-income patients. Signage must state that no client will be denied services for inability to pay.

   a. As an alternative, the contractor may post, in a public and conspicuous location, a notice to clients that a sliding fee scale is available and that no client will be denied services for inability to pay. The sliding fee scale must be updated annually based on USDHHS Poverty guidelines as published in the Federal Register, submitted to and approved by DPHS *<u>prior to implementation.</u>*

6. The primary care contract entered into here shall be the payer of last resort. The contractor shall make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid, for all reimbursable services rendered.

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B) Numbers Served

1. The contract funds shall be expended to provide the above services to a minimum of 3000 users annually with 9000 medical encounters, as defined in the Data and Reporting Requirements. Breast and Cervical Cancer Screening for eligible women, as defined by the Breast and Cervical Cancer Program (BCCP), shall be provided to 300 women annually and billed directly to the BCCP. Clinical service reimbursements shall not exceed the Medicare rate.

C) Culturally and Linguistically Appropriate Standards of Care

The Department of Health and Human Services (DHHS) recognizes that culture and language have considerable impact on how consumers access and respond to public health services. Culturally and linguistically diverse populations experience barriers in efforts to access health services. To ensure equal access to quality health services, the Division of Public Health Services (DPHS) expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.

2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.

3. *Provide* clients of limited English proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.

4. Offer consumers a forum through which clients have the opportunity to provide feedback to providers and organizations regarding cultural and linguistic issues that may deserve response.

5. The contractor shall maintain a program policy that sets forth compliance with Title VI, Language Efficiency and Proficiency Citation 45 CFR 80.3(b) (2). The policy shall describe the way in which the items listed above were addressed and shall indicate the circumstances in which interpretation services are provided and the method of providing service (e.g. trained interpreter, staff person who speaks the language of the client, language line).

D) State and Federal Laws

The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. The Contractor shall report all cases of communicable diseases according to New Hampshire RSA 141-C and He-P 301, adopted 6/3/08.

2. Persons employed by the contractor shall comply with the reporting requirements of New Hampshire RSA 169:C, Child Protection Act; RSA 161:F46, Protective Services to Adults, RSA 631:6, Assault and Related Offences and RSA 130:A, Lead Paint Poisoning and Control.

3. Immunizations shall be conducted in accordance with RSA 141-C and the Immunization Rules promulgated hereunder.

E) Relevant Policies and Guidelines

1. The Contractor shall design and provide the services described above to meet the unique and identified health needs of the populations within the contracted service area.

2. Primary Care funds shall be targeted to populations in need. Populations in need are defined as follows:

   a) uninsured;

   b) under-insured;

   c) families and individuals with significant psychosocial and economic risk, including low income status;

   d) all life cycles including perinatal, child, adolescent, adult, and elderly who meet one or more of the above criteria.

3. The Contractor shall design and implement systems of governance, administration, financial management, information management, and clinical services which are adequate to assure the provision of contracted services, and to meet the data and reporting requirements. These systems shall meet the most current minimum standards described in at least one of the following: Health Resources and Services Administration (HRSA) Office of Performance Review protocols, Joint Commission on Accreditation of Health Care Organizations (JCAHO), Accreditation Association for Ambulatory Healthcare (AAAHC), Community Health Accreditation Program (CHAP), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey.

4. *The Contractor shall have an agency emergency preparedness and response plan in accordance with HRSA Health Center Emergency Management Program Expectations, Document #2007-15 or most recent version. Such plan shall also include a Continuity of Operations plan.*

5. The Contractor shall carry out the work as described in the performance Workplan submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

6. No Workplan is required by the Breast and Cervical Cancer Program (BCCP). The contractor shall be required to respond to the Quality Improvement Feedback Report twice a year.

7. The Contractor shall carry out the work as described in the Supplemental Funding Form submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

F) Publications Funded Under Contract

1. The DHHS and/or its funders will retain COPYRIGHT ownership for any and all original materials produced with DHHS contract funding, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports.

2. All documents (written, video, audio, *electronic*) produced, reproduced, or purchased under the contract shall have prior approval from DPHS before printing, production, distribution, or use.

3. The Contractor shall credit DHHS on all materials produced under this contract following the instructions outlined in Exhibit C (14).

G) Subcontractors

1. If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing *and approve the subcontractual agreement,* prior to initiation of the subcontract.

2. In addition, the original DPHS contractor will remain liable for all requirements included in this Exhibit and carried out by subcontractors.

II. Minimal Standards of Core Services

A) Service Requirements

1. *Medical Home*

The Contractor shall provide a Medical Home that:

a) *Facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family.*

b) ***Provides care facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.***

2. Primary Care Services

The Contractor shall provide office-based primary care services to populations in need who reside in the contractor's service area. Primary care services shall include:

a) Health care provided by a New Hampshire licensed MD, DO, APRN, or PA, including diagnosis and treatment of acute and chronic illnesses within the scope of family practice; preventive services, screenings, and health education according to established, documented state or national guidelines; assessment of need for social and nutrition services, and appropriate referrals to health, *oral health*, and behavioral health specialty providers.

b) ***Referral to the WIC Nutrition Program for all eligible pregnant women, infants and children.***

c) In-hospital care for conditions within the scope of family practice must be provided at a hospital, within the agency service area, through a staff clinician with full hospital privileges, or in the alternative, through a formal referral and admissions procedure available to clients on a 24 hour/7 day a week basis.

d) Access to a healthcare provider, directly or by referral or subcontract, by telephone twenty-four hours per day, seven days per week.

e) Assessment of psychosocial risk for all clients at least annually and for children at scheduled preventive care visits, including, at a minimum, age appropriate assessment of safety in the home, domestic violence, adequacy of food and housing, care and welfare of children, transportation needs, and provision of necessary social services to address the priority needs and safety issues of clients and families.

f) Falls prevention screening for patients 65 years and older using the algorithm and guidelines of the American Geriatrics Society.

g) Behavioral health care directly or by referral to an agency or provider with a sliding fee scale.

h) *Nutrition assessment for all clients as part of the health maintenance visit.* Therapeutic nutrition services shall be provided *as indicated* directly or by referral to an agency or provider with a sliding fee scale. These services shall be recorded in the medical record.

i) Formal arrangements with a local hospital for emergency care must be in place and reviewed annually.

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j) Home health care directly or by referral to an agency or provider with a sliding fee scale.

k) Assisted living and skilled nursing facility care by referral.

l) *Oral screening annually for all clients 19 years and older to note obvious dental decay and soft tissue abnormalities with a reminder to the patient that poor oral health impacts total health.*

m) *Diagnosis and management of pediatric and adult patients with asthma provided according to National Heart Lung Blood Institute, National Asthma Education and Prevention Program, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, 2007.*

2. Breast and Cervical Cancer Screening

a) Women age 18 to 64 who are eligible for Breast and Cervical Cancer Program (BCCP) services according to income (equal to or under 250% of poverty, underinsured/uninsured) *and insurance status* criteria shall be provided the following services:

i. cervical cancer screening including a pelvic examination and Pap smear;
ii. annual breast cancer screening including a clinical breast exam, mammogram and,
iii. referrals for diagnostic and treatment services based on screening results,
iv. case management services.

b) All referrals under this provision shall be to approved certified laboratory, pathology, radiology, and surgical services. Mammography units shall be accredited by the American College of Radiology, and must be FDA certified under MQSA. Laboratories shall be CLIA certified.

c) All services shall be provided in accordance with the Breast and Cervical Cancer Program (BCCP) Policy and Procedure Manual.

d) Follow-up and tracking of all tests done, and referrals made shall be provided in accordance with the minimum standards outlined in the Breast and Cervical Cancer Program Policy and Procedure Manual.

e) All services for women enrolled in the Breast and Cervical Cancer Program (BCCP) shall be billed directly to the BCCP in accordance with protocols established by the Breast and Cervical Cancer Program.

3. Reproductive Health Services

The Contractor shall provide prenatal, interconceptional and preconception medical care, social services, nutrition services, education, and nursing care to all women of childbearing age. Preconceptional care includes the preconception, interconceptional, and postpartum periods in women's health. It is recommended that preconceptional and interconceptional care visits focus on maintaining or achieving the optimal health of the mother, lowering the risk of future adverse pregnancy outcomes, the family's future plans, and how additional children fit into that plan. Preconceptional counseling may be done during an office, group or home visit.

a) In the event prenatal care is not provided directly by the Contractor a formal Memorandum/a of Agreement for coordinated referral to an appropriately qualified provider must be maintained.

b) Prenatal care shall, at minimum, be provided in accordance with the Guidelines for Perinatal Care, sixth or most current edition, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and /or the Centers for Disease Control.

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c) Age appropriate reproductive health care shall, at a minimum, be provided in accordance with the American College of Obstetricians and Gynecologists, or the USDHHS Centers for Disease Control (CDC) current guidelines.

d) *Pregnant women enrolled in the WIC Nutrition Program shall be referred to WIC for breastfeeding education and referral to the WIC Nutrition Program peer counselors.*

e. Family planning counseling for prevention of subsequent pregnancy following an infant's birth shall be discussed with the infant's mother *at the first postpartum visit and at the infant's 2-month visit and other visits as appropriate.* Rationale for birth intervals of 18-24 months shall be presented.

f) A referral to a Title X Family Planning Clinic or other reproductive health care provider shall be made as appropriate.

4. Services for Children and Adolescents

The Contractor shall provide as a minimum, comprehensive and age-appropriate health care, screenings, and health education according to the American Academy of Pediatrics' most recent periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent. Children and adolescent visits shall include:

a) Blood lead testing shall be performed in accordance with "New Hampshire Childhood Lead Poisoning Screening and Management Guidelines", issued by the New Hampshire Department of Health and Human Services, 2009 or subsequent revisions.

b) All children enrolled in either Healthy Kids-Gold or the Women, Infant, and Children (WIC) Program and/or who are ≤ 185% poverty, regardless of town of residence, are required to have a blood lead test at ages one and two years. All children ages three to six years who have not been previously tested shall have a capillary or venous blood lead test performed.

c) All children shall be screened for iron deficiency anemia as outlined in the Centers for Disease Control and Prevention document "Recommendations to Prevent and Control Iron Deficiency in the United States (4/2/98)".

d) Age-appropriate anticipatory guidance, dietary guidance, and *feeding practice counseling* for optimal oral health shall be provided at each well child visit according to the American Academy of Pediatrics' periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent edition. Starting at age 6 months, it is recommended that all children receive an oral health assessment at every well child visit.

e) Supplemental fluoride shall be prescribed as needed based upon the fluoride levels in the child's *drinking* water supply. The fluoride dosage regimen accepted by the American Academy of Pediatrics shall be followed. No fluoride shall be prescribed without obtaining water from private wells or noting the presence or absence of fluoride in the public water supply. *Supplemental fluoride may include bottled water containing fluoride and topical applications such as varnishes.*

f) *For infants enrolled in the WIC Nutrition Program, parents shall be referred to WIC for breastfeeding support and referral to the WIC Nutrition Program peer counselors.*

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5. Sexually Transmitted Infections

Primary Care Services shall provide age appropriate screening and treatment of sexually transmitted infections.

a) Treatment for sexually transmitted infections shall be provided according to the United States Centers for Disease Control Sexually Transmitted Diseases Treatment Guidelines, 2010 or subsequent revisions.

b) All clients, including women, shall be offered HIV testing following the most current recommendations of the United States Centers for Disease Control.

c) The contractor shall be responsible for ensuring referral to appropriate treatment services for any woman found to screen positive.

d) Appropriate risk reduction counseling shall be provided based on client needs.

6. Substance Use Services

a) A substance use screening history using a formal, validated screening tool shall be obtained for all clients as soon after entry into care as possible. Substance use counseling *or other substance abuse intervention, treatment, or recovery services* by an appropriately credentialed provider shall be provided on-site, or by referral, to clients with identified needs for these services. *For these identified clients, ongoing primary care services should include follow up monitoring relative to substance abuse.*

b) All clients, including pregnant women, identified as smokers shall receive counseling *using the 5A's (ask, advise, assess, assist, and arrange) treatment available through the NH Tobacco Helpline* as cited in the US Public Health Services report "Tobacco Use and Dependence", 2008, or "Smoking Cessation During Pregnancy: *A Clinician's Guide to Helping Pregnant Women Quit Smoking*", American College of Obstetricians and Gynecologists, 2011. *With prior approval, agencies may also opt to participate in the DPHS best practice initiative of the 2A's and R (ask, advise and refer).*

7. Immunizations

a) The Contractor shall adhere to the most current version of the "Recommended Adult Immunization Schedule United States", approved by the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

b) The Contractor shall administer vaccines according to the most current version of the *"Recommended Immunization Schedule for Persons Aged 0 Through 6 Years - United States", and "Recommended Immunization Schedule for Persons Aged 7 Through 18 Years – United States"* approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians, based upon availability of vaccine from the New Hampshire Immunization Program.

8. Prenatal Genetic Screening

a) A genetic screening history shall be obtained on all prenatal clients as soon after entry into care as possible.

b) All pregnant women should be offered voluntary genetic screening for fetal chromosomal abnormalities at the appropriate time following recommendations found in the American College of Obstetricians and Gynecologists' "Screening for Fetal Chromosomal

Abnormalities (2007)" or more recent guidelines. The Contractor shall be responsible for ensuring referral to appropriate genetic testing and counseling for any woman found to have a positive screening test.

9. Additional Requirements

   a) The Contractor's Medical Director shall participate in the development and approval of specific guidelines for medical care that supplement minimal clinical standards. Supplemental guidelines should be reviewed, signed, and dated annually, and updated as indicated.

   b) Contractors considering clinical or sociological research using clients as subjects must adhere to the legal requirements governing human subjects research. Contractors must inform the DPHS, MCHS prior to initiating any research related to this contract.

   c) *The Contractor shall provide information to all employees annually about the Medical Reserve Corps Unit within their Public Health Region to enhance recruitment.*

   d) *The Contractor shall provide information to all employees annually regarding the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) managed by the NH Department of Health and Human Services' Emergency Services Unit, to enhance recruitment.*

B) Staffing Provisions

The Contractor shall have, at minimum, the following staff positions:

a) executive director

b) fiscal director

c) registered nurse

d) clinical coordinator

e) medical service director

f) nutritionist *(on site or by referral)*

g) social worker

Staff positions required to provide direct services on-site include:

a) registered nurse

b) clinical coordinator

c) social worker

1. Qualifications

   All health and allied health professionals shall have the appropriate New Hampshire licenses whether directly employed, contracted, or subcontracted.

   In addition the following minimum qualifications shall be met for:

   a) Registered Nurse

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a. A registered nurse licensed in the state of New Hampshire, Bachelor's degree preferred. Minimum of one-year experience in a community health setting.

b) Nutritionists:

a. A Bachelor's degree in nutritional sciences or dietetics, or a Master's degree in nutritional sciences, nutrition education, or public health nutrition or current Registered Dietitian status in accordance with the Commission on dietetic Registration of the American Dietetic Association.

b. Individuals who perform functions similar to a nutritionist but do not meet the above qualifications shall not use the title of nutritionist.

c) Social Workers shall have:

a. A Bachelor's or Master's degree in social work or Bachelor's or Master's degree in a related social science or human behavior field. A minimum of one year of experience in a community health or social services setting is preferred.

b. Individuals who perform functions similar to a social worker but do not meet the above qualifications shall not use the title of social worker.

d) Clinical Coordinators shall be:

a. A registered nurse (RN), physician, physician assistant, or nurse practitioner with a license to practice in New Hampshire.

b. The coordinator is a clinical position that oversees and takes responsibility for the clinical and administrative functions of each program.

c. The coordinator may be responsible for more than one MCH funded program.

2. New Hires

The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing within one month of hire when a new administrator, clinical coordinator, or any staff person essential to carrying out contracted services is hired to work in the program. A resume of the employee shall accompany the aforesaid notification.

3. Vacancies

a) The Contractor must notify the MCHS in writing if any critical position is vacant for more than one month, or if at any time funded under this contract does not have adequate staffing to perform all required services for more than one month. This may be done through a budget revision.

b) Before an agency hires new program personnel that do not meet the required staff qualifications, the agency shall notify the MCHS in writing requesting a waiver of the applicable staffing requirements. The Section may grant waivers based on the need of the program, individuals' experience, and additional training.

C) Coordination of Services

1. The Contractor shall coordinate, where possible, with other service providers within the contractor's community. At a minimum, such collaboration shall include interagency referrals and coordination of care.

2. The Contractor shall participate in activities *in the Public Health Region in which they provide services* as appropriate. These activities enhance the integration of community-based public health

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prevention and health care initiatives that are being implemented by the contractor and may include community needs assessments, public health performance assessments, and/or the development of regional health improvement plans.

3. The Contractor agrees to *participate* in and coordinate public health activities as requested by the Division of Public Health Services during any *disease outbreak* and/or *emergency*, natural or man made, affecting the public's health.

4. The Contractor is responsible for case management of the client enrolled in the program and for program follow-up activities. Case management services shall promote effective and efficient organization and utilization of resources to assure access to necessary comprehensive medical, nutritional, and social services for clients.

5. The Contractor shall assure that *appropriate, responsive, and timely* referrals and linkages for other needed services are made, carried through, and documented. Such services shall include, but not be limited to: dental services, genetic counseling, high risk prenatal services, mental health, social services, including domestic violence crisis centers, substance abuse services; and family planning services, Early Supports and Services Program, local WIC/CSF Program, Home Visiting New Hampshire Programs and health and social service agencies which serve children and families in need of those services.

D) Meetings and Trainings

The contractor will be responsible for sending staff to meetings and training required by the MCHS program, including but not limited to:

1. MCHS Agency Directors' meetings
2. Prenatal and Child Health Coordinators' meetings
3. MCHS Agency Medical Services Directors' meetings

III. Quality or Performance Improvement (QI/PI)

A) Workplans

1. Performance Workplans are required for this program and are used to monitor achievement of standard measures of performance of the services provided under this contract. The workplans are a key component of the RHPCS and the MCHS performance-based contracting system and of this contract. Outcomes shall be reported by clinical site.

2. Submit Performance Workplans and Workplan Outcome reports according to the schedule and instructions provided by the MCHS. The MCHS shall notify the Contractor at least 30 days in advance of any changes in the submission schedule.

3. The Contractor shall incorporate required and developmental performance measures, defined by the MCHS into the agency's Performance Workplan. Reports on Workplan Progress/Outcomes shall detail the Performance Workplan and activities that monitor and evaluate the agency's progress toward performance measure targets.

4. The Contractor shall comply with modifications and/or additions to the workplan and annual report format as requested by RHPCS and MCHS. MCHS will provide the contractor with reasonable notice of such changes.

5. Agencies contracting for Primary Care Services must submit the workplans for Primary Care *Clinical and Financial*, Child Health, and Prenatal Care.

B) Additional Reporting requirements

In addition to Performance Workplans, the Contractor shall submit to MCHS the following data and information listed below which are used to monitor program performance:

1. In years when contracts or amendments are not required, the DPHS Budget Form, Budget Justification, Sources of Revenue and Program Staff list forms must be completed according to the relevant instructions and submitted as requested by DPHS and, at minimum, by April 30 of each year.
2. The Sources of Revenue report must be resubmitted at any point when changes in revenue threaten the ability of the agency to carry out the planned program.
3. Completed Uniform Data Set (UDS) tables reflecting program performance in the previous calendar year, by March 31 of each year.
4. The Perinatal Client Data Form (PCDF) shall be submitted electronically according to the instructions set forth by the MCHS.
5. A copy of the agency's updated Sliding Fee Scale including the amount(s) of any client fees and the schedule of discounts must be submitted by March 31st of each year. The agency's sliding fee scale must be updated annually based on the US DHHS Poverty guidelines as published in the Federal Register.
6. An annual summary of program-specific patient satisfaction results obtained during the prior contract period and the method by which the results were obtained shall be submitted annually as an addendum to the Workplan Outcome/Progress reports.

C) On-site reviews

1. The contractor shall allow a team or person authorized by the Division of Public Health Services to periodically review the contractor's systems of governance, administration, data collection and submission, clinical and financial management, and delivery of education services in order to assure systems are adequate to provide the contracted services.
2. Reviews shall include client record reviews to measure compliance with this exhibit.
3. The contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.
4. On-Site reviews may be waived or abbreviated at the discretion of MCHS, upon submission of satisfactory reports of reviews such as Health Services Resources Administration (HRSA): Office of Performance Review (OPR), or reviews from nationally accreditation organizations such as the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), Medicare, the Community Health Accreditation Program (CHAP), Accreditation Association for Ambulatory Healthcare (AAAHC), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey. Abbreviated reviews will focus on any deficiencies found in previous reviews, issues of compliance with this exhibit, and actions to strengthen performance as outlined in the agency Performance Workplan.

State of New Hampshire
Department of Health and Human Services
Amendment #1 to the
Health First Family Care Center

This 1st Amendment to the Health First Family Care Center, contract (hereinafter referred to as "Amendment One") dated this 21st day of March, 2014, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Health First Family Care Center, (hereinafter referred to as "the Contractor"), a corporation with a place of business at 841 Central Street, Franklin, New Hampshire 03235.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on June 20, 2012, 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, the State and the Contractor have agreed to make changes to the scope of work, payment schedules and terms and conditions of the contract; and

WHEREAS, pursuant to the General Provisions, Paragraph 18, the State may modify the scope of work and the payment schedule of the contract by written agreement of the parties;

WHEREAS, the Department desires to provide additional primary health care services for preventive and episodic health care for acute and chronic health conditions for people of all ages.

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 as follows:

To amend as follows:

- Form P-37, to change:
  Block 1.7 to read: June 30, 2015
  Block 1.8 to read: $748,658

- Exhibit A, Scope of Services to add:
  Exhibit A – Amendment 1

- Exhibit B, Purchase of Services, Contract Price, to add:

  Paragraph 1.1 to Paragraph 1:
  The contract price shall increase by $55,968 for SFY 2014 and $292,214 for SFY 2015.

  Paragraph 1.2 to Paragraph 1:
  Funding is available as follows:
- $55,968 from 05-95-90-902010-5190-102-500731, 100% General Funds;
- $280,648 from 05-95-90-902010-5190-102-500731, 6.7% Federal Funds from the US Department of Health and Human Services Administration, Maternal and Child Health Bureau, CFDA #93.994 and 93.3% General Funds;

Contractor Initials: [signature]
Date: 3/21/14

- $11,566 from 05-95-90-902010-5659-102-500731, 100% Federal Funds from the US Department of Health and Human Services, Centers for Disease Control and Prevention, CFDA #93.283;

  Add Paragraph 8
  8. Notwithstanding paragraph 18 of the General Provisions P-37, an amendment limited to adjustments to amounts between and among account numbers, within the price limitation, may be made by written agreement of both parties and may be made without obtaining approval of the Governor and Executive Council.

- Budget, to add:
  Exhibit B-1 (2014) - Amendment 1,
  Exhibit B-1 (2015) - Amendment 1

This amendment shall be in effect July 1, 2013, effective upon the date of Governor and Executive Council approval.

Contractor Initials: [signature]
Date: 3/21/14

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

3/28/14
Date

Brook Dupee
Bureau Chief

Health First Family Care Center

3/21/2014
Date

Name: Jane White
Title: Board Chair

Acknowledgement:

State of NH, County of Belknap on 3/21/2014, before the undersigned officer, personally appeared the person identified above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.

Signature of Notary Public ~~or Justice of the Peace~~
ELIZABETH KANTOWSKI, Notary Public
My Commission Expires September 14, 2016

Name and Title of Notary or Justice of the Peace

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

OFFICE OF THE ATTORNEY GENERAL

4-2-14
Date

Name: Rosemary Wiant
Title: Asst. Attorney General

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

OFFICE OF THE SECRETARY OF STATE

Date

Name:
Title:

EXHIBIT A – AMENDMENT 1

Scope of Services

The Department desires to continue the relationship with the primary care agencies to provide additional primary health care services for preventive and episodic health care for acute and chronic health conditions for people of all ages.

I. General Provisions

A) Eligibility and Income Determination

1. Office-based primary care services will be provided to low-income individuals and families (defined as ≤ 185% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), in the State of New Hampshire.

2. Breast and Cervical Cancer screening services will be provided to low-income (defined as ≤ 250% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), New Hampshire women age 21– 64, uninsured or underinsured. BCCP changes.

3. The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing if, at any time, the practice is closed to new patients, or maintains a wait list for new patients, or any other mechanism is used that limits access for new patients for more than a one month period.

4. The Contractor shall document annually, for each client enrolled in the program, family income and family size, and calculate percentage of the federal poverty level. If calculations indicate that the client may be eligible for enrollment in Medicaid, the Contractor shall complete with the client the most recent version of the 800P form.

5. The Contractor shall implement, and post in a public and conspicuous location, a sliding fee payment schedule, approved in advance by the Division of Public Health Services (DPHS), for low-income patients. Signage must state that no client will be denied services for inability to pay.

   a. As an alternative, the contractor may post, in a public and conspicuous location, a notice to clients that a sliding fee scale is available and that no client will be denied services for inability to pay. The sliding fee scale must be updated annually based on USDHHS Poverty guidelines as published in the Federal Register, submitted to and approved by DPHS prior to implementation.

6. The primary care contract entered into here shall be the payer of last resort. The contractor shall make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid, for all reimbursable services rendered.

B) Numbers Served

1. The contract funds shall be expended to provide the above services to a minimum of 3,700 users annually with 14,500 medical encounters, as defined in the Data and Reporting Requirements. Breast and Cervical Cancer Screening for eligible women, as defined by the Breast and Cervical Cancer Program (BCCP), shall be provided to 75 women annually and billed directly to the BCCP. Clinical service reimbursements shall not exceed the Medicare rate.

C) Culturally and Linguistically Appropriate Standards of Care

The Department of Health and Human Services (DHHS) recognizes that culture and language have considerable impact on how consumers access and respond to public health services. Culturally and linguistically diverse populations experience barriers in efforts to access health services. To ensure equal access to quality health services, the Division of Public Health Services (DPHS) expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.
2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.
3. Provide clients of limited English proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.
4. Offer consumers a forum through which clients have the opportunity to provide feedback to providers and organizations regarding cultural and linguistic issues that may deserve response.
5. The contractor shall maintain a program policy that sets forth compliance with Title VI, Language Efficiency and Proficiency Citation 45 CFR 80.3(b) (2). The policy shall describe the way in which the items listed above were addressed and shall indicate the circumstances in which interpretation services are provided and the method of providing service (e.g. trained interpreter, staff person who speaks the language of the client, language line).

D) State and Federal Laws

The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. The Contractor shall report all cases of communicable diseases according to New Hampshire RSA 141-C and He-P 301, adopted 6/3/08.

2. Persons employed by the contractor shall comply with the reporting requirements of New Hampshire RSA 169:C, Child Protection Act; RSA 161:F46, Protective Services to Adults, RSA 631:6, Assault and Related Offences and RSA 130:A, Lead Paint Poisoning and Control.

3. Immunizations shall be conducted in accordance with RSA 141-C and the Immunization Rules promulgated hereunder.

E) Relevant Policies and Guidelines

1. The Contractor shall design and provide the services described above to meet the unique and identified health needs of the populations within the contracted service area.

2. Primary Care funds shall be targeted to populations in need. Populations in need are defined as follows:

   a) uninsured;

   b) under-insured;

   c) families and individuals with significant psychosocial and economic risk, including low income status;

   d) all life cycles including perinatal, child, adolescent, adult, and elderly who meet one or more of the above criteria.

3. The Contractor shall design and implement systems of governance, administration, financial management, information management, and clinical services which are adequate to assure the provision of contracted services, and to meet the data and reporting requirements. These systems shall meet the most current minimum standards described in at least one of the following: Health Resources and Services Administration (HRSA) Office of Performance Review protocols, Joint Commission on Accreditation of Health Care Organizations (JCAHO), Accreditation Association for Ambulatory Healthcare (AAAHC), Community Health Accreditation Program (CHAP), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey.

4. The Contractor shall have an agency emergency preparedness and response plan in accordance with HRSA Health Center Emergency Management Program Expectations, Document #2007-15 or most recent version. Such plan shall also include a Continuity of Operations plan.

5. The Contractor shall carry out the work as described in the performance Workplan submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

6. No Workplan is required by the Breast and Cervical Cancer Program (BCCP). The contractor shall be required to respond to the Quality Improvement Feedback Report twice a year.

7. The Contractor shall carry out the work as described in the Supplemental Funding Form submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

F) Publications Funded Under Contract

1. The DHHS and/or its funders will retain COPYRIGHT ownership for any and all original materials produced with DHHS contract funding, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports.

2. All documents (written, video, audio, electronic) produced, reproduced, or purchased under the contract shall have prior approval from DPHS before printing, production, distribution, or use.

3. The Contractor shall credit DHHS on all materials produced under this contract following the instructions outlined in Exhibit C (14).

G) Subcontractors

If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing and approve the subcontractual agreement, prior to initiation of the subcontract.

1. If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing and approve the subcontractual agreement, prior to initiation of the subcontract.

2. In addition, the original DPHS contractor will remain liable for all requirements included in this Exhibit and carried out by subcontractors.

II. Minimal Standards of Core Services

A. Service Requirements

1. Medical Home

The Contractor shall provide a Medical Home that:

a) Facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family.

b) Provides care facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

2. Primary Care Services

The Contractor shall provide office-based primary care services to populations in need who reside in the contractor's service area. Primary care services shall include:

a) Health care provided by a New Hampshire licensed MD, DO, APRN, or PA, including diagnosis and treatment of acute and chronic illnesses within the scope of family practice; preventive services, screenings, and health education according to established, documented state or national guidelines; assessment of need for social and nutrition services, and appropriate referrals to health, oral health, and behavioral health specialty providers.

b) Referral to the WIC Nutrition Program for all eligible pregnant women, infants and children.

c) In-hospital care for conditions within the scope of family practice must be provided at a hospital, within the agency service area, through a staff clinician with full hospital privileges, or in the alternative, through a formal referral and admissions procedure available to clients on a 24 hour/7 day a week basis.

d) Access to a healthcare provider, directly or by referral or subcontract, by telephone twenty-four hours per day, seven days per week.

e) Assessment of psychosocial risk for all clients at least annually and for children at scheduled preventive care visits, including, at a minimum, age appropriate assessment of safety in the home, domestic violence, adequacy of food and housing, care and welfare of children, transportation needs, and provision of necessary social services to address the priority needs and safety issues of clients and families.

f) Falls prevention screening for patients 65 years and older using the algorithm and guidelines of the American Geriatrics Society.

g) Behavioral health care directly or by referral to an agency or provider with a sliding fee scale.

h) Nutrition assessment for all clients as part of the health maintenance visit. Therapeutic nutrition services shall be provided as indicated directly or by referral to an agency or provider with a sliding fee scale. These services shall be recorded in the medical record.

i) Formal arrangements with a local hospital for emergency care must be in place and reviewed annually.

j) Home health care directly or by referral to an agency or provider with a sliding fee scale.

k) Assisted living and skilled nursing facility care by referral.

l) Oral screening annually for all clients 21 years and older to note obvious dental decay and soft tissue abnormalities with a reminder to the patient that poor oral health impacts total health.

m) Diagnosis and management of pediatric and adult patients with asthma provided according to National Heart Lung Blood Institute, National Asthma Education and Prevention Program, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, 2007.

3. Breast and Cervical Cancer Screening

a) Women age 21 to 64 who are eligible for Breast and Cervical Cancer Program (BCCP) services according to income (equal to or under 250% of poverty, underinsured/uninsured) and insurance status criteria shall be provided the following services, following USPSTF screening recommendations:

i. cervical cancer screening including a pelvic examination and Pap smear;
ii. breast cancer screening including a clinical breast exam, mammogram and,
iii. referrals for diagnostic and treatment services based on screening results,
iv. case management services.

b) All referrals under this provision shall be to approved certified laboratory, pathology, radiology, and surgical services. Mammography units shall be accredited by the American College of Radiology, and must be FDA certified under MQSA. Laboratories shall be CLIA certified.

c) All services shall be provided in accordance with the Breast and Cervical Cancer Program (BCCP) Policy and Procedure Manual.

d) Follow-up and tracking of all tests done, and referrals made shall be provided in accordance with the minimum standards outlined in the Breast and Cervical Cancer Program Policy and Procedure Manual.

e) All services for women enrolled in the Breast and Cervical Cancer Program (BCCP) shall be billed directly to the BCCP in accordance with protocols established by the Breast and Cervical Cancer Program.

f) The Contractor shall provide the NH Breast and Cervical Cancer Program with breast and cervical cancer screening rates for all women served by the practice as requested, but not more than twice per SFY.

g) The contractor shall work with the NH Breast and Cervical Cancer Program staff to increase the breast and cervical cancer screening rates among all women serviced by the practice.

4. Reproductive Health Services

The Contractor shall provide prenatal, interconceptional and preconception medical care, social services, nutrition services, education, and nursing care to all women of childbearing age. Preconceptional care includes the preconception, interconceptional, and postpartum periods in women's health. It is recommended that preconceptional and interconceptional care visits focus on maintaining or achieving the optimal health of the mother, lowering the risk of future adverse pregnancy outcomes, the family's future plans, and how additional children fit into that plan. Preconceptional counseling may be done during an office, group or home visit.

a) In the event prenatal care is not provided directly by the Contractor a formal Memorandum/a of Agreement for coordinated referral to an appropriately qualified provider must be maintained.

b) Prenatal care shall, at minimum, be provided in accordance with the Guidelines for Perinatal Care, sixth or most current edition, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and /or the Centers for Disease Control.

c) Age appropriate reproductive health care shall, at a minimum, be provided in accordance with the American College of Obstetricians and Gynecologists, or the USDHHS Centers for Disease Control (CDC) current guidelines.

d) Pregnant women enrolled in the WIC Nutrition Program shall be referred to WIC for breastfeeding education and referral to the WIC Nutrition Program peer counselors.

e. Family planning counseling for prevention of subsequent pregnancy following an infant's birth shall be discussed with the infant's mother at the first postpartum visit and at the infant's 2-month visit and other visits as appropriate. Rationale for birth intervals of 18-24 months shall be presented.

f) A referral to a Title X Family Planning Clinic or other reproductive health care provider shall be made as appropriate.

5. Services for Children and Adolescents

The Contractor shall provide as a minimum, comprehensive and age-appropriate health care, screenings, and health education according to the American Academy of Pediatrics' most recent periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent. Children and adolescent visits shall include:

a) The World Health Organization (WHO) growth charts shall be used to monitor growth for infants and children birth up to age 2 years. The Centers for Disease Control and Prevention (CDC) growth charts shall be used for children age 2 years and older.

b) Blood lead testing shall be performed in accordance with "New Hampshire Childhood Lead Poisoning Screening and Management Guidelines", issued by the New Hampshire Department of Health and Human Services, 2009 or subsequent revisions.

c) All children enrolled in either Medicaid, Head Start, or the Women, Infant, and Children (WIC) Program and/or who are ≤ 185%_poverty, regardless of town of residence, are required to have a blood lead test at ages one and two years. All children ages three to six years who have not been previously tested shall have a blood lead test performed.

d) All children shall be screened for iron deficiency anemia as outlined in the Centers for Disease Control and Prevention document "Recommendations to Prevent and Control Iron Deficiency in the United States (4/2/98)".

e) Age-appropriate anticipatory guidance, dietary guidance, and *feeding practice counseling* for optimal oral health shall be provided at each well child visit according to the American Academy of Pediatrics' periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent edition. Starting at age 6 months, it is recommended that all children receive an oral health assessment at every well child visit, and a referral for the child's first visit to the dentist by age one as recommended by the American Academy of Pediatrics and the American Academy of Pediatric Dentistry.

f) Supplemental fluoride shall be prescribed as needed based upon the fluoride levels in the child's drinking water supply. The fluoride dosage regimen accepted by the American Academy of Pediatrics shall be followed. No fluoride shall be prescribed without obtaining water from private wells or noting the presence or absence of fluoride in the public water supply. Supplemental fluoride may include bottled water containing fluoride and topical applications such as varnishes.

g) For infants enrolled in the WIC Nutrition Program, parents shall be referred to WIC for breastfeeding support and referral to the WIC Nutrition Program peer counselors.

6. Sexually Transmitted Infections

Primary Care Services shall provide age appropriate screening and treatment of sexually transmitted infections.

a) Treatment for sexually transmitted infections shall be provided according to the United States Centers for Disease Control Sexually Transmitted Diseases Treatment Guidelines, 2010 or subsequent revisions.

b) All clients, including women, shall be offered HIV testing following the most current recommendations of the United States Centers for Disease Control.

c) The contractor shall be responsible for ensuring referral to appropriate treatment services for any woman found to screen positive.

d) Appropriate risk reduction counseling shall be provided based on client needs.

7. Substance Use Services

a) A substance use screening history using a formal, validated screening tool shall be obtained for all clients as soon after entry into care as possible. Substance use counseling or other substance abuse intervention, treatment, or recovery services by an appropriately credentialed provider shall be provided on-site, or by referral, to clients with identified needs for these services. For these identified clients, ongoing primary care services should include follow up monitoring relative to substance abuse.

b) All clients, including pregnant women, identified as smokers shall receive counseling using the 5A's (ask, advise, assess, assist, and arrange) treatment available through the NH Tobacco Helpline as cited in the US Public Health Services report "Tobacco Use and Dependence", 2008, or "Smoking Cessation During Pregnancy: A Clinician's Guide to Helping Pregnant Women Quit Smoking", American College of Obstetricians and Gynecologists, 2011. With prior approval, agencies may also opt to participate in the DPHS best practice initiative of the 2A's and R (ask, advise and refer).

8. Immunizations

a) The Contractor shall adhere to the most current version of the "Recommended Adult Immunization Schedule for Adults (19 years and older) by Age and Medical Condition - United States", approved by the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

b) The Contractor shall administer vaccines according to the most current version of the "Recommended Immunization Schedule for Persons Aged 0 Through 6 Years - United States", and "Recommended Immunization Schedule for Persons Aged 7 Through 18 Years – United States" approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians, based upon availability of vaccine from the New Hampshire Immunization Program.

9. Prenatal Genetic Screening

a) A genetic screening history shall be obtained on all prenatal clients as soon after entry into care as possible.

b) All pregnant women should be offered voluntary genetic screening for fetal chromosomal abnormalities at the appropriate time following recommendations found in the American College of Obstetricians and Gynecologists' "Screening for Fetal Chromosomal Abnormalities (2007)" or more recent guidelines. The Contractor shall be responsible for ensuring referral to appropriate genetic testing and counseling for any woman found to have a positive screening test.

10. Additional Requirements

a) The Contractor's Medical Director shall participate in the development and approval of specific guidelines for medical care that supplement minimal clinical standards. Supplemental guidelines should be reviewed, signed, and dated annually, and updated as indicated.

b) Contractors considering clinical or sociological research using clients as subjects must adhere to the legal requirements governing human subjects research. Contractors must inform the DPHS, MCHS prior to initiating any research related to this contract.

c) The Contractor shall provide information to all employees annually about the Medical Reserve Corps Unit within their Public Health Region to enhance recruitment.

d) The Contractor shall provide information to all employees annually regarding the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) managed by the NH Department of Health and Human Services' Emergency Services Unit, to enhance recruitment.

B) Staffing Provisions

The Contractor shall have, at minimum, the following staff positions:

a) executive director

b) fiscal director

c) registered nurse

d) clinical coordinator

e) medical service director

f) nutritionist (on site or by referral)

g) social worker

Staff positions required to provide direct services on-site include:

a) registered nurse

b) clinical coordinator

c) social worker

1. Qualifications

All health and allied health professionals shall have the appropriate New Hampshire licenses whether directly employed, contracted, or subcontracted.

In addition the following minimum qualifications shall be met for:

a) Registered Nurse
   a. A registered nurse licensed in the state of New Hampshire, Bachelor's degree preferred. Minimum of one-year experience in a community health setting.

b) Nutritionists:
   a. A Bachelor's degree in nutritional sciences or dietetics, or a Master's degree in nutritional sciences, nutrition education, or public health nutrition or current Registered Dietitian status in accordance with the Commission on dietetic Registration of the American Dietetic Association.
   b. Individuals who perform functions similar to a nutritionist but do not meet the above qualifications shall not use the title of nutritionist.

c) Social Workers shall have:
   a. A Bachelor's or Master's degree in social work or Bachelor's or Master's degree in a related social science or human behavior field. A minimum of one year of experience in a community health or social services setting is preferred.
   b. Individuals who perform functions similar to a social worker but do not meet the above qualifications shall not use the title of social worker.

d) Clinical Coordinators shall be:
   a. A registered nurse (RN), physician, physician assistant, or nurse practitioner with a license to practice in New Hampshire.
   b. The coordinator is a clinical position that oversees and takes responsibility for the clinical and administrative functions of each program.
   c. The coordinator may be responsible for more than one MCH funded program.

2. New Hires

EXHIBIT A – AMENDMENT 1

The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing within one month of hire when a new administrator, clinical coordinator, or any staff person essential to carrying out contracted services is hired to work in the program. A resume of the employee shall accompany the aforesaid notification.

3. Vacancies

   a) The Contractor must notify the MCHS in writing if any critical position is vacant for more than one month, or if at any time funded under this contract does not have adequate staffing to perform all required services for more than one month. This may be done through a budget revision.

   b) Before an agency hires new program personnel that do not meet the required staff qualifications, the agency shall notify the MCHS in writing requesting a waiver of the applicable staffing requirements. The Section may grant waivers based on the need of the program, individuals' experience, and additional training.

C) Coordination of Services

1. The Contractor shall coordinate, where possible, with other service providers within the contractor's community. At a minimum, such collaboration shall include interagency referrals and coordination of care.

2. The Contractor shall participate in activities in the Public Health Region in which they provide services as appropriate. These activities enhance the integration of community-based public health prevention and health care initiatives that are being implemented by the contractor and may include community needs assessments, public health performance assessments, and/or the development of regional health improvement plans.

3. The Contractor agrees to participate in and coordinate public health activities as requested by the Division of Public Health Services during any disease outbreak and/or emergency, natural or man-made, affecting the public's health.

4. The Contractor is responsible for case management of the client enrolled in the program and for program follow-up activities. Case management services shall promote effective and efficient organization and utilization of resources to assure access to necessary comprehensive medical, nutritional, and social services for clients.

5. The Contractor shall assure that appropriate, responsive, and timely referrals and linkages for other needed services are made, carried through, and documented. Such services shall include, but not be limited to: dental services, genetic counseling, high risk prenatal services, mental health, social services, including domestic violence crisis centers, substance abuse services; and family planning services, Early Supports and Services Program, local WIC/CSF Program, Home Visiting New Hampshire Programs and health and social service agencies which serve children and families in need of those services.

D) Meetings and Trainings

The contractor will be responsible for sending staff to meetings and training required by the MCHS program, including but not limited to:

1. MCHS Agency Directors' meetings
2. Prenatal and Child Health Coordinators' meetings
3. MCHS Agency Medical Services Directors' meetings

III. <u>Quality or Performance Improvement (QI/PI)</u>

A) Workplans

1. Performance Workplans are required for this program and are used to monitor achievement of standard measures of performance of the services provided under this contract. The workplans are a key component of the RHPCS and the MCHS performance-based contracting system and of this contract. Outcomes shall be reported by clinical site.
2. Performance Workplans and Workplan Outcome reports according to the schedule and instructions provided by the MCHS. The MCHS shall notify the Contractor at least 30 days in advance of any changes in the submission schedule.
3. The Contractor shall incorporate required and developmental performance measures, defined by the MCHS into the agency's Performance Workplan. Reports on Workplan Progress/Outcomes shall detail the Performance Workplan plans and activities that monitor and evaluate the agency's progress toward performance measure targets.
4. The Contractor shall comply with modifications and/or additions to the workplan and annual report format as requested by RHPCS and MCHS. MCHS will provide the contractor with reasonable notice of such changes.
5. Agencies contracting for Primary Care Services must submit the workplans for Primary Care Clinical and Financial, Child Health, and Prenatal Care.

B) Additional Reporting requirements

In addition to Performance Workplans, the Contractor shall submit to MCHS the following data and information listed below which are used to monitor program performance:

1. In years when contracts or amendments are not required, the DPHS Budget Form, Budget Justification, Sources of Revenue and Program Staff list forms must be

completed according to the relevant instructions and submitted as requested by DPHS and, at minimum, by April 30 of each year.

2. The Sources of Revenue report must be resubmitted at any point when changes in revenue threaten the ability of the agency to carry out the planned program.

3. Completed Uniform Data Set (UDS) tables reflecting program performance in the previous calendar year, by March 31 of each year.

4. The Perinatal Client Data Form (PCDF) shall be submitted electronically according to the instructions set forth by the MCHS.

5. A copy of the agency's updated Sliding Fee Scale including the amount(s) of any client fees and the schedule of discounts must be submitted by March 31st of each year. The agency's sliding fee scale must be updated annually based on the US DHHS Poverty guidelines as published in the Federal Register.

6. An annual summary of program-specific patient satisfaction results obtained during the prior contract period and the method by which the results were obtained shall be submitted annually as an addendum to the Workplan Outcome/Progress reports.

C) On-site reviews

1. The contractor shall allow a team or person authorized by the Division of Public Health Services to periodically review the contractor's systems of governance, administration, data collection and submission, clinical and financial management, and delivery of education services in order to assure systems are adequate to provide the contracted services.

2. Reviews shall include client record reviews to measure compliance with this exhibit.

3. The contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.

4. On-Site reviews may be waived or abbreviated at the discretion of MCHS, upon submission of satisfactory reports of reviews such as Health Services Resources Administration (HRSA): Office of Performance Review (OPR), or reviews from nationally accreditation organizations such as the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), Medicare, the Community Health Accreditation Program (CHAP), Accreditation Association for Ambulatory Healthcare (AAAHC), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey. Abbreviated reviews will focus on any deficiencies found in previous reviews, issues of compliance with this exhibit, and actions to strengthen performance as outlined in the agency Performance Workplan.

PRIMARY CARE CHILD HEALTH DIRECT CARE SERVICES
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Please note, for all measures, the following should be used **unless otherwise indicated:**

- Less than 19 years of age
- Served within the scope of this MCH contract during State Fiscal Year 2015 (July 1, 2014 – June 30, 2015)
- Each client can only be counted once (unduplicated)

Child Health Direct (CH – D) Performance Measure #1

Measure: 92%* of eligible children will be enrolled in Medicaid

Goal: To increase access to health care for children through the provision of health insurance

Definition: **Numerator-**
Of those in the denominator, the number of children enrolled in Medicaid.

Denominator-
Number of children who meet all of the following criteria:

- Less than 19 years of age
- Had 3 or more visits/encounters** during the reporting period
- As of the last visit during the reporting period were eligible for Medicaid

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**An encounter is face to face contact between a user and a provider who exercises independent judgment in the provision of services to the individual (UDS Table Definition).

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #2

Measure: 85%* of at-risk** children who were screened for blood lead between 18 and 30 months of age

Goal: To prevent childhood lead poisoning through early identification of lead exposure

Definition: **Numerator-**
Of those in the denominator, number of children screened for blood lead by capillary or venous on or after their 18-month birthday and prior to their 30-month birthday.

Denominator-
Number of at-risk** children who reached age 30 months during the reporting period. If discharged prior to 30 months, do not include in denominator.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**At risk = During the reporting period, the children were 18-29 months of age, and fit at least one of the following criteria:

- "Low income" (less than 185% poverty guidelines)
- Over 185% and resided in a town considered needing "Universal" screening per NH Childhood Lead Poisoning Prevention Program
- Over 185%, resided in a town considered "Target" and had a positive response to the risk questionnaire
- Refugee children -A refugee is defined as a person outside of his or her country of nationality who is unable or unwilling to return because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion (U.S. Citizenship and Immigration Services definition).

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #3

Measure: 71%* of children age two to nineteen years receiving primary care preventive health services with a Body Mass Index (BMI) percentile greater than or equal to the 85%ile with documented discussion of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Goal: To increase the percent of children receiving primary care preventive health services who have an elevated BMI percentile who receive guidance about promoting a healthier lifestyle.

Definition: **Numerator-**
Of those in the denominator, the number of children who had documentation in their medical record of there being discussion at least once during the reporting period of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Denominator-
Number of children who turned twenty-four months during or before the reporting period, up to the age of nineteen years, with one or more well child visit after their twenty-fourth month of age within the reporting year, and had an age and gender appropriate BMI percentile greater than or equal to the 85 % percentile at least once during the reporting period.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

Rationale: Children between the 85th – 94th percentiles BMI are encouraged to have 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks. (Discussion of the importance of family meal time, limiting eating out, consuming a healthy breakfast, preparing own foods, and promotion of breastfeeding is also encouraged.) American Academy of Pediatrics' guidance for Prevention and Treatment of Childhood Overweight and Obesity, (http://www.aap.org/obesity/health_professionals.html), from AAP Policy Statement: *Prevention of Pediatric Overweight and Obesity* and the AAP endorsed Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Children and Adolescent Overweight and Obesity, 2007.

*Target based on 2012 & 2013 Data Trend Table averages.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) #4

Measure: 75%* of eligible** infants and children with client record documentation of enrollment in WIC

Goal: To increase access to nutrition education, breastfeeding support, and healthy food through enrollment in the WIC Nutrition Program

Definition: **Numerator** -
Of those in the denominator, the number of infants and children who, as of the last well child visit during the reporting period, had client record documentation that infant or child was enrolled in WIC.

Denominator -
Unduplicated number of infants and children less than 5 years of age, enrolled in the agency, during the reporting period, who were eligible** for WIC.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**WIC Eligibility Requirements:

- Infants, and children up to their fifth birthday
- Must be income eligible (income guidelines are up to 185% of federal gross income, and are based on family size)

Child Health Direct (CH – D) Performance Measure #5

Measure: 23%* of infants who were exclusively** breastfed for the first three months, at their four month well baby visit

Goal: To provide optimum nutrition to infants in their first three months of life

Definition: **Numerator -**
Of those in the denominator, the number of infants who had client record documentation that the infant had been exclusively breastfed for their first three months when checked at their four month well baby visit.

Denominator -
Number of infants who received one or more visits during or before the reporting period and were seen for a four-month well baby visit during the reporting period.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

Benmarks: 2011 PedNSS (WIC) exclusive at 3 months: NH 22.9%, National (2010) 10.7%
2013 CDC Report Card (NIS, provisional 2010 births): NH 49.5%, National 37.7%
Healthy People 2020 goal: 44%

Rationale: The AAP recommends exclusive breastfeeding for about 6 months, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant, a recommendation concurred to by the World Health Organization and the Institute of Medicine. (American Academy of Pediatrics Policy Statement on Breastfeeding and the Use of Human Milk, 2012)

*Target based on 2012 & 2013 Data Trend Table averages.
**Exclusive means breast milk only, no supplemental formula, cereal/baby food, or water/fluids.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE: ADULT

PERFORMANCE MEASURES DEFINITIONS

State Fiscal Year 2015

Primary Care: Adult Performance Measure #1

Measure:* 58%** of adult patients 18 – 85 years of age diagnosed with hypertension will have a blood pressure measurement less than 140/90*** mm at the time of their last measurement.

Goal: To ensure patients diagnosed with hypertension are adequately controlled.

Definition: **Numerator-** Number of patients from the denominator with blood pressure measurement less than 140/90 mm at the time of their last measurement.

Denominator- Number of patients age 18 – 85 with diagnosed hypertension must have been diagnosed with hypertension 6 or more months before the measurement date. (Excludes pregnant women and patients with End Stage Renal Disease.)

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

*Measure based on the National Quality Forum 0018

**Health People 2020 National Target is 61.2%

***Both the numerator and denominator must be less that 140/90 mm

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE CLINICAL
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Primary Care Clinical Adolescent (PC-C) Performance Measure #1

Measure: 61%* of adolescents aged 11-21 years received an annual health maintenance visits in the past 12 months.

Goal: To enhance adolescent health by assuring annual, recommended, adolescent well -visits.

Definition:

Numerator-
Number of adolescents in the denominator who received an annual health maintenance "well" visit during the reporting year.

Denominator-
Total number of adolescents aged 11-21 years who were enrolled in the primary care clinic as primary care clients during the reporting year period.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

.
***Target based on 2012 & 2013 Data Trend Table averages.**

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Primary Care Clinical Prenatal (PC-C) Performance Measure #2

Measure: 31%* of women and adolescent girls aged 15-44 take multi-vitamins with folic acid.

Goal: To enhance pregnancy outcomes by reducing neural tube defects.

Definition:

Numerator-
The number of women and adolescent girls aged 15-44 who take a multi-vitamin with folic acid.

Denominator-
The number of women and adolescent girls aged 15-44 who were seen in primary care for a well visit in the past year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

***Target based on 2012 & 2013 Data Trend Table averages.**

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE - FINANCIAL
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Primary Care (PC) Performance Measure #1

Measure: Patient Payor Mix

Goal: To allow monitoring of payment method trends at State funded primary care sites.

Definition: Patients enrolled in Medicare, Medicaid, Commercial insurance, or uninsured.

Data Source: Provided by agency

Primary Care (PC) Performance Measure #2

Measure: Accounts Receivables (AR) Days

Goal: To allow monitoring of financial sustainability trends at State funded primary care sites.

Definition: AR Days: Net Patient Accounts Receivable **multiplied by** 365 **divided by** Net Patient Revenue

Data Source: Provided by agency

Primary Care (PC) Performance Measure #3

Measure: Current Ratio

Goal: To allow monitoring of financial sustainability trends at State funded primary care sites.

Definition: Current Ratio = Current Assets **divided by** Current Liabilities

Data Source: Provided by agency

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRENATAL
PERFORMANCE MEASURES DEFINITIONS
State Fiscal Year 2015

Prenatal (PN) Performance Measure #1

Measure: 85%* of pregnant women who are enrolled in the agency's prenatal program will begin prenatal care during the first trimester of pregnancy.

Goal: To enhance pregnancy outcomes by assuring early entrance into prenatal care.

Definition: **Numerator-**
Number of women in the denominator who had a documented prenatal visit during the first trimester (on or before 13.6 weeks gestation).

Denominator-
Number of women enrolled in the agency prenatal program who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

* Target based on 2012 & 2013 Data Trend Table averages.

Prenatal (PN) Performance Measure #2

Measure: 20%* of pregnant women who are identified as cigarette smokers will be referred to QuitWorks-New Hampshire.

Goal: To reduce tobacco use during pregnancy through focused tobacco use cessation activities at public health prenatal clinics.

Definition: **Numerator-**
Number of women in the denominator who received at least one referral to QuitWorks-New Hampshire during pregnancy.

A referral is defined as signing the patient up for QuitWorks-NH via phone, fax, or EMR. It is not defined as discussing QuitWorks-NH with the patient and encouraging her to sign up.

Denominator-
Number of women enrolled in the agency prenatal program and identified as tobacco users who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

*Target set in consultation with the NH Tobacco Program & FY13 Data Trend Table average.

Prenatal (PN) Performance Measure #3

Measure: 79%* of pregnant women will be screened, using a formal valid screening tool, for alcohol and other substance use during every trimester they are enrolled in the prenatal program.

Goal: To reduce prenatal substance use through systematic screening and identification.

Definition: **Numerator-** Number of women in the denominator who were screened for substance and alcohol use, using a formal and valid screening tool, during each trimester that they were enrolled in the prenatal program.

Denominator- Number of women enrolled in the agency prenatal program and who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

* Target based on 2012 & 2013 Data Trend Table averages.

Exhibit B-1 (2014) -Amendment 1
Budget

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: Health First Family Care Center

Budget Request for: MCH Primary Care
(Name of RFP)

Budget Period: SFY 2014

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages	$ 55,968.00	$ -	$ 55,968.00	
2. Employee Benefits	$ -	$ -	$ -	
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	$ -	$ -	$ -	
13. Other (specific details mandatory):	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
TOTAL	**$ 55,968.00**	**$ -**	**$ 55,968.00**	

Indirect As A Percent of Direct 0.0%

Contractor Initials: JW

Date: 3/21/14

Exhibit B-1 (2015) -Amendment 1
Budget

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: Health First Family Care Center

Budget Request for: MCH Primary Care & BCCP
(Name of RFP)

Budget Period: SFY 2015

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages	$ 285,214.00	$ -	$ 285,214.00	0
2. Employee Benefits	$ -	$ -	$ -	0
3. Consultants	$ -	$ -	$ -	0
4. Equipment:	$ -	$ -	$ -	0
Rental	$ -	$ -	$ -	0
Repair and Maintenance	$ -	$ -	$ -	0
Purchase/Depreciation	$ -	$ -	$ -	0
5. Supplies:	$ -	$ -	$ -	0
Educational	$ -	$ -	$ -	0
Lab	$ -	$ -	$ -	0
Pharmacy	$ -	$ -	$ -	0
Medical	$ -	$ -	$ -	0
Office	$ -	$ -	$ -	0
6. Travel	$ -	$ -	$ -	0
7. Occupancy	$ -	$ -	$ -	0
8. Current Expenses	$ -	$ -	$ -	0
Telephone	$ -	$ -	$ -	0
Postage	$ -	$ -	$ -	0
Subscriptions	$ -	$ -	$ -	0
Audit and Legal	$ -	$ -	$ -	0
Insurance	$ -	$ -	$ -	0
Board Expenses	$ -	$ -	$ -	0
9. Software	$ -	$ -	$ -	0
10. Marketing/Communications	$ -	$ -	$ -	0
11. Staff Education and Training	$ -	$ -	$ -	0
12. Subcontracts/Agreements	$ -	$ -	$ -	0
13. Other (specific details mandatory):	$ -	$ -	$ -	0
Breast screening services in clinic	$ 7,000.00	$ -	$ 7,000.00	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
	$ -	$ -	$ -	0
TOTAL	**$ 292,214.00**	**$ -**	**$ 292,214.00**	0

Indirect As A Percent of Direct 0.0%

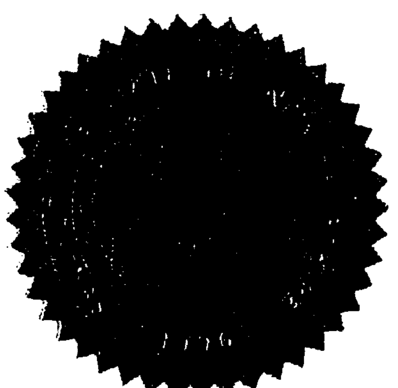
Contractor Initials: [signature]

Date: 3/21/14

State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that Health First Family Care Center is a New Hampshire nonprofit corporation formed April 23, 1996. I further certify that it is in good standing as far as this office is concerned, having filed the return(s) and paid the fees required by law.



In TESTIMONY WHEREOF, I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 1st day of April A.D. 2013

William M. Gardner
Secretary of State

CERTIFICATE OF VOTE

I, Tom Clairmont, of HealthFirst Family Care Center, do hereby certify that:

1. I am the duly elected Secretary/Treasurer of HealthFirst Family Care Center;
2. The following are true copies of two resolutions duly adopted at a meeting of the Board of Directors of the corporation, duly held on February 26, 2014;

   RESOLVED: That this corporation enters into a contract with the State of New Hampshire, acting through its Division of Public Health Services.

   RESOLVED: That the Board Chair is hereby authorized on behalf of this corporation to enter into said contract with the State and to execute any and all documents, agreements, and other instruments; and any amendments, revisions, or modifications thereto, as he/she may deem necessary, desirable, or appropriate. Jane White is the duly elected Chair of the organization or James Wells, the duly appointed Vice Chair.

3. The foregoing resolutions have not been amended or revoked and remain in full force and effect as of March 21, 2014.

IN WITNESS WHEREOF, I have hereunto set my hand as the clerk of the corporation this 21st day of March 21, 2014.

Tom Clairmont, Secretary/Treasurer BOD
Health First Family Care Center

STATE OF NEW HAMPSHIRE
COUNTY OF BELKNAP

The foregoing instrument was acknowledged before me this 21st day of March 2014 by Tom Clairmont.

Notary Public/Justice of the Peace
My Commission Expires:

ELIZABETH KANTOWSKI, Notary Public
My Commission Expires September 14, 2016

HEALFIR-01 LMICHALS

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 3/18/2014

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 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 # AGR8150
Clark Insurance
80 Canal St
Manchester, NH 03101

CONTACT NAME: Lorraine Michals
PHONE (A/C, No, Ext): (603) 622-2855 FAX (A/C, No): (603) 622-2854
E-MAIL ADDRESS: lmichals@clarkinsurance.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Citizens Ins Co of America	31534
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Health First Family Care Center
841 Central St
Franklin, NH 03235

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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC			OBVA044172	07/01/2013	07/01/2014	EACH OCCURRENCE	$ 1,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 300,000
							MED EXP (Any one person)	$ 5,000
							PERSONAL & ADV INJURY	$ 1,000,000
							GENERAL AGGREGATE	$ 2,000,000
							PRODUCTS - COMP/OP AGG	$ 2,000,000
								$
A	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS X HIRED AUTOS X NON-OWNED AUTOS			OBVA044172	07/01/2013	07/01/2014	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (PER ACCIDENT)	$
								$
A	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DED RETENTION $			OBVA044172	07/01/2013	07/01/2014	EACH OCCURRENCE	$ 1,000,000
							AGGREGATE	$ 1,000,000
								$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N: N If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		WBVA044167	07/01/2013	07/01/2014	X WC STATU-TORY LIMITS OTH-ER	
							E.L. EACH ACCIDENT	$ 500,000
							E.L. DISEASE - EA EMPLOYEE	$ 500,000
							E.L. DISEASE - POLICY LIMIT	$ 500,000

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

CERTIFICATE HOLDER

DHHS
Contracts and Procurement Unit
129 Pleasant Street
Concord, NH 03301

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

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HEALTH FIRST FAMILY CARE CENTER, INC.

AUDITED FINANCIAL STATEMENTS

SEPTEMBER 30, 2013 AND 2012

BRAD BORBIDGE, P.A.
CERTIFIED PUBLIC ACCOUNTANTS
197 LOUDON ROAD, SUITE 350
CONCORD, NEW HAMPSHIRE 03301
TELEPHONE 603/224-0849
FAX 603/224-2397

Independent Auditor's Report

Board of Directors
Health First Family Care Center, Inc.
Franklin, New Hampshire

We have audited the accompanying financial statements of Health First Family Care Center, Inc., which comprise the balance sheets as of September 30, 2013 and 2012, the related statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the 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 entity'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 financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Health First Family Care Center, Inc. as of September 30, 2013 and 2012, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The accompanying schedule of expenditures of federal awards is presented for purposes of additional analysis as required by U.S. Office of Management and Budget Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations, and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the schedule of expenditures of federal awards is fairly stated in all material respects in relation to the financial statements as a whole.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated January 29, 2014, on our consideration of the Organization's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and important for assessing the results of our audit.

Concord, New Hampshire
January 29, 2014

HEALTH FIRST FAMILY CARE CENTER, INC.

BALANCE SHEETS

SEPTEMBER 30, 2013 AND 2012

ASSETS

	2013	2012
Current Assets		
Cash and cash equivalents	$ 179,086	$ 5,527
Patient accounts receivable, net of allowance for uncollectible accounts of $176,208 and $170,000 at September 30, 2013 and 2012, respectively	333,824	365,221
Grant receivables	59,805	40,533
Other current assets	18,144	19,032
Total Current Assets	590,859	430,313
Assets Limited As To Use	76,707	71,967
Furniture and Equipment, Net	1,564,870	1,651,115
TOTAL ASSETS	$ 2,232,436	$ 2,153,395

LIABILITIES AND NET ASSETS

	2013	2012
Current Liabilities		
Line of credit	$ 122,129	$ 185,129
Accounts payable and accrued expenses	74,471	124,799
Accrued payroll and related expenses	134,836	110,730
Deferred revenue	21,229	62,673
Due to third party payers	124,923	-
Current maturities on long-term debt	38,081	36,545
Total Current Liabilities	515,669	519,876
Long-term Debt, Less Current Maturities	1,437,064	1,475,145
Total Liabilities	1,952,733	1,995,021
Net Assets		
Unrestricted	279,703	158,374
TOTAL LIABILITIES AND NET ASSETS	$ 2,232,436	$ 2,153,395

(See accompanying notes to these financial statements)

HEALTH FIRST FAMILY CARE CENTER, INC.

STATEMENTS OF OPERATIONS AND CHANGES IN UNRESTRICTED NET ASSETS

FOR THE YEARS ENDED SEPTEMBER 30, 2013 AND 2012

	2013	2012
Operating Revenue		
Patient service revenue	$ 2,122,638	$ 1,657,065
Provision for bad debts	(312,778)	(225,087)
Net Patient Service Revenue	1,809,860	1,431,978
Grants, contracts, and contributions, net	1,072,675	1,158,133
Managed grant revenue	86,927	242,376
Other operating revenue	54,325	34,745
Total Operating Revenue	3,023,787	2,867,232
Operating Expenses		
Salaries and benefits	1,863,187	1,668,786
Other operating expenses	807,739	693,929
Managed grant expense	83,599	252,986
Depreciation	91,464	94,962
Interest expense	61,688	63,395
Total Operating Expenses	2,907,677	2,774,058
OPERATING INCOME AND EXCESS OF REVENUE OVER EXPENSES	116,110	93,174
Grants Received For Capital Acquisitions	5,219	11,329
INCREASE IN UNRESTRICTED NET ASSETS	121,329	104,503
Net Assets, Beginning of Period	158,374	53,871
NET ASSETS, END OF PERIOD	$ 279,703	$ 158,374

(See accompanying notes to these financial statements)

HEALTH FIRST FAMILY CARE CENTER, INC.

STATEMENTS OF CASH FLOWS

FOR THE YEARS ENDED SEPTEMBER 30, 2013 AND 2012

	2013	2012
Cash Flows From Operating Activities		
Change in net assets	$ 121,329	$ 104,503
Adjustments to reconcile change in net assets to net cash provided (used) by operating activities		
Provision for bad debts	312,778	225,087
Depreciation	91,464	94,962
Grants received for capital acquisitions	(5,219)	(11,329)
Increase (decrease) in the following assets:		
Patient accounts receivable	(281,381)	(396,055)
Grant receivables	(19,272)	34,883
Prepaid expenses	888	(5,029)
Increase (decrease) in the following liabilities:		
Accounts payable and accrued expenses	(50,328)	17,660
Accrued payroll and related expenses	24,106	19,234
Deferred revenue	(41,444)	(47,345)
Due to third party payers	124,923	(46,056)
Net Cash Provided (Used) by Operating Activities	277,844	(9,485)
Cash Flows From Investing Activities		
Capital expenditures	(5,219)	(11,329)
Increase in assets limited as to use	(4,740)	32,164
Net Cash (Used) Provided by Investing Activities	(9,959)	20,835
Cash Flows From Financing Activities		
Proceeds from line of credit	-	20,000
Payments on line of credit	(63,000)	(13,512)
Grants received for capital acquisitions	5,219	11,329
Principal payment of long-term debt	(36,545)	(34,837)
Net Cash Used by Financing Activities	(94,326)	(17,020)
Net Increase (Decrease) in Cash and Cash Equivalents	173,559	(5,670)
Cash and Cash Equivalents, Beginning of Year	5,527	11,197
CASH AND CASH EQUIVALENTS, END OF YEAR	$ 179,086	$ 5,527
Supplemental Disclosures of Cash Flow Information:		
Cash paid for interest	$ 61,688	$ 63,395

(See accompanying notes to these financial statements)

HEALTH FIRST
FAMILY CARE CENTER

Our Mission

It is the mission of Health First Family Care Center to provide high quality primary healthcare, treatment, prevention and education services required by the residents of the service area, regardless of ability to pay or insurance status, depending upon available Health First resources.

Health First coordinates and cooperates with other community and regional health care providers to assure the people of the region the fullest possible range of health and prevention services.

HEALTH FIRST
FAMILY CARE CENTER

Board of Directors

Revised 02/26/2014

Tom Clairmont, Agency Representative, Secretary/Treasurer Started: 02/2002
Tim Dow, Sr., Client Representative Started: 10/2013
Julie Ellerbeck, Client Representative Started: 08/2012
Sarah Gagnon, Agency Representative Started: 02/26/2014
Maria Hernandez, Client Representative Started: 03/2011
Michael Stanley, Client Representative Started: 07/2012
Jim Wells, Client Representative, Vice-Chair **Started: 03/2005**
Jane White, Agency Representative, Board Chair **Started: 02/2012**
Susan Wnuk, Agency Representative Started: 03/2009

***Officers of the Board of Directors are indicated in bold.**

KEY ADMINISTRATIVE PERSONNEL

NH Department of Health and Human Services

Contractor Name: Health First Family Care Center, Inc

Name of Bureau/Section: MCH Primary Care

BUDGET PERIOD: SFY 14

Program Area: MCH Primary Care

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Richard Silverberg	Executive Director	$125,000	2.98%	$3,725.00
Steven Youngs	Medical Director	$198,000	2.98%	$5,900.40
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$9,625.40**

KEY ADMINISTRATIVE PERSONNEL

NH Department of Health and Human Services

Contractor Name: Health First Family Care Center, Inc

Name of Bureau/Section: MCH Primary Care & BCCP

BUDGET PERIOD: SFY 15

Program Area: MCH Primary Care Services

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Richard Silverberg	Executive Director	$128,750	14.95%	$19,248.13
Steven Youngs	Medical Director	$203,940	14.95%	$30,489.03
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$49,737.16**

Program Area: Breast and Cervical Cancer Program Services

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Richard Silverberg	Executive Director	$128,750	0.00%	$0.00
Steven Youngs	Medical Director	$203,940	0.00%	$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$0.00**

Richard D. Silverberg MSSW, LICSW

EXPERIENCE

1995-Present	Caring Community Network of the Twin Rivers/Health First Family Care Center, Franklin, NH **Managing Director** Caring Community Network of the Twin Rivers **Executive Director Health** First Family Care Center
1994-Present	Synergy Works Consulting **Principal**
1979-1994	Central New Hampshire Community Mental Health, Concord, New Hampshire
(1987-1994)	**Vice-President,** Planning, Program Development and Community Support
(1979-1987)	**Director,** Community Housing, Consultation and Education, EAPs
1978-1979	Consortium for Youth of South Central Connecticut, New Haven, Connecticut **Community Systems Developer**
1975-1978	Human Services and Resources Center, West Haven, Connecticut **Community Based Social Worker**
1979-Present	Appalachian Mountain Club **Director:** Winter and Spring and Fall Mountain Safety Schools for New Hampshire Chapter

TEACHING EXPERIENCE

1994-2007	University of New Hampshire, Graduate School of Social Work **Instructor:** "Social Welfare Policy", "Community Organization", and "SW Management"
1994-Present	University of New Hampshire, Graduate School of Social Work Field Instructor
1977-1993	UCONN, UNE, Plymouth State College and Boston University **Field Supervisor** and **guest lecturer** to graduate social work students

EDUCATION

BS, 1974, Major Biology and Social Work, University of Wisconsin Madison Wisconsin
MSSW, 1975, Master of Science and Social Work, University of Wisconsin, Madison

MEMBERSHIPS/CERTIFICATIONS

NASW, National Association Social Workers, ACSW, Certified since 1978, LICSW, 1994
Appalachian Mountain Club, New Hampshire Chapter, Concord Community Players (Theater group)
Association of Experiential Education

COMMUNITY BOARDS

1988-2004	Founding member of Concord Area Trust for Community Housing (CATCH)
1995-Present	Caring Community Network of the Twin Rivers
1997-Present	Community Health Access Network (CHAN)
2000-2009	Endowment for Health Advisory council
1999-Present	BiState Primary Care Assn.
2008-Present	Bridges 2 Prevention Alcohol and Drug Abuse Prevention board

Richard D. Silverberg MSSW, LICSW

SKILLS

MANAGEMENT AND ADMINISTRATION

- Directed integrated health and human services network
- Executive Director, start up, community primary health care center (FQHC)
- Managed nine departments combined staff of 75 with budget of $5 million
- Administered direct service programs for adults and children
- Director consultation, education and Employee Assistance Programs
- Led major program reorganization and systems change efforts
- Wrote proposals and administered grant funded programs
- Recruited, trained and supervised diverse professional staff, students and volunteers
- Prepared budgets and administered financial/service contract compliance for positive bottom line
- Worked with diverse funding, Medicaid, Medicare, HMO, self pay, and capitated contracts, cost based

PROGRAM PLANNING AND DEVELOPMENT

- Established interdisciplinary teams of professionals to provide comprehensive services
- Conducted comprehensive, citizen participatory, regional needs assessment and planning process
- Designed and administered community consultation, education and training program
- Worked with community groups, schools, agencies, business and industry to assess needs and develop contracts for consultation and training services
- Designed and developed community housing continuum (150 beds)
- Developed primary health care and prevention programs in the community
- Marketed and developed Managed Care and Employee Assistance programs
- Organized multi-agency consortia and affiliate networks to streamline service delivery

DIRECT SERVICE

- Initiated group services which utilized adaptive Outward Bound adventure challenge techniques
- Delivered direct community needs assessment, education, consultation, and training services
- Carried caseload for individual, family and group treatment, and provided crises intervention service
- Planned and instituted conferences and community prevention programs

TECHNICAL SKILLS

- Facilitates planning, all aspects of site selection and design considerations for specified clinical usage
- Proposal and bid package development and review, negotiating contracts for construction
- Knowledgeable of building, life safety, licensing and JCAHO requirements
- Fixed assets management, including buildings vehicles and computers
- Computer systems, Windows, MACs, Networks, spreadsheets, relational data bases, web sites
- Designed and developed networked computerized clinical database systems, EMR/EHR

OTHER

Married, two children, hiker, camper, cross country skier, snowshoer, woodworker, built own house, volunteers to design and build stage settings with local theatre groups. Instructor in outdoor leadership.

SUMMARY

Thirty-six years of management and direct experience with agencies, organizations, business, community systems, Networks, groups and individuals. Outstanding skills in community systems analysis, program planning and new starts, linking innovative human and technological solutions.

Steven W. Youngs, DO

Education:

1974-1978 College of William and Mary, Williamsburg, VA – BS Geology

1978-1981 Washington State Unitiversity, Pullman, WA - MS Structural Geology

1983-1988 University of Wisconsin, Madison, WI – MS Water Resources Management

2001-2005 University of New England College of Osteopathic Medicine, Biddeford, ME – Doctor of Osteopathy

Work Experience

Current — Health First Family Care Center, Franklin NH - Medical Director/Primary Care Physician
Provide direct medical primary care physicians services to clients of Health First and in the role of medical director to assist and the planning, development, and directing of medical activities in accordance with current applicable federal, state, local and Health First and professional standards and assure quality patient care is maintained at all times.

2005-2008 — Eastern Maine Medical Center, Bangor, Maine – Resident, Family Practice

- Completed PGY1 year at program oriented toward broad based, rural medicine emphasis program; hospital coverage rotations in internal medicine, pediatrics and obstetrics, with additional rotations in surgery, ophthalmology, urology, cardiology, ENT and orthopedics.
- Management of outpatient panel through the EMMC family practice clinic serving a dominantly underserved population with high percentage of Mainecare patients.
- Routine use of EMR, including Logician (Centricity), Powerchart, PACS
- Service on geriatrics curriculum review committee, adult medicine teaching service review committee.

1998-2001 — Miller Engineering, Inc.; Nobis Engineering, Inc., Provan and Lorbar, Inc. Project Scientist, Hydrogeologist, Project Manager

- Project geologist supervising drill crews on subsurface investigations.
- Site investigator for environmental assessments of properties for real estate transactions.
- Project Scientist for environmental investigations at contaminant release sites.
- Project manager for environmental investigations, water supply studies, and geotechnical investigations. Duties included project budgeting and proposals as well as staff management.

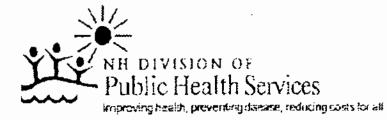
Accreditations — ACLS, BLS, NALS

Professional Memberships
American Academy of Family Physicians
American Osteopathic Association
American Academy of Osteopathy

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

29 HAZEN DRIVE, CONCORD, NH 03301-6527
603-271-4517 1-800-852-3345 Ext. 4517
Fax: 603-271-4519 TDD Access: 1-800-735-2964



Nicholas A. Toumpas
Commissioner

José Thier Montero
Director

May 2, 2012

APPROVED G&C #131
DATE 6/20/12
NOT APPROVED

His Excellency, Governor John H. Lynch
and the Honorable Executive Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Public Health Services, Bureau of Population Health and Community Services, Maternal and Child Health Section, to enter into an agreement with Health First Family Care Center (Vendor #158221-B001), 841 Central Street, Franklin, New Hampshire 03235, in an amount not to exceed $400,476.00, to provide primary care services and breast and cervical cancer screening, to be effective July 1, 2012 or date of Governor and Executive Council approval, whichever is later, through June 30, 2014. Funds are available in the following accounts for SFY 2013, and are anticipated to be available in SFY 2014 upon the availability and continued appropriation of funds in the future operating budgets.

05-95-90-902010-5190 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES, MATERNAL AND CHILD HEALTH

Fiscal Year	Class/Object	Class Title	Job Number	Total Amount
SFY 2013	102-500731	Contracts for Program Services	90080000	$187,367
SFY 2014	102-500731	Contracts for Program Services	90080000	$187,367
			Sub-Total	$374,734

05-95-90-902010-5659 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES, COMPREHENSIVE CANCER

Fiscal Year	Class/Object	Class Title	Job Number	Total Amount
SFY 2013	102-500731	Contracts for Program Services	90080081	$12,871
SFY 2014	102-500731	Contracts for Program Services	90080081	$12,871
			Sub-Total	$25,742
			Total	$400,476

EXPLANATION

Funds in this agreement will be used to provide breast and cervical cancer screening and office-based primary care services for low-income and uninsured families. This agreement provides funds for services as a last resort; contractor is required to make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid.

Primary health care services include preventive and episodic health care for acute and chronic health conditions for people of all ages, including pregnant women, children, adolescents, adults, and the elderly. Community health agencies that receive support through the Division of Public Health Services deliver primary and preventive health care services to underserved people who face barriers to accessing health care, due to issues such as a lack of insurance, inability to pay, language barriers, and geographic isolation. In addition to medical care, community health centers are unique among primary care providers for the array of patient-centered services they offer, including care coordination, translation, transportation, outreach, eligibility assistance, and health education. These services help individuals overcome barriers to getting the care they need and achieving their optimal health. One area of particular success has been in ensuring that eligible families maintain consistent enrollment in Medicaid for their children. Community health centers provide support for families in filling out applications and ensuring that children have continuity of care.

Community health agencies throughout New Hampshire have demonstrated success in meeting the health care needs of the uninsured and under-insured citizens of the state. Division of Public Health Services funded primary care providers participate in rigorous quality improvement efforts utilizing standard performance measures that focus attention on improving health outcomes for patients. For example, in State Fiscal Year 2011:

- 88% of eligible children served were enrolled in Medicaid/Healthy Kids Gold.
- 86% of children 24-35 months, served received the appropriate schedule of immunizations.
- 82% of infants born to women served received prenatal care beginning in the first trimester of pregnancy.

In addition, breast and cervical cancers continue to be ongoing public health issues for New Hampshire. The Division of Public Health Services, Breast and Cervical Cancer Screening Program provides support for breast and cervical cancer screening services that include clinical examinations, pap smears and referral for mammography. Through this program, women found to have abnormal screening results, following their testing, receive additional coverage for diagnostic work-up and, if necessary, have their care coordinated through the initiation of treatment.

Should Governor and Executive Council not authorize this Request, a minimum of 7,000 low-income individuals from the following areas Alexandria, Andover, Ashland, Belmont, Bridgewater, Bristol, Center Harbor, Danbury, Franklin, Gilford, Gilmanton, Groton, Hebron, Hill, Laconia, Meredith, Moultonborough, New Hampton, Northfield, Salisbury, Sanbornton, Sandwich and Tilton may not have access to primary care services, and eligible women may not receive recommended breast and cervical cancer screenings. A strong primary care infrastructure reduces costs for uncompensated care, improves health outcomes, and reduces health disparities. Additionally women that receive recommended breast and cervical cancer screenings are at lower risk of late diagnosis of breast and cervical cancers.

Health First Family Care Center was selected for this project through a competitive bid process. A Request for Proposals was posted on the Department of Health and Human Services' web site from January 10, 2012 through February 16, 2012. In addition, a bidder's conference, conference call, and web conference were held on January 19, 2012 to alert agencies to this bid.

Thirteen proposals were received in response to the posting. Each proposal was scored by three professionals, who work internal and external to the Department of Health and Human Services. All reviewers have between three to twenty years experience either in clinical settings, providing community-based family support services, and managing agreements with vendors for various public health programs. Areas of specific expertise include maternal and child health; quality assurance and performance improvement; chronic and communicable diseases and public health infrastructure. The reviewers used a standardized form to score agencies' relevant experience and capacity to carry out the activities outlined in the proposal. Reviewers look for realistic targets when scoring performance measures in addition to detailed workplans including evaluation components. Budgets were reviewed to be reasonable, justified and consistent with the intent of the program goals and outcomes. There were no competing applications within each of the separate service areas. Scores were averaged and all proposals were recommended for funding. In those instances where scores were less than ideal, agency specific remedial actions were recommended and completed. Some primary care agencies are being funded at levels higher than they requested. Agencies were instructed to develop budgets based on previous allocations. While some proposed budgets higher than what was available for funding, others proposed budgets lower than what was available. There was an increase in breast and cervical cancer screening funds that bidders were unaware of when they drafted budgets. Adjustments were made accordingly for those agencies that proposed budgets at levels lower than available funds. This is a contract where that situation occurred. The Bid Summary is attached.

As referenced in the Request for Proposals, Renewals Section, this competitively procured Agreement has the option to renew for two additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties and approval of the Governor and Executive Council. These services were contracted previously with this agency in SFY 2011 and SFY 2012 in the amount of $689,460. This represents a decrease of $288,984. The decrease is due to budget reductions.

The performance measures used to measure the effectiveness of the agreement are attached.

Area served: Alexandria, Andover, Ashland, Belmont, Bridgewater, Bristol, Center Harbor, Danbury, Franklin, Gilford, Gilmanton, Groton, Hebron, Hill, Laconia, Meredith, Moultonborough, New Hampton, Northfield, Salisbury, Sanbornton, Sandwich and Tilton.

Source of Funds: 25.10% Federal Funds from US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau and 74.90% General Funds.

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

Respectfully submitted,

José Thier Montero, MD
Director

Approved by:
Nicholas A. Toumpas
Commissioner

JTM/PMT/sc

Primary Care Performance Measures

State Fiscal Year 2013

Primary Care Prenatal (PN) Performance Measure #1

Measure: Percent of infants born to women receiving prenatal care beginning in the first trimester of pregnancy.

Primary Care Prenatal (PN) Performance Measure #2

Measure: Percent of pregnant women identified as cigarette smokers that are referred to QuitWorks-New Hampshire.

Primary Care Prenatal (PN) Performance Measure #3

Measure: Percent of pregnant women who were screened, using a formal valid screening tool, for alcohol and other drug use during every trimester the patient was enrolled.

Primary Care Child Health Direct (CH – D) Performance Measure #1

Measure: Percent of eligible children enrolled in Medicaid

Primary Care Child Health Direct (CH – D) Performance Measure #2

Measure: Percent of at-risk children who were screened for blood lead between 18 and 30 months of age

Primary Care Child Health Direct (CH – D) Performance Measure #3

Measure: Percent of children age two to nineteen years receiving primary care preventive health services with a Body Mass Index (BMI) percentile greater than or equal to the 85th percentile with documented discussion of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Primary Care Child Health Direct (CH – D) Performance Measure #4

Measure: Percent of eligible infants and children with client record documentation of enrollment in Women Infant Children Program.

Primary Care Child Health Direct (CH – D) Performance Measure #5

Measure: Percent of infants who were exclusively breastfed for the first three months, at their four month well baby visit.

Primary Care Financial (PC) Performance Measure #1

Measure: Patient Payor Mix

Primary Care Financial (PC) Performance Measure #2

Measure: Accounts Receivables (AR) Days

Primary Care Financial (PC) Performance Measure #3

Measure: Current Ratio

Primary Care Performance Measures

State Fiscal Year 2013

Primary Care Clinical Adolescent (PC-C) Performance Measure #1

Measure: Percent of adolescents aged 10-21 years who received annual health maintenance visits in the past 12 months.

Primary Care Clinical Prenatal (PC-C) Performance Measure #2

Measure: Percent of women and adolescent girls aged 15-44 who take a multi-vitamin with folic acid.

FORM NUMBER P-37 (version 1/09)

Subject: Primary Care Services

AGREEMENT

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

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 **State Agency Name** NH Department of Health and Human Services Division of Public Health Services		1.2 **State Agency Address** 29 Hazen Drive Concord, NH 03301-6504	
1.3 **Contractor Name** Health First Family Care Center		1.4 **Contractor Address** 841 Central Street Franklin, New Hampshire 03235	
1.5 **Contractor Phone Number** 603-934-0177	1.6 **Account Number** 010-090-5190-102-500731 010-090-5656-102-500731	1.7 **Completion Date** June 30, 2014	1.8 **Price Limitation** $400,476
1.9 **Contracting Officer for State Agency** Joan H. Ascheim, Bureau Chief		1.10 **State Agency Telephone Number** 603-271-4501	
1.11 **Contractor Signature** [signature]		1.12 **Name and Title of Contractor Signatory** Glenna Goodman Board of Directors, Chair	

1.13 **Acknowledgement:** State of NH, County of Belknap

On 3/28/12 before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.

1.13.1 **Signature of Notary Public or ~~Justice of the Peace~~**

Elizabeth Kantowski

[Seal]

1.13.2 **Name and Title of Notary ~~or Justice of the Peace~~**

Elizabeth Kantowski, Notary

ELIZABETH KANTOWSKI, Notary Public
My Commission Expires September 14, 2016

1.14 **State Agency Signature** [signature]	1.15 **Name and Title of State Agency Signatory** Joan H. Ascheim, Bureau Chief

1.16 **Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)***

By: Director, On:

1.17 **Approval by the Attorney General (Form, Substance and Execution)**

By: Jeanne P. Herrick, Attorney On: 14 May 2012

1.18 **Approval by the Governor and Executive Council**

By: On:

NH Department of Health and Human Services

Exhibit A

Scope of Services

Primary Care Services

CONTRACT PERIOD: July 1, 2012 or date of G&C approval, whichever is later, through June 30, 2014

CONTRACTOR NAME: Health First Family Care Center

ADDRESS: 841 Central Street
Franklin, New Hampshire 03235
Executive Director: Richard Silverberg
TELEPHONE: 603-934-0177

The Contractor shall:

I. General Provisions

A) Eligibility and Income Determination

1. Office-based primary care services will be provided to low-income individuals and families (defined as ≤ 185% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), in the State of New Hampshire.

2. Breast and Cervical Cancer screening services will be provided to low-income (defined as ≤ 250% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), New Hampshire women age 18 – 64, *uninsured or underinsured*.

3. The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing if, at any time, the practice is closed to new patients, or maintains a wait list for new patients, or any other mechanism is used that limits access for new patients for more than a one month period.

4. The Contractor shall document annually, for each client enrolled in the program, family income and family size, and calculate percentage of the federal poverty level. If calculations indicate that the client may be eligible for enrollment in Medicaid, the Contractor shall complete with the client the most recent version of the 800P form.

5. The Contractor shall implement, and post in a public and conspicuous location, a sliding fee payment schedule, approved in advance by the Division of Public Health Services (DPHS), for low-income patients. Signage must state that no client will be denied services for inability to pay.

   a. As an alternative, the contractor may post, in a public and conspicuous location, a notice to clients that a sliding fee scale is available and that no client will be denied services for inability to pay. The sliding fee scale must be updated annually based on USDHHS Poverty guidelines as published in the Federal Register, submitted to and approved by DPHS *prior to implementation.*

6. The primary care contract entered into here shall be the payer of last resort. The contractor shall make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid, for all reimbursable services rendered.

B) Numbers Served

1. The contract funds shall be expended to provide the above services to a minimum of 3500 users annually with 14,000 medical encounters, as defined in the Data and Reporting Requirements. Breast and Cervical Cancer Screening for eligible women, as defined by the Breast and Cervical Cancer Program (BCCP), shall be provided to 75 women annually and billed directly to the BCCP. Clinical service reimbursements shall not exceed the Medicare rate.

C) **Culturally and Linguistically Appropriate Standards of Care**

The Department of Health and Human Services (DHHS) recognizes that culture and language have considerable impact on how consumers access and respond to public health services. Culturally and linguistically diverse populations experience barriers in efforts to access health services. To ensure equal access to quality health services, the Division of Public Health Services (DPHS) expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.

2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.

3. *Provide* clients of limited English proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.

4. Offer consumers a forum through which clients have the opportunity to provide feedback to providers and organizations regarding cultural and linguistic issues that may deserve response.

5. The contractor shall maintain a program policy that sets forth compliance with Title VI, Language Efficiency and Proficiency Citation 45 CFR 80.3(b) (2). The policy shall describe the way in which the items listed above were addressed and shall indicate the circumstances in which interpretation services are provided and the method of providing service (e.g. trained interpreter, staff person who speaks the language of the client, language line).

D) **State and Federal Laws**

The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. The Contractor shall report all cases of communicable diseases according to New Hampshire RSA 141-C and He-P 301, adopted 6/3/08.

2. Persons employed by the contractor shall comply with the reporting requirements of New Hampshire RSA 169:C, Child Protection Act; RSA 161:F46, Protective Services to Adults, RSA 631:6, Assault and Related Offences and RSA 130:A, Lead Paint Poisoning and Control.

3. Immunizations shall be conducted in accordance with RSA 141-C and the Immunization Rules promulgated hereunder.

E) **Relevant Policies and Guidelines**

1. The Contractor shall design and provide the services described above to meet the unique and identified health needs of the populations within the contracted service area.

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2. Primary Care funds shall be targeted to populations in need. Populations in need are defined as follows:

   a) uninsured;

   b) under-insured;

   c) families and individuals with significant psychosocial and economic risk, including low income status;

   d) all life cycles including perinatal, child, adolescent, adult, and elderly who meet one or more of the above criteria.

3. The Contractor shall design and implement systems of governance, administration, financial management, information management, and clinical services which are adequate to assure the provision of contracted services, and to meet the data and reporting requirements. These systems shall meet the most current minimum standards described in at least one of the following: Health Resources and Services Administration (HRSA) Office of Performance Review protocols, Joint Commission on Accreditation of Health Care Organizations (JCAHO), Accreditation Association for Ambulatory Healthcare (AAAHC), Community Health Accreditation Program (CHAP), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey.

4. *The Contractor shall have an agency emergency preparedness and response plan in accordance with HRSA Health Center Emergency Management Program Expectations, Document #2007-15 or most recent version. Such plan shall also include a Continuity of Operations plan.*

5. The Contractor shall carry out the work as described in the performance Workplan submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

6. No Workplan is required by the Breast and Cervical Cancer Program (BCCP). The contractor shall be required to respond to the Quality Improvement Feedback Report twice a year.

7. The Contractor shall carry out the work as described in the Supplemental Funding Form submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

F) Publications Funded Under Contract

1. The DHHS and/or its funders will retain COPYRIGHT ownership for any and all original materials produced with DHHS contract funding, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports.

2. All documents (written, video, audio, *electronic*) produced, reproduced, or purchased under the contract shall have prior approval from DPHS before printing, production, distribution, or use.

3. The Contractor shall credit DHHS on all materials produced under this contract following the instructions outlined in Exhibit C (14).

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G) Subcontractors

1. If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing *and approve the subcontractual agreement*, prior to initiation of the subcontract.

2. In addition, the original DPHS contractor will remain liable for all requirements included in this Exhibit and carried out by subcontractors.

II. Minimal Standards of Core Services

A) Service Requirements

1. *Medical Home*

The Contractor shall provide a Medical Home that:

a) *Facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family.*

b) ***Provides care facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.***

2. Primary Care Services

The Contractor shall provide office-based primary care services to populations in need who reside in the contractor's service area. Primary care services shall include:

a) Health care provided by a New Hampshire licensed MD, DO, APRN, or PA, including diagnosis and treatment of acute and chronic illnesses within the scope of family practice; preventive services, screenings, and health education according to established, documented state or national guidelines; assessment of need for social and nutrition services, and appropriate referrals to health, *oral health*, and behavioral health specialty providers.

b) ***Referral to the WIC Nutrition Program for all eligible pregnant women, infants and children.***

c) In-hospital care for conditions within the scope of family practice must be provided at a hospital, within the agency service area, through a staff clinician with full hospital privileges, or in the alternative, through a formal referral and admissions procedure available to clients on a 24 hour/7 day a week basis.

d) Access to a healthcare provider, directly or by referral or subcontract, by telephone twenty-four hours per day, seven days per week.

e) Assessment of psychosocial risk for all clients at least annually and for children at scheduled preventive care visits, including, at a minimum, age appropriate assessment of safety in the home, domestic violence, adequacy of food and housing, care and welfare of children, transportation needs, and provision of necessary social services to address the priority needs and safety issues of clients and families.

f) Falls prevention screening for patients 65 years and older using the algorithm and guidelines of the American Geriatrics Society.

g) Behavioral health care directly or by referral to an agency or provider with a sliding fee scale.

h) *Nutrition assessment for all clients as part of the health maintenance visit.* Therapeutic nutrition services shall be provided *as indicated* directly or by referral to an agency or provider with a sliding fee scale. These services shall be recorded in the medical record.

i) Formal arrangements with a local hospital for emergency care must be in place and reviewed annually.

j) Home health care directly or by referral to an agency or provider with a sliding fee scale.

k) Assisted living and skilled nursing facility care by referral.

l) *Oral screening annually for all clients 19 years and older to note obvious dental decay and soft tissue abnormalities with a reminder to the patient that poor oral health impacts total health.*

m) *Diagnosis and management of pediatric and adult patients with asthma provided according to National Heart Lung Blood Institute, National Asthma Education and Prevention Program, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, 2007.*

2. Breast and Cervical Cancer Screening

a) Women age 18 to 64 who are eligible for Breast and Cervical Cancer Program (BCCP) services according to income (equal to or under 250% of poverty, underinsured/uninsured) *and insurance status* criteria shall be provided the following services:

i. cervical cancer screening including a pelvic examination and Pap smear;
ii. annual breast cancer screening including a clinical breast exam, mammogram and,
iii. referrals for diagnostic and treatment services based on screening results,
iv. case management services.

b) All referrals under this provision shall be to approved certified laboratory, pathology, radiology, and surgical services. Mammography units shall be accredited by the American College of Radiology, and must be FDA certified under MQSA. Laboratories shall be CLIA certified.

c) All services shall be provided in accordance with the Breast and Cervical Cancer Program (BCCP) Policy and Procedure Manual.

d) Follow-up and tracking of all tests done, and referrals made shall be provided in accordance with the minimum standards outlined in the Breast and Cervical Cancer Program Policy and Procedure Manual.

e) All services for women enrolled in the Breast and Cervical Cancer Program (BCCP) shall be billed directly to the BCCP in accordance with protocols established by the Breast and Cervical Cancer Program.

3. Reproductive Health Services

The Contractor shall provide prenatal, interconceptional and preconception medical care, social services, nutrition services, education, and nursing care to all women of childbearing age. Preconceptional care includes the preconception, interconceptional, and postpartum periods in women's health. It is recommended that preconceptional and interconceptional care visits focus on maintaining or achieving the optimal health of the mother, lowering the risk of future adverse pregnancy outcomes, the family's future plans, and how additional children fit into that plan. Preconceptional counseling may be done during an office, group or home visit.

a) In the event prenatal care is not provided directly by the Contractor a formal Memorandum/a of Agreement for coordinated referral to an appropriately qualified provider must be maintained.

b) Prenatal care shall, at minimum, be provided in accordance with the Guidelines for Perinatal Care, sixth or most current edition, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and /or the Centers for Disease Control.

c) Age appropriate reproductive health care shall, at a minimum, be provided in accordance with the American College of Obstetricians and Gynecologists, or the USDHHS Centers for Disease Control (CDC) current guidelines.

d) *Pregnant women enrolled in the WIC Nutrition Program shall be referred to WIC for breastfeeding education and referral to the WIC Nutrition Program peer counselors.*

e. Family planning counseling for prevention of subsequent pregnancy following an infant's birth shall be discussed with the infant's mother *at the first postpartum visit and at the infant's 2-month visit and other visits as appropriate.* Rationale for birth intervals of 18-24 months shall be presented.

f) A referral to a Title X Family Planning Clinic or other reproductive health care provider shall be made as appropriate.

4. Services for Children and Adolescents

The Contractor shall provide as a minimum, comprehensive and age-appropriate health care, screenings, and health education according to the American Academy of Pediatrics' most recent periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent. Children and adolescent visits shall include:

a) Blood lead testing shall be performed in accordance with "New Hampshire Childhood Lead Poisoning Screening and Management Guidelines", issued by the New Hampshire Department of Health and Human Services, 2009 or subsequent revisions.

b) All children enrolled in either Healthy Kids-Gold or the Women, Infant, and Children (WIC) Program and/or who are $\leq$ 185% poverty, regardless of town of residence, are required to have a blood lead test at ages one and two years. All children ages three to six years who have not been previously tested shall have a capillary or venous blood lead test performed.

c) All children shall be screened for iron deficiency anemia as outlined in the Centers for Disease Control and Prevention document "Recommendations to Prevent and Control Iron Deficiency in the United States (4/2/98)".

d) Age-appropriate anticipatory guidance, dietary guidance, and *feeding practice counseling* for optimal oral health shall be provided at each well child visit according to the American Academy of Pediatrics' periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent edition. Starting at age 6 months, it is recommended that all children receive an oral health assessment at every well child visit.

e) Supplemental fluoride shall be prescribed as needed based upon the fluoride levels in the child's *drinking* water supply. The fluoride dosage regimen accepted by the American Academy of Pediatrics shall be followed. No fluoride shall be prescribed without obtaining water from private wells or noting the presence or absence of fluoride in the public water

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supply. *Supplemental fluoride may include bottled water containing fluoride and topical applications such as varnishes*

f) *For infants enrolled in the WIC Nutrition Program, parents shall be referred to WIC for breastfeeding support and referral to the WIC Nutrition Program peer counselors.*

5. Sexually Transmitted Infections

Primary Care Services shall provide age appropriate screening and treatment of sexually transmitted infections.

a) Treatment for sexually transmitted infections shall be provided according to the United States Centers for Disease Control Sexually Transmitted Diseases Treatment Guidelines, 2010 or subsequent revisions.

b) All clients, including women, shall be offered HIV testing following the most current recommendations of the United States Centers for Disease Control.

c) The contractor shall be responsible for ensuring referral to appropriate treatment services for any woman found to screen positive.

d) Appropriate risk reduction counseling shall be provided based on client needs.

6. Substance Use Services

a) A substance use screening history using a formal, validated screening tool shall be obtained for all clients as soon after entry into care as possible. Substance use counseling *or other substance abuse intervention, treatment, or recovery services* by an appropriately credentialed provider shall be provided on-site, or by referral, to clients with identified needs for these services. *For these identified clients, ongoing primary care services should include follow up monitoring relative to substance abuse.*

b) All clients, including pregnant women, identified as smokers shall receive counseling *using the 5A's (ask, advise, assess, assist, and arrange) treatment available through the NH Tobacco Helpline* as cited in the US Public Health Services report "Tobacco Use and Dependence", 2008, or "Smoking Cessation During Pregnancy: *A Clinician's Guide to Helping Pregnant Women Quit Smoking*", American College of Obstetricians and Gynecologists, 2011. *With prior approval, agencies may also opt to participate in the DPHS best practice initiative of the 2A's and R (ask, advise and refer).*

7. Immunizations

a) The Contractor shall adhere to the most current version of the "Recommended Adult Immunization Schedule United States", approved by the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

b) The Contractor shall administer vaccines according to the most current version of the *"Recommended Immunization Schedule for Persons Aged 0 Through 6 Years - United States", and "Recommended Immunization Schedule for Persons Aged 7 Through 18 Years – United States"* approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians, based upon availability of vaccine from the New Hampshire Immunization Program.

8. Prenatal Genetic Screening

a) A genetic screening history shall be obtained on all prenatal clients as soon after entry into care as possible.

b) All pregnant women should be offered voluntary genetic screening for fetal chromosomal abnormalities at the appropriate time following recommendations found in the American College of Obstetricians and Gynecologists' "Screening for Fetal Chromosomal Abnormalities (2007)" or more recent guidelines. The Contractor shall be responsible for ensuring referral to appropriate genetic testing and counseling for any woman found to have a positive screening test.

9. Additional Requirements

a) The Contractor's Medical Director shall participate in the development and approval of specific guidelines for medical care that supplement minimal clinical standards. Supplemental guidelines should be reviewed, signed, and dated annually, and updated as indicated.

b) Contractors considering clinical or sociological research using clients as subjects must adhere to the legal requirements governing human subjects research. Contractors must inform the DPHS, MCHS prior to initiating any research related to this contract.

c) *The Contractor shall provide information to all employees annually about the Medical Reserve Corps Unit within their Public Health Region to enhance recruitment.*

d) ***The Contractor shall provide information to all employees annually regarding the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) managed by the NH Department of Health and Human Services' Emergency Services Unit, to enhance recruitment.***

B) Staffing Provisions

The Contractor shall have, at minimum, the following staff positions:

a) executive director

b) fiscal director

c) registered nurse

d) clinical coordinator

e) medical service director

f) nutritionist *(on site or by referral)*

g) social worker

Staff positions required to provide direct services on-site include:

a) registered nurse

b) clinical coordinator

c) social worker

1. Qualifications

All health and allied health professionals shall have the appropriate New Hampshire licenses whether directly employed, contracted, or subcontracted.

In addition the following minimum qualifications shall be met for:

a) Registered Nurse
   a. A registered nurse licensed in the state of New Hampshire, Bachelor's degree preferred. Minimum of one-year experience in a community health setting.

b) Nutritionists:
   a. A Bachelor's degree in nutritional sciences or dietetics, or a Master's degree in nutritional sciences, nutrition education, or public health nutrition or current Registered Dietitian status in accordance with the Commission on dietetic Registration of the American Dietetic Association.

   b. Individuals who perform functions similar to a nutritionist but do not meet the above qualifications shall not use the title of nutritionist.

c) Social Workers shall have:
   a. A Bachelor's or Master's degree in social work or Bachelor's or Master's degree in a related social science or human behavior field. A minimum of one year of experience in a community health or social services setting is preferred.

   b. Individuals who perform functions similar to a social worker but do not meet the above qualifications shall not use the title of social worker.

d) Clinical Coordinators shall be:

   a. A registered nurse (RN), physician, physician assistant, or nurse practitioner with a license to practice in New Hampshire.

   b. The coordinator is a clinical position that oversees and takes responsibility for the clinical and administrative functions of each program.

   c. The coordinator may be responsible for more than one MCH funded program.

2. New Hires

The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing within one month of hire when a new administrator, clinical coordinator, or any staff person essential to carrying out contracted services is hired to work in the program. A resume of the employee shall accompany the aforesaid notification.

3. Vacancies

a) The Contractor must notify the MCHS in writing if any critical position is vacant for more than one month, or if at any time funded under this contract does not have adequate staffing to perform all required services for more than one month. This may be done through a budget revision.

b) Before an agency hires new program personnel that do not meet the required staff qualifications, the agency shall notify the MCHS in writing requesting a waiver of the applicable staffing requirements. The Section may grant waivers based on the need of the program, individuals' experience, and additional training.

C) Coordination of Services

1. The Contractor shall coordinate, where possible, with other service providers within the contractor's community. At a minimum, such collaboration shall include interagency referrals and coordination of care.

2. The Contractor shall participate in activities *in the Public Health Region in which they provide services* as appropriate. These activities enhance the integration of community-based public health prevention and health care initiatives that are being implemented by the contractor and may include community needs assessments, public health performance assessments, and/or the development of regional health improvement plans.

3. The Contractor agrees to *participate* in and coordinate public health activities as requested by the Division of Public Health Services during any *disease outbreak* and/or *emergency*, natural or man made, affecting the public's health.

4. The Contractor is responsible for case management of the client enrolled in the program and for program follow-up activities. Case management services shall promote effective and efficient organization and utilization of resources to assure access to necessary comprehensive medical, nutritional, and social services for clients.

5. The Contractor shall assure that *appropriate, responsive, and timely* referrals and linkages for other needed services are made, carried through, and documented. Such services shall include, but not be limited to: dental services, genetic counseling, high risk prenatal services, mental health, social services, including domestic violence crisis centers, substance abuse services; and family planning services, Early Supports and Services Program, local WIC/CSF Program, Home Visiting New Hampshire Programs and health and social service agencies which serve children and families in need of those services.

D) Meetings and Trainings

The contractor will be responsible for sending staff to meetings and training required by the MCHS program, including but not limited to:

1. MCHS Agency Directors' meetings

2. Prenatal and Child Health Coordinators' meetings

3. MCHS Agency Medical Services Directors' meetings

III. Quality or Performance Improvement (QI/PI)

A) Workplans

1. Performance Workplans are required for this program and are used to monitor achievement of standard measures of performance of the services provided under this contract. The workplans are a key component of the RHPCS and the MCHS performance-based contracting system and of this contract. Outcomes shall be reported by clinical site.

2. Submit Performance Workplans and Workplan Outcome reports according to the schedule and instructions provided by the MCHS. The MCHS shall notify the Contractor at least 30 days in advance of any changes in the submission schedule.

3. The Contractor shall incorporate required and developmental performance measures, defined by the MCHS into the agency's Performance Workplan. Reports on Workplan Progress/Outcomes shall detail the Performance Workplan and activities that monitor and evaluate the agency's progress toward performance measure targets.

4. The Contractor shall comply with modifications and/or additions to the workplan and annual report format as requested by RHPCS and MCHS. MCHS will provide the contractor with reasonable notice of such changes.

5. Agencies contracting for Primary Care Services must submit the workplans for Primary Care *Clinical and Financial*, Child Health, and Prenatal Care.

B) Additional Reporting requirements

In addition to Performance Workplans, the Contractor shall submit to MCHS the following data and information listed below which are used to monitor program performance:

1. In years when contracts or amendments are not required, the DPHS Budget Form, Budget Justification, Sources of Revenue and Program Staff list forms must be completed according to the relevant instructions and submitted as requested by DPHS and, at minimum, by April 30 of each year.

2. The Sources of Revenue report must be resubmitted at any point when changes in revenue threaten the ability of the agency to carry out the planned program.

3. Completed Uniform Data Set (UDS) tables reflecting program performance in the previous calendar year, by March 31 of each year.

4. The Perinatal Client Data Form (PCDF) shall be submitted electronically according to the instructions set forth by the MCHS.

5. A copy of the agency's updated Sliding Fee Scale including the amount(s) of any client fees and the schedule of discounts must be submitted by March 31st of each year. The agency's sliding fee scale must be updated annually based on the US DHHS Poverty guidelines as published in the Federal Register.

6. An annual summary of program-specific patient satisfaction results obtained during the prior contract period and the method by which the results were obtained shall be submitted annually as an addendum to the Workplan Outcome/Progress reports.

C) On-site reviews

1. The contractor shall allow a team or person authorized by the Division of Public Health Services to periodically review the contractor's systems of governance, administration, data collection and submission, clinical and financial management, and delivery of education services in order to assure systems are adequate to provide the contracted services.
2. Reviews shall include client record reviews to measure compliance with this exhibit.
3. The contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.
4. On-Site reviews may be waived or abbreviated at the discretion of MCHS, upon submission of satisfactory reports of reviews such as Health Services Resources Administration (HRSA): Office of Performance Review (OPR), or reviews from nationally accreditation organizations such as the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), Medicare, the Community Health Accreditation Program (CHAP), Accreditation Association for Ambulatory Healthcare (AAAHC), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey. Abbreviated reviews will focus on any deficiencies found in previous reviews, issues of compliance with this exhibit, and actions to strengthen performance as outlined in the agency Performance Workplan.

State of New Hampshire
Department of Health and Human Services
Amendment #1 to the
Indian Stream Health Center, Inc.

This 1st Amendment to the Indian Stream Health Center, Inc., contract (hereinafter referred to as "Amendment One") dated this 11th day of March, 2014, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Indian Stream Health Center, Inc., (hereinafter referred to as "the Contractor"), a corporation with a place of business at 141 Corliss Lane, Colebrook, New Hampshire 03576.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on June 20, 2012, 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, the State and the Contractor have agreed to make changes to the scope of work, payment schedules and terms and conditions of the contract; and

WHEREAS, pursuant to the General Provisions, Paragraph 18, the State may modify the scope of work and the payment schedule of the contract by written agreement of the parties;

WHEREAS, the Department desires to provide additional primary health care services for preventive and episodic health care for acute and chronic health conditions for people of all ages.

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 as follows:

To amend as follows:

- Form P-37, to change:
  Block 1.7 to read: June 30, 2015
  Block 1.8 to read: $259,157

- Exhibit A, Scope of Services to add:
  Exhibit A – Amendment 1

- Exhibit B, Purchase of Services, Contract Price, to add:

  Paragraph 1.1 to Paragraph 1:
  The contract price shall increase by $18,030 for SFY 2014 and $100,409 for SFY 2015.

  Paragraph 1.2 to Paragraph 1:
  Funding is available as follows:
- $18,030 from 05-95-90-902010-5190-102-500731, 100% General Funds;
- $90,409 from 05-95-90-902010-5190-102-500731, 6.7% Federal Funds from the US Department of Health and Human Services Administration, Maternal and Child Health Bureau, CFDA #93.994 and 93.3% General Funds;

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- $10,000 from 05-95-90-901010-7965-102-500731, 100% General Funds.

  Add Paragraph 8
  8. Notwithstanding paragraph 18 of the General Provisions P-37, an amendment limited to adjustments to amounts between and among account numbers, within the price limitation, may be made by written agreement of both parties and may be made without obtaining approval of the Governor and Executive Council.

- Budget, to add:
  Exhibit B-1 (2014) - Amendment 1,
  Exhibit B-1 (2015) - Amendment 1

This amendment shall be in effect July 1, 2013, effective upon the date of Governor and Executive Council approval.

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

State of New Hampshire
Department of Health and Human Services

3/28/14
Date

Brook Dupee
Bureau Chief

Indian Stream Health Center, Inc.

3/11/2014
Date

Name: Shirley M. Powell
Title: CEO

Acknowledgement:

State of NH, County of Coos on 3/11/2014, before the undersigned officer, personally appeared the person identified above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.

Signature of Notary Public or Justice of the Peace

Name and Title of Notary or Justice of the Peace

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

OFFICE OF THE ATTORNEY GENERAL

4-2-14
Date

Name: Rosemary Wiant
Title: Asst. Attorney General

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:

Contractor Initials: SMP
Date: 3-11-14

EXHIBIT A – AMENDMENT 1

Scope of Services

The Department desires to continue the relationship with the primary care agencies to provide additional primary health care services for preventive and episodic health care for acute and chronic health conditions for people of all ages.

I. General Provisions

A) Eligibility and Income Determination

1. Office-based primary care services will be provided to low-income individuals and families (defined as ≤ 185% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), in the State of New Hampshire.

2. The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing if, at any time, the practice is closed to new patients, or maintains a wait list for new patients, or any other mechanism is used that limits access for new patients for more than a one month period.

3. The Contractor shall document annually, for each client enrolled in the program, family income and family size, and calculate percentage of the federal poverty level. If calculations indicate that the client may be eligible for enrollment in Medicaid, the Contractor shall complete with the client the most recent version of the 800P form.

4. The Contractor shall implement, and post in a public and conspicuous location, a sliding fee payment schedule, approved in advance by the Division of Public Health Services (DPHS), for low-income patients. Signage must state that no client will be denied services for inability to pay.

   a. As an alternative, the contractor may post, in a public and conspicuous location, a notice to clients that a sliding fee scale is available and that no client will be denied services for inability to pay. The sliding fee scale must be updated annually based on USDHHS Poverty guidelines as published in the Federal Register, submitted to and approved by DPHS prior to implementation.

5. The primary care contract entered into here shall be the payer of last resort. The contractor shall make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid, for all reimbursable services rendered.

B) Numbers Served

1. The contract funds shall be expended to provide the above services to a minimum of 850 users annually with 2100 medical encounters, as defined in the Data and Reporting Requirements. Clinical service reimbursements shall not exceed the Medicare rate.

EXHIBIT A – AMENDMENT 1

C) Culturally and Linguistically Appropriate Standards of Care

The Department of Health and Human Services (DHHS) recognizes that culture and language have considerable impact on how consumers access and respond to public health services. Culturally and linguistically diverse populations experience barriers in efforts to access health services. To ensure equal access to quality health services, the Division of Public Health Services (DPHS) expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.

2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.

3. Provide clients of limited English proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.

4. Offer consumers a forum through which clients have the opportunity to provide feedback to providers and organizations regarding cultural and linguistic issues that may deserve response.

5. The contractor shall maintain a program policy that sets forth compliance with Title VI, Language Efficiency and Proficiency Citation 45 CFR 80.3(b) (2). The policy shall describe the way in which the items listed above were addressed and shall indicate the circumstances in which interpretation services are provided and the method of providing service (e.g. trained interpreter, staff person who speaks the language of the client, language line).

D) State and Federal Laws

The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. The Contractor shall report all cases of communicable diseases according to New Hampshire RSA 141-C and He-P 301, adopted 6/3/08.

2. Persons employed by the contractor shall comply with the reporting requirements of New Hampshire RSA 169:C, Child Protection Act; RSA 161:F46, Protective Services to Adults, RSA 631:6, Assault and Related Offences and RSA 130:A, Lead Paint Poisoning and Control.

3. Immunizations shall be conducted in accordance with RSA 141-C and the Immunization Rules promulgated hereunder.

EXHIBIT A – AMENDMENT 1

E) Relevant Policies and Guidelines

1. The Contractor shall design and provide the services described above to meet the unique and identified health needs of the populations within the contracted service area.

2. Primary Care funds shall be targeted to populations in need. Populations in need are defined as follows:

   a) uninsured;

   b) under-insured;

   c) families and individuals with significant psychosocial and economic risk, including low income status;

   d) all life cycles including perinatal, child, adolescent, adult, and elderly who meet one or more of the above criteria.

3. The Contractor shall design and implement systems of governance, administration, financial management, information management, and clinical services which are adequate to assure the provision of contracted services, and to meet the data and reporting requirements. These systems shall meet the most current minimum standards described in at least one of the following: Health Resources and Services Administration (HRSA) Office of Performance Review protocols, Joint Commission on Accreditation of Health Care Organizations (JCAHO), Accreditation Association for Ambulatory Healthcare (AAAHC), Community Health Accreditation Program (CHAP), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey.

4. The Contractor shall have an agency emergency preparedness and response plan in accordance with HRSA Health Center Emergency Management Program Expectations, Document #2007-15 or most recent version. Such plan shall also include a Continuity of Operations plan.

5. The Contractor shall carry out the work as described in the performance Workplan submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

6. No Workplan is required by the Breast and Cervical Cancer Program (BCCP). The contractor shall be required to respond to the Quality Improvement Feedback Report twice a year.

7. The Contractor shall carry out the work as described in the Supplemental Funding Form submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

F) Publications Funded Under Contract

1. The DHHS and/or its funders will retain COPYRIGHT ownership for any and all original materials produced with DHHS contract funding, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports.

2. All documents (written, video, audio, electronic) produced, reproduced, or purchased under the contract shall have prior approval from DPHS before printing, production, distribution, or use.

3. The Contractor shall credit DHHS on all materials produced under this contract following the instructions outlined in Exhibit C (14).

G) Subcontractors

If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing and approve the subcontractual agreement, prior to initiation of the subcontract.

1. If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing and approve the subcontractual agreement, prior to initiation of the subcontract.

2. In addition, the original DPHS contractor will remain liable for all requirements included in this Exhibit and carried out by subcontractors.

II. <u>Minimal Standards of Core Services</u>

A. Service Requirements

1. Medical Home

   The Contractor shall provide a Medical Home that:

   a) Facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family.

   b) Provides care facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

2. Primary Care Services

   The Contractor shall provide office-based primary care services to populations in need who reside in the contractor's service area. Primary care services shall include:

EXHIBIT A – AMENDMENT 1

a) Health care provided by a New Hampshire licensed MD, DO, APRN, or PA, including diagnosis and treatment of acute and chronic illnesses within the scope of family practice; preventive services, screenings, and health education according to established, documented state or national guidelines; assessment of need for social and nutrition services, and appropriate referrals to health, oral health, and behavioral health specialty providers.

b) Referral to the WIC Nutrition Program for all eligible pregnant women, infants and children.

c) In-hospital care for conditions within the scope of family practice must be provided at a hospital, within the agency service area, through a staff clinician with full hospital privileges, or in the alternative, through a formal referral and admissions procedure available to clients on a 24 hour/7 day a week basis.

d) Access to a healthcare provider, directly or by referral or subcontract, by telephone twenty-four hours per day, seven days per week.

e) Assessment of psychosocial risk for all clients at least annually and for children at scheduled preventive care visits, including, at a minimum, age appropriate assessment of safety in the home, domestic violence, adequacy of food and housing, care and welfare of children, transportation needs, and provision of necessary social services to address the priority needs and safety issues of clients and families.

f) Falls prevention screening for patients 65 years and older using the algorithm and guidelines of the American Geriatrics Society.

g) Behavioral health care directly or by referral to an agency or provider with a sliding fee scale.

h) Nutrition assessment for all clients as part of the health maintenance visit. Therapeutic nutrition services shall be provided as indicated directly or by referral to an agency or provider with a sliding fee scale. These services shall be recorded in the medical record.

i) Formal arrangements with a local hospital for emergency care must be in place and reviewed annually.

j) Home health care directly or by referral to an agency or provider with a sliding fee scale.

k) Assisted living and skilled nursing facility care by referral.

l) Oral screening annually for all clients 21 years and older to note obvious dental decay and soft tissue abnormalities with a reminder to the patient that poor oral health impacts total health.

m) Diagnosis and management of pediatric and adult patients with asthma provided according to National Heart Lung Blood Institute, National Asthma Education and Prevention Program, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, 2007.

3. Reproductive Health Services

The Contractor shall provide prenatal, interconceptional and preconception medical care, social services, nutrition services, education, and nursing care to all women of childbearing age. Preconceptional care includes the preconception, interconceptional, and postpartum periods in women's health. It is recommended that preconceptional and interconceptional care visits focus on maintaining or achieving the optimal health of the mother, lowering the risk of future adverse pregnancy outcomes, the family's future plans, and how additional children fit into that plan. Preconceptional counseling may be done during an office, group or home visit.

a) In the event prenatal care is not provided directly by the Contractor a formal Memorandum/a of Agreement for coordinated referral to an appropriately qualified provider must be maintained.

b) Prenatal care shall, at minimum, be provided in accordance with the Guidelines for Perinatal Care, sixth or most current edition, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and /or the Centers for Disease Control.

c) Age appropriate reproductive health care shall, at a minimum, be provided in accordance with the American College of Obstetricians and Gynecologists, or the USDHHS Centers for Disease Control (CDC) current guidelines.

d) Pregnant women enrolled in the WIC Nutrition Program shall be referred to WIC for breastfeeding education and referral to the WIC Nutrition Program peer counselors.

e. Family planning counseling for prevention of subsequent pregnancy following an infant's birth shall be discussed with the infant's mother at the first postpartum visit and at the infant's 2-month visit and other visits as appropriate. Rationale for birth intervals of 18-24 months shall be presented.

f) A referral to a Title X Family Planning Clinic or other reproductive health care provider shall be made as appropriate.

4. Services for Children and Adolescents

The Contractor shall provide as a minimum, comprehensive and age-appropriate health care, screenings, and health education according to the American Academy of Pediatrics' most recent periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of

 Contractor Initials SMP

 Date 3-11-14

EXHIBIT A – AMENDMENT 1

Infants, Children, and Adolescents", Third Edition or most recent. Children and adolescent visits shall include:

a) The World Health Organization (WHO) growth charts shall be used to monitor growth for infants and children birth up to age 2 years. The Centers for Disease Control and Prevention (CDC) growth charts shall be used for children age 2 years and older.

b) Blood lead testing shall be performed in accordance with "New Hampshire Childhood Lead Poisoning Screening and Management Guidelines", issued by the New Hampshire Department of Health and Human Services, 2009 or subsequent revisions.

c) All children enrolled in either Medicaid, Head Start, or the Women, Infant, and Children (WIC) Program and/or who are ≤ 185%_poverty, regardless of town of residence, are required to have a blood lead test at ages one and two years. All children ages three to six years who have not been previously tested shall have a blood lead test performed.

d) All children shall be screened for iron deficiency anemia as outlined in the Centers for Disease Control and Prevention document "Recommendations to Prevent and Control Iron Deficiency in the United States (4/2/98)".

e) Age-appropriate anticipatory guidance, dietary guidance, and *feeding practice counseling* for optimal oral health shall be provided at each well child visit according to the American Academy of Pediatrics' periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent edition. Starting at age 6 months, it is recommended that all children receive an oral health assessment at every well child visit, and a referral for the child's first visit to the dentist by age one as recommended by the American Academy of Pediatrics and the American Academy of Pediatric Dentistry.

f) Supplemental fluoride shall be prescribed as needed based upon the fluoride levels in the child's drinking water supply. The fluoride dosage regimen accepted by the American Academy of Pediatrics shall be followed. No fluoride shall be prescribed without obtaining water from private wells or noting the presence or absence of fluoride in the public water supply. Supplemental fluoride may include bottled water containing fluoride and topical applications such as varnishes.

g) For infants enrolled in the WIC Nutrition Program, parents shall be referred to WIC for breastfeeding support and referral to the WIC Nutrition Program peer counselors.

5. Sexually Transmitted Infections

Primary Care Services shall provide age appropriate screening and treatment of sexually transmitted infections.

a) Treatment for sexually transmitted infections shall be provided according to the United States Centers for Disease Control Sexually Transmitted Diseases Treatment Guidelines, 2010 or subsequent revisions.

b) All clients, including women, shall be offered HIV testing following the most current recommendations of the United States Centers for Disease Control.

c) The contractor shall be responsible for ensuring referral to appropriate treatment services for any woman found to screen positive.

d) Appropriate risk reduction counseling shall be provided based on client needs.

6. Substance Use Services

a) A substance use screening history using a formal, validated screening tool shall be obtained for all clients as soon after entry into care as possible. Substance use counseling or other substance abuse intervention, treatment, or recovery services by an appropriately credentialed provider shall be provided on-site, or by referral, to clients with identified needs for these services. For these identified clients, ongoing primary care services should include follow up monitoring relative to substance abuse.

b) All clients, including pregnant women, identified as smokers shall receive counseling using the 5A's (ask, advise, assess, assist, and arrange) treatment available through the NH Tobacco Helpline as cited in the US Public Health Services report "Tobacco Use and Dependence", 2008, or "Smoking Cessation During Pregnancy: A Clinician's Guide to Helping Pregnant Women Quit Smoking", American College of Obstetricians and Gynecologists, 2011. With prior approval, agencies may also opt to participate in the DPHS best practice initiative of the 2A's and R (ask, advise and refer).

7. Immunizations

a) The Contractor shall adhere to the most current version of the "Recommended Adult Immunization Schedule for Adults (19 years and older) by Age and Medical Condition - United States", approved by the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

b) The Contractor shall administer vaccines according to the most current version of the "Recommended Immunization Schedule for Persons Aged 0 Through 6 Years - United States", and "Recommended Immunization Schedule for Persons Aged 7 Through 18 Years – United States" approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians, based upon availability of vaccine from the New Hampshire Immunization Program.

8. Prenatal Genetic Screening

a) A genetic screening history shall be obtained on all prenatal clients as soon after entry into care as possible.

b) All pregnant women should be offered voluntary genetic screening for fetal chromosomal abnormalities at the appropriate time following recommendations found in the American College of Obstetricians and Gynecologists' "Screening for Fetal Chromosomal Abnormalities (2007)" or more recent guidelines. The Contractor shall be responsible for ensuring referral to appropriate genetic testing and counseling for any woman found to have a positive screening test.

9. Additional Requirements

a) The Contractor's Medical Director shall participate in the development and approval of specific guidelines for medical care that supplement minimal clinical standards. Supplemental guidelines should be reviewed, signed, and dated annually, and updated as indicated.

b) Contractors considering clinical or sociological research using clients as subjects must adhere to the legal requirements governing human subjects research. Contractors must inform the DPHS, MCHS prior to initiating any research related to this contract.

c) The Contractor shall provide information to all employees annually about the Medical Reserve Corps Unit within their Public Health Region to enhance recruitment.

d) The Contractor shall provide information to all employees annually regarding the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) managed by the NH Department of Health and Human Services' Emergency Services Unit, to enhance recruitment.

B) Staffing Provisions

The Contractor shall have, at minimum, the following staff positions:

a) executive director

b) fiscal director

c) registered nurse

d) clinical coordinator

e) medical service director

f) nutritionist (on site or by referral)

g) social worker

EXHIBIT A – AMENDMENT 1

Staff positions required to provide direct services on-site include:

a) registered nurse

b) clinical coordinator

c) social worker

1. Qualifications

All health and allied health professionals shall have the appropriate New Hampshire licenses whether directly employed, contracted, or subcontracted.

In addition the following minimum qualifications shall be met for:

a) Registered Nurse
   a. A registered nurse licensed in the state of New Hampshire, Bachelor's degree preferred. Minimum of one-year experience in a community health setting.

b) Nutritionists:

   a. A Bachelor's degree in nutritional sciences or dietetics, or a Master's degree in nutritional sciences, nutrition education, or public health nutrition or current Registered Dietitian status in accordance with the Commission on dietetic Registration of the American Dietetic Association.

   b. Individuals who perform functions similar to a nutritionist but do not meet the above qualifications shall not use the title of nutritionist.

c) Social Workers shall have:

   a. A Bachelor's or Master's degree in social work or Bachelor's or Master's degree in a related social science or human behavior field. A minimum of one year of experience in a community health or social services setting is preferred.

   b. Individuals who perform functions similar to a social worker but do not meet the above qualifications shall not use the title of social worker.

d) Clinical Coordinators shall be:

   a. A registered nurse (RN), physician, physician assistant, or nurse practitioner with a license to practice in New Hampshire.

   b. The coordinator is a clinical position that oversees and takes responsibility for the clinical and administrative functions of each program.

   c. The coordinator may be responsible for more than one MCH funded program.

2. New Hires

The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing within one month of hire when a new administrator, clinical coordinator, or any staff person essential to carrying out contracted services is hired to work in the program. A resume of the employee shall accompany the aforesaid notification.

3. Vacancies

   a) The Contractor must notify the MCHS in writing if any critical position is vacant for more than one month, or if at any time funded under this contract does not have adequate staffing to perform all required services for more than one month. This may be done through a budget revision.

   b) Before an agency hires new program personnel that do not meet the required staff qualifications, the agency shall notify the MCHS in writing requesting a waiver of the applicable staffing requirements. The Section may grant waivers based on the need of the program, individuals' experience, and additional training.

C) Coordination of Services

1. The Contractor shall coordinate, where possible, with other service providers within the contractor's community. At a minimum, such collaboration shall include interagency referrals and coordination of care.

2. The Contractor shall participate in activities in the Public Health Region in which they provide services as appropriate. These activities enhance the integration of community-based public health prevention and health care initiatives that are being implemented by the contractor and may include community needs assessments, public health performance assessments, and/or the development of regional health improvement plans.

3. The Contractor agrees to participate in and coordinate public health activities as requested by the Division of Public Health Services during any disease outbreak and/or emergency, natural or man-made, affecting the public's health.

4. The Contractor is responsible for case management of the client enrolled in the program and for program follow-up activities. Case management services shall promote effective and efficient organization and utilization
of resources to assure access to necessary comprehensive medical, nutritional, and social services for clients.

5. The Contractor shall assure that appropriate, responsive, and timely referrals and linkages for other needed services are made, carried through, and documented. Such services shall include, but not be limited to: dental services, genetic counseling, high risk prenatal services, mental health, social services, including domestic violence crisis centers, substance abuse services; and family planning services, Early Supports and Services Program, local WIC/CSF Program, Home Visiting New Hampshire Programs and health and social service agencies which serve children and families in need of those services.

D) Meetings and Trainings

The contractor will be responsible for sending staff to meetings and training required by the MCHS program, including but not limited to:

1. MCHS Agency Directors' meetings
2. Prenatal and Child Health Coordinators' meetings
3. MCHS Agency Medical Services Directors' meetings

III. Quality or Performance Improvement (QI/PI)

A) Workplans

1. Performance Workplans are required for this program and are used to monitor achievement of standard measures of performance of the services provided under this contract. The workplans are a key component of the RHPCS and the MCHS performance-based contracting system and of this contract. Outcomes shall be reported by clinical site.
2. Performance Workplans and Workplan Outcome reports according to the schedule and instructions provided by the MCHS. The MCHS shall notify the Contractor at least 30 days in advance of any changes in the submission schedule.
3. The Contractor shall incorporate required and developmental performance measures, defined by the MCHS into the agency's Performance Workplan. Reports on Workplan Progress/Outcomes shall detail the Performance Workplan plans and activities that monitor and evaluate the agency's progress toward performance measure targets.
4. The Contractor shall comply with modifications and/or additions to the workplan and annual report format as requested by RHPCS and MCHS. MCHS will provide the contractor with reasonable notice of such changes.
5. Agencies contracting for Primary Care Services must submit the workplans for Primary Care Clinical and Financial, Child Health, and Prenatal Care.

B) Additional Reporting requirements

In addition to Performance Workplans, the Contractor shall submit to MCHS the following data and information listed below which are used to monitor program performance:

1. In years when contracts or amendments are not required, the DPHS Budget Form, Budget Justification, Sources of Revenue and Program Staff list forms must be

completed according to the relevant instructions and submitted as requested by DPHS and, at minimum, by April 30 of each year.

2. The Sources of Revenue report must be resubmitted at any point when changes in revenue threaten the ability of the agency to carry out the planned program.

3. Completed Uniform Data Set (UDS) tables reflecting program performance in the previous calendar year, by March 31 of each year.

4. The Perinatal Client Data Form (PCDF) shall be submitted electronically according to the instructions set forth by the MCHS.

5. A copy of the agency's updated Sliding Fee Scale including the amount(s) of any client fees and the schedule of discounts must be submitted by March 31st of each year. The agency's sliding fee scale must be updated annually based on the US DHHS Poverty guidelines as published in the Federal Register.

6. An annual summary of program-specific patient satisfaction results obtained during the prior contract period and the method by which the results were obtained shall be submitted annually as an addendum to the Workplan Outcome/Progress reports.

C) On-site reviews

1. The contractor shall allow a team or person authorized by the Division of Public Health Services to periodically review the contractor's systems of governance, administration, data collection and submission, clinical and financial management, and delivery of education services in order to assure systems are adequate to provide the contracted services.
2. Reviews shall include client record reviews to measure compliance with this exhibit.
3. The contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.
4. On-Site reviews may be waived or abbreviated at the discretion of MCHS, upon submission of satisfactory reports of reviews such as Health Services Resources Administration (HRSA): Office of Performance Review (OPR), or reviews from nationally accreditation organizations such as the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), Medicare, the Community Health Accreditation Program (CHAP), Accreditation Association for Ambulatory Healthcare (AAAHC), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey. Abbreviated reviews will focus on any deficiencies found in previous reviews, issues of compliance with this exhibit, and actions to strengthen performance as outlined in the agency Performance Workplan.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE CHILD HEALTH DIRECT CARE SERVICES
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Please note, for all measures, the following should be used **unless otherwise indicated:**

- Less than 19 years of age
- Served within the scope of this MCH contract during State Fiscal Year 2015 (July 1, 2014 – June 30, 2015)
- Each client can only be counted once (unduplicated)

Child Health Direct (CH – D) Performance Measure #1

Measure: 92%* of eligible children will be enrolled in Medicaid

Goal: To increase access to health care for children through the provision of health insurance

Definition: **Numerator-**
Of those in the denominator, the number of children enrolled in Medicaid.

Denominator-
Number of children who meet all of the following criteria:

- Less than 19 years of age
- Had 3 or more visits/encounters** during the reporting period
- As of the last visit during the reporting period were eligible for Medicaid

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**An encounter is face to face contact between a user and a provider who exercises independent judgment in the provision of services to the individual (UDS Table Definition).

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #2

Measure: 85%* of at-risk** children who were screened for blood lead between 18 and 30 months of age

Goal: To prevent childhood lead poisoning through early identification of lead exposure

Definition: **Numerator-**
Of those in the denominator, number of children screened for blood lead by capillary or venous on or after their 18-month birthday and prior to their 30-month birthday.

Denominator-
Number of at-risk** children who reached age 30 months during the reporting period. If discharged prior to 30 months, do not include in denominator.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**At risk = During the reporting period, the children were 18-29 months of age, and fit at least one of the following criteria:

- "Low income" (less than 185% poverty guidelines)
- Over 185% and resided in a town considered needing "Universal" screening per NH Childhood Lead Poisoning Prevention Program
- Over 185%, resided in a town considered "Target" and had a positive response to the risk questionnaire
- Refugee children -A refugee is defined as a person outside of his or her country of nationality who is unable or unwilling to return because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion (U.S. Citizenship and Immigration Services definition).

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #3

Measure: 71%* of children age two to nineteen years receiving primary care preventive health services with a Body Mass Index (BMI) percentile greater than or equal to the 85%ile with documented discussion of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Goal: To increase the percent of children receiving primary care preventive health services who have an elevated BMI percentile who receive guidance about promoting a healthier lifestyle.

Definition: **Numerator-**
Of those in the denominator, the number of children who had documentation in their medical record of there being discussion at least once during the reporting period of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Denominator-
Number of children who turned twenty-four months during or before the reporting period, up to the age of nineteen years, with one or more well child visit after their twenty-fourth month of age within the reporting year, and had an age and gender appropriate BMI percentile greater than or equal to the 85 % percentile at least once during the reporting period.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

Rationale: Children between the 85th – 94th percentiles BMI are encouraged to have 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks. (Discussion of the importance of family meal time, limiting eating out, consuming a healthy breakfast, preparing own foods, and promotion of breastfeeding is also encouraged.) American Academy of Pediatrics' guidance for Prevention and Treatment of Childhood Overweight and Obesity, (http://www.aap.org/obesity/health_professionals.html), from AAP Policy Statement: *Prevention of Pediatric Overweight and Obesity* and the AAP endorsed Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Children and Adolescent Overweight and Obesity, 2007.

*Target based on 2012 & 2013 Data Trend Table averages.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) #4

Measure: 75%* of eligible** infants and children with client record documentation of enrollment in WIC

Goal: To increase access to nutrition education, breastfeeding support, and healthy food through enrollment in the WIC Nutrition Program

Definition: **Numerator** -
Of those in the denominator, the number of infants and children who, as of the last well child visit during the reporting period, had client record documentation that infant or child was enrolled in WIC.

Denominator -
Unduplicated number of infants and children less than 5 years of age, enrolled in the agency, during the reporting period, who were eligible** for WIC.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**WIC Eligibility Requirements:

- Infants, and children up to their fifth birthday
- Must be income eligible (income guidelines are up to 185% of federal gross income, and are based on family size)

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #5

Measure: 23%* of infants who were exclusively** breastfed for the first three months, at their four month well baby visit

Goal: To provide optimum nutrition to infants in their first three months of life

Definition: **Numerator -**
Of those in the denominator, the number of infants who had client record documentation that the infant had been exclusively breastfed for their first three months when checked at their four month well baby visit.

Denominator -
Number of infants who received one or more visits during or before the reporting period and were seen for a four-month well baby visit during the reporting period.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

Benmarks: 2011 PedNSS (WIC) exclusive at 3 months: NH 22.9%, National (2010) 10.7%
2013 CDC Report Card (NIS, provisional 2010 births): NH 49.5%, National 37.7%
Healthy People 2020 goal: 44%

Rationale: The AAP recommends exclusive breastfeeding for about 6 months, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant, a recommendation concurred to by the World Health Organization and the Institute of Medicine. (American Academy of Pediatrics Policy Statement on Breastfeeding and the Use of Human Milk, 2012)

*Target based on 2012 & 2013 Data Trend Table averages.
**Exclusive means breast milk only, no supplemental formula, cereal/baby food, or water/fluids.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE: ADULT

PERFORMANCE MEASURES DEFINITIONS

State Fiscal Year 2015

Primary Care: Adult Performance Measure #1

Measure:* 58%** of adult patients 18 – 85 years of age diagnosed with hypertension will have a blood pressure measurement less than 140/90*** mm at the time of their last measurement.

Goal: To ensure patients diagnosed with hypertension are adequately controlled.

Definition: **Numerator-** Number of patients from the denominator with blood pressure measurement less than 140/90 mm at the time of their last measurement.

Denominator- Number of patients age 18 – 85 with diagnosed hypertension must have been diagnosed with hypertension 6 or more months before the measurement date. (Excludes pregnant women and patients with End Stage Renal Disease.)

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

*Measure based on the National Quality Forum 0018

**Health People 2020 National Target is 61.2%

***Both the numerator and denominator must be less that 140/90 mm

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE CLINICAL PERFORMANCE MEASURE DEFINITIONS Fiscal Year 2015

Primary Care Clinical Adolescent (PC-C) Performance Measure #1

Measure: 61%* of adolescents aged 11-21 years received an annual health maintenance visits in the past 12 months.

Goal: To enhance adolescent health by assuring annual, recommended, adolescent well -visits.

Definition: **Numerator-**
Number of adolescents in the denominator who received an annual health maintenance "well" visit during the reporting year.

Denominator-
Total number of adolescents aged 11-21 years who were enrolled in the primary care clinic as primary care clients during the reporting year period.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

***Target based on 2012 & 2013 Data Trend Table averages.**

Primary Care Clinical Prenatal (PC-C) Performance Measure #2

Measure: 31%* of women and adolescent girls aged 15-44 take multi-vitamins with folic acid.

Goal: To enhance pregnancy outcomes by reducing neural tube defects.

Definition: **Numerator-**
The number of women and adolescent girls aged 15-44 who take a multi-vitamin with folic acid.

Denominator-
The number of women and adolescent girls aged 15-44 who were seen in primary care for a well visit in the past year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

***Target based on 2012 & 2013 Data Trend Table averages.**

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE - FINANCIAL
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Primary Care (PC) Performance Measure #1

Measure: Patient Payor Mix

Goal: To allow monitoring of payment method trends at State funded primary care sites.

Definition: Patients enrolled in Medicare, Medicaid, Commercial insurance, or uninsured.

Data Source: Provided by agency

Primary Care (PC) Performance Measure #2

Measure: Accounts Receivables (AR) Days

Goal: To allow monitoring of financial sustainability trends at State funded primary care sites.

Definition: AR Days: Net Patient Accounts Receivable **multiplied by** 365 **divided by** Net Patient Revenue

Data Source: Provided by agency

Primary Care (PC) Performance Measure #3

Measure: Current Ratio

Goal: To allow monitoring of financial sustainability trends at State funded primary care sites.

Definition: Current Ratio = Current Assets **divided by** Current Liabilities

Data Source: Provided by agency

PRENATAL
PERFORMANCE MEASURES DEFINITIONS
State Fiscal Year 2015

Prenatal (PN) Performance Measure #1

Measure: 85%* of pregnant women who are enrolled in the agency's prenatal program will begin prenatal care during the first trimester of pregnancy.

Goal: To enhance pregnancy outcomes by assuring early entrance into prenatal care.

Definition:

Numerator-
Number of women in the denominator who had a documented prenatal visit during the first trimester (on or before 13.6 weeks gestation).

Denominator-
Number of women enrolled in the agency prenatal program who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

* Target based on 2012 & 2013 Data Trend Table averages.

Prenatal (PN) Performance Measure #2

Measure: 20%* of pregnant women who are identified as cigarette smokers will be referred to QuitWorks-New Hampshire.

Goal: To reduce tobacco use during pregnancy through focused tobacco use cessation activities at public health prenatal clinics.

Definition:

Numerator-
Number of women in the denominator who received at least one referral to QuitWorks-New Hampshire during pregnancy.

A referral is defined as signing the patient up for QuitWorks-NH via phone, fax, or EMR. It is not defined as discussing QuitWorks-NH with the patient and encouraging her to sign up.

Denominator-
Number of women enrolled in the agency prenatal program and identified as tobacco users who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

*Target set in consultation with the NH Tobacco Program & FY13 Data Trend Table average.

Prenatal (PN) Performance Measure #3

Measure: 79%* of pregnant women will be screened, using a formal valid screening tool, for alcohol and other substance use during every trimester they are enrolled in the prenatal program.

Goal: To reduce prenatal substance use through systematic screening and identification.

Definition: **Numerator-** Number of women in the denominator who were screened for substance and alcohol use, using a formal and valid screening tool, during each trimester that they were enrolled in the prenatal program.

Denominator- Number of women enrolled in the agency prenatal program and who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

* Target based on 2012 & 2013 Data Trend Table averages.

Exhibit B-1 (2014) -Amendment 1
Budget

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: Indian Stream Health Center

Budget Request for: MCH Primary Care
(Name of RFP)

Budget Period: SFY 2014

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages	$ -	$ -	$ -	
2. Employee Benefits	$ -	$ -	$ -	
3. Consultants	$ -	$ -	$ -	
4. Equipment:	$ 18,030.00	$ -	$ 18,030.00	
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	$ -	$ -	$ -	
13. Other (specific details mandatory):	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
TOTAL	**$ 18,030.00**	**$ -**	**$ 18,030.00**	

Indirect As A Percent of Direct 0.0%

Contractor Initials: SMP

Date: 3-11-14

Exhibit B-1 (2015) -Amendment 1
Budget

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: Indian Stream Health Center

Budget Request for: MCH Primary Care & RHPC
(Name of RFP)

Budget Period: SFY 2015

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages	$ 78,842.40	$ -	$ 78,842.40	0
2. Employee Benefits	$ 11,566.60	$ -	$ 11,566.60	0
3. Consultants	$ -	$ -	$ -	0
4. Equipment:	$ -	$ -	$ -	0
Rental	$ -	$ -	$ -	0
Repair and Maintenance	$ -	$ -	$ -	0
Purchase/Depreciation	$ -	$ -	$ -	0
5. Supplies:	$ -	$ -	$ -	0
Educational	$ -	$ -	$ -	0
Lab	$ -	$ -	$ -	0
Pharmacy	$ -	$ -	$ -	0
Medical	$ -	$ -	$ -	0
Office	$ 1,000.00	$ -	$ 1,000.00	0
6. Travel	$ 1,000.00	$ -	$ 1,000.00	0
7. Occupancy	$ -	$ -	$ -	0
8. Current Expenses	$ -	$ -	$ -	0
Telephone	$ -	$ -	$ -	0
Postage	$ 600.00	$ -	$ 600.00	0
Subscriptions	$ 900.00	$ -	$ 900.00	0
Audit and Legal	$ -	$ -	$ -	0
Insurance	$ -	$ -	$ -	0
Board Expenses	$ -	$ -	$ -	0
9. Software	$ -	$ -	$ -	0
10. Marketing/Communications	$ 2,500.00	$ -	$ 2,500.00	0
11. Staff Education and Training	$ 4,000.00	$ -	$ 4,000.00	0
12. Subcontracts/Agreements	$ -	$ -	$ -	0
13. Other (specific details mandatory):	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
	$ -	$ -	$ -	0
TOTAL	**$ 100,409.00**	**$ -**	**$ 100,409.00**	0

Indirect As A Percent of Direct 0.0%

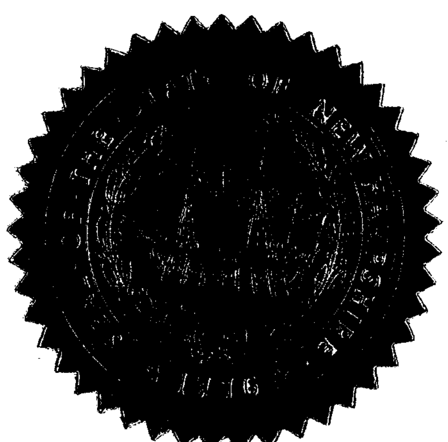
Contractor Initials: SMP

Date: 3-11-14

State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that INDIAN STREAM HEALTH CENTER, INC. is a New Hampshire nonprofit corporation formed June 1, 2002. I further certify that it is in good standing as far as this office is concerned, having filed the return(s) and paid the fees required by law.



In TESTIMONY WHEREOF, I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 22nd day of April A.D. 2013

William M. Gardner
Secretary of State

"MAXIMIZING THE QUALITY OF LIFE OF AREA RESIDENTS"

Certificate of Vote/Authority

I, Gail Fisher, of the Indian Stream Health Center, do hereby certify that:

1. I am the duly elected President of the Indian Stream Health Center;
2. The following are true copies of two resolutions duly adopted at a meeting of the Board of Directors of the corporation, duly held on February 26, 2014;

RESOLVED: That this corporation may enter into any and all contracts, amendments, renewals, revisions or modifications thereto, with the State of New Hampshire, acting through its Department of Health and Human Services.

RESOLVED: That the Chief Executive Officer (CEO) is hereby authorized on behalf of this corporation to enter into said contracts with the State and to execute any and all documents, agreements, and other instruments, and any amendments, revisions, or modifications thereto, as he/she may deem necessary, desirable or appropriate. Shirley M. Powell is the acting CEO of the corporation.

3. The foregoing resolutions have not been amended or revoked and remain in full force and effect as of March 11, 2014.

IN WITNESS WHEREOF, I have hereunto set my hand as the President of the corporation this 11th day of March, 2014.

Gail Fisher, President of Board of Directors

STATE OF NH
COUNTY OF Coos
The foregoing instrument was acknowledged before me this 11th day of March, 2014 by Gail Fisher.

Notary Public/Justice of the Peace

My Commission Expires: Notary Public, My Commission Expires August 11, 2015

141 Corliss Lane
Colebrook NH 03576
Telephone: (603) 237-8336 Facsimile: (603) 237-4467
www.indianstream.org

INDIA-1 OP ID: AT

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 03/04/14

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 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
CENTURION CORPORATION
Centurion Place, PO Drawer 959
Hanover, NH 03755-0959
A. W. Cunningham, CIC

Phone: 603-643-2000
Fax: 603-643-2740

CONTACT NAME:
PHONE (A/C, No, Ext): FAX (A/C, No):
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Hanover Insurance Co.	
INSURER B : Farmington Casualty Co	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Indian Stream Health Cntr,Inc
Shirley Powell
141 Corliss Lane
Colebrook, NH 03576

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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY [ ] COMMERCIAL GENERAL LIABILITY [ ] CLAIMS-MADE [X] OCCUR [X] Business Owners GEN'L AGGREGATE LIMIT APPLIES PER: [ ] POLICY [ ] PRO-JECT [ ] LOC			OHV-3454292-05	07/01/13	07/01/14	EACH OCCURRENCE	$ 1,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 300,000
							MED EXP (Any one person)	$ 5,000
							PERSONAL & ADV INJURY	$
							GENERAL AGGREGATE	$ 2,000,000
							PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY [ ] ANY AUTO [ ] ALL OWNED AUTOS [ ] SCHEDULED AUTOS [X] HIRED AUTOS [X] NON-OWNED AUTOS			OHV-3454292-05	07/01/13	07/01/14	COMBINED SINGLE LIMIT (Ea accident)	$
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
A	[X] UMBRELLA LIAB [X] OCCUR [ ] EXCESS LIAB [ ] CLAIMS-MADE [ ] DED [X] RETENTION $ 0			OHV-3454292-05	07/01/13	07/01/14	EACH OCCURRENCE	$ 10,000,000
							AGGREGATE	$ 10,000,000
								$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [ ] (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		IFUB-4101T99-A-13	07/01/13	07/01/14	WC STATU-TORY LIMITS / OTH-ER	
							E.L. EACH ACCIDENT	$ 500,000
							E.L. DISEASE - EA EMPLOYEE	$ 500,000
							E.L. DISEASE - POLICY LIMIT	$ 500,000

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

CERTIFICATE HOLDER

DHHS
Contracts and Procurement Unit
129 Pleasant Street
Concord, NH 03301

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

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INDIAN STREAM HEALTH CENTER, INC.

AUDITED FINANCIAL STATEMENTS

DECEMBER 31, 2012 AND 2011

BRAD BORBIDGE, P.A.
CERTIFIED PUBLIC ACCOUNTANTS
197 LOUDON ROAD, SUITE 350
CONCORD, NEW HAMPSHIRE 03301

TELEPHONE 603/224-0849
FAX 603/224-2397

Independent Auditor's Report on Financial Statements

Board of Directors
Indian Stream Health Center, Inc.
Colebrook, New Hampshire

We have audited the accompanying financial statements of Indian Stream Health Center, Inc., which comprise the balance sheets as of December 31, 2012 and 2011, the related statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the 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 entity'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 financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Indian Stream Health Center, Inc. as of December 31, 2012 and 2011, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The accompanying schedule of expenditures of federal awards is presented for purposes of additional analysis as required by U.S. Office of Management and Budget Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations, and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the schedule of expenditures of federal awards is fairly stated in all material respects in relation to the financial statements as a whole.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated May 22, 2013, on our consideration of the Organization's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and important for assessing the results of our audit.

Concord, New Hampshire
May 22, 2013

INDIAN STREAM HEALTH CENTER, INC.

BALANCE SHEETS

DECEMBER 31, 2012 AND 2011

ASSETS

	2012	2011
Current Assets		
Cash and cash equivalents	$ 594,500	$ 344,682
Patient accounts receivable, net of allowance for doubtful accounts of $277,454 and $176,585 at December 31, 2012 and 2011, respectively	154,584	166,507
Grants receivable	480,893	205,350
Other receivables	142,509	13,192
Prepaid expenses	14,702	15,589
Total Current Assets	1,387,188	745,320
Assets Limited As To Use	149,929	41,671
Property And Equipment, Net	1,333,786	1,143,944
Other Assets	5,721	5,925
TOTAL ASSETS	$ 2,876,624	$ 1,936,860

LIABILITIES AND NET ASSETS

	2012	2011
Current Liabilities		
Accounts payable and accrued expenses	$ 88,919	$ 34,610
Accrued payroll and related expenses	52,023	60,575
Deferred revenue	371,269	152,793
Current maturities of long-term debt	17,877	49,285
Total Current Liabilities	530,088	297,263
Long-term Debt, Less Current Maturities	682,629	798,242
Total Liabilities	1,212,717	1,095,505
Net Assets		
Unrestricted	1,513,978	799,684
Temporarily restricted	149,929	41,671
Total Net Assets	1,663,907	841,355
TOTAL LIABILITIES AND NET ASSETS	$ 2,876,624	$ 1,936,860

(See accompanying notes to these financial statements)

INDIAN STREAM HEALTH CENTER, INC.

STATEMENTS OF OPERATIONS

FOR THE YEARS ENDED DECEMBER 31, 2012 AND 2011

	2012	2011
Operating Revenue		
Patient service revenue	$ 1,687,419	$ 1,601,991
Provision for bad debt	(182,856)	(119,468)
Net patient service revenue	1,504,563	1,482,523
Grant revenue	1,003,194	1,083,855
Community benefit grants	100,000	100,000
Other operating revenue	1,270,796	130,540
Net assets released from restrictions for operations	1,111	19,034
Total Operating Revenue	3,879,664	2,815,952
Operating Expenses		
Salaries and benefits	1,825,367	1,856,920
Other operating expenses	1,474,483	908,366
Depreciation and amortization	60,335	68,370
Interest expense	47,047	49,391
Total Operating Expenses	3,407,232	2,883,047
OPERATING SURPLUS (LOSS) AND EXCESS (DEFICIT) OF REVENUE OVER EXPENSES	472,432	(67,095)
Grants for capital acquisition	241,862	-
Net assets released from restriction for capital acquisition	-	64,547
INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS	$ 714,294	$ (2,548)

(See accompanying notes to these financial statements)

INDIAN STREAM HEALTH CENTER, INC.

STATEMENTS OF CHANGES IN NET ASSETS

FOR THE YEARS ENDED DECEMBER 31, 2012 AND 2011

	2012	2011
Unrestricted Net Assets:		
Excess (deficit) of revenue over expenses	$ 472,432	$ (67,095)
Grants for capital acquisition	241,862	-
Net assets released from restriction for capital acquisition	-	64,547
Increase (Decrease) in Unrestricted Net Assets	714,294	(2,548)
Temporarily Restricted Net Assets:		
Contributions for capital acquisition	109,369	106,917
Net assets released from restrictions for operations	(1,111)	(19,034)
Net assets released from restriction for capital acquisition	-	(64,547)
Increase in Temporarily Restricted Net Assets	108,258	23,336
Change in Net Assets	822,552	20,788
Net Assets, Beginning of Year	841,355	820,567
NET ASSETS, END OF YEAR	$ 1,663,907	$ 841,355

(See accompanying notes to these financial statements)

INDIAN STREAM HEALTH CENTER, INC.

STATEMENTS OF CASH FLOWS

FOR THE YEARS ENDED DECEMBER 31, 2012 AND 2011

	2012	2011
Cash Flows From Operating Activities		
Change in net assets	$ 822,552	$ 20,788
Adjustments to reconcile change in net assets to net cash provided (used)by operating activities		
Provision for bad debts	182,856	119,468
Depreciation and amortization	60,335	68,370
Grants for capital acquisition	(241,862)	-
Restricted contributions for capital acquisition	(109,369)	(106,917)
(Increase) decrease in the following assets:		
Patient accounts receivable	(170,933)	(124,824)
Grants receivable	(275,543)	22,072
Other receivables	(129,317)	(13,192)
Prepaid expenses	887	11,320
Increase (decrease) in the following liabilities:		
Accounts payable and accrued expenses	54,309	(8,869)
Accrued payroll and related expenses	(8,552)	13,566
Deferred revenue	218,476	(13,425)
Net Cash Provided (Used) by Operating Activities	403,839	(11,643)
Cash Flows From Investing Activities		
Increase in assets limited as to use	(108,258)	(23,336)
Capital expenditures	(249,973)	(19,905)
Net Cash Used by Investing Activities	(358,231)	(43,241)
Cash Flows From Financing Activities		
Grants for capital acquisition	241,862	-
Restricted contributions for capital acquisition	109,369	106,917
Proceeds from issuance of long-term debt	-	50,000
Principal payments on long-term debt	(147,021)	(46,722)
Net Cash Provided by Financing Activities	204,210	110,195

INDIAN STREAM HEALTH CENTER, INC.

STATEMENTS OF CASH FLOWS (CONTINUED)

FOR THE YEARS ENDED DECEMBER 31, 2012 AND 2011

	2012	2011
Net Increase in Cash and Cash Equivalents	249,818	55,311
Cash and Cash Equivalents, Beginning of Year	344,682	289,371
CASH AND CASH EQUIVALENTS, END OF YEAR	$ 594,500	$ 344,682
Supplemental Disclosures of Cash Flow Information:		
Cash paid for interest	$ 47,047	$ 49,391

(See accompanying notes to these financial statements)

"MAXIMIZING THE QUALITY OF LIFE OF AREA RESIDENTS"

Our Mission:

"Our mission is to provide excellent preventive, acute, and wellness-focused health care to residents within the organization's service area regardless of a patient's ability to pay.

We will focus our resources to maximize the quality of life of area residents in a cost-effective and efficient manner."

141 Corliss Lane
Colebrook NH 03576
Telephone: (603) 237-8336 Facsimile: (603) 237-4467
www.indianstream.org

"MAXIMIZING THE QUALITY OF LIFE OF AREA RESIDENTS"

Indian Stream Health Center

Board of Directors

Updated 3/13/2014

Name	Officer	Term Expires
Gail Fisher	President	6/14
Melissa Shaw	Vice President	6/18
Bill Freedman	Treasurer	6/14
Linda Lomasney	Secretary	6/17
Julie Riffon		6/15
Dallas Chase		6/19
Erin Meenan		6/19
Steve Ellis		6/17
Charlie White		6/18
Bridget Freudenberger		6/14

141 Corliss Lane

Colebrook NH 03576

Telephone: (603) 237-8336 Facsimile: (603) 237-4467

www.indianstream.org

KEY ADMINISTRATIVE PERSONNEL

NH Department of Health and Human Services

Contractor Name: Indian Stream Health Center

Name of Bureau/Section: MCH Primary Care

BUDGET PERIOD: **SFY 14**

Program Area: MCH Primary Care

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Shirley Powell	CEO	$90,000	0.00%	$0.00
Jill Gregoire RN, MSN	QA/CO Director	$70,000	0.00%	$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$0.00**

KEY ADMINISTRATIVE PERSONNEL

NH Department of Health and Human Services

Contractor Name: Indian Stream Health Center

Name of Bureau/Section: MCH Primary Care

BUDGET PERIOD: SFY 15

Program Area: MCH Primary Care Services

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Shirley Powell	CEO	$90,000	0.00%	$0.00
Jill Gregoire RN, MSN	QA/CO Director	$75,000	0.00%	$0.00
		$0	0.00%	$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$0.00**

Program Area: Rural Health and Primary Care Services

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Shirley Powell	CEO	$90,000	0.00%	$0.00
Jill Gregoire RN, MSN	QA/CO Director	$75,000	0.00%	$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$0.00**

Shirley M. Powell

141 Corliss Lane
Colebrook, NH
03576
603-388-2416

Shirley.M.Powell@indianstream.org

EMPLOYMENT

Chief Executive Officer — June 2007 - Present
Indian Stream Health Center
141 Corliss Lane
Colebrook New Hampshire 03576

- Provide executive management of a relatively new FQHC (Federally Qualified Health Center)
- Provide leadership to staff of health center
- Develop administrative and financial policies and procedures
- Provide Board and staff training related to FQHC regulations
- Work closely with Bureau of Primary Health Care representatives to assure health center compliance and management of Federal funds

Independent Consultant — June 2000 – Present
SMP Associates
99 Main Street, PO Box 326
Bethel ME 04217

Assist primary health care practices, with an emphasis on Federally Qualified Health Centers, in:

- Organizational assessment and problem solving
- Board and staff training
- Strategic planning
- Practice assessment and development
- Enhancement of financial reimbursement from third parties
- Grants writing development and management
- Interim management including the following organizations:

Acting Chief Executive Officer — June 2006 – March 2007
Little Rivers Health Care Inc.
Bradford Vermont
Same as above

Acting Executive Director — June 2004 – November 2004
Norwalk Community Health Center
Norwalk Connecticut
Same as above

Acting Executive Director — June – Dec. 2000
Rural Health Centers of Maine (RHCM)
Augusta, ME

- Reorganized this network of four community health centers to a statewide migrant health program
- Assisted the health centers to transition from group of centers working within a network to independent status
- Worked closely with the Boards of Directors of RHCM as well as the health centers in this transition process
- Managed the legal and financial issues related to Federal grants financing
- Assisted the Board in recruitment of permanent Executive Director
- Provided Board and staff training including strategic planning

Community Relations Manager 1990 – 1998
Androscoggin Home Care and Hospice, Inc.
Lewiston, ME

- Served on the Senior Management Team of the largest home health agency in Northern New England
- Developed and managed its fundraising program
- Organized and managed its speaker's bureau
- Developed and wrote the quarterly newsletter
- Planned and managed community relations activities throughout its tri-county service area
- Supervised its volunteer program

Rural Health Centers of Maine 1988 - 1989
Augusta, ME

- Served as consultant to a network of Rural Health Centers throughout central and eastern Maine
- Specifically responsible for the Federal grants programs in four health centers in the following communities: Bucksport, Harrington, Eastport and Ashland

Executive Director 1978 – 1988
Bethel Area Health Center
Bethel, ME

- Wrote the first Federal grant securing rural health initiative funding
- Served as the Center's first Executive Director
- Oversaw all operations including recruitment and supervision of personnel, fiscal and grants management and program development
- During my tenure the Center grew from a part-time physician practice with a student nurse practitioner to a practice employing two full-time family physicians, a full time physician assistant, outreach and support personnel

EDUCATION

University of New Hampshire System, Granite State College
Concord, NH

- Bachelor of Science Degree, Health Care Studies

National Training Labs
Bethel, ME

- Organizational Development and Assessment
- Interpersonal and Group Communication Skills

KNOWLEDGE

- Federally Qualified Health Center requirements and regulations
- Primary health care management systems and practices
- Grass roots advocacy and community development
- Marketing and fundraising techniques
- Grants identification, development and management
- Organizational and Group Development and Behavior
- Human Behavior and Development

SKILLS

- Organizational Development and Management
- Leadership training
- Group facilitation and management
- Interpersonal Communication and Facilitation
- Conflict identification, management and resolution
- Written and Verbal Communication
- Business Management

141 Corliss Lane
Colebrook, NH 03576

Phone 603-388-2422
E-mail
Jill.M.Gregoire@indianstream.org

Jill M. Gregoire RN, MSN

Summary of qualifications

1987-1989 New Hampshire Vocational Technical College
Berlin, NH

- Associate Degree in Nursing

2003-2004 Saint Leo University, Saint Leo, Florida

- Associate of Arts in Liberal Arts

2002-2004 Jacksonville University, Jacksonville, Florida

- Bachelor of Science in Nursing Degree

2008-2010 University of Phoenix, Phoenix, Arizona

- Master of Science in Nursing

1989-current

- Registered Nurse in the State of New Hampshire

License #: 034069-21

Professional experience

1988 - 1989
Upper Connecticut Valley Hospital Colebrook, NH

- Worked part time as an LPN in M/S, CSR, ED, and post-partum obstetrics while attending college for ADN

1989 - 2002
Upper Connecticut Valley Hospital Colebrook, NH

- Staff RN cross trained in Critical Care, Emergency Department, Labor and Delivery, Post-Partum and Nursery care, Perioperative Nursing (Scrub and Circulate), PACU and Med/Surg

1991-1996

- SCU Nurse Manager: Responsible for quality improvement, policies and procedures and nurse education/training for the department

1998-2000

- Nursing Services Coordinator: Responsible for coordinating nursing scheduling, competencies, performance evaluations, personnel interviews associated with hiring new employees, policies and procedures, and quality improvement for all nursing departments. (M/S, SCU, ED, OB, and OR)

2000-2002

- Continued working as a staff nurse, participating on Medication Error Prevention Committee, locally and also as part of the VHA New England Medication Error Prevention Initiative, regionally representing the Upper Connecticut Valley Hospital. I was also a member of the Drug Utilization and Therapeutic Oversight committee at UCVH as well as chair person of the Pain

Management Committee

2002-May 2006 Concord Hospital, Concord, New Hampshire

- Worked full time as a staff RN in the Critical Care Unit. Experience involved working in the ICU and CCU as well as caring for cardiothoracic surgical patients. Continued participation in the VHA New England Medication Error Prevention Initiative, representing Concord Hospital in the region. I was also a member of Concord Hospital's Medication Safety Committee and Medication Reconciliation Team.

May 2006-current: Indian Stream Health Center, Colebrook, New Hampshire

- Quality Assurance/ Clinical Operations Director
- Responsible for quality assurance and quality improvement efforts. This includes development of quality initiatives that promote high quality primary care in accordance with national standards. Coordinate peer review. Assist in grant writing process. Management of the State of New Hampshire primary care, oral health, and family planning grants. 2010 Project Director for Small Health Care Provider Quality Improvement Grant funded by Health Resources and Services Administration.
- Oversight of all clinical programs including care management, 340B pharmacy program, family planning services, oral health program, and primary care team functions. Directly supervise the clinical outreach program. Responsible for OSHA blood borne pathogen exposure control plan and infection control training.
- Monitoring of patient complaints and risk management issues. Responsible for Federal Tort Claims Act training and resource for organization.
- Responsible for electronic medical record (EMR) software management, troubleshooting, training and forms building
- Senior leadership role includes collaboration with neighboring critical access hospital

References Available on request

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

29 HAZEN DRIVE, CONCORD, NH 03301-6527
603-271-4517 1-800-852-3345 Ext. 4517
Fax: 603-271-4519 TDD Access: 1-800-735-2964

Nicholas A. Toumpas
Commissioner

José Thier Montero
Director

May 1, 2012

APPROVED F/C ________
DATE ________
APPROVED G&C # 125
DATE 6|20|12
NOT APPROVED ________

His Excellency, Governor John H. Lynch
and the Honorable Executive Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Public Health Services, Bureau of Population Health and Community Services, Maternal and Child Health Section, to enter into an agreement with Indian Stream Health Center, Inc. (Vendor #165274-B001), 141 Corliss Lane, Colebrook New Hampshire 03576, in an amount not to exceed $140,718, to provide primary care services, to be effective July 1, 2012 or date of Governor and Executive Council approval, whichever is later, through June 30, 2014. Funds are available in the following accounts for SFY 2013, and are anticipated to be available in SFY 2014 upon the availability and continued appropriation of funds in the future operating budgets.

05-95-90-902010-5190 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH; BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES, MATERNAL AND CHILD HEALTH

Fiscal Year	Class/Object	Class Title	Job Number	Total Amount
SFY 2013	102-500731	Contracts for Program Services	90080000	$60,359
SFY 2014	102-500731	Contracts for Program Services	90080000	$60,359
			Sub-Total	$120,718

05-95-90-901010-5149 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF PUBLIC HEALTH SYSTEMS, POLICY AND PERFORMANCE, RURAL HEALTH AND PRIMARY CARE

Fiscal Year	Class/Object	Class Title	Job Number	Total Amount
SFY 2013	102-500731	Contracts for Program Services	90073001	$10,000
SFY 2014	102-500731	Contracts for Program Services	90073001	$10,000
			Sub-Total	$20,000
			Total	$140,718

EXPLANATION

Funds in this agreement will be used to provide office-based primary care services for low-income and uninsured families. This agreement provides funds for services as a last resort; contractor is required to make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid.

Primary health care services include preventive and episodic health care for acute and chronic health conditions for people of all ages, including pregnant women, children, adolescents, adults, and the elderly. Community health agencies that receive support through the Division of Public Health Services deliver primary and preventive health care services to underserved people who face barriers to accessing health care, due to issues such as a lack of insurance, inability to pay, language barriers, and geographic isolation. In addition to medical care, community health centers are unique among primary care providers for the array of patient-centered services they offer, including care coordination, translation, transportation, outreach, eligibility assistance, and health education. These services help individuals overcome barriers to getting the care they need and achieving their optimal health. One area of particular success has been in ensuring that eligible families maintain consistent enrollment in Medicaid for their children. Community health centers provide support for families in filling out applications and ensuring that children have continuity of care.

Community health agencies throughout New Hampshire have demonstrated success in meeting the health care needs of the uninsured and under-insured citizens of the state. Division of Public Health Services funded primary care providers participate in rigorous quality improvement efforts utilizing standard performance measures that focus attention on improving health outcomes for patients. For example, in State Fiscal Year 2011:

- 88% of eligible children served were enrolled in Medicaid/Healthy Kids Gold.
- 86% of children 24-35 months, served received the appropriate schedule of immunizations.
- 82% of infants born to women served received prenatal care beginning in the first trimester of pregnancy.

Should Governor and Executive Council not authorize this Request, a minimum of 8,919 low-income individuals from the Northern Coos County and Colebrook area may not have access to primary care services. A strong primary care infrastructure reduces costs for uncompensated care, improves health outcomes, and reduces health disparities.

Indian Stream Health Center, Inc. was selected for this project through a competitive bid process. A Request for Proposals was posted on the Department of Health and Human Services' web site from January 10, 2012 through February 16, 2012. In addition, a bidder's conference, conference call, and web conference were held on January 19, 2012 to alert agencies to this bid.

Thirteen proposals were received in response to the posting. Each proposal was scored by three professionals, who work internal and external to the Department of Health and Human Services. All reviewers have between three to twenty years experience either in clinical settings, providing community-based family support services, and managing agreements with vendors for various public health programs. Areas of specific expertise include maternal and child health; quality assurance and performance improvement; chronic and communicable diseases and public health infrastructure. The reviewers used a standardized form to score agencies' relevant experience and capacity to carry out the activities outlined in the proposal. Reviewers look for realistic targets when scoring performance measures in addition to detailed workplans including evaluation components. Budgets were reviewed to be reasonable, justified and consistent with the intent of the program goals and outcomes. There were no competing applications within each of the separate service areas. Scores were

averaged and all proposals were recommended for funding. In those instances where scores were less than ideal, agency specific remedial actions were recommended and completed. The Bid Summary is attached.

As referenced in the Request for Proposals, Renewals Section, this competitively procured Agreement has the option to renew for two additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties and approval of the Governor and Executive Council. These services were contracted previously with this agency in SFY 2011 and SFY 2012 in the amount of $230,586. This represents a decrease of $89,868. The decrease is due to budget reductions.

The performance measures used to measure the effectiveness of the agreement are attached.

Area served: Northern Coos County and Colebrook area.

Source of Funds: 17.11% Federal Funds from US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau and 82.89% General Funds.

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

Respectfully submitted,

José Thier Montero, MD
Director

Approved by:
Nicholas A. Toumpas
Commissioner

JTM/PMT/sc

Primary Care Performance Measures

State Fiscal Year 2013

Primary Care Prenatal (PN) Performance Measure #1

Measure: Percent of infants born to women receiving prenatal care beginning in the first trimester of pregnancy.

Primary Care Prenatal (PN) Performance Measure #2

Measure: Percent of pregnant women identified as cigarette smokers that are referred to QuitWorks-New Hampshire.

Primary Care Prenatal (PN) Performance Measure #3

Measure: Percent of pregnant women who were screened, using a formal valid screening tool, for alcohol and other drug use during every trimester the patient was enrolled.

Primary Care Child Health Direct (CH – D) Performance Measure #1

Measure: Percent of eligible children enrolled in Medicaid

Primary Care Child Health Direct (CH – D) Performance Measure #2

Measure: Percent of at-risk children who were screened for blood lead between 18 and 30 months of age

Primary Care Child Health Direct (CH – D) Performance Measure #3

Measure: Percent of children age two to nineteen years receiving primary care preventive health services with a Body Mass Index (BMI) percentile greater than or equal to the 85th percentile with documented discussion of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Primary Care Child Health Direct (CH – D) Performance Measure #4

Measure: Percent of eligible infants and children with client record documentation of enrollment in Women Infant Children Program.

Primary Care Child Health Direct (CH – D) Performance Measure #5

Measure: Percent of infants who were exclusively breastfed for the first three months, at their four month well baby visit.

Primary Care Financial (PC) Performance Measure #1

Measure: Patient Payor Mix

Primary Care Financial (PC) Performance Measure #2

Measure: Accounts Receivables (AR) Days

Primary Care Financial (PC) Performance Measure #3

Measure: Current Ratio

Primary Care Performance Measures

State Fiscal Year 2013

Primary Care Clinical Adolescent (PC-C) Performance Measure #1

Measure: Percent of adolescents aged 10-21 years who received annual health maintenance visits in the past 12 months.

Primary Care Clinical Prenatal (PC-C) Performance Measure #2

Measure: Percent of women and adolescent girls aged 15-44 who take a multi-vitamin with folic acid.

Subject: Primary Care Services

AGREEMENT

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

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name NH Department of Health and Human Services Division of Public Health Services		**1.2 State Agency Address** 29 Hazen Drive Concord, NH 03301-6504	
1.3 Contractor Name Indian Stream Health Center, Inc.		**1.4 Contractor Address** 141 Corliss Lane Colebrook, New Hampshire 03576	
1.5 Contractor Phone Number 603-388-2422	**1.6 Account Number** 010-090-5190-102-500731 010-090-5149-102-500731	**1.7 Completion Date** June 30, 2014	**1.8 Price Limitation** $140,718
1.9 Contracting Officer for State Agency Joan H. Ascheim, Bureau Chief		**1.10 State Agency Telephone Number** 603-271-4501	
1.11 Contractor Signature [signature]		**1.12 Name and Title of Contractor Signatory** Shirley M. Powell, CEO	

1.13 Acknowledgement: State of NH, County of Coos

On March 28, 2012, before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.

1.13.1 Signature of Notary Public or Justice of the Peace

[Seal] [signature]

SHARON L. CLEVELAND, Notary Public
My Commission Expires March 4, 2014

1.13.2 Name and Title of Notary or Justice of the Peace

SHARON CLEVELAND: NOTARY PUBLIC

1.14 State Agency Signature [signature]	**1.15 Name and Title of State Agency Signatory** Joan H. Ascheim, Bureau Chief

1.16 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)*

By: Director, On:

1.17 Approval by the Attorney General (Form, Substance and Execution)

By: [signature] Jeanne P. Herrick, Attorney On: 8 May 2012

1.18 Approval by the Governor and Executive Council

By: On:

Exhibit A

Scope of Services

Primary Care Services

CONTRACT PERIOD: July 1, 2012 or date of G&C approval, whichever is later, through June 30, 2014

CONTRACTOR NAME: Indian Stream Health Center, Inc.

ADDRESS: 141 Corliss Lane
Colebrook, New Hampshire 03576
Chief Executive Officer: Shirley Powell
TELEPHONE: 603-388-2422

<u>The Contractor shall:</u>

I. <u>General Provisions</u>

A) Eligibility and Income Determination

1. Office-based primary care services will be provided to low-income individuals and families (defined as ≤ 185% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), in the State of New Hampshire.

2. The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing if, at any time, the practice is closed to new patients, or maintains a wait list for new patients, or any other mechanism is used that limits access for new patients for more than a one month period.

3. The Contractor shall document annually, for each client enrolled in the program, family income and family size, and calculate percentage of the federal poverty level. If calculations indicate that the client may be eligible for enrollment in Medicaid, the Contractor shall complete with the client the most recent version of the 800P form.

4. The Contractor shall implement, and post in a public and conspicuous location, a sliding fee payment schedule, approved in advance by the Division of Public Health Services (DPHS), for low-income patients. Signage must state that no client will be denied services for inability to pay.

   a. As an alternative, the contractor may post, in a public and conspicuous location, a notice to clients that a sliding fee scale is available and that no client will be denied services for inability to pay. The sliding fee scale must be updated annually based on USDHHS Poverty guidelines as published in the Federal Register, submitted to and approved by DPHS <u>*prior to implementation.*</u>

5. The primary care contract entered into here shall be the payer of last resort. The contractor shall make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid, for all reimbursable services rendered.

B) Numbers Served

1. The contract funds shall be expended to provide the above services to a minimum of 550 users annually with 2160 medical encounters, as defined in the Data and Reporting Requirements. Clinical service reimbursements shall not exceed the Medicare rate.

C) **Culturally and Linguistically Appropriate Standards of Care**

The Department of Health and Human Services (DHHS) recognizes that culture and language have considerable impact on how consumers access and respond to public health services. Culturally and linguistically diverse populations experience barriers in efforts to access health services. To ensure equal access to quality health services, the Division of Public Health Services (DPHS) expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.

2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.

3. *Provide* clients of limited English proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.

4. Offer consumers a forum through which clients have the opportunity to provide feedback to providers and organizations regarding cultural and linguistic issues that may deserve response.

5. The contractor shall maintain a program policy that sets forth compliance with Title VI, Language Efficiency and Proficiency Citation 45 CFR 80.3(b) (2). The policy shall describe the way in which the items listed above were addressed and shall indicate the circumstances in which interpretation services are provided and the method of providing service (e.g. trained interpreter, staff person who speaks the language of the client, language line).

D) **State and Federal Laws**

The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. The Contractor shall report all cases of communicable diseases according to New Hampshire RSA 141-C and He-P 301, adopted 6/3/08.

2. Persons employed by the contractor shall comply with the reporting requirements of New Hampshire RSA 169:C, Child Protection Act; RSA 161:F46, Protective Services to Adults, RSA 631:6, Assault and Related Offences and RSA 130:A, Lead Paint Poisoning and Control.

3. Immunizations shall be conducted in accordance with RSA 141-C and the Immunization Rules promulgated hereunder.

E) **Relevant Policies and Guidelines**

1. The Contractor shall design and provide the services described above to meet the unique and identified health needs of the populations within the contracted service area.

2. Primary Care funds shall be targeted to populations in need. Populations in need are defined as follows:

a) uninsured;

b) under-insured;

c) families and individuals with significant psychosocial and economic risk, including low income status;

d) all life cycles including perinatal, child, adolescent, adult, and elderly who meet one or more of the above criteria.

3. The Contractor shall design and implement systems of governance, administration, financial management, information management, and clinical services which are adequate to assure the provision of contracted services, and to meet the data and reporting requirements. These systems shall meet the most current minimum standards described in at least one of the following: Health Resources and Services Administration (HRSA) Office of Performance Review protocols, Joint Commission on Accreditation of Health Care Organizations (JCAHO), Accreditation Association for Ambulatory Healthcare (AAAHC), Community Health Accreditation Program (CHAP), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey.

4. *The Contractor shall have an agency emergency preparedness and response plan in accordance with HRSA Health Center Emergency Management Program Expectations, Document #2007-15 or most recent version. Such plan shall also include a Continuity of Operations plan.*

5. The Contractor shall carry out the work as described in the performance Workplan submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

6. The Contractor shall carry out the work as described in the Supplemental Funding Form submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

F) Publications Funded Under Contract

1. The DHHS and/or its funders will retain COPYRIGHT ownership for any and all original materials produced with DHHS contract funding, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports.

2. All documents (written, video, audio, *electronic*) produced, reproduced, or purchased under the contract shall have prior approval from DPHS before printing, production, distribution, or use.

3. The Contractor shall credit DHHS on all materials produced under this contract following the instructions outlined in Exhibit C (14).

G) Subcontractors

1. If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing *and approve the subcontractual agreement*, prior to initiation of the subcontract.

2. In addition, the original DPHS contractor will remain liable for all requirements included in this Exhibit and carried out by subcontractors.

II. Minimal Standards of Core Services

A) Service Requirements

1. *Medical Home*

The Contractor shall provide a Medical Home that:

a) *Facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family.*

b) *Provides care facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.*

2. Primary Care Services

The Contractor shall provide office-based primary care services to populations in need who reside in the contractor's service area. Primary care services shall include:

a) Health care provided by a New Hampshire licensed MD, DO, APRN, or PA, including diagnosis and treatment of acute and chronic illnesses within the scope of family practice; preventive services, screenings, and health education according to established, documented state or national guidelines; assessment of need for social and nutrition services, and appropriate referrals to health, *oral health*, and behavioral health specialty providers.

b) *Referral to the WIC Nutrition Program for all eligible pregnant women, infants and children.*

c) In-hospital care for conditions within the scope of family practice must be provided at a hospital, within the agency service area, through a staff clinician with full hospital privileges, or in the alternative, through a formal referral and admissions procedure available to clients on a 24 hour/7 day a week basis.

d) Access to a healthcare provider, directly or by referral or subcontract, by telephone twenty-four hours per day, seven days per week.

e) Assessment of psychosocial risk for all clients at least annually and for children at scheduled preventive care visits, including, at a minimum, age appropriate assessment of safety in the home, domestic violence, adequacy of food and housing, care and welfare of children, transportation needs, and provision of necessary social services to address the priority needs and safety issues of clients and families.

f) Falls prevention screening for patients 65 years and older using the algorithm and guidelines of the American Geriatrics Society.

g) Behavioral health care directly or by referral to an agency or provider with a sliding fee scale.

h) *Nutrition assessment for all clients as part of the health maintenance visit.* Therapeutic nutrition services shall be provided *as indicated* directly or by referral to an agency or provider with a sliding fee scale. These services shall be recorded in the medical record.

i) Formal arrangements with a local hospital for emergency care must be in place and reviewed annually.

Contractor Initials: SMP
Date: 6/5/12

j) Home health care directly or by referral to an agency or provider with a sliding fee scale.

k) Assisted living and skilled nursing facility care by referral.

l) *Oral screening annually for all clients 19 years and older to note obvious dental decay and soft tissue abnormalities with a reminder to the patient that poor oral health impacts total health.*

m) *Diagnosis and management of pediatric and adult patients with asthma provided according to National Heart Lung Blood Institute, National Asthma Education and Prevention Program, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, 2007.*

n) ***Breast and cervical cancer screening directly or by referral to an agency or provider with a sliding fee scale using screening guidelines from a nationally accepted organization.***

3. Reproductive Health Services

The Contractor shall provide prenatal, interconceptional and preconception medical care, social services, nutrition services, education, and nursing care to all women of childbearing age. Preconceptional care includes the preconception, interconceptional, and postpartum periods in women's health. It is recommended that preconceptional and interconceptional care visits focus on maintaining or achieving the optimal health of the mother, lowering the risk of future adverse pregnancy outcomes, the family's future plans, and how additional children fit into that plan. Preconceptional counseling may be done during an office, group or home visit.

a) In the event prenatal care is not provided directly by the Contractor a formal Memorandum/a of Agreement for coordinated referral to an appropriately qualified provider must be maintained.

b) Prenatal care shall, at minimum, be provided in accordance with the Guidelines for Perinatal Care, sixth or most current edition, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and /or the Centers for Disease Control.

c) Age appropriate reproductive health care shall, at a minimum, be provided in accordance with the American College of Obstetricians and Gynecologists, or the USDHHS Centers for Disease Control (CDC) current guidelines.

d) *Pregnant women enrolled in the WIC Nutrition Program shall be referred to WIC for breastfeeding education and referral to the WIC Nutrition Program peer counselors.*

e) Family planning counseling for prevention of subsequent pregnancy following an infant's birth shall be discussed with the infant's mother *at the first postpartum visit and at the infant's 2-month visit and other visits as appropriate.* Rationale for birth intervals of 18-24 months shall be presented.

f) A referral to a Title X Family Planning Clinic or other reproductive health care provider shall be made as appropriate.

4. Services for Children and Adolescents

The Contractor shall provide as a minimum, comprehensive and age-appropriate health care, screenings, and health education according to the American Academy of Pediatrics' most recent periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent. Children and adolescent visits shall include:

Contractor Initials: SMD
Date: 6/5/12

a) Blood lead testing shall be performed in accordance with "New Hampshire Childhood Lead Poisoning Screening and Management Guidelines", issued by the New Hampshire Department of Health and Human Services, 2009 or subsequent revisions.

b) All children enrolled in either Healthy Kids-Gold or the Women, Infant, and Children (WIC) Program and/or who are ≤ 185%_poverty, regardless of town of residence, are required to have a blood lead test at ages one and two years. All children ages three to six years who have not been previously tested shall have a capillary or venous blood lead test performed.

c) All children shall be screened for iron deficiency anemia as outlined in the Centers for Disease Control and Prevention document "Recommendations to Prevent and Control Iron Deficiency in the United States (4/2/98)".

d) Age-appropriate anticipatory guidance, dietary guidance, and *feeding practice counseling* for optimal oral health shall be provided at each well child visit according to the American Academy of Pediatrics' periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent edition. Starting at age 6 months, it is recommended that all children receive an oral health assessment at every well child visit.

e) Supplemental fluoride shall be prescribed as needed based upon the fluoride levels in the child's *drinking* water supply. The fluoride dosage regimen accepted by the American Academy of Pediatrics shall be followed. No fluoride shall be prescribed without obtaining water from private wells or noting the presence or absence of fluoride in the public water supply. ***Supplemental fluoride may include bottled water containing fluoride and topical applications such as varnishes.***

f) ***For infants enrolled in the WIC Nutrition Program, parents shall be referred to WIC for breastfeeding support and referral to the WIC Nutrition Program peer counselors.***

5. Sexually Transmitted Infections

Primary Care Services shall provide age appropriate screening and treatment of sexually transmitted infections.

a) Treatment for sexually transmitted infections shall be provided according to the United States Centers for Disease Control Sexually Transmitted Diseases Treatment Guidelines, 2010 or subsequent revisions.

b) All clients, including women, shall be offered HIV testing following the most current recommendations of the United States Centers for Disease Control.

c) The contractor shall be responsible for ensuring referral to appropriate treatment services for any woman found to screen positive.

d) Appropriate risk reduction counseling shall be provided based on client needs.

6. Substance Use Services

a) A substance use screening history using a formal, validated screening tool shall be obtained for all clients as soon after entry into care as possible. Substance use counseling *or other substance abuse intervention, treatment, or recovery services* by an appropriately credentialed provider shall be provided on-site, or by referral, to clients with identified needs for these services. *For these identified clients, ongoing primary care services should include follow up monitoring relative to substance abuse.*

Contractor Initials: SMP
Date: 6/5/12

b) All clients, including pregnant women, identified as smokers shall receive counseling *using the 5A's (ask, advise, assess, assist, and arrange) treatment available through the NH Tobacco Helpline* as cited in the US Public Health Services report "Tobacco Use and Dependence", 2008, or "Smoking Cessation During Pregnancy: *A Clinician's Guide to Helping Pregnant Women Quit Smoking*", American College of Obstetricians and Gynecologists, 2011. *With prior approval, agencies may also opt to participate in the DPHS best practice initiative of the 2A's and R (ask, advise and refer).*

7. Immunizations

a) The Contractor shall adhere to the most current version of the "Recommended Adult Immunization Schedule United States", approved by the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

b) The Contractor shall administer vaccines according to the most current version of the *"Recommended Immunization Schedule for Persons Aged 0 Through 6 Years - United States", and "Recommended Immunization Schedule for Persons Aged 7 Through 18 Years – United States"* approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians, based upon availability of vaccine from the New Hampshire Immunization Program.

8. Prenatal Genetic Screening

a) A genetic screening history shall be obtained on all prenatal clients as soon after entry into care as possible.

b) All pregnant women should be offered voluntary genetic screening for fetal chromosomal abnormalities at the appropriate time following recommendations found in the American College of Obstetricians and Gynecologists' "Screening for Fetal Chromosomal Abnormalities (2007)" or more recent guidelines. The Contractor shall be responsible for ensuring referral to appropriate genetic testing and counseling for any woman found to have a positive screening test.

9. Additional Requirements

a) The Contractor's Medical Director shall participate in the development and approval of specific guidelines for medical care that supplement minimal clinical standards. Supplemental guidelines should be reviewed, signed, and dated annually, and updated as indicated.

b) Contractors considering clinical or sociological research using clients as subjects must adhere to the legal requirements governing human subjects research. Contractors must inform the DPHS, MCHS prior to initiating any research related to this contract.

c) *The Contractor shall provide information to all employees annually about the Medical Reserve Corps Unit within their Public Health Region to enhance recruitment.*

d) *The Contractor shall provide information to all employees annually regarding the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) managed by the NH Department of Health and Human Services' Emergency Services Unit, to enhance recruitment.*

B) **Staffing Provisions**

The Contractor shall have, at minimum, the following staff positions:

Contractor Initials: SMP
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a) executive director

b) fiscal director
c) registered nurse

d) clinical coordinator

e) medical service director

f) nutritionist *(on site or by referral)*

g) social worker

Staff positions required to provide direct services on-site include:
a) registered nurse

b) clinical coordinator

c) social worker

1. Qualifications

All health and allied health professionals shall have the appropriate New Hampshire licenses whether directly employed, contracted, or subcontracted.

In addition the following minimum qualifications shall be met for:
a) Registered Nurse
   a. A registered nurse licensed in the state of New Hampshire, Bachelor's degree preferred. Minimum of one-year experience in a community health setting.

b) Nutritionists:
   a. A Bachelor's degree in nutritional sciences or dietetics, or a Master's degree in nutritional sciences, nutrition education, or public health nutrition or current Registered Dietitian status in accordance with the Commission on dietetic Registration of the American Dietetic Association.

   b. Individuals who perform functions similar to a nutritionist but do not meet the above qualifications shall not use the title of nutritionist.

c) Social Workers shall have:
   a. A Bachelor's or Master's degree in social work or Bachelor's or Master's degree in a related social science or human behavior field. A minimum of one year of experience in a community health or social services setting is preferred.

   b. Individuals who perform functions similar to a social worker but do not meet the above qualifications shall not use the title of social worker.

d) Clinical Coordinators shall be:

   a. A registered nurse (RN), physician, physician assistant, or nurse practitioner with a license to practice in New Hampshire.

   b. The coordinator is a clinical position that oversees and takes responsibility for the clinical and administrative functions of each program.

   c. The coordinator may be responsible for more than one MCH funded program.

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2. New Hires

The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing within one month of hire when a new administrator, clinical coordinator, or any staff person essential to carrying out contracted services is hired to work in the program. A resume of the employee shall accompany the aforesaid notification.

3. Vacancies

a) The Contractor must notify the MCHS in writing if any critical position is vacant for more than one month, or if at any time funded under this contract does not have adequate staffing to perform all required services for more than one month. This may be done through a budget revision.

b) Before an agency hires new program personnel that do not meet the required staff qualifications, the agency shall notify the MCHS in writing requesting a waiver of the applicable staffing requirements. The Section may grant waivers based on the need of the program, individuals' experience, and additional training.

C) Coordination of Services

1. The Contractor shall coordinate, where possible, with other service providers within the contractor's community. At a minimum, such collaboration shall include interagency referrals and coordination of care.

2. The Contractor shall participate in activities ***in the Public Health Region in which they provide services*** as appropriate. These activities enhance the integration of community-based public health prevention and health care initiatives that are being implemented by the contractor and may include community needs assessments, public health performance assessments, and/or the development of regional health improvement plans.

3. The Contractor agrees to ***participate*** in and coordinate public health activities as requested by the Division of Public Health Services during any ***disease outbreak*** and/or ***emergency***, natural or man made, affecting the public's health.

4. The Contractor is responsible for case management of the client enrolled in the program and for program follow-up activities. Case management services shall promote effective and efficient organization and utilization of resources to assure access to necessary comprehensive medical, nutritional, and social services for clients.

5. The Contractor shall assure that ***appropriate, responsive, and timely*** referrals and linkages for other needed services are made, carried through, and documented. Such services shall include, but not be limited to: dental services, genetic counseling, high risk prenatal services, mental health, social services, including domestic violence crisis centers, substance abuse services; and family planning services, Early Supports and Services Program, local WIC/CSF Program, Home Visiting New Hampshire Programs and health and social service agencies which serve children and families in need of those services.

D) Meetings and Trainings

The contractor will be responsible for sending staff to meetings and training required by the MCHS program, including but not limited to:

1. MCHS Agency Directors' meetings

2. Prenatal and Child Health Coordinators' meetings

3. MCHS Agency Medical Services Directors' meetings

III. Quality or Performance Improvement (QI/PI)

A) **Workplans**

1. Performance Workplans are required for this program and are used to monitor achievement of standard measures of performance of the services provided under this contract. The workplans are a key component of the RHPCS and the MCHS performance-based contracting system and of this contract. Outcomes shall be reported by clinical site.

2. Submit Performance Workplans and Workplan Outcome reports according to the schedule and instructions provided by the MCHS. The MCHS shall notify the Contractor at least 30 days in advance of any changes in the submission schedule.

3. The Contractor shall incorporate required and developmental performance measures, defined by the MCHS into the agency's Performance Workplan. Reports on Workplan Progress/Outcomes shall detail the Performance Workplan plans and activities that monitor and evaluate the agency's progress toward performance measure targets.

4. The Contractor shall comply with modifications and/or additions to the workplan and annual report format as requested by RHPCS and MCHS. MCHS will provide the contractor with reasonable notice of such changes.

5. Agencies contracting for Primary Care Services must submit the workplans for Primary Care *Clinical and Financial*, Child Health, and Prenatal Care.

B) **Additional Reporting requirements**

In addition to Performance Workplans, the Contractor shall submit to MCHS the following data and information listed below which are used to monitor program performance:

1. In years when contracts or amendments are not required, the DPHS Budget Form, Budget Justification, Sources of Revenue and Program Staff list forms must be completed according to the relevant instructions and submitted as requested by DPHS and, at minimum, by April 30 of each year.

2. The Sources of Revenue report must be resubmitted at any point when changes in revenue threaten the ability of the agency to carry out the planned program.

3. Completed Uniform Data Set (UDS) tables reflecting program performance in the previous calendar year, by March 31 of each year.

4. The Perinatal Client Data Form (PCDF) shall be submitted electronically according to the instructions set forth by the MCHS.

5. A copy of the agency's updated Sliding Fee Scale including the amount(s) of any client fees and the schedule of discounts must be submitted by March 31st of each year. The agency's sliding fee scale must be updated annually based on the US DHHS Poverty guidelines as published in the Federal Register.

6. An annual summary of program-specific patient satisfaction results obtained during the prior contract period and the method by which the results were obtained shall be submitted annually as an addendum to the Workplan Outcome/Progress reports.

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C) On-site reviews

1. The contractor shall allow a team or person authorized by the Division of Public Health Services to periodically review the contractor's systems of governance, administration, data collection and submission, clinical and financial management, and delivery of education services in order to assure systems are adequate to provide the contracted services.
2. Reviews shall include client record reviews to measure compliance with this exhibit.
3. The contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.
4. On-Site reviews may be waived or abbreviated at the discretion of MCHS, upon submission of satisfactory reports of reviews such as Health Services Resources Administration (HRSA): Office of Performance Review (OPR), or reviews from nationally accreditation organizations such as the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), Medicare, the Community Health Accreditation Program (CHAP), Accreditation Association for Ambulatory Healthcare (AAAHC), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey. Abbreviated reviews will focus on any deficiencies found in previous reviews, issues of compliance with this exhibit, and actions to strengthen performance as outlined in the agency Performance Workplan.

Contractor Initials: SMP
Date: 6/5/12

State of New Hampshire
Department of Health and Human Services
Amendment #1 to the
Lamprey Health Care, Inc.

This 1st Amendment to the Lamprey Health Care, Inc., contract (hereinafter referred to as "Amendment One") dated this 12 day of March, 2014, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Lamprey Health Care, Inc., (hereinafter referred to as "the Contractor"), a corporation with a place of business at 207 South Main Street, Newmarket, New Hampshire 03857.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on June 20, 2012, 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, the State and the Contractor have agreed to make changes to the scope of work, payment schedules and terms and conditions of the contract; and

WHEREAS, pursuant to the General Provisions, Paragraph 18, the State may modify the scope of work and the payment schedule of the contract by written agreement of the parties;

WHEREAS, the Department desires to provide additional primary health care services for preventive and episodic health care for acute and chronic health conditions for people of all ages.

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 as follows:

To amend as follows:

- Form P-37, to change:
  Block 1.7 to read: June 30, 2015
  Block 1.8 to read: $1,696,513

- Exhibit A, Scope of Services to add:
  Exhibit A – Amendment 1

- Exhibit B, Purchase of Services, Contract Price, to add:

  Paragraph 1.1 to Paragraph 1:
  The contract price shall increase by $119,828 for SFY 2014 and $654,249 for SFY 2015.

  Paragraph 1.2 to Paragraph 1:
  Funding is available as follows:
- $119,828 from 05-95-90-902010-5190-102-500731, 100% General Funds;
- $600,864 from 05-95-90-902010-5190-102-500731, 6.7% Federal Funds from the US Department of Health and Human Services Administration, Maternal and Child Health Bureau, CFDA #93.994 and 93.3% General Funds;

Contractor Initials: [signature]
Date: 3.12.14

- $53,385 from 05-95-90-902010-5659-102-500731, 100% Federal Funds from the US Department of Health and Human Services, Centers for Disease Control and Prevention, CFDA #93.283;

  Add Paragraph 8
  8. Notwithstanding paragraph 18 of the General Provisions P-37, an amendment limited to adjustments to amounts between and among account numbers, within the price limitation, may be made by written agreement of both parties and may be made without obtaining approval of the Governor and Executive Council.

- Budget, to add:
  Exhibit B-1 (2014) - Amendment 1,
  Exhibit B-1 (2015) - Amendment 1

This amendment shall be in effect July 1, 2013, effective upon the date of Governor and Executive Council approval.

Contractor Initials: [signature]
Date: 3-12-14

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

3/28/14
Date

Brook Dupee
Bureau Chief

Lamprey Health Care, Inc.

March 12, 14
Date

Name: George Donovan
Title: Vice-President of the Board of Directors

Acknowledgement:

State of NH, County of Rockingham on March 12, 14, before the undersigned officer, personally appeared the person identified above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.

Michelle L Gaudet
Signature of Notary Public or Justice of the Peace

Michelle Gaudet, Notary
Name and Title of Notary or Justice of the Peace

MICHELLE L. GAUDET, Notary Public
My Commission Expires August 22, 2017

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

OFFICE OF THE ATTORNEY GENERAL

4-3-14
Date

Name: Rosemary Wiant
Title: Asst Attorney General

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:

Contractor Initials:
Date: 3-12-14

EXHIBIT A – AMENDMENT 1

Scope of Services

The Department desires to continue tl relationship with the primary care agencies to provide additional primary health care servic s or preventive and episodic health care for acute and chronic health conditions for peopl of all ages.

I. General Provisions

A) Eligibility and Income Determination

1. Office-based primary care services will be provided to low-income individuals and families (defined as ≤ 185% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), in the State of New Hampshire.

2. Breast and Cervical Cancer screening services will be provided to low-income (defined as ≤ 250% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), New Hampshire women age 21– 64, uninsured or underinsured. BCCP changes.

3. The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing if, at any time, the practice is closed to new patients, or maintains a wait list for new patients, or any othe mechanism is used that limits access for new patients for more than a one month period.

4. The Contractor shall document annually, for each client enrolled in the program, family income and family size, and calculate percentage of the federal poverty level. If calculations indicate that the client may be eligible for enrollment in Medicaid, the Contractor shall complete with the client the most recent version of the 800P form.

5. The Contractor shall implement, and post in a public and conspicuous location, a sliding fee payment schedule, approved in advance by the Division of Public Health Services (DPHS), for low-income patients. Signage must state that no client will be denied services for inability to pay.

   a. As an alternative, the contractor may post, in a public and conspicuous location, a notice to clients that a sliding fee scale is available and that no client will be denied services for inability to pay. The sliding fee scale must be updated annually based on USDHHS Poverty guidelines as published in the Federal Register, submitted to and approved by DPHS prior to implementation.

6. The primary care contract entered into here shall be the payer of last resort. The contractor shall make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid, for all reimbursable services rendered.

B) Numbers Served

1. The contract funds shall be expended to provide the above services to a minimum of 1,200 users annually with 3,265 medical encounters, as defined in the Data and Reporting Requirements. Breast and Cervical Cancer Screening for eligible women, as defined by the Breast and Cervical Cancer Program (BCCP), shall be provided to 300 women annually and billed directly to the BCCP. Clinical service reimbursements shall not exceed the Medicare rate.

C) Culturally and Linguistically Appropriate Standards of Care

The Department of Health and Human Services (DHHS) recognizes that culture and language have considerable impact on how consumers access and respond to public health services. Culturally and linguistically diverse populations experience barriers in efforts to access health services. To ensure equal access to quality health services, the Division of Public Health Services (DPHS) expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.

2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.

3. Provide clients of limited English proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.

4. Offer consumers a forum through which clients have the opportunity to provide feedback to providers and organizations regarding cultural and linguistic issues that may deserve response.

5. The contractor shall maintain a program policy that sets forth compliance with Title VI, Language Efficiency and Proficiency Citation 45 CFR 80.3(b) (2). The policy shall describe the way in which the items listed above were addressed and shall indicate the circumstances in which interpretation services are provided and the method of providing service (e.g. trained interpreter, staff person who speaks the language of the client, language line).

D) State and Federal Laws

The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. The Contractor shall report all cases of communicable diseases according to New Hampshire RSA 141-C and He-P 301, adopted 6/3/08.

2. Persons employed by the contractor shall comply with the reporting requirements of New Hampshire RSA 169:C, Child Protection Act; RSA 161:F46, Protective Services to Adults, RSA 631:6, Assault and Related Offences and RSA 130:A, Lead Paint Poisoning and Control.

3. Immunizations shall be conducted in accordance with RSA 141-C and the Immunization Rules promulgated hereunder.

E) Relevant Policies and Guidelines

1. The Contractor shall design and provide the services described above to meet the unique and identified health needs of the populations within the contracted service area.

2. Primary Care funds shall be targeted to populations in need. Populations in need are defined as follows:

    a) uninsured;

    b) under-insured;

    c) families and individuals with significant psychosocial and economic risk, including low income status;

    d) all life cycles including perinatal, child, adolescent, adult, and elderly who meet one or more of the above criteria.

3. The Contractor shall design and implement systems of governance, administration, financial management, information management, and clinical services which are adequate to assure the provision of contracted services, and to meet the data and reporting requirements. These systems shall meet the most current minimum standards described in at least one of the following: Health Resources and Services Administration (HRSA) Office of Performance Review protocols, Joint Commission on Accreditation of Health Care Organizations (JCAHO), Accreditation Association for Ambulatory Healthcare (AAAHC), Community Health Accreditation Program (CHAP), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey.

4. The Contractor shall have an agency emergency preparedness and response plan in accordance with HRSA Health Center Emergency Management Program Expectations, Document #2007-15 or most recent version. Such plan shall also include a Continuity of Operations plan.

5. The Contractor shall carry out the work as described in the performance Workplan submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

6. No Workplan is required by the Breast and Cervical Cancer Program (BCCP). The contractor shall be required to respond to the Quality Improvement Feedback Report twice a year.

7. The Contractor shall carry out the work as described in the Supplemental Funding Form submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

F) Publications Funded Under Contract

1. The DHHS and/or its funders will retain COPYRIGHT ownership for any and all original materials produced with DHHS contract funding, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports.

2. All documents (written, video, audio, electronic) produced, reproduced, or purchased under the contract shall have prior approval from DPHS before printing, production, distribution, or use.

3. The Contractor shall credit DHHS on all materials produced under this contract following the instructions outlined in Exhibit C (14).

G) Subcontractors

If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing and approve the subcontractual agreement, prior to initiation of the subcontract.

1. If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing and approve the subcontractual agreement, prior to initiation of the subcontract.

2. In addition, the original DPHS contractor will remain liable for all requirements included in this Exhibit and carried out by subcontractors.

II. <u>Minimal Standards of Core Services</u>

A. Service Requirements

1. Medical Home

   The Contractor shall provide a Medical Home that:

   a) Facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family.

b) Provides care facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

2. Primary Care Services

The Contractor shall provide office-based primary care services to populations in need who reside in the contractor's service area. Primary care services shall include:

a) Health care provided by a New Hampshire licensed MD, DO, APRN, or PA, including diagnosis and treatment of acute and chronic illnesses within the scope of family practice; preventive services, screenings, and health education according to established, documented state or national guidelines; assessment of need for social and nutrition services, and appropriate referrals to health, oral health, and behavioral health specialty providers.

b) Referral to the WIC Nutrition Program for all eligible pregnant women, infants and children.

c) In-hospital care for conditions within the scope of family practice must be provided at a hospital, within the agency service area, through a staff clinician with full hospital privileges, or in the alternative, through a formal referral and admissions procedure available to clients on a 24 hour/7 day a week basis.

d) Access to a healthcare provider, directly or by referral or subcontract, by telephone twenty-four hours per day, seven days per week.

e) Assessment of psychosocial risk for all clients at least annually and for children at scheduled preventive care visits, including, at a minimum, age appropriate assessment of safety in the home, domestic violence, adequacy of food and housing, care and welfare of children, transportation needs, and provision of necessary social services to address the priority needs and safety issues of clients and families.

f) Falls prevention screening for patients 65 years and older using the algorithm and guidelines of the American Geriatrics Society.

g) Behavioral health care directly or by referral to an agency or provider with a sliding fee scale.

h) Nutrition assessment for all clients as part of the health maintenance visit. Therapeutic nutrition services shall be provided as indicated directly or by referral to an agency or provider with a sliding fee scale. These services shall be recorded in the medical record.

i) Formal arrangements with a local hospital for emergency care must be in place and reviewed annually.

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EXHIBIT A – AMENDMENT 1

j) Home health care directly or by referral to an agency or provider with a sliding fee scale.

k) Assisted living and skilled nursing facility care by referral.

l) Oral screening annually for all clients 21 years and older to note obvious dental decay and soft tissue abnormalities with a reminder to the patient that poor oral health impacts total health.

m) Diagnosis and management of pediatric and adult patients with asthma provided according to National Heart Lung Blood Institute, National Asthma Education and Prevention Program, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, 2007.

3. Breast and Cervical Cancer Screening

a) Women age 21 to 64 who are eligible for Breast and Cervical Cancer Program (BCCP) services according to income (equal to or under 250% of poverty, underinsured/uninsured) and insurance status criteria shall be provided the following services, following USPSTF screening recommendations:

i. cervical cancer screening including a pelvic examination and Pap smear;
ii. breast cancer screening including a clinical breast exam, mammogram and,
iii. referrals for diagnostic and treatment services based on screening results,
iv. case management services.

b) All referrals under this provision shall be to approved certified laboratory, pathology, radiology, and surgical services. Mammography units shall be accredited by the American College of Radiology, and must be FDA certified under MQSA. Laboratories shall be CLIA certified.

c) All services shall be provided in accordance with the Breast and Cervical Cancer Program (BCCP) Policy and Procedure Manual.

d) Follow-up and tracking of all tests done, and referrals made shall be provided in accordance with the minimum standards outlined in the Breast and Cervical Cancer Program Policy and Procedure Manual.

e) All services for women enrolled in the Breast and Cervical Cancer Program (BCCP) shall be billed directly to the BCCP in accordance with protocols established by the Breast and Cervical Cancer Program.

f) The Contractor shall provide the NH Breast and Cervical Cancer Program with breast and cervical cancer screening rates for all women served by the practice as requested, but not more than twice per SFY.

EXHIBIT A – AMENDMENT 1

g) The contractor shall work with the NH Breast and Cervical Cancer Program staff to increase the breast and cervical cancer screening rates among all women serviced by the practice.

4. Reproductive Health Services

The Contractor shall provide prenatal, interconceptional and preconception medical care, social services, nutrition services, education, and nursing care to all women of childbearing age. Preconceptional care includes the preconception, interconceptional, and postpartum periods in women's health. It is recommended that preconceptional and interconceptional care visits focus on maintaining or achieving the optimal health of the mother, lowering the risk of future adverse pregnancy outcomes, the family's future plans, and how additional children fit into that plan. Preconceptional counseling may be done during an office, group or home visit.

a) In the event prenatal care is not provided directly by the Contractor a formal Memorandum/a of Agreement for coordinated referral to an appropriately qualified provider must be maintained.

b) Prenatal care shall, at minimum, be provided in accordance with the Guidelines for Perinatal Care, sixth or most current edition, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and /or the Centers for Disease Control.

c) Age appropriate reproductive health care shall, at a minimum, be provided in accordance with the American College of Obstetricians and Gynecologists, or the USDHHS Centers for Disease Control (CDC) current guidelines.

d) Pregnant women enrolled in the WIC Nutrition Program shall be referred to WIC for breastfeeding education and referral to the WIC Nutrition Program peer counselors.

e. Family planning counseling for prevention of subsequent pregnancy following an infant's birth shall be discussed with the infant's mother at the first postpartum visit and at the infant's 2-month visit and other visits as appropriate. Rationale for birth intervals of 18-24 months shall be presented.

f) A referral to a Title X Family Planning Clinic or other reproductive health care provider shall be made as appropriate.

5. Services for Children and Adolescents

The Contractor shall provide as a minimum, comprehensive and age-appropriate health care, screenings, and health education according to the American Academy of Pediatrics' most recent periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent. Children and adolescent visits shall include:

EXHIBIT A – AMENDMENT 1

a) The World Health Organization (WHO) growth charts shall be used to monitor growth for infants and children birth up to age 2 years. The Centers for Disease Control and Prevention (CDC) growth charts shall be used for children age 2 years and older.

b) Blood lead testing shall be performed in accordance with "New Hampshire Childhood Lead Poisoning Screening and Management Guidelines", issued by the New Hampshire Department of Health and Human Services, 2009 or subsequent revisions.

c) All children enrolled in either Medicaid, Head Start, or the Women, Infant, and Children (WIC) Program and/or who are ≤ 185%_poverty, regardless of town of residence, are required to have a blood lead test at ages one and two years. All children ages three to six years who have not been previously tested shall have a blood lead test performed.

d) All children shall be screened for iron deficiency anemia as outlined in the Centers for Disease Control and Prevention document "Recommendations to Prevent and Control Iron Deficiency in the United States (4/2/98)".

e) Age-appropriate anticipatory guidance, dietary guidance, and *feeding practice counseling* for optimal oral health shall be provided at each well child visit according to the American Academy of Pediatrics' periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent edition. Starting at age 6 months, it is recommended that all children receive an oral health assessment at every well child visit, and a referral for the child's first visit to the dentist by age one as recommended by the American Academy of Pediatrics and the American Academy of Pediatric Dentistry.

f) Supplemental fluoride shall be prescribed as needed based upon the fluoride levels in the child's drinking water supply. The fluoride dosage regimen accepted by the American Academy of Pediatrics shall be followed. No fluoride shall be prescribed without obtaining water from private wells or noting the presence or absence of fluoride in the public water supply. Supplemental fluoride may include bottled water containing fluoride and topical applications such as varnishes.

g) For infants enrolled in the WIC Nutrition Program, parents shall be referred to WIC for breastfeeding support and referral to the WIC Nutrition Program peer counselors.

6. Sexually Transmitted Infections

Primary Care Services shall provide age appropriate screening and treatment of sexually transmitted infections.

EXHIBIT A – AMENDMENT 1

a) Treatment for sexually transmitted infections shall be provided according to the United States Centers for Disease Control Sexually Transmitted Diseases Treatment Guidelines, 2010 or subsequent revisions.

b) All clients, including women, shall be offered HIV testing following the most current recommendations of the United States Centers for Disease Control.

c) The contractor shall be responsible for ensuring referral to appropriate treatment services for any woman found to screen positive.

d) Appropriate risk reduction counseling shall be provided based on client needs.

7. Substance Use Services

a) A substance use screening history using a formal, validated screening tool shall be obtained for all clients as soon after entry into care as possible. Substance use counseling or other substance abuse intervention, treatment, or recovery services by an appropriately credentialed provider shall be provided on-site, or by referral, to clients with identified needs for these services. For these identified clients, ongoing primary care services should include follow up monitoring relative to substance abuse.

b) All clients, including pregnant women, identified as smokers shall receive counseling using the 5A's (ask, advise, assess, assist, and arrange) treatment available through the NH Tobacco Helpline as cited in the US Public Health Services report "Tobacco Use and Dependence", 2008, or "Smoking Cessation During Pregnancy: A Clinician's Guide to Helping Pregnant Women Quit Smoking", American College of Obstetricians and Gynecologists, 2011. With prior approval, agencies may also opt to participate in the DPHS best practice initiative of the 2A's and R (ask, advise and refer).

8. Immunizations

a) The Contractor shall adhere to the most current version of the "Recommended Adult Immunization Schedule for Adults (19 years and older) by Age and Medical Condition - United States", approved by the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

b) The Contractor shall administer vaccines according to the most current version of the "Recommended Immunization Schedule for Persons Aged 0 Through 6 Years - United States", and "Recommended Immunization Schedule for Persons Aged 7 Through 18 Years – United States" approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians, based upon availability of vaccine from the New Hampshire Immunization Program.

9. Prenatal Genetic Screening

a) A genetic screening history shall be obtained on all prenatal clients as soon after entry into care as possible.

b) All pregnant women should be offered voluntary genetic screening for fetal chromosomal abnormalities at the appropriate time following recommendations found in the American College of Obstetricians and Gynecologists' "Screening for Fetal Chromosomal Abnormalities (2007)" or more recent guidelines. The Contractor shall be responsible for ensuring referral to appropriate genetic testing and counseling for any woman found to have a positive screening test.

10. Additional Requirements

a) The Contractor's Medical Director shall participate in the development and approval of specific guidelines for medical care that supplement minimal clinical standards. Supplemental guidelines should be reviewed, signed, and dated annually, and updated as indicated.

b) Contractors considering clinical or sociological research using clients as subjects must adhere to the legal requirements governing human subjects research. Contractors must inform the DPHS, MCHS prior to initiating any research related to this contract.

c) The Contractor shall provide information to all employees annually about the Medical Reserve Corps Unit within their Public Health Region to enhance recruitment.

d) The Contractor shall provide information to all employees annually regarding the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) managed by the NH Department of Health and Human Services' Emergency Services Unit, to enhance recruitment.

B) Staffing Provisions

The Contractor shall have, at minimum, the following staff positions:

a) executive director

b) fiscal director

c) registered nurse

d) clinical coordinator

e) medical service director

f) nutritionist (on site or by referral)

g) social worker

Staff positions required to provide direct services on-site include:

a) registered nurse

b) clinical coordinator

c) social worker

1. Qualifications

All health and allied health professionals shall have the appropriate New Hampshire licenses whether directly employed, contracted, or subcontracted.

In addition the following minimum qualifications shall be met for:

a) Registered Nurse
   a. A registered nurse licensed in the state of New Hampshire, Bachelor's degree preferred. Minimum of one-year experience in a community health setting.

b) Nutritionists:
   a. A Bachelor's degree in nutritional sciences or dietetics, or a Master's degree in nutritional sciences, nutrition education, or public health nutrition or current Registered Dietitian status in accordance with the Commission on dietetic Registration of the American Dietetic Association.
   b. Individuals who perform functions similar to a nutritionist but do not meet the above qualifications shall not use the title of nutritionist.

c) Social Workers shall have:
   a. A Bachelor's or Master's degree in social work or Bachelor's or Master's degree in a related social science or human behavior field. A minimum of one year of experience in a community health or social services setting is preferred.
   b. Individuals who perform functions similar to a social worker but do not meet the above qualifications shall not use the title of social worker.

d) Clinical Coordinators shall be:
   a. A registered nurse (RN), physician, physician assistant, or nurse practitioner with a license to practice in New Hampshire.
   b. The coordinator is a clinical position that oversees and takes responsibility for the clinical and administrative functions of each program.
   c. The coordinator may be responsible for more than one MCH funded program.

2. New Hires

The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing within one month of hire when a new administrator, clinical coordinator, or any staff person essential to carrying out contracted services is hired to work in the program. A resume of the employee shall accompany the aforesaid notification.

3. Vacancies

   a) The Contractor must notify the MCHS in writing if any critical position is vacant for more than one month, or if at any time funded under this contract does not have adequate staffing to perform all required services for more than one month. This may be done through a budget revision.

   b) Before an agency hires new program personnel that do not meet the required staff qualifications, the agency shall notify the MCHS in writing requesting a waiver of the applicable staffing requirements. The Section may grant waivers based on the need of the program, individuals' experience, and additional training.

C) Coordination of Services

1. The Contractor shall coordinate, where possible, with other service providers within the contractor's community. At a minimum, such collaboration shall include interagency referrals and coordination of care.

2. The Contractor shall participate in activities in the Public Health Region in which they provide services as appropriate. These activities enhance the integration of community-based public health prevention and health care initiatives that are being implemented by the contractor and may include community needs assessments, public health performance assessments, and/or the development of regional health improvement plans.

3. The Contractor agrees to participate in and coordinate public health activities as requested by the Division of Public Health Services during any disease outbreak and/or emergency, natural or man-made, affecting the public's health.

4. The Contractor is responsible for case management of the client enrolled in the program and for program follow-up activities. Case management services shall promote effective and efficient organization and utilization
   of resources to assure access to necessary comprehensive medical, nutritional, and social services for clients.

5. The Contractor shall assure that appropriate, responsive, and timely referrals and linkages for other needed services are made, carried through, and documented. Such services shall include, but not be limited to: dental services, genetic counseling, high risk prenatal services, mental health, social services, including domestic violence crisis centers, substance abuse services; and family planning services, Early Supports and Services Program, local WIC/CSF Program, Home Visiting New Hampshire Programs and health and social service agencies which serve children and families in need of those services.

D) Meetings and Trainings

The contractor will be responsible for sending staff to meetings and training required by the MCHS program, including but not limited to:

1. MCHS Agency Directors' meetings
2. Prenatal and Child Health Coordinators' meetings
3. MCHS Agency Medical Services Directors' meetings

III. Quality or Performance Improvement (QI/PI)

A) Workplans

1. Performance Workplans are required for this program and are used to monitor achievement of standard measures of performance of the services provided under this contract. The workplans are a key component of the RHPCS and the MCHS performance-based contracting system and of this contract. Outcomes shall be reported by clinical site.
2. Performance Workplans and Workplan Outcome reports according to the schedule and instructions provided by the MCHS. The MCHS shall notify the Contractor at least 30 days in advance of any changes in the submission schedule.
3. The Contractor shall incorporate required and developmental performance measures, defined by the MCHS into the agency's Performance Workplan. Reports on Workplan Progress/Outcomes shall detail the Performance Workplan plans and activities that monitor and evaluate the agency's progress toward performance measure targets.
4. The Contractor shall comply with modifications and/or additions to the workplan and annual report format as requested by RHPCS and MCHS. MCHS will provide the contractor with reasonable notice of such changes.
5. Agencies contracting for Primary Care Services must submit the workplans for Primary Care Clinical and Financial, Child Health, and Prenatal Care.

B) Additional Reporting requirements

In addition to Performance Workplans, the Contractor shall submit to MCHS the following data and information listed below which are used to monitor program performance:

1. In years when contracts or amendments are not required, the DPHS Budget Form, Budget Justification, Sources of Revenue and Program Staff list forms must be

completed according to the relevant instructions and submitted as requested by DPHS and, at minimum, by April 30 of each year.

2. The Sources of Revenue report must be resubmitted at any point when changes in revenue threaten the ability of the agency to carry out the planned program.

3. Completed Uniform Data Set (UDS) tables reflecting program performance in the previous calendar year, by March 31 of each year.

4. The Perinatal Client Data Form (PCDF) shall be submitted electronically according to the instructions set forth by the MCHS.

5. A copy of the agency's updated Sliding Fee Scale including the amount(s) of any client fees and the schedule of discounts must be submitted by March 31st of each year. The agency's sliding fee scale must be updated annually based on the US DHHS Poverty guidelines as published in the Federal Register.

6. An annual summary of program-specific patient satisfaction results obtained during the prior contract period and the method by which the results were obtained shall be submitted annually as an addendum to the Workplan Outcome/Progress reports.

C) On-site reviews

1. The contractor shall allow a team or person authorized by the Division of Public Health Services to periodically review the contractor's systems of governance, administration, data collection and submission, clinical and financial management, and delivery of education services in order to assure systems are adequate to provide the contracted services.
2. Reviews shall include client record reviews to measure compliance with this exhibit.
3. The contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.

4. On-Site reviews may be waived or abbreviated at the discretion of MCHS, upon submission of satisfactory reports of reviews such as Health Services Resources Administration (HRSA): Office of Performance Review (OPR), or reviews from nationally accreditation organizations such as the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), Medicare, the Community Health Accreditation Program (CHAP), Accreditation Association for Ambulatory Healthcare (AAAHC), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey. Abbreviated reviews will focus on any deficiencies found in previous reviews, issues of compliance with this exhibit, and actions to strengthen performance as outlined in the agency Performance Workplan.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE CHILD HEALTH DIRECT CARE SERVICES
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Please note, for all measures, the following should be used **unless otherwise indicated:**

- Less than 19 years of age
- Served within the scope of this MCH contract during State Fiscal Year 2015 (July 1, 2014 – June 30, 2015)
- Each client can only be counted once (unduplicated)

Child Health Direct (CH – D) Performance Measure #1

Measure: 92%* of eligible children will be enrolled in Medicaid

Goal: To increase access to health care for children through the provision of health insurance

Definition: **Numerator-**
Of those in the denominator, the number of children enrolled in Medicaid.

Denominator-
Number of children who meet all of the following criteria:

- Less than 19 years of age
- Had 3 or more visits/encounters** during the reporting period
- As of the last visit during the reporting period were eligible for Medicaid

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**An encounter is face to face contact between a user and a provider who exercises independent judgment in the provision of services to the individual (UDS Table Definition).

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #2

Measure: 85%* of at-risk** children who were screened for blood lead between 18 and 30 months of age

Goal: To prevent childhood lead poisoning through early identification of lead exposure

Definition: **Numerator-**
Of those in the denominator, number of children screened for blood lead by capillary or venous on or after their 18-month birthday and prior to their 30-month birthday.

Denominator-
Number of at-risk** children who reached age 30 months during the reporting period. If discharged prior to 30 months, do not include in denominator.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**At risk = During the reporting period, the children were 18-29 months of age, and fit at least one of the following criteria:

- "Low income" (less than 185% poverty guidelines)
- Over 185% and resided in a town considered needing "Universal" screening per NH Childhood Lead Poisoning Prevention Program
- Over 185%, resided in a town considered "Target" and had a positive response to the risk questionnaire
- Refugee children -A refugee is defined as a person outside of his or her country of nationality who is unable or unwilling to return because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion (U.S. Citizenship and Immigration Services definition).

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #3

Measure: 71%* of children age two to nineteen years receiving primary care preventive health services with a Body Mass Index (BMI) percentile greater than or equal to the 85%ile with documented discussion of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Goal: To increase the percent of children receiving primary care preventive health services who have an elevated BMI percentile who receive guidance about promoting a healthier lifestyle.

Definition: **Numerator-**
Of those in the denominator, the number of children who had documentation in their medical record of there being discussion at least once during the reporting period of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Denominator-
Number of children who turned twenty-four months during or before the reporting period, up to the age of nineteen years, with one or more well child visit after their twenty-fourth month of age within the reporting year, and had an age and gender appropriate BMI percentile greater than or equal to the 85 % percentile at least once during the reporting period.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

Rationale: Children between the 85th – 94th percentiles BMI are encouraged to have 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks. (Discussion of the importance of family meal time, limiting eating out, consuming a healthy breakfast, preparing own foods, and promotion of breastfeeding is also encouraged.) American Academy of Pediatrics' guidance for Prevention and Treatment of Childhood Overweight and Obesity, (http://www.aap.org/obesity/health_professionals.html), from AAP Policy Statement: *Prevention of Pediatric Overweight and Obesity* and the AAP endorsed Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Children and Adolescent Overweight and Obesity, 2007.

*Target based on 2012 & 2013 Data Trend Table averages.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) #4

Measure: 75%* of eligible** infants and children with client record documentation of enrollment in WIC

Goal: To increase access to nutrition education, breastfeeding support, and healthy food through enrollment in the WIC Nutrition Program

Definition: **Numerator** -
Of those in the denominator, the number of infants and children who, as of the last well child visit during the reporting period, had client record documentation that infant or child was enrolled in WIC.

Denominator -
Unduplicated number of infants and children less than 5 years of age, enrolled in the agency, during the reporting period, who were eligible** for WIC.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**WIC Eligibility Requirements:

- Infants, and children up to their fifth birthday
- Must be income eligible (income guidelines are up to 185% of federal gross income, and are based on family size)

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #5

Measure: 23%* of infants who were exclusively** breastfed for the first three months, at their four month well baby visit

Goal: To provide optimum nutrition to infants in their first three months of life

Definition: **Numerator -**
Of those in the denominator, the number of infants who had client record documentation that the infant had been exclusively breastfed for their first three months when checked at their four month well baby visit.

Denominator -
Number of infants who received one or more visits during or before the reporting period and were seen for a four-month well baby visit during the reporting period.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

Benmarks: 2011 PedNSS (WIC) exclusive at 3 months: NH 22.9%, National (2010) 10.7%
2013 CDC Report Card (NIS, provisional 2010 births): NH 49.5%, National 37.7%
Healthy People 2020 goal: 44%

Rationale: The AAP recommends exclusive breastfeeding for about 6 months, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant, a recommendation concurred to by the World Health Organization and the Institute of Medicine. (American Academy of Pediatrics Policy Statement on Breastfeeding and the Use of Human Milk, 2012)

*Target based on 2012 & 2013 Data Trend Table averages.
**Exclusive means breast milk only, no supplemental formula, cereal/baby food, or water/fluids.

PRIMARY CARE: ADULT

PERFORMANCE MEASURES DEFINITIONS

State Fiscal Year 2015

Primary Care: Adult Performance Measure #1

Measure:* 58%** of adult patients 18 – 85 years of age diagnosed with hypertension will have a blood pressure measurement less than 140/90*** mm at the time of their last measurement.

Goal: To ensure patients diagnosed with hypertension are adequately controlled.

Definition: **Numerator-** Number of patients from the denominator with blood pressure measurement less than 140/90 mm at the time of their last measurement.

Denominator- Number of patients age 18 – 85 with diagnosed hypertension must have been diagnosed with hypertension 6 or more months before the measurement date. (Excludes pregnant women and patients with End Stage Renal Disease.)

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

*Measure based on the National Quality Forum 0018

**Health People 2020 National Target is 61.2%

***Both the numerator and denominator must be less that 140/90 mm

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE CLINICAL
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Primary Care Clinical Adolescent (PC-C) Performance Measure #1

Measure: 61%* of adolescents aged 11-21 years received an annual health maintenance visits in the past 12 months.

Goal: To enhance adolescent health by assuring annual, recommended, adolescent well -visits.

Definition:

Numerator-
Number of adolescents in the denominator who received an annual health maintenance "well" visit during the reporting year.

Denominator-
Total number of adolescents aged 11-21 years who were enrolled in the primary care clinic as primary care clients during the reporting year period.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

***Target based on 2012 & 2013 Data Trend Table averages.**

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Primary Care Clinical Prenatal (PC-C) Performance Measure #2

Measure: 31%* of women and adolescent g[illegible]s aged 15-44 take multi-vitamins with folic acid.

Goal: To enhance pregnancy outcomes by reducing neural tube defects.

Definition:

Numerator-
The number of women and adolescent girls aged 15-44 who take a multi-vitamin with folic acid.

Denominator-
The number of women and adolescent girls aged 15-44 who were seen in primary care for a well visit in the past year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

***Target based on 2012 & 2013 Data Trend Table averages.**

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE - FINANCIAL
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Primary Care (PC) Performance Measure #1

Measure: Patient Payor Mix

Goal: To allow monitoring of payment method trends at State funded primary care sites.

Definition: Patients enrolled in Medicare, Medicaid, Commercial insurance, or uninsured.

Data Source: Provided by agency

Primary Care (PC) Performance Measure #2

Measure: Accounts Receivables (AR) Days

Goal: To allow monitoring of financial sustainability trends at State funded primary care sites.

Definition: AR Days: Net Patient Accounts Receivable **multiplied by** 365 **divided by** Net Patient Revenue

Data Source: Provided by agency

Primary Care (PC) Performance Measure #3

Measure: Current Ratio

Goal: To allow monitoring of financial sustainability trends at State funded primary care sites.

Definition: Current Ratio = Current Assets **divided by** Current Liabilities

Data Source: Provided by agency

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRENATAL
PERFORMANCE MEASURES DEFINITIONS
State Fiscal Year 2015

Prenatal (PN) Performance Measure #1

Measure: 85%* of pregnant women who are enrolled in the agency's prenatal program will begin prenatal care during the first trimester of pregnancy.

Goal: To enhance pregnancy outcomes by assuring early entrance into prenatal care.

Definition:

Numerator-
Number of women in the denominator who had a documented prenatal visit during the first trimester (on or before 13.6 weeks gestation).

Denominator-
Number of women enrolled in the agency prenatal program who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

* Target based on 2012 & 2013 Data Trend Table averages.

Prenatal (PN) Performance Measure #2

Measure: 20%* of pregnant women who are identified as cigarette smokers will be referred to QuitWorks-New Hampshire.

Goal: To reduce tobacco use during pregnancy through focused tobacco use cessation activities at public health prenatal clinics.

Definition:

Numerator-
Number of women in the denominator who received at least one referral to QuitWorks-New Hampshire during pregnancy.

A referral is defined as signing the patient up for QuitWorks-NH via phone, fax, or EMR. It is not defined as discussing QuitWorks-NH with the patient and encouraging her to sign up.

Denominator-
Number of women enrolled in the agency prenatal program and identified as tobacco users who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

*Target set in consultation with the NH Tobacco Program & FY13 Data Trend Table average.

Prenatal (PN) Performance Measure #3

Measure: 79%* of pregnant women will be screened, using a formal valid screening tool, for alcohol and other substance use during every trimester they are enrolled in the prenatal program.

Goal: To reduce prenatal substance use through systematic screening and identification.

Definition: **Numerator-** Number of women in the denominator who were screened for substance and alcohol use, using a formal and valid screening tool, during each trimester that they were enrolled in the prenatal program.

Denominator- Number of women enrolled in the agency prenatal program and who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

* Target based on 2012 & 2013 Data Trend Table averages.

Exhibit B-1 (2014) -Amendment 1
Budget

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: Lamprey Health Care, Inc.

Budget Request for: MCH Primary Care
(Name of RFP)

Budget Period: SFY 2014

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages	$ 95,863.00	$ -	$ 95,863.00	
2. Employee Benefits	$ 23,965.00	$ -	$ 23,965.00	
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	$ -	$ -	$ -	
13. Other (specific details mandatory):	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
TOTAL	**$ 119,828.00**	**$ -**	**$ 119,828.00**	

Indirect As A Percent of Direct 0.0%

Contractor Initials: ______

Date: 3-12-14

Exhibit B-1 (2015) -Amendment 1
Budget

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: Lamprey Health Care, Inc.

Budget Request for: MCH Primary Care & BCCP
(Name of RFP)

Budget Period: SFY 2015

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages	$ 500,196.00	$ -	$ 500,196.00	0
2. Employee Benefits	$ 124,191.00	$ -	$ 124,191.00	0
3. Consultants	$ -	$ -	$ -	0
4. Equipment:	$ -	$ -	$ -	0
Rental	$ -	$ -	$ -	0
Repair and Maintenance	$ -	$ -	$ -	0
Purchase/Depreciation	$ -	$ -	$ -	0
5. Supplies:	$ -	$ -	$ -	0
Educational	$ -	$ -	$ -	0
Lab	$ -	$ -	$ -	0
Pharmacy	$ -	$ -	$ -	0
Medical	$ -	$ -	$ -	0
Office	$ -	$ -	$ -	0
6. Travel	$ -	$ -	$ -	0
7. Occupancy	$ -	$ -	$ -	0
8. Current Expenses	$ -	$ -	$ -	0
Telephone	$ -	$ -	$ -	0
Postage	$ -	$ -	$ -	0
Subscriptions	$ -	$ -	$ -	0
Audit and Legal	$ -	$ -	$ -	0
Insurance	$ -	$ -	$ -	0
Board Expenses	$ -	$ -	$ -	0
9. Software	$ -	$ -	$ -	0
10. Marketing/Communications	$ -	$ -	$ -	0
11. Staff Education and Training	$ -	$ -	$ -	0
12. Subcontracts/Agreements	$ -	$ -	$ -	0
13. Other - CLINICAL SERVICES	$ 29,862.00	$ -	$ 29,862.00	0
	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
	$ -	$ -	$ -	0
TOTAL	**$ 654,249.00**	**$ -**	**$ 654,249.00**	0

Indirect As A Percent of Direct 0.0%

Contractor Initials: [signature]

Date: 3-12-14

State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that LAMPREY HEALTH CARE, INC. is a New Hampshire nonprofit corporation formed August 16, 1971. I further certify that it is in good standing as far as this office is concerned, having filed the return(s) and paid the fees required by law.

In TESTIMONY WHEREOF, I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 10th day of April A.D. 2013

William M. Gardner
Secretary of State

CERTIFICATE OF VOTE/AUTHORITY

I, Janis Reams, of the Lamprey Health Care, do hereby certify that:

1. I am the duly elected Secretary of the Lamprey Health Care;

2. The following are true copies of two resolutions duly adopted at a meeting of the Board of Directors of the Lamprey Health Care, duly held on March 5, 2014;

   RESOLVED: That this corporation enters into any and all contracts, amendments, renewals, revisions or modifications thereto, with the State of New Hampshire, acting through its Department of Health and Human Services, Division of Public Health Services.

   RESOLVED: That the President and Vice-President are hereby authorized on behalf of this corporation to enter into said contracts with the State and to execute any and all documents, agreements, and other instruments; and any amendments, revisions, or modifications thereto, as he/she may deem necessary, desirable, or appropriate. Audrey Ashton – Savage is the duly elected President of the corporation and George Donovan is the duly elected Vice-President of the corporation.

3. The foregoing resolutions have not been amended or revoked and remain in full force and effect as of March 5th, 2014.

IN WITNESS WHEREOF, I have hereunto set my hand as the Secretary of the corporation this 12th day of March, 2014.

Janis Reams

Janis Reams, Secretary

STATE OF NEW HAMPSHIRE
COUNTY OF ROCKINGHAM

The foregoing instrument was acknowledged before me this 12th day of March, 2014 by Janis Reams.

Michelle L Gaudet

Notary Public
My Commission Expires:

MICHELLE L. GAUDET, Notary Public
My Commission Expires August 22, 2017

Client#: 246027 LAMPREYHEA1

ACORD™ **CERTIFICATE OF LIABILITY INSURANCE**

DATE (MM/DD/YYYY) 03/07/2014

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 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
HUB Healthcare Solutions
HUB International New England, LLC
136 Turnpike Road, Suite 105
Southborough, MA 01772

CONTACT NAME: Amanda Keaveney
PHONE (A/C, No, Ext): 508-303-9471 FAX (A/C, No): 508-303-9476
E-MAIL ADDRESS: amanda.keaveney@hubinternational.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Philadelphia Indemnity	
INSURER B : Atlantic Charter	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Lamprey Health Care, Inc.
207 South Main Street
Newmarket, NH 03857

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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT LOC			PHPK1032990	07/01/2013	07/01/2014	EACH OCCURRENCE	$1,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$1,000,000
							MED EXP (Any one person)	$20,000
							PERSONAL & ADV INJURY	$1,000,000
							GENERAL AGGREGATE	$3,000,000
							PRODUCTS - COMP/OP AGG	$3,000,000
								$
A	AUTOMOBILE LIABILITY X ANY AUTO ALL OWNED AUTOS / SCHEDULED AUTOS X HIRED AUTOS / X NON-OWNED AUTOS			PHPK1032990	07/01/2013	07/01/2014	COMBINED SINGLE LIMIT (Ea accident)	$1,000,000
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
A	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DED X RETENTION $10,000			PHUB423959	07/01/2013	07/01/2014	EACH OCCURRENCE	$5,000,000
							AGGREGATE	$5,000,000
								$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		WCA00545401	07/01/2013	07/01/2014	X WC STATU-TORY LIMITS OTH-ER	
							E.L. EACH ACCIDENT	$500,000
							E.L. DISEASE - EA EMPLOYEE	$500,000
							E.L. DISEASE - POLICY LIMIT	$500,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
For Record Purposes

CERTIFICATE HOLDER
DHHS
Contracts and Procurement Unit
129 Pleasant Street
Concord, NH 03301

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

AUTHORIZED REPRESENTATIVE

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LAMPREY HEALTH CARE, INC.
AND
FRIENDS OF LAMPREY HEALTH CARE, INC.

AUDITED CONSOLIDATED FINANCIAL STATEMENTS

SEPTEMBER 30, 2013 AND 2012

BRAD BORBIDGE, P.A.
CERTIFIED PUBLIC ACCOUNTANTS
197 LOUDON ROAD, SUITE 350
CONCORD, NEW HAMPSHIRE 03301

TELEPHONE 603/224-0849
FAX 603/224-2397

Independent Auditor's Report on Consolidated Financial Statements

Board of Directors
Lamprey Health Care, Inc. and
Friends of Lamprey Health Care, Inc.
Newmarket, New Hampshire

We have audited the accompanying consolidated financial statements of Lamprey Health Care, Inc. and Friends of Lamprey Health Care, Inc., which comprise the balance sheets as of September 30, 2013 and 2012, the related statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's 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, the auditor considers internal control relevant to the entity'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 entity'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 opinions.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Lamprey Health Care, Inc. and Friends of Lamprey Health Care, Inc. as of September 30, 2013 and 2012, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating statements are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the consolidating statements are fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying schedule of expenditures of federal awards is presented for purposes of additional analysis as required by U.S. Office of Management and Budget Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations, and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the schedule of expenditures of federal awards is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated December 19, 2013, on our consideration of the Association's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and important for assessing the results of our audit.

Concord, New Hampshire
December 19, 2013

LAMPREY HEALTH CARE, INC.
AND FRIENDS OF LAMPREY HEALTH CARE, INC.

CONSOLIDATED BALANCE SHEETS

SEPTEMBER 30, 2013 AND 2012

ASSETS

	2013	2012
Current Assets		
Cash and cash equivalents	$ 2,141,018	$ 1,645,176
Accounts receivable, less allowance for doubtful accounts of $136,707 and $133,624 at September 30, 2013 and 2012, respectively	697,315	770,908
Grants receivable	2,342,884	2,251,407
Other receivables	285,546	372,770
Other current assets	101,303	109,491
Total Current Assets	5,568,066	5,149,752
Assets Limited As To Use	1,983,526	1,613,108
Property And Equipment, Net	8,247,061	8,539,363
TOTAL ASSETS	$ 15,798,653	$ 15,302,223

LIABILITIES AND NET ASSETS

	2013	2012
Current Liabilities		
Accounts payable and accrued expenses	$ 172,258	$ 317,177
Accrued salaries and related expenses	1,004,995	852,333
Due to third party payers	73,250	73,250
Deferred revenue	2,547,702	2,457,045
Current maturities of long-term debt	106,330	101,378
Total Current Liabilities	3,904,535	3,801,183
Long-term Debt, Less Current Maturities	2,738,135	2,900,729
Total Liabilities	6,642,670	6,701,912
Net Assets		
Unrestricted	8,733,063	8,084,907
Temporarily restricted	422,920	515,404
Total Net Assets	9,155,983	8,600,311
TOTAL LIABILITIES AND NET ASSETS	$ 15,798,653	$ 15,302,223

(See accompanying notes to these consolidated financial statements)

LAMPREY HEALTH CARE, INC.
AND FRIENDS OF LAMPREY HEALTH CARE, INC.

CONSOLIDATED STATEMENTS OF OPERATIONS

FOR THE YEARS ENDED SEPTEMBER 30, 2013 AND 2012

	2013	2012
Operating Revenue		
Patient service revenue	$ 6,801,083	$ 6,692,069
Provision for bad debts	(401,602)	(324,237)
Net patient service revenue	6,399,481	6,367,832
Grants, contracts, and contributions, net	3,933,920	4,376,140
Other operating revenue	2,470,950	1,056,114
Interest income	1,879	1,812
Total Operating Revenue	12,806,230	11,801,898
Operating Expenses		
Payroll and related expenses	9,366,421	8,893,431
Other operating expenses	2,495,061	2,349,344
Depreciation	379,796	381,313
Interest expense	134,376	127,818
Total Operating Expenses	12,375,654	11,751,906
OPERATING INCOME AND EXCESS OF REVENUE OVER EXPENSES PRIOR TO LOSS FROM FLOOD DAMAGE	430,576	49,992
Loss From Flood Damage, Net	-	(154,501)
EXCESS (DEFICIT) OF REVENUE OVER EXPENSE AFTER LOSS FROM FLOOD DAMAGE	$ 430,576	$ (104,509)

(See accompanying notes to these consolidated financial statements)

LAMPREY HEALTH CARE, INC.
AND FRIENDS OF LAMPREY HEALTH CARE, INC.

CONSOLIDATED STATEMENT OF CHANGES IN NET ASSETS

FOR THE YEARS ENDED SEPTEMBER 30, 2013 AND 2012

	2013	2012
Unrestricted Net Assets:		
Excess (Deficit) of revenue over expenses after loss from flood damage	$ 430,576	$ (104,509)
Grant for capital acquisitions	-	2,000
Change in fair value of financial instrument	56,115	(59,678)
Net assets released from restrictions for capital acquisitions	161,465	9,229
Increase (Decrease) in Unrestricted Net Assets	648,156	(152,958)
Temporarily Restricted Net Assets:		
Contributions	68,981	108,377
Net assets released from restrictions for capital acquisitions	(161,465)	(9,229)
(Decrease) Increase in Temporarily Restricted Net Assets	(92,484)	99,148
Change in Net Assets	555,672	(53,810)
Net assets, beginning of year	8,600,311	8,654,121
NET ASSETS, END OF YEAR	$ 9,155,983	$ 8,600,311

(See accompanying notes to these consolidated financial statements)

LAMPREY HEALTH CARE, INC.
AND FRIENDS OF LAMPREY HEALTH CARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

FOR THE YEARS ENDED SEPTEMBER 30, 2013 AND 2012

	2013	2012
Cash Flows From Operating Activities		
Change in net assets	$ 555,672	$ (53,810)
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Provision for bad debt	401,602	324,237
Depreciation	379,796	381,313
Grant for capital acquisitions	-	(2,000)
Change in fair value of financial instrument	(56,115)	59,678
Restricted contributions	(68,981)	(108,377)
(Increase) decrease in the following assets:		
Patients accounts receivable	(328,009)	(356,141)
Grants receivable	(91,477)	509,778
Other receivables	87,224	(83,653)
Other current assets	8,188	16,815
Increase (decrease) in the following liabilities:		
Accounts payable and accrued expenses	(144,919)	(169,082)
Accrued payroll and related expenses	152,662	(66,570)
Deferred revenue	90,657	6,256
Net Cash Provided by Operating Activities	986,300	458,444
Cash Flows From Investing Activities:		
Increase in assets limited as to use	(370,418)	(141,815)
Capital expenditures	(87,494)	(286,215)
Net Cash Used by Investing Activities	(457,912)	(428,030)

LAMPREY HEALTH CARE, INC.
AND FRIENDS OF LAMPREY HEALTH CARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS (CONTINUED)

FOR THE YEARS ENDED SEPTEMBER 30, 2013 AND 2012

	2013	2012
Cash Flows From Financing Activities		
Grants for capital acquisition	-	2,000
Restricted contributions	68,981	108,377
Principal payments on long-term debt	(101,527)	(93,815)
Net Cash (Used) Provided by Financing Activities	(32,546)	16,562
Net Increase in Cash and Cash Equivalents	495,842	46,976
Cash and Cash Equivalents, Beginning of Year	1,645,176	1,598,200
CASH AND CASH EQUIVALENTS, END OF YEAR	$ 2,141,018	$ 1,645,176
Supplemental disclosure of cash flow information:		
Cash paid for interest	$ 134,376	$ 127,818

(See accompanying notes to these consolidated financial statements)

LAMPREY HEALTH CARE

Our Mission

The mission of Lamprey Health Care is to provide high quality primary medical care and health related services, with an emphasis on prevention and lifestyle management, to all individuals regardless of ability to pay.

We seek to be **a leader in providing access** to medical and health services that improve the health status of the individuals and families in the communities we serve.

Our mission is to **remove barriers that prevent access to care**; we strive to eliminate such barriers as language, cultural stereotyping, finances and/or lack of transportation.

Lamprey Health Care's **commitment to the community** extends to providing and/or coordinating access to a full range of comprehensive services.

Lamprey Health Care is committed to achieving the highest level of patient satisfaction through a personal and caring approach and **exceeding standards of excellence in quality and service**.

Our Vision

We will be the **outstanding primary care choice** for our patients, our communities and our service area, and the standard by which others are judged.

We will continue as **pacesetter** in the use of new knowledge for lifestyle improvement, quality of life.
We will be a **center of excellence** in service, quality and teaching.

We will be **part of an integrated system** of care to ensure access to medical care for all individuals and families in our communities.

We will be an **innovator** to foster development of the best primary care practices, adoption of the tools of technology and teaching.

We will **establish partnerships**, linkages, networks and referrals with other organizations to provide access to a full range of services to meet our communities' needs.

Our Values

We exist to **serve the needs of our patients**.

We value a positive **caring approach** in delivering patient services.

We are committed to **improving the health** and total well-being of our communities.

We are committed to **being proactive** in identifying and meeting our communities' health care needs.

We provide a supportive environment for **the professional and personal growth, and healthy lifestyles of our employees**.

We provide an **atmosphere of learning** and growth for both patients and employees as well as for those seeking training in primary care.

We succeed by utilizing a **team approach** that values a positive, constructive commitment to Lamprey Health Care's mission.

LAMPREY HEALTH CARE

Board of Directors
2014

Audrey Ashton-Savage
President, Director
Term Ends 2015

George D. Donovan, Jr.
Vice President, Director
Term Ends 2016

Carol LaCross
Treasurer, Director
Term Ends 2015

Janis Reams
Secretary, Director
Term Ends 2016

Elizabeth Crepeau
Immediate Past President, Director
Term ends 2015

Thomas "Chris" Drew
Director
Term Ends 2016

Cynthia Giguere-Unrein
Director
Term Ends 2016

Raymond Goodman, III
Director
Term ends 2016

Frank Goodspeed
Director
Term Ends 2014

Mark E. Howard, Esq.
Director
Term Ends 2014

Amanda Pears Kelly
Director Term Ends 2014

Michael Merenda
Director
Term Ends 2015

December 18, 2013

KEY ADMINISTRATIVE PERSONNEL

NH Department of Health and Human Services

Contractor Name: Lamprey Health Care

Name of Bureau/Section: MCH Primary Care

BUDGET PERIOD: SFY 14

Program Area: MCH Primary Care

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Greg White	CEO	$159,975	0.00%	$0.00
Sandra Pardus	CFO/Chief Information Officer	$111,400	0.00%	$0.00
Marcy Doyle	COO	$90,850	69.50%	$63,140.75
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$63,140.75**

KEY ADMINISTRATIVE PERSONNEL

NH Department of Health and Human Services

Contractor Name: Lamprey Health Care

Name of Bureau/Section: MCH Primary Care & BCCP

BUDGET PERIOD: SFY 15

Program Area: MCH Primary Care Services

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Greg White	CEO	$159,975	0.00%	$0.00
Sandra Pardus	CFO/Chief Information Officer	$111,400	0.00%	$0.00
Marcy Doyle	COO	$90,850	69.50%	$63,140.75
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$63,140.75**

Program Area: Breast and Cervical Cancer Program Services

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Greg White	CEO	$159,975	0.00%	$0.00
Sandra Pardus	CFO/Chief Information Officer	$111,400	0.00%	$0.00
Marcy Doyle	COO	$90,850	0.00%	$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$0.00**

Gregory A. White, CPA

207 South Main Street
Newmarket, NH 03857
(603) 659-2494
gwhite@lampreyhealth.org

Summary

Senior Level Executive with extensive hands-on experience in management, business leadership, and working with boards, banks and other external stake holders. A CPA with an established record of success in Community Health Center management. Strong in budgets, cash forecasts, grants, and team leadership.

Professional Experience

Lamprey Health Care – Newmarket, NH **2013 to present**

Chief Executive Officer

- Responsible for the leadership, operation and overall strategic direction of New Hampshire's largest Federally Qualified Health Center.
- Ensuring continuity and high quality primary medical care in three sites, both urban rural, serving over 16,000 patients in 40 communities.
- Leading a high performing senior management team in the direction of over 150 staff and providers.
- Engaging with leaders and stakeholders at the local, state and national levels to ensure that Lamprey is at the forefront of innovative, high quality health care delivery.

Lowell Community Health Center – Lowell, MA **2009 to 2013**

Chief Financial Officer

- Responsible for the integrity of financial information and systems for this Federally Qualified Health Center, employing 315 staff and providing over 120,000 visits annually. Upgraded financial and administrative infrastructure to meet requirements during a time of rapid expansion.
- Lead the financing and budget development for a $42 million capital facility project to include: traditional debt, multiple tax credit sources, federal grants, loan guarantees, and private funds.
- Directed key projects for: 340(b) pharmacy implementation; 403(b) tax deferred savings plan; multiple federal stimulus grants; and revised operating budget development.
- Representative to the Lowell General PHO for managed care contract negotiation
- Recruited and managed a team of five directors to oversee and manage four support and one programmatic department

Manchester Community Health Center – Manchester, NH **1999 to 2009**

Chief Financial Officer

- Recruited by the CEO to bring structure and process to the functional areas of the Center's financial operations. Provided direction and oversight to key business areas; General Administration, Patient Registration, Human Resources, FTCA/Legal and Medical Records.

Gregory A. White, CPA
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(603) 659-2494
gwhite@lampreyhealth.org

- Responsible for the development of key programs, Corporate Compliance, HIPAA, selection of a new practice management system. Supported Joint Commission accreditation and the implementation of an electronic medical record system.
- Led the development of financing for the Center's new facility.

Greater Lawrence Family Health Center – Lawrence, MA **1993 to 1998**

Controller **1997 to 1998**

Accounting Manager **1995 to 1997**

Senior Accountant/Analyst **1993 to 1995**

- Progressively responsible for all day to day financial operations of a Federally Qualified Health Center, including: Accounts Payable, Payroll, General Ledger, Cash Management, Cost Reporting, Patient Accounts, and Financial Reporting. Presented budgets, analysis, projections and periodic reporting to the Board of Directors.
- Key leader for projects involving: selection of new financial accounting software; selection of new practice management system; provider productivity measurement and analysis and group purchasing. Oversaw budget of $5 million construction project.
- Developed reimbursement model for an innovative Family Practice Residency program.

Alexander, Aronson, Finning & Co., CPA's – Westborough, MA **1990 to 1993**

Staff Accountant/Auditor

Education & Professional Affiliations

Babson College, Wellesley, MA

BS, Accounting - 1990

Commonwealth of Massachusetts

Certified Public Accountant- 1996

Healthcare Financial Management Association

Certified Healthcare Financial Professional - 2008

National Association of CHC's

Excel Leadership Program - 2003

National Registry of Emergency Medical Technicians

EMT - N.H. license number 18991-I

Boards, Advisory & Volunteer Experience

Massachusetts League of Community Health Centers – Special Finance Committee

SANDRA KNORR PARDUS
207 South Main Street
Newmarket, NH 03857
(603) 659-2494
spardus@lampreyhealth.org

EXPERIENCE

Chief Fiscal Officer/Chief Information Officer **April 1981 to Present**
Lamprey Health Care, Inc., Newmarket, NH

- Facilitated the operational planning and budgeting and implementation for $12+ million Federally Qualified Health Center (FQHC). Net income was within 1% of budget for all years.
- Negotiated financing for the construction of eight medical/administrative facilities.
- Raised funds and implemented Electronic Health Record for four medical sites.
- Implemented Health Information Exchange for network of 10 FQHC's
- Played key role in discussion with New Hampshire's Department of Health and Human Services (DHHS) to insure adequate APM reimbursement for FQHC's in State of NH including the development of an FQHC billing manual.
- Led Accounting and IT Departments in the screening and hiring of audit professionals for 403B, annual and Security audits.
- Negotiated with managed care companies on contracts for commercial and Medicaid managed care.
- Researched and implemented 403B vendors with focus on performance and compliance.
- Developed an analysis of needs and possible vendors for insurance services, moving business to an A+ broker with a cost savings of 10%.
- Centralized purchasing role for the agency, standardizing supplies ordered with savings of 15%.
-

Network Information Officer
Community Health Access Network **July 1996 to present**

- Instrumental in the formation of a Health Center Controlled Network (HCCN), Community Health Access Network (CHAN), to standardize clinical operations between 10 FQHC's.
- Led the implementation of EHR at 10 member sites.
- Played key role in a major security upgrade to the CHAN infrastructure.
- Assisted in the development of standards for HCCN's through a Health Resources and Services Administration (HRSA) funded program focused on the expansion of HCCN's.

PROFESSIONAL MEMBERSHIP
National Association of Community Health Centers
Health Information and Management Systems Society

COMMITTEES
Bi-State Primary Care Association Finance Committee
Health Information and Management Systems Society Davies Award Committee

TRAININGS AND EDUCATION

Boston University, Boston, MA
Master of Business Administration
Information Systems Concentration, June 1991

University of New Hampshire, Durham, NH
Bachelor of Science, 1981

Harvard School of Public Health
Leadership Strategies for Information Technologies in Health Care, 2011

National Association of Community Health Centers (NACHC)
NACHC Financial and Operations Training Level 1, 2 and 3

AWARDS

2008 **HIMMS Davies Award of Excellence** was awarded to CHAN and Lamprey Health Care for their excellence in the implementation and value of health information technology and electronic health records (EHR).

2006 **Jeffrey T. Latman Award for Leadership in Health Care Finance** to Sandra Pardus by National Association of Community Health Centers for her achievements as an outstanding fiscal officer.

Marcy Doyle, MHS, MSN, RN, CNL

207 South Main Street **(603) 659-2494**
Newmarket, NH 03857 **mdoyle@lampreyhealth.org**

Education

University of New Hampshire 1/05-12/06
Masters of Nursing in Clinical Nurse Leadership

Johns Hopkins University, School of Hygiene & Public Health 9/97-5/99
Masters of Health Science
Certificate in Health Care Finance and Management

University of New Hampshire 8/93-5/97
Bachelors of Science in Microbiology

Awards

2004 Achievement and Innovations Award for *Best New Report Solution* presented by Centricity Healthcare Users Group to Community Health Access Network at General Electric's annual medical conference. Spearheaded report solution which improved data access for eight New Hampshire health centers locations.

Professional Employment

Lamprey Healthcare
Chief Operating Officer 12/12-present
Director of Quality 06/09- 12/12

- Responsible for educating and coordinating Joint Commission readiness efforts for the organization, participating in corporate quality initiatives, and supporting medical executive PI initiatives.
- Leads new quality initiatives, such as NCQA medical home
- Researches and recommends implementation of "evidence-based" performance measures
- Coordinates the integration of a "dashboard" for clinical outcomes, critical interventions, cost, utilization, and satisfaction
- Responsible for electronic improvements and leadership. Works with CEO and site leadership to advance electronic use/implementation

Site Administrator 08/09-present

- Responsible for operations management of the Newmarket site, including budget management, personnel management, patient satisfaction, risk management, productivity performance, facility maintenance, policies and procedures and overall financial management and leadership of the center.

Performance Improvement Coordinator 09/07-06/09

- Responsible for leading and evaluating a comprehensive Performance Improvement Initiative
- Coordinates Joint Commission readiness efforts for the organization, participating in corporate performance improvement initiatives, and supporting medical executive PI initiatives.
- Translates organizational values, goals and objectives to physicians/managers/staff and others.

Family Planning and Community Education Director 09/07-present

- Ensure that client needs are met and quality standards are maintained and monitored in a cost effective manner by: supervising program personnel, annually assessing relevance of current programs to community needs; achieving and maintaining appropriate standards/guidelines as determined by title X legislation.
- Ensure the LHC/Nashua Site Family Planning Services are consistent with LHC's mission, values, and the strategic plan to ensure family planning programming is relevant to existing and emerging client and community needs.

Clinical Systems Analyst 3/06-01/08

- Evaluated clinical microsystems to determine if electronic solutions could be applied to increase the quality of health care provided, reduce financial risk and optimized workflows
- Identified clinical and cost outcomes that improve safety, effectiveness, timeliness, efficiency, quality and the degree to which they are client-centered
- Used information systems and technology at the point of care to improve health-care outcomes
- Assimilated and applied researched-based information to design, implement and evaluate client care plans

Frisbie Memorial Hospital
Consultant 12/05-12/06

- Reduced administrative tasks via the development of billing reports
- Streamlined outpatient oncology clinical workflows via the use of reports
- Developed monitoring system to retain and increase internal and external surgery referrals
- Oversaw the integrity of all Crystal Reports® during the Centricity® upgrade from EMR 5.5 to EMR 2005

Community Health Access Network 12/05-9/06
Consultant

- Optimized health care reporting by developing tables in the MS SQL 2000 Database Server

Community Health Access Network
Disease Management Patient Service Coordinator 8/01-1/05

- Assisted community health centers with the development and implementation of chronic disease management programs
- Assisted with program marketing and implementation
- Collaborated with partner agencies to establish community based programs
- Designed surveys to assess program deployment and sustainability
- Managed large scale mailings
- Evaluated the use of workflows and disease management tools to improve outcomes

Clinical Data Analyst 9/02-1/05

- Developed and prepared in-depth clinical, operational and administrative reports to assist high-level internal and external audiences in trend analysis and quality improvement
- Identified information management inefficiencies and formulated recommendations for improvement
- Developed population based reports to improve health outcomes
- Implemented Crystal Enterprise Reporting System to facilitate report deployment among eight community health centers in southern New Hampshire
- Oversaw the development and submission of chronic care data to the Health Disparities Collaborative
- Dramatically expanded CHAN's reporting portfolio and data capture abilities. Reports included: lifecycle reports, prevention reports, chronic care reports, case management reports, health outcome reports, safety monitoring and risk reports.

Lowell Community Health Center *1/00-1/01*
Medication Adherence Program Coordinator/Counselor

- Educated, advocated and provided service assessment/planning for HIV positive patients and their families
- Developed and implemented medication adherence program
- Improved treatment outcomes in diverse HIV positive population by developing behavioral models to increase medication compliance
- Designed both internal and external workshops targeted at a variety of audiences
- Assisted director in writing and obtaining funding through grant opportunities
- Contacted and built relationships with other service organizations
- Collaborated with infectious disease specialists, primary care providers and patients to assist in treatment planning
- Assisted program director in obtaining speakers to lecture on a variety of topics
- Maintained HIV educational library for providers, patients and health center staff

New Hampshire Public Laboratories, Concord, NH 5/97-9/97
Laboratory Assistant

- Resolved data conflicts with providers regarding specimens and patient information
- Revised infectious disease policies/procedures
- Developed an electronic inventory tracking system

Computer Skills

- Experienced with Crystal Reports, Crystal Enterprise, Centricity Medical Record, Microsoft Office®, SQL and TOAD

STATE OF NEW HAMPSHIRE

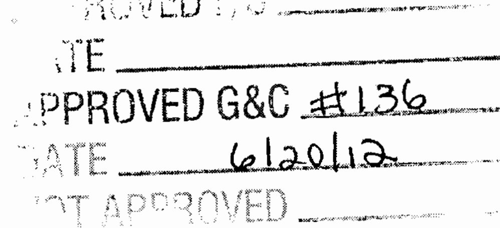
DEPARTMENT OF HEALTH AND HUMAN SERVICES

29 HAZEN DRIVE, CONCORD, NH 03301-6527
603-271-4517 1-800-852-3345 Ext. 4517
Fax: 603-271-4519 TDD Access: 1-800-735-2964

Nicholas A. Toumpas
Commissioner

José Thier Montero
Director

May 2, 2012



His Excellency, Governor John H. Lynch
and the Honorable Executive Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Public Health Services, Bureau of Population Health and Community Services, Maternal and Child Health Section, to enter into an agreement with Lamprey Health Care, Inc. (Vendor #177677-B001), 207 South Main Street, Newmarket, New Hampshire 03857, in an amount not to exceed $922,436.00, to provide primary care services and breast and cervical cancer screening, to be effective July 1, 2012 or date of Governor and Executive Council approval, whichever is later, through June 30, 2014. Funds are available in the following accounts for SFY 2013, and are anticipated to be available in SFY 2014 upon the availability and continued appropriation of funds in the future operating budgets.

05-95-90-902010-5190 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES, MATERNAL AND CHILD HEALTH

Fiscal Year	Class/Object	Class Title	Job Number	Total Amount
SFY 2013	102-500731	Contracts for Program Services	90080000	$401,151
SFY 2014	102-500731	Contracts for Program Services	90080000	$401,151
			Sub-Total	$802,302

05-95-90-902010-5659 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES, COMPREHENSIVE CANCER

Fiscal Year	Class/Object	Class Title	Job Number	Total Amount
SFY 2013	102-500731	Contracts for Program Services	90080081	$60,067
SFY 2014	102-500731	Contracts for Program Services	90080081	$60,067
			Sub-Total	$120,134
			Total	$922,436

EXPLANATION

Funds in this agreement will be used to provide breast and cervical cancer screening and office-based primary care services for low-income and uninsured families. This agreement provides funds for services as a last resort; contractor is required to make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid.

Primary health care services include preventive and episodic health care for acute and chronic health conditions for people of all ages, including pregnant women, children, adolescents, adults, and the elderly. Community health agencies that receive support through the Division of Public Health Services deliver primary and preventive health care services to underserved people who face barriers to accessing health care, due to issues such as a lack of insurance, inability to pay, language barriers, and geographic isolation. In addition to medical care, community health centers are unique among primary care providers for the array of patient-centered services they offer, including care coordination, translation, transportation, outreach, eligibility assistance, and health education. These services help individuals overcome barriers to getting the care they need and achieving their optimal health. One area of particular success has been in ensuring that eligible families maintain consistent enrollment in Medicaid for their children. Community health centers provide support for families in filling out applications and ensuring that children have continuity of care.

Community health agencies throughout New Hampshire have demonstrated success in meeting the health care needs of the uninsured and under-insured citizens of the state. Division of Public Health Services funded primary care providers participate in rigorous quality improvement efforts utilizing standard performance measures that focus attention on improving health outcomes for patients. For example, in State Fiscal Year 2011:

- 88% of eligible children served were enrolled in Medicaid/Healthy Kids Gold.
- 86% of children 24-35 months, served received the appropriate schedule of immunizations.
- 82% of infants born to women served received prenatal care beginning in the first trimester of pregnancy.

In addition, breast and cervical cancers continue to be ongoing public health issues for New Hampshire. The Division of Public Health Services, Breast and Cervical Cancer Screening Program provides support for breast and cervical cancer screening services that include clinical examinations, pap smears and referral for mammography. Through this program, women found to have abnormal screening results, following their testing, receive additional coverage for diagnostic work-up and, if necessary, have their care coordinated through the initiation of treatment.

Should Governor and Executive Council not authorize this Request, a minimum of 32,570 low-income individuals from the following areas Amherst, Brookline, Hollis, Hudson, Litchfield, Lyndeborough, Merrimack, Milford, Mount Vernon, Nashua, Pelham, Wilton, Barrington, Brentwood, Candia, Chester, Danville, Exeter, Fremont, Lee, Newfields, Newmarket, Northwood, Nottingham, Raymond and Stratham may not have access to primary care services, and eligible women may not receive recommended breast and cervical cancer screenings. A strong primary care infrastructure reduces costs for uncompensated care, improves health outcomes, and reduces health disparities. Additionally women that receive recommended breast and cervical cancer screenings are at lower risk of late diagnosis of breast and cervical cancers.

Lamprey Health Care, Inc. was selected for this project through a competitive bid process. A Request for Proposals was posted on the Department of Health and Human Services' web site from January 10, 2012 through February 16, 2012. In addition, a bidder's conference, conference call, and web conference were held on January 19, 2012 to alert agencies to this bid.

Thirteen proposals were received in response to the posting. Each proposal was scored by three professionals, who work internal and external to the Department of Health and Human Services. All reviewers have between three to twenty years experience either in clinical settings, providing community-based family support services, and managing agreements with vendors for various public health programs. Areas of specific expertise include maternal and child health; quality assurance and performance improvement; chronic and communicable diseases and public health infrastructure. The reviewers used a standardized form to score agencies' relevant experience and capacity to carry out the activities outlined in the proposal. Reviewers look for realistic targets when scoring performance measures in addition to detailed workplans including evaluation components. Budgets were reviewed to be reasonable, justified and consistent with the intent of the program goals and outcomes. There were no competing applications within each of the separate service areas. Scores were averaged and all proposals were recommended for funding. In those instances where scores were less than ideal, agency specific remedial actions were recommended and completed. Some primary care agencies are being funded at levels higher than they requested. Agencies were instructed to develop budgets based on previous allocations. While some proposed budgets higher than what was available for funding, others proposed budgets lower than what was available. There was an increase in breast and cervical cancer screening funds that bidders were unaware of when they drafted budgets. Adjustments were made accordingly for those agencies that proposed budgets at levels lower than available funds. This is a contract where that situation occurred. The Bid Summary is attached.

As referenced in the Request for Proposals, Renewals Section, this competitively procured Agreement has the option to renew for two additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties and approval of the Governor and Executive Council. These services were contracted previously with this agency in SFY 2011 and SFY 2012 in the amount of $1,478,362. This represents a decrease of $555,926. The decrease is due to budget reductions.

The performance measures used to measure the effectiveness of the agreement are attached.

Area served: Amherst, Brookline, Hollis, Hudson, Litchfield, Lyndeborough, Merrimack, Milford, Mount Vernon, Nashua, Pelham, Wilton, Barrington, Brentwood, Candia, Chester, Danville, Exeter, Fremont, Lee, Newfields, Newmarket, Northwood, Nottingham, Raymond and Stratham.

Source of Funds: 30.38% Federal Funds from US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau and 69.62% General Funds.

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

Respectfully submitted,

José Thier Montero, MD
Director

Approved by:
Nicholas A. Toumpas
Commissioner

JTM/PMT/sc

Primary Care Performance Measures

State Fiscal Year 2013

Primary Care Prenatal (PN) Performance Measure #1

Measure: Percent of infants born to women receiving prenatal care beginning in the first trimester of pregnancy.

Primary Care Prenatal (PN) Performance Measure #2

Measure: Percent of pregnant women identified as cigarette smokers that are referred to QuitWorks-New Hampshire.

Primary Care Prenatal (PN) Performance Measure #3

Measure: Percent of pregnant women who were screened, using a formal valid screening tool, for alcohol and other drug use during every trimester the patient was enrolled.

Primary Care Child Health Direct (CH – D) Performance Measure #1

Measure: Percent of eligible children enrolled in Medicaid

Primary Care Child Health Direct (CH – D) Performance Measure #2

Measure: Percent of at-risk children who were screened for blood lead between 18 and 30 months of age

Primary Care Child Health Direct (CH – D) Performance Measure #3

Measure: Percent of children age two to nineteen years receiving primary care preventive health services with a Body Mass Index (BMI) percentile greater than or equal to the 85th percentile with documented discussion of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Primary Care Child Health Direct (CH – D) Performance Measure #4

Measure: Percent of eligible infants and children with client record documentation of enrollment in Women Infant Children Program.

Primary Care Child Health Direct (CH – D) Performance Measure #5

Measure: Percent of infants who were exclusively breastfed for the first three months, at their four month well baby visit.

Primary Care Financial (PC) Performance Measure #1

Measure: Patient Payor Mix

Primary Care Financial (PC) Performance Measure #2

Measure: Accounts Receivables (AR) Days

Primary Care Financial (PC) Performance Measure #3

Measure: Current Ratio

Primary Care Performance Measures

State Fiscal Year 2013

Primary Care Clinical Adolescent (PC-C) Performance Measure #1

Measure: Percent of adolescents aged 10-21 years who received annual health maintenance visits in the past 12 months.

Primary Care Clinical Prenatal (PC-C) Performance Measure #2

Measure: Percent of women and adolescent girls aged 15-44 who take a multi-vitamin with folic acid.

Subject: Primary Care Services

AGREEMENT

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

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name NH Department of Health and Human Services Division of Public Health Services		**1.2 State Agency Address** 29 Hazen Drive Concord, NH 03301-6504	
1.3 Contractor Name Lamprey Health Care, Inc.		**1.4 Contractor Address** 207 South Main Street Newmarket, New Hampshire 03857	
1.5 Contractor Phone Number 603-659-2494	**1.6 Account Number** 010-090-5190-102-500731 010-090-5659-102-500731	**1.7 Completion Date** June 30, 2014	**1.8 Price Limitation** $922,436
1.9 Contracting Officer for State Agency Joan H. Ascheim, Bureau Chief		**1.10 State Agency Telephone Number** 603-271-4501	
1.11 Contractor Signature E. Crepeau 3.28.2012		**1.12 Name and Title of Contractor Signatory** Elizabeth Crepeau, President	

1.13 Acknowledgement: State of New Hampshire, County of Rockingham

On 3/28/2012, before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.

1.13.1 Signature of Notary Public or Justice of the Peace

[Seal] [signature]

Anita R. Rozeff, Notary Public

My commission expires March 16, 2016

1.13.2 Name and Title of Notary or Justice of the Peace

ANITA R. Rozeff, Notary Public

1.14 State Agency Signature [signature]	**1.15 Name and Title of State Agency Signatory** Joan H. Ascheim, Bureau Chief

1.16 Approval by the N.H. Department of Administration, Division of Personnel ***(if applicable)***

By: Director, On:

1.17 Approval by the Attorney General (Form, Substance and Execution)

By: [signature] Jeanne P. Herrick, Attorney On: 14 May 2012

1.18 Approval by the Governor and Executive Council

By: On:

NH Department of Health and Human Services

Exhibit A

Scope of Services

Primary Care Services

CONTRACT PERIOD: July 1, 2012 or date of G&C approval, whichever is later, through June 30, 2014

CONTRACTOR NAME: Lamprey Health Care, Inc.

ADDRESS: 207 South Main Street
Newmarket, New Hampshire 03857
Chief Executive Officer: Ann Peters
TELEPHONE: 603-659-2494

The Contractor shall:

I. General Provisions

A) Eligibility and Income Determination

1. Office-based primary care services will be provided to low-income individuals and families (defined as ≤ 185% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), in the State of New Hampshire.

2. Breast and Cervical Cancer screening services will be provided to low-income (defined as ≤ 250% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), New Hampshire women age 18 – 64, ***uninsured or underinsured.***

3. The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing if, at any time, the practice is closed to new patients, or maintains a wait list for new patients, or any other mechanism is used that limits access for new patients for more than a one month period.

4. The Contractor shall document annually, for each client enrolled in the program, family income and family size, and calculate percentage of the federal poverty level. If calculations indicate that the client may be eligible for enrollment in Medicaid, the Contractor shall complete with the client the most recent version of the 800P form.

5. The Contractor shall implement, and post in a public and conspicuous location, a sliding fee payment schedule, approved in advance by the Division of Public Health Services (DPHS), for low-income patients. Signage must state that no client will be denied services for inability to pay.

   a. As an alternative, the contractor may post, in a public and conspicuous location, a notice to clients that a sliding fee scale is available and that no client will be denied services for inability to pay. The sliding fee scale must be updated annually based on USDHHS Poverty guidelines as published in the Federal Register, submitted to and approved by DPHS *prior to implementation.*

6. The primary care contract entered into here shall be the payer of last resort. The contractor shall make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid, for all reimbursable services rendered.

B) Numbers Served

1. The contract funds shall be expended to provide the above services to a minimum of 16,285 users annually with 70,075 medical encounters, as defined in the Data and Reporting Requirements. Breast and Cervical Cancer Screening for eligible women, as defined by the Breast and Cervical Cancer Program (BCCP), shall be provided to 300 women annually and billed directly to the BCCP. Clinical service reimbursements shall not exceed the Medicare rate.

C) Culturally and Linguistically Appropriate Standards of Care

The Department of Health and Human Services (DHHS) recognizes that culture and language have considerable impact on how consumers access and respond to public health services. Culturally and linguistically diverse populations experience barriers in efforts to access health services. To ensure equal access to quality health services, the Division of Public Health Services (DPHS) expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.

2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.

3. *Provide* clients of limited English proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.

4. Offer consumers a forum through which clients have the opportunity to provide feedback to providers and organizations regarding cultural and linguistic issues that may deserve response.

5. The contractor shall maintain a program policy that sets forth compliance with Title VI, Language Efficiency and Proficiency Citation 45 CFR 80.3(b) (2). The policy shall describe the way in which the items listed above were addressed and shall indicate the circumstances in which interpretation services are provided and the method of providing service (e.g. trained interpreter, staff person who speaks the language of the client, language line).

D) State and Federal Laws

The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. The Contractor shall report all cases of communicable diseases according to New Hampshire RSA 141-C and He-P 301, adopted 6/3/08.

2. Persons employed by the contractor shall comply with the reporting requirements of New Hampshire RSA 169:C, Child Protection Act; RSA 161:F46, Protective Services to Adults, RSA 631:6, Assault and Related Offences and RSA 130:A, Lead Paint Poisoning and Control.

3. Immunizations shall be conducted in accordance with RSA 141-C and the Immunization Rules promulgated hereunder.

E) Relevant Policies and Guidelines

1. The Contractor shall design and provide the services described above to meet the unique and identified health needs of the populations within the contracted service area.

Contractor Initials: ELC

Date: 3 29 2012

2. Primary Care funds shall be targeted to populations in need. Populations in need are defined as follows:

   a) uninsured;

   b) under-insured;

   c) families and individuals with significant psychosocial and economic risk, including low income status;

   d) all life cycles including perinatal, child, adolescent, adult, and elderly who meet one or more of the above criteria.

3. The Contractor shall design and implement systems of governance, administration, financial management, information management, and clinical services which are adequate to assure the provision of contracted services, and to meet the data and reporting requirements. These systems shall meet the most current minimum standards described in at least one of the following: Health Resources and Services Administration (HRSA) Office of Performance Review protocols, Joint Commission on Accreditation of Health Care Organizations (JCAHO), Accreditation Association for Ambulatory Healthcare (AAAHC), Community Health Accreditation Program (CHAP), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey.

4. *The Contractor shall have an agency emergency preparedness and response plan in accordance with HRSA Health Center Emergency Management Program Expectations, Document #2007-15 or most recent version. Such plan shall also include a Continuity of Operations plan.*

5. The Contractor shall carry out the work as described in the performance Workplan submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

6. No Workplan is required by the Breast and Cervical Cancer Program (BCCP). The contractor shall be required to respond to the Quality Improvement Feedback Report twice a year.

7. The Contractor shall carry out the work as described in the Supplemental Funding Form submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

F) Publications Funded Under Contract

1. The DHHS and/or its funders will retain COPYRIGHT ownership for any and all original materials produced with DHHS contract funding, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports.

2. All documents (written, video, audio, *electronic*) produced, reproduced, or purchased under the contract shall have prior approval from DPHS before printing, production, distribution, or use.

3. The Contractor shall credit DHHS on all materials produced under this contract following the instructions outlined in Exhibit C (14).

G) Subcontractors

1. If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing *and approve the subcontractual agreement,* prior to initiation of the subcontract.

2. In addition, the original DPHS contractor will remain liable for all requirements included in this Exhibit and carried out by subcontractors.

II. Minimal Standards of Core Services

A) Service Requirements

1. *Medical Home*

The Contractor shall provide a Medical Home that:

a) *Facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family.*

b) ***Provides care facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.***

2. Primary Care Services

The Contractor shall provide office-based primary care services to populations in need who reside in the contractor's service area. Primary care services shall include:

a) Health care provided by a New Hampshire licensed MD, DO, APRN, or PA, including diagnosis and treatment of acute and chronic illnesses within the scope of family practice; preventive services, screenings, and health education according to established, documented state or national guidelines; assessment of need for social and nutrition services, and appropriate referrals to health, ***oral health***, and behavioral health specialty providers.

b) ***Referral to the WIC Nutrition Program for all eligible pregnant women, infants and children.***

c) In-hospital care for conditions within the scope of family practice must be provided at a hospital, within the agency service area, through a staff clinician with full hospital privileges, or in the alternative, through a formal referral and admissions procedure available to clients on a 24 hour/7 day a week basis.

d) Access to a healthcare provider, directly or by referral or subcontract, by telephone twenty-four hours per day, seven days per week.

e) Assessment of psychosocial risk for all clients at least annually and for children at scheduled preventive care visits, including, at a minimum, age appropriate assessment of safety in the home, domestic violence, adequacy of food and housing, care and welfare of children, transportation needs, and provision of necessary social services to address the priority needs and safety issues of clients and families.

f) Falls prevention screening for patients 65 years and older using the algorithm and guidelines of the American Geriatrics Society.

g) Behavioral health care directly or by referral to an agency or provider with a sliding fee scale.

h) *Nutrition assessment for all clients as part of the health maintenance visit.* Therapeutic nutrition services shall be provided *as indicated* directly or by referral to an agency or provider with a sliding fee scale. These services shall be recorded in the medical record.

i) Formal arrangements with a local hospital for emergency care must be in place and reviewed annually.

Contractor Initials: ELC

Date: 3-29-2012

j) Home health care directly or by referral to an agency or provider with a sliding fee scale.

k) Assisted living and skilled nursing facility care by referral.

l) *Oral screening annually for all clients 19 years and older to note obvious dental decay and soft tissue abnormalities with a reminder to the patient that poor oral health impacts total health.*

m) *Diagnosis and management of pediatric and adult patients with asthma provided according to National Heart Lung Blood Institute, National Asthma Education and Prevention Program, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, 2007.*

2. Breast and Cervical Cancer Screening

   a) Women age 18 to 64 who are eligible for Breast and Cervical Cancer Program (BCCP) services according to income (equal to or under 250% of poverty, underinsured/uninsured) *and insurance status* criteria shall be provided the following services:

      i. cervical cancer screening including a pelvic examination and Pap smear;
      ii. annual breast cancer screening including a clinical breast exam, mammogram and,
      iii. referrals for diagnostic and treatment services based on screening results,
      iv. case management services.

   b) All referrals under this provision shall be to approved certified laboratory, pathology, radiology, and surgical services. Mammography units shall be accredited by the American College of Radiology, and must be FDA certified under MQSA. Laboratories shall be CLIA certified.

   c) All services shall be provided in accordance with the Breast and Cervical Cancer Program (BCCP) Policy and Procedure Manual.

   d) Follow-up and tracking of all tests done, and referrals made shall be provided in accordance with the minimum standards outlined in the Breast and Cervical Cancer Program Policy and Procedure Manual.

   e) All services for women enrolled in the Breast and Cervical Cancer Program (BCCP) shall be billed directly to the BCCP in accordance with protocols established by the Breast and Cervical Cancer Program.

3. Reproductive Health Services

   The Contractor shall provide prenatal, interconceptional and preconception medical care, social services, nutrition services, education, and nursing care to all women of childbearing age. Preconceptional care includes the preconception, interconceptional, and postpartum periods in women's health. It is recommended that preconceptional and interconceptional care visits focus on maintaining or achieving the optimal health of the mother, lowering the risk of future adverse pregnancy outcomes, the family's future plans, and how additional children fit into that plan. Preconceptional counseling may be done during an office, group or home visit.

   a) In the event prenatal care is not provided directly by the Contractor a formal Memorandum/a of Agreement for coordinated referral to an appropriately qualified provider must be maintained.

   b) Prenatal care shall, at minimum, be provided in accordance with the Guidelines for Perinatal Care, sixth or most current edition, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and /or the Centers for Disease Control.

Contractor Initials: ELC

Date: 3 28 2012

c) Age appropriate reproductive health care shall, at a minimum, be provided in accordance with the American College of Obstetricians and Gynecologists, or the USDHHS Centers for Disease Control (CDC) current guidelines.

d) *Pregnant women enrolled in the WIC Nutrition Program shall be referred to WIC for breastfeeding education and referral to the WIC Nutrition Program peer counselors.*

e. Family planning counseling for prevention of subsequent pregnancy following an infant's birth shall be discussed with the infant's mother *at the first postpartum visit and at the infant's 2-month visit and other visits as appropriate.* Rationale for birth intervals of 18-24 months shall be presented.

f) A referral to a Title X Family Planning Clinic or other reproductive health care provider shall be made as appropriate.

4. Services for Children and Adolescents

The Contractor shall provide as a minimum, comprehensive and age-appropriate health care, screenings, and health education according to the American Academy of Pediatrics' most recent periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent. Children and adolescent visits shall include:

a) Blood lead testing shall be performed in accordance with "New Hampshire Childhood Lead Poisoning Screening and Management Guidelines", issued by the New Hampshire Department of Health and Human Services, 2009 or subsequent revisions.

b) All children enrolled in either Healthy Kids-Gold or the Women, Infant, and Children (WIC) Program and/or who are ≤ 185% poverty, regardless of town of residence, are required to have a blood lead test at ages one and two years. All children ages three to six years who have not been previously tested shall have a capillary or venous blood lead test performed.

c) All children shall be screened for iron deficiency anemia as outlined in the Centers for Disease Control and Prevention document "Recommendations to Prevent and Control Iron Deficiency in the United States (4/2/98)".

d) Age-appropriate anticipatory guidance, dietary guidance, and *feeding practice counseling* for optimal oral health shall be provided at each well child visit according to the American Academy of Pediatrics' periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent edition. Starting at age 6 months, it is recommended that all children receive an oral health assessment at every well child visit.

e) Supplemental fluoride shall be prescribed as needed based upon the fluoride levels in the child's *drinking* water supply. The fluoride dosage regimen accepted by the American Academy of Pediatrics shall be followed. No fluoride shall be prescribed without obtaining water from private wells or noting the presence or absence of fluoride in the public water supply. *Supplemental fluoride may include bottled water containing fluoride and topical applications such as varnishes.*

f) *For infants enrolled in the WIC Nutrition Program, parents shall be referred to WIC for breastfeeding support and referral to the WIC Nutrition Program peer counselors.*

Contractor Initials: SLC

Date: 3-28-2012

5. Sexually Transmitted Infections

Primary Care Services shall provide age appropriate screening and treatment of sexually transmitted infections.

a) Treatment for sexually transmitted infections shall be provided according to the United States Centers for Disease Control Sexually Transmitted Diseases Treatment Guidelines, 2010 or subsequent revisions.

b) All clients, including women, shall be offered HIV testing following the most current recommendations of the United States Centers for Disease Control.

c) The contractor shall be responsible for ensuring referral to appropriate treatment services for any woman found to screen positive.

d) Appropriate risk reduction counseling shall be provided based on client needs.

6. Substance Use Services

a) A substance use screening history using a formal, validated screening tool shall be obtained for all clients as soon after entry into care as possible. Substance use counseling *or other substance abuse intervention, treatment, or recovery services* by an appropriately credentialed provider shall be provided on-site, or by referral, to clients with identified needs for these services. ***For these identified clients, ongoing primary care services should include follow up monitoring relative to substance abuse.***

b) All clients, including pregnant women, identified as smokers shall receive counseling *using the 5A's (ask, advise, assess, assist, and arrange) treatment available through the NH Tobacco Helpline* as cited in the US Public Health Services report "Tobacco Use and Dependence", 2008, or "Smoking Cessation During Pregnancy: *A Clinician's Guide to Helping Pregnant Women Quit Smoking*", American College of Obstetricians and Gynecologists, 2011. *With prior approval, agencies may also opt to participate in the DPHS best practice initiative of the 2A's and R (ask, advise and refer).*

7. Immunizations

a) The Contractor shall adhere to the most current version of the "Recommended Adult Immunization Schedule United States", approved by the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

b) The Contractor shall administer vaccines according to the most current version of the *"Recommended Immunization Schedule for Persons Aged 0 Through 6 Years - United States", and "Recommended Immunization Schedule for Persons Aged 7 Through 18 Years – United States"* approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians, based upon availability of vaccine from the New Hampshire Immunization Program.

8. Prenatal Genetic Screening

a) A genetic screening history shall be obtained on all prenatal clients as soon after entry into care as possible.

b) All pregnant women should be offered voluntary genetic screening for fetal chromosomal abnormalities at the appropriate time following recommendations found in the American College of Obstetricians and Gynecologists' "Screening for Fetal Chromosomal

Abnormalities (2007)" or more recent guidelines. The Contractor shall be responsible for ensuring referral to appropriate genetic testing and counseling for any woman found to have a positive screening test.

9. Additional Requirements

   a) The Contractor's Medical Director shall participate in the development and approval of specific guidelines for medical care that supplement minimal clinical standards. Supplemental guidelines should be reviewed, signed, and dated annually, and updated as indicated.

   b) Contractors considering clinical or sociological research using clients as subjects must adhere to the legal requirements governing human subjects research. Contractors must inform the DPHS, MCHS prior to initiating any research related to this contract.

   c) *The Contractor shall provide information to all employees annually about the Medical Reserve Corps Unit within their Public Health Region to enhance recruitment.*

   d) *The Contractor shall provide information to all employees annually regarding the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) managed by the NH Department of Health and Human Services' Emergency Services Unit, to enhance recruitment.*

B) Staffing Provisions

The Contractor shall have, at minimum, the following staff positions:

a) executive director

b) fiscal director

c) registered nurse

d) clinical coordinator

e) medical service director

f) nutritionist *(on site or by referral)*

g) social worker

Staff positions required to provide direct services on-site include:

a) registered nurse

b) clinical coordinator

c) social worker

1. Qualifications

   All health and allied health professionals shall have the appropriate New Hampshire licenses whether directly employed, contracted, or subcontracted.

   In addition the following minimum qualifications shall be met for:

   a) Registered Nurse

a. A registered nurse licensed in the state of New Hampshire. Bachelor's degree preferred. Minimum of one-year experience in a community health setting.

b) Nutritionists:
   a. A Bachelor's degree in nutritional sciences or dietetics, or a Master's degree in nutritional sciences, nutrition education, or public health nutrition or current Registered Dietitian status in accordance with the Commission on dietetic Registration of the American Dietetic Association.

   b. Individuals who perform functions similar to a nutritionist but do not meet the above qualifications shall not use the title of nutritionist.

c) Social Workers shall have:
   a. A Bachelor's or Master's degree in social work or Bachelor's or Master's degree in a related social science or human behavior field. A minimum of one year of experience in a community health or social services setting is preferred.

   b. Individuals who perform functions similar to a social worker but do not meet the above qualifications shall not use the title of social worker.

d) Clinical Coordinators shall be:
   a. A registered nurse (RN), physician, physician assistant, or nurse practitioner with a license to practice in New Hampshire.
   b. The coordinator is a clinical position that oversees and takes responsibility for the clinical and administrative functions of each program.
   c. The coordinator may be responsible for more than one MCH funded program.

2. New Hires

The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing within one month of hire when a new administrator, clinical coordinator, or any staff person essential to carrying out contracted services is hired to work in the program. A resume of the employee shall accompany the aforesaid notification.

3. Vacancies

a) The Contractor must notify the MCHS in writing if any critical position is vacant for more than one month, or if at any time funded under this contract does not have adequate staffing to perform all required services for more than one month. This may be done through a budget revision.

b) Before an agency hires new program personnel that do not meet the required staff qualifications, the agency shall notify the MCHS in writing requesting a waiver of the applicable staffing requirements. The Section may grant waivers based on the need of the program, individuals' experience, and additional training.

C) **Coordination of Services**

1. The Contractor shall coordinate, where possible, with other service providers within the contractor's community. At a minimum, such collaboration shall include interagency referrals and coordination of care.

2. The Contractor shall participate in activities *in the Public Health Region in which they provide services* as appropriate. These activities enhance the integration of community-based public health

prevention and health care initiatives that are being implemented by the contractor and may include community needs assessments, public health performance assessments, and/or the development of regional health improvement plans.

3. The Contractor agrees to *participate* in and coordinate public health activities as requested by the Division of Public Health Services during any *disease outbreak* and/or *emergency*, natural or man made, affecting the public's health.

4. The Contractor is responsible for case management of the client enrolled in the program and for program follow-up activities. Case management services shall promote effective and efficient organization and utilization of resources to assure access to necessary comprehensive medical, nutritional, and social services for clients.

5. The Contractor shall assure that *appropriate, responsive, and timely* referrals and linkages for other needed services are made, carried through, and documented. Such services shall include, but not be limited to: dental services, genetic counseling, high risk prenatal services, mental health, social services, including domestic violence crisis centers, substance abuse services; and family planning services, Early Supports and Services Program, local WIC/CSF Program, Home Visiting New Hampshire Programs and health and social service agencies which serve children and families in need of those services.

D) Meetings and Trainings

The contractor will be responsible for sending staff to meetings and training required by the MCHS program, including but not limited to:

1. MCHS Agency Directors' meetings

2. Prenatal and Child Health Coordinators' meetings

3. MCHS Agency Medical Services Directors' meetings

III. Quality or Performance Improvement (QI/PI)

A) Workplans

1. Performance Workplans are required for this program and are used to monitor achievement of standard measures of performance of the services provided under this contract. The workplans are a key component of the RHPCS and the MCHS performance-based contracting system and of this contract. Outcomes shall be reported by clinical site.

2. Submit Performance Workplans and Workplan Outcome reports according to the schedule and instructions provided by the MCHS. The MCHS shall notify the Contractor at least 30 days in advance of any changes in the submission schedule.

3. The Contractor shall incorporate required and developmental performance measures, defined by the MCHS into the agency's Performance Workplan. Reports on Workplan Progress/Outcomes shall detail the Performance Workplan plans and activities that monitor and evaluate the agency's progress toward performance measure targets.

4. The Contractor shall comply with modifications and/or additions to the workplan and annual report format as requested by RHPCS and MCHS. MCHS will provide the contractor with reasonable notice of such changes.

5. Agencies contracting for Primary Care Services must submit the workplans for Primary Care *Clinical and Financial*, Child Health, and Prenatal Care.

Contractor Initials: ELC

Date: 3-29-2012

B) Additional Reporting requirements

In addition to Performance Workplans, the Contractor shall submit to MCHS the following data and information listed below which are used to monitor program performance:

1. In years when contracts or amendments are not required, the DPHS Budget Form, Budget Justification, Sources of Revenue and Program Staff list forms must be completed according to the relevant instructions and submitted as requested by DPHS and, at minimum, by April 30 of each year.

2. The Sources of Revenue report must be resubmitted at any point when changes in revenue threaten the ability of the agency to carry out the planned program.

3. Completed Uniform Data Set (UDS) tables reflecting program performance in the previous calendar year, by March 31 of each year.

4. The Perinatal Client Data Form (PCDF) shall be submitted electronically according to the instructions set forth by the MCHS.

5. A copy of the agency's updated Sliding Fee Scale including the amount(s) of any client fees and the schedule of discounts must be submitted by March 31st of each year. The agency's sliding fee scale must be updated annually based on the US DHHS Poverty guidelines as published in the Federal Register.

6. An annual summary of program-specific patient satisfaction results obtained during the prior contract period and the method by which the results were obtained shall be submitted annually as an addendum to the Workplan Outcome/Progress reports.

C) On-site reviews

1. The contractor shall allow a team or person authorized by the Division of Public Health Services to periodically review the contractor's systems of governance, administration, data collection and submission, clinical and financial management, and delivery of education services in order to assure systems are adequate to provide the contracted services.
2. Reviews shall include client record reviews to measure compliance with this exhibit.
3. The contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.
4. On-Site reviews may be waived or abbreviated at the discretion of MCHS, upon submission of satisfactory reports of reviews such as Health Services Resources Administration (HRSA): Office of Performance Review (OPR), or reviews from nationally accreditation organizations such as the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), Medicare, the Community Health Accreditation Program (CHAP), Accreditation Association for Ambulatory Healthcare (AAAHC), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey. Abbreviated reviews will focus on any deficiencies found in previous reviews, issues of compliance with this exhibit, and actions to strengthen performance as outlined in the agency Performance Workplan.

State of New Hampshire
Department of Health and Human Services
Amendment #1 to the
Manchester Community Health Center

This 1st Amendment to the Manchester Community Health Center contract (hereinafter referred to as "Amendment One") dated this 12th day of March, 2014, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Manchester Community Health Center (hereinafter referred to as "the Contractor"), a corporation with a place of business at 145 Hollis Street, Manchester, New Hampshire 03101.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on June 20, 2012, 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, the State and the Contractor have agreed to make changes to the scope of work, payment schedules and terms and conditions of the contract; and

WHEREAS, pursuant to the General Provisions, Paragraph 18, the State may modify the scope of work and the payment schedule of the contract by written agreement of the parties;

WHEREAS, the Department desires to provide additional primary health care services for preventive and episodic health care for acute and chronic health conditions for people of all ages.

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 as follows:

To amend as follows:

- Form P-37, to change:
  Block 1.7 to read: June 30, 2015
  Block 1.8 to read: $1,051,425

- Exhibit A, Scope of Services to add:
  Exhibit A – Amendment 1

- Exhibit B, Purchase of Services, Contract Price, to add:

  Paragraph 1.1 to Paragraph 1:
  The contract price shall increase by $71,392 for SFY 2014 and $407,637 for SFY 2015.

  Paragraph 1.2 to Paragraph 1:
  Funding is available as follows:
- $71,392 from 05-95-90-902010-5190-102-500731, 100% General Funds;
- $357,989 from 05-95-90-902010-5190-102-500731, 6.7% Federal Funds from the US Department of Health and Human Services Administration, Maternal and Child Health Bureau, CFDA #93.994 and 93.3% General Funds;

Contractor Initials: LK
Date: 3/12/14

- $49,648 from 05-95-90-902010-5659-102-500731, 100% Federal Funds from the US Department of Health and Human Services, Centers for Disease Control and Prevention, CFDA #93.283;

  Add Paragraph 8
  8. Notwithstanding paragraph 18 of the General Provisions P-37, an amendment limited to adjustments to amounts between and among account numbers, within the price limitation, may be made by written agreement of both parties and may be made without obtaining approval of the Governor and Executive Council.

- Budget, to add:
  Exhibit B-1 (2014) - Amendment 1,
  Exhibit B-1 (2015) - Amendment 1

This amendment shall be in effect July 1, 2013, effective upon the date of Governor and Executive Council approval.

Contractor Initials:
Date:

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

3/28/14
Date

Brook Dupee
Bureau Chief

Manchester Community Health Center

3/12/14
Date

Name: Kirsten Mackneicen
Title: President/CEO

Acknowledgement:

State of New Hampshire, County of Hillsborough on 3/12/14, before the undersigned officer, personally appeared the person identified above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.

LAURIE A. GARLAND MY COMMISSION EXPIRES FEB. 12, 2019 NOTARY PUBLIC NEW HAMPSHIRE

Signature of Notary Public or Justice of the Peace

Laurie Garland, Notary Public
Name and Title of Notary or Justice of the Peace

Contractor Initials: KM
Date: 3/12/14

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

OFFICE OF THE ATTORNEY GENERAL

4-3-14
Date

Name: Rosemary Wiant
Title: Asst Attorney General

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:

Contractor Initials: [initials]
Date: 3/12/14

EXHIBIT A – AMENDMENT 1

Scope of Services

The Department desires to continue the relationship with the primary care agencies to provide additional primary health care services for preventive and episodic health care for acute and chronic health conditions for people of all ages.

I. General Provisions

A) Eligibility and Income Determination

1. Office-based primary care services will be provided to low-income individuals and families (defined as ≤ 185% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), in the State of New Hampshire.

2. Breast and Cervical Cancer screening services will be provided to low-income (defined as ≤ 250% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), New Hampshire women age 21– 64, uninsured or underinsured. BCCP changes.

3. The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing if, at any time, the practice is closed to new patients, or maintains a wait list for new patients, or any other mechanism is used that limits access for new patients for more than a one month period.

4. The Contractor shall document annually, for each client enrolled in the program, family income and family size, and calculate percentage of the federal poverty level. If calculations indicate that the client may be eligible for enrollment in Medicaid, the Contractor shall complete with the client the most recent version of the 800P form.

5. The Contractor shall implement, and post in a public and conspicuous location, a sliding fee payment schedule, approved in advance by the Division of Public Health Services (DPHS), for low-income patients. Signage must state that no client will be denied services for inability to pay.

   a. As an alternative, the contractor may post, in a public and conspicuous location, a notice to clients that a sliding fee scale is available and that no client will be denied services for inability to pay. The sliding fee scale must be updated annually based on USDHHS Poverty guidelines as published in the Federal Register, submitted to and approved by DPHS prior to implementation.

6. The primary care contract entered into here shall be the payer of last resort. The contractor shall make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid, for all reimbursable services rendered.

EXHIBIT A – AMENDMENT 1

B) Numbers Served

1. The contract funds shall be expended to provide the above services to a minimum of 9,425 users annually with 37,620 medical encounters, as defined in the Data and Reporting Requirements. Breast and Cervical Cancer Screening for eligible women, as defined by the Breast and Cervical Cancer Program (BCCP), shall be provided to 279 women annually and billed directly to the BCCP. Clinical service reimbursements shall not exceed the Medicare rate.

C) Culturally and Linguistically Appropriate Standards of Care

The Department of Health and Human Services (DHHS) recognizes that culture and language have considerable impact on how consumers access and respond to public health services. Culturally and linguistically diverse populations experience barriers in efforts to access health services. To ensure equal access to quality health services, the Division of Public Health Services (DPHS) expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.
2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.
3. Provide clients of limited English proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.
4. Offer consumers a forum through which clients have the opportunity to provide feedback to providers and organizations regarding cultural and linguistic issues that may deserve response.
5. The contractor shall maintain a program policy that sets forth compliance with Title VI, Language Efficiency and Proficiency Citation 45 CFR 80.3(b) (2). The policy shall describe the way in which the items listed above were addressed and shall indicate the circumstances in which interpretation services are provided and the method of providing service (e.g. trained interpreter, staff person who speaks the language of the client, language line).

D) State and Federal Laws

The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. The Contractor shall report all cases of communicable diseases according to New Hampshire RSA 141-C and He-P 301, adopted 6/3/08.

2. Persons employed by the contractor shall comply with the reporting requirements of New Hampshire RSA 169:C, Child Protection Act; RSA 161:F46, Protective Services to Adults, RSA 631:6, Assault and Related Offences and RSA 130:A, Lead Paint Poisoning and Control.

3. Immunizations shall be conducted in accordance with RSA 141-C and the Immunization Rules promulgated hereunder.

E) Relevant Policies and Guidelines

1. The Contractor shall design and provide the services described above to meet the unique and identified health needs of the populations within the contracted service area.

2. Primary Care funds shall be targeted to populations in need. Populations in need are defined as follows:

   a) uninsured;

   b) under-insured;

   c) families and individuals with significant psychosocial and economic risk, including low income status;

   d) all life cycles including perinatal, child, adolescent, adult, and elderly who meet one or more of the above criteria.

3. The Contractor shall design and implement systems of governance, administration, financial management, information management, and clinical services which are adequate to assure the provision of contracted services, and to meet the data and reporting requirements. These systems shall meet the most current minimum standards described in at least one of the following: Health Resources and Services Administration (HRSA) Office of Performance Review protocols, Joint Commission on Accreditation of Health Care Organizations (JCAHO), Accreditation Association for Ambulatory Healthcare (AAAHC), Community Health Accreditation Program (CHAP), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey.

4. The Contractor shall have an agency emergency preparedness and response plan in accordance with HRSA Health Center Emergency Management Program Expectations, Document #2007-15 or most recent version. Such plan shall also include a Continuity of Operations plan.

5. The Contractor shall carry out the work as described in the performance Workplan submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

6. No Workplan is required by the Breast and Cervical Cancer Program (BCCP). The contractor shall be required to respond to the Quality Improvement Feedback Report twice a year.

7. The Contractor shall carry out the work as described in the Supplemental Funding Form submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

F) Publications Funded Under Contract

1. The DHHS and/or its funders will retain COPYRIGHT ownership for any and all original materials produced with DHHS contract funding, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports.

2. All documents (written, video, audio, electronic) produced, reproduced, or purchased under the contract shall have prior approval from DPHS before printing, production, distribution, or use.

3. The Contractor shall credit DHHS on all materials produced under this contract following the instructions outlined in Exhibit C (14).

G) Subcontractors

If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing and approve the subcontractual agreement, prior to initiation of the subcontract.

1. If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing and approve the subcontractual agreement, prior to initiation of the subcontract.

2. In addition, the original DPHS contractor will remain liable for all requirements included in this Exhibit and carried out by subcontractors.

II. <u>Minimal Standards of Core Services</u>

A. Service Requirements

1. Medical Home

The Contractor shall provide a Medical Home that:

a) Facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family.

b) Provides care facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

2. Primary Care Services

The Contractor shall provide office-based primary care services to populations in need who reside in the contractor's service area. Primary care services shall include:

a) Health care provided by a New Hampshire licensed MD, DO, APRN, or PA, including diagnosis and treatment of acute and chronic illnesses within the scope of family practice; preventive services, screenings, and health education according to established, documented state or national guidelines; assessment of need for social and nutrition services, and appropriate referrals to health, oral health, and behavioral health specialty providers.

b) Referral to the WIC Nutrition Program for all eligible pregnant women, infants and children.

c) In-hospital care for conditions within the scope of family practice must be provided at a hospital, within the agency service area, through a staff clinician with full hospital privileges, or in the alternative, through a formal referral and admissions procedure available to clients on a 24 hour/7 day a week basis.

d) Access to a healthcare provider, directly or by referral or subcontract, by telephone twenty-four hours per day, seven days per week.

e) Assessment of psychosocial risk for all clients at least annually and for children at scheduled preventive care visits, including, at a minimum, age appropriate assessment of safety in the home, domestic violence, adequacy of food and housing, care and welfare of children, transportation needs, and provision of necessary social services to address the priority needs and safety issues of clients and families.

f) Falls prevention screening for patients 65 years and older using the algorithm and guidelines of the American Geriatrics Society.

g) Behavioral health care directly or by referral to an agency or provider with a sliding fee scale.

h) Nutrition assessment for all clients as part of the health maintenance visit. Therapeutic nutrition services shall be provided as indicated directly or by referral to an agency or provider with a sliding fee scale. These services shall be recorded in the medical record.

i) Formal arrangements with a local hospital for emergency care must be in place and reviewed annually.

EXHIBIT A – AMENDMENT 1

j) Home health care directly or by referral to an agency or provider with a sliding fee scale.

k) Assisted living and skilled nursing facility care by referral.

l) Oral screening annually for all clients 21 years and older to note obvious dental decay and soft tissue abnormalities with a reminder to the patient that poor oral health impacts total health.

m) Diagnosis and management of pediatric and adult patients with asthma provided according to National Heart Lung Blood Institute, National Asthma Education and Prevention Program, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, 2007.

3. Breast and Cervical Cancer Screening

a) Women age 21 to 64 who are eligible for Breast and Cervical Cancer Program (BCCP) services according to income (equal to or under 250% of poverty, underinsured/uninsured) and insurance status criteria shall be provided the following services, following USPSTF screening recommendations:

i. cervical cancer screening including a pelvic examination and Pap smear;
ii. breast cancer screening including a clinical breast exam, mammogram and,
iii. referrals for diagnostic and treatment services based on screening results,
iv. case management services.

b) All referrals under this provision shall be to approved certified laboratory, pathology, radiology, and surgical services. Mammography units shall be accredited by the American College of Radiology, and must be FDA certified under MQSA. Laboratories shall be CLIA certified.

c) All services shall be provided in accordance with the Breast and Cervical Cancer Program (BCCP) Policy and Procedure Manual.

d) Follow-up and tracking of all tests done, and referrals made shall be provided in accordance with the minimum standards outlined in the Breast and Cervical Cancer Program Policy and Procedure Manual.

e) All services for women enrolled in the Breast and Cervical Cancer Program (BCCP) shall be billed directly to the BCCP in accordance with protocols established by the Breast and Cervical Cancer Program.

f) The Contractor shall provide the NH Breast and Cervical Cancer Program with breast and cervical cancer screening rates for all women served by the practice as requested, but not more than twice per SFY.

g) The contractor shall work with the NH Breast and Cervical Cancer Program staff to increase the breast and cervical cancer screening rates among all women serviced by the practice.

4. Reproductive Health Services

The Contractor shall provide prenatal, interconceptional and preconception medical care, social services, nutrition services, education, and nursing care to all women of childbearing age. Preconceptional care includes the preconception, interconceptional, and postpartum periods in women's health. It is recommended that preconceptional and interconceptional care visits focus on maintaining or achieving the optimal health of the mother, lowering the risk of future adverse pregnancy outcomes, the family's future plans, and how additional children fit into that plan. Preconceptional counseling may be done during an office, group or home visit.

a) In the event prenatal care is not provided directly by the Contractor a formal Memorandum/a of Agreement for coordinated referral to an appropriately qualified provider must be maintained.

b) Prenatal care shall, at minimum, be provided in accordance with the Guidelines for Perinatal Care, sixth or most current edition, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and /or the Centers for Disease Control.

c) Age appropriate reproductive health care shall, at a minimum, be provided in accordance with the American College of Obstetricians and Gynecologists, or the USDHHS Centers for Disease Control (CDC) current guidelines.

d) Pregnant women enrolled in the WIC Nutrition Program shall be referred to WIC for breastfeeding education and referral to the WIC Nutrition Program peer counselors.

e. Family planning counseling for prevention of subsequent pregnancy following an infant's birth shall be discussed with the infant's mother at the first postpartum visit and at the infant's 2-month visit and other visits as appropriate. Rationale for birth intervals of 18-24 months shall be presented.

f) A referral to a Title X Family Planning Clinic or other reproductive health care provider shall be made as appropriate.

5. Services for Children and Adolescents

The Contractor shall provide as a minimum, comprehensive and age-appropriate health care, screenings, and health education according to the American Academy of Pediatrics' most recent periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent. Children and adolescent visits shall include:

a) The World Health Organization (WHO) growth charts shall be used to monitor growth for infants and children birth up to age 2 years. The Centers for Disease Control and Prevention (CDC) growth charts shall be used for children age 2 years and older.

b) Blood lead testing shall be performed in accordance with "New Hampshire Childhood Lead Poisoning Screening and Management Guidelines", issued by the New Hampshire Department of Health and Human Services, 2009 or subsequent revisions.

c) All children enrolled in either Medicaid, Head Start, or the Women, Infant, and Children (WIC) Program and/or who are ≤ 185%_poverty, regardless of town of residence, are required to have a blood lead test at ages one and two years. All children ages three to six years who have not been previously tested shall have a blood lead test performed.

d) All children shall be screened for iron deficiency anemia as outlined in the Centers for Disease Control and Prevention document "Recommendations to Prevent and Control Iron Deficiency in the United States (4/2/98)".

e) Age-appropriate anticipatory guidance, dietary guidance, and *feeding practice counseling* for optimal oral health shall be provided at each well child visit according to the American Academy of Pediatrics' periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent edition. Starting at age 6 months, it is recommended that all children receive an oral health assessment at every well child visit, and a referral for the child's first visit to the dentist by age one as recommended by the American Academy of Pediatrics and the American Academy of Pediatric Dentistry.

f) Supplemental fluoride shall be prescribed as needed based upon the fluoride levels in the child's drinking water supply. The fluoride dosage regimen accepted by the American Academy of Pediatrics shall be followed. No fluoride shall be prescribed without obtaining water from private wells or noting the presence or absence of fluoride in the public water supply. Supplemental fluoride may include bottled water containing fluoride and topical applications such as varnishes.

g) For infants enrolled in the WIC Nutrition Program, parents shall be referred to WIC for breastfeeding support and referral to the WIC Nutrition Program peer counselors.

6. Sexually Transmitted Infections

Primary Care Services shall provide age appropriate screening and treatment of sexually transmitted infections.

a) Treatment for sexually transmitted infections shall be provided according to the United States Centers for Disease Control Sexually Transmitted Diseases Treatment Guidelines, 2010 or subsequent revisions.

b) All clients, including women, shall be offered HIV testing following the most current recommendations of the United States Centers for Disease Control.

c) The contractor shall be responsible for ensuring referral to appropriate treatment services for any woman found to screen positive.

d) Appropriate risk reduction counseling shall be provided based on client needs.

7. Substance Use Services

a) A substance use screening history using a formal, validated screening tool shall be obtained for all clients as soon after entry into care as possible. Substance use counseling or other substance abuse intervention, treatment, or recovery services by an appropriately credentialed provider shall be provided on-site, or by referral, to clients with identified needs for these services. For these identified clients, ongoing primary care services should include follow up monitoring relative to substance abuse.

b) All clients, including pregnant women, identified as smokers shall receive counseling using the 5A's (ask, advise, assess, assist, and arrange) treatment available through the NH Tobacco Helpline as cited in the US Public Health Services report "Tobacco Use and Dependence", 2008, or "Smoking Cessation During Pregnancy: A Clinician's Guide to Helping Pregnant Women Quit Smoking", American College of Obstetricians and Gynecologists, 2011. With prior approval, agencies may also opt to participate in the DPHS best practice initiative of the 2A's and R (ask, advise and refer).

8. Immunizations

a) The Contractor shall adhere to the most current version of the "Recommended Adult Immunization Schedule for Adults (19 years and older) by Age and Medical Condition - United States", approved by the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

b) The Contractor shall administer vaccines according to the most current version of the "Recommended Immunization Schedule for Persons Aged 0 Through 6 Years - United States", and "Recommended Immunization Schedule for Persons Aged 7 Through 18 Years – United States" approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians, based upon availability of vaccine from the New Hampshire Immunization Program.

9. Prenatal Genetic Screening

a) A genetic screening history shall be obtained on all prenatal clients as soon after entry into care as possible.

b) All pregnant women should be offered voluntary genetic screening for fetal chromosomal abnormalities at the appropriate time following recommendations found in the American College of Obstetricians and Gynecologists' "Screening for Fetal Chromosomal Abnormalities (2007)" or more recent guidelines. The Contractor shall be responsible for ensuring referral to appropriate genetic testing and counseling for any woman found to have a positive screening test.

10. Additional Requirements

a) The Contractor's Medical Director shall participate in the development and approval of specific guidelines for medical care that supplement minimal clinical standards. Supplemental guidelines should be reviewed, signed, and dated annually, and updated as indicated.

b) Contractors considering clinical or sociological research using clients as subjects must adhere to the legal requirements governing human subjects research. Contractors must inform the DPHS, MCHS prior to initiating any research related to this contract.

c) The Contractor shall provide information to all employees annually about the Medical Reserve Corps Unit within their Public Health Region to enhance recruitment.

d) The Contractor shall provide information to all employees annually regarding the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) managed by the NH Department of Health and Human Services' Emergency Services Unit, to enhance recruitment.

B) Staffing Provisions

The Contractor shall have, at minimum, the following staff positions:

a) executive director

b) fiscal director

c) registered nurse

d) clinical coordinator

e) medical service director

f) nutritionist (on site or by referral)

g) social worker

EXHIBIT A – AMENDMENT 1

Staff positions required to provide direct services on-site include:

a) registered nurse

b) clinical coordinator

c) social worker

1. Qualifications

All health and allied health professionals shall have the appropriate New Hampshire licenses whether directly employed, contracted, or subcontracted.

In addition the following minimum qualifications shall be met for:

a) Registered Nurse
   a. A registered nurse licensed in the state of New Hampshire, Bachelor's degree preferred. Minimum of one-year experience in a community health setting.

b) Nutritionists:
   a. A Bachelor's degree in nutritional sciences or dietetics, or a Master's degree in nutritional sciences, nutrition education, or public health nutrition or current Registered Dietitian status in accordance with the Commission on dietetic Registration of the American Dietetic Association.
   b. Individuals who perform functions similar to a nutritionist but do not meet the above qualifications shall not use the title of nutritionist.

c) Social Workers shall have:
   a. A Bachelor's or Master's degree in social work or Bachelor's or Master's degree in a related social science or human behavior field. A minimum of one year of experience in a community health or social services setting is preferred.
   b. Individuals who perform functions similar to a social worker but do not meet the above qualifications shall not use the title of social worker.

d) Clinical Coordinators shall be:
   a. A registered nurse (RN), physician, physician assistant, or nurse practitioner with a license to practice in New Hampshire.
   b. The coordinator is a clinical position that oversees and takes responsibility for the clinical and administrative functions of each program.
   c. The coordinator may be responsible for more than one MCH funded program.

2. New Hires

The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing within one month of hire when a new administrator, clinical coordinator, or any staff person essential to carrying out contracted services is hired to work in the program. A resume of the employee shall accompany the aforesaid notification.

3. Vacancies

a) The Contractor must notify the MCHS in writing if any critical position is vacant for more than one month, or if at any time funded under this contract does not have adequate staffing to perform all required services for more than one month. This may be done through a budget revision.

b) Before an agency hires new program personnel that do not meet the required staff qualifications, the agency shall notify the MCHS in writing requesting a waiver of the applicable staffing requirements. The Section may grant waivers based on the need of the program, individuals' experience, and additional training.

C) Coordination of Services

1. The Contractor shall coordinate, where possible, with other service providers within the contractor's community. At a minimum, such collaboration shall include interagency referrals and coordination of care.

2. The Contractor shall participate in activities in the Public Health Region in which they provide services as appropriate. These activities enhance the integration of community-based public health prevention and health care initiatives that are being implemented by the contractor and may include community needs assessments, public health performance assessments, and/or the development of regional health improvement plans.

3. The Contractor agrees to participate in and coordinate public health activities as requested by the Division of Public Health Services during any disease outbreak and/or emergency, natural or man-made, affecting the public's health.

4. The Contractor is responsible for case management of the client enrolled in the program and for program follow-up activities. Case management services shall promote effective and efficient organization and utilization
of resources to assure access to necessary comprehensive medical, nutritional, and social services for clients.

5. The Contractor shall assure that appropriate, responsive, and timely referrals and linkages for other needed services are made, carried through, and documented. Such services shall include, but not be limited to: dental services, genetic counseling, high risk prenatal services, mental health, social services, including domestic violence crisis centers, substance abuse services; and family planning services, Early Supports and Services Program, local WIC/CSF Program, Home Visiting New Hampshire Programs and health and social service agencies which serve children and families in need of those services.

 Contractor Initials VL

Date 3/12/14

D) Meetings and Trainings

The contractor will be responsible for sending staff to meetings and training required by the MCHS program, including but not limited to:

1. MCHS Agency Directors' meetings
2. Prenatal and Child Health Coordinators' meetings
3. MCHS Agency Medical Services Directors' meetings

III. Quality or Performance Improvement (QI/PI)

A) Workplans

1. Performance Workplans are required for this program and are used to monitor achievement of standard measures of performance of the services provided under this contract. The workplans are a key component of the RHPCS and the MCHS performance-based contracting system and of this contract. Outcomes shall be reported by clinical site.
2. Performance Workplans and Workplan Outcome reports according to the schedule and instructions provided by the MCHS. The MCHS shall notify the Contractor at least 30 days in advance of any changes in the submission schedule.
3. The Contractor shall incorporate required and developmental performance measures, defined by the MCHS into the agency's Performance Workplan. Reports on Workplan Progress/Outcomes shall detail the Performance Workplan plans and activities that monitor and evaluate the agency's progress toward performance measure targets.
4. The Contractor shall comply with modifications and/or additions to the workplan and annual report format as requested by RHPCS and MCHS. MCHS will provide the contractor with reasonable notice of such changes.
5. Agencies contracting for Primary Care Services must submit the workplans for Primary Care Clinical and Financial, Child Health, and Prenatal Care.

B) Additional Reporting requirements

In addition to Performance Workplans, the Contractor shall submit to MCHS the following data and information listed below which are used to monitor program performance:

1. In years when contracts or amendments are not required, the DPHS Budget Form, Budget Justification, Sources of Revenue and Program Staff list forms must be

completed according to the relevant instructions and submitted as requested by DPHS and, at minimum, by April 30 of each year.

2. The Sources of Revenue report must be resubmitted at any point when changes in revenue threaten the ability of the agency to carry out the planned program.

3. Completed Uniform Data Set (UDS) tables reflecting program performance in the previous calendar year, by March 31 of each year.

4. The Perinatal Client Data Form (PCDF) shall be submitted electronically according to the instructions set forth by the MCHS.

5. A copy of the agency's updated Sliding Fee Scale including the amount(s) of any client fees and the schedule of discounts must be submitted by March 31st of each year. The agency's sliding fee scale must be updated annually based on the US DHHS Poverty guidelines as published in the Federal Register.

6. An annual summary of program-specific patient satisfaction results obtained during the prior contract period and the method by which the results were obtained shall be submitted annually as an addendum to the Workplan Outcome/Progress reports.

C) On-site reviews

1. The contractor shall allow a team or person authorized by the Division of Public Health Services to periodically review the contractor's systems of governance, administration, data collection and submission, clinical and financial management, and delivery of education services in order to assure systems are adequate to provide the contracted services.

2. Reviews shall include client record reviews to measure compliance with this exhibit.

3. The contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.

4. On-Site reviews may be waived or abbreviated at the discretion of MCHS, upon submission of satisfactory reports of reviews such as Health Services Resources Administration (HRSA): Office of Performance Review (OPR), or reviews from nationally accreditation organizations such as the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), Medicare, the Community Health Accreditation Program (CHAP), Accreditation Association for Ambulatory Healthcare (AAAHC), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey. Abbreviated reviews will focus on any deficiencies found in previous reviews, issues of compliance with this exhibit, and actions to strengthen performance as outlined in the agency Performance Workplan.

PRIMARY CARE CHILD HEALTH DIRECT CARE SERVICES
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Please note, for all measures, the following should be used **unless otherwise indicated:**

- Less than 19 years of age
- Served within the scope of this MCH contract during State Fiscal Year 2015 (July 1, 2014 – June 30, 2015)
- Each client can only be counted once (unduplicated)

Child Health Direct (CH – D) Performance Measure #1

Measure: 92%* of eligible children will be enrolled in Medicaid

Goal: To increase access to health care for children through the provision of health insurance

Definition: **Numerator-**
Of those in the denominator, the number of children enrolled in Medicaid.

Denominator-
Number of children who meet all of the following criteria:

- Less than 19 years of age
- Had 3 or more visits/encounters** during the reporting period
- As of the last visit during the reporting period were eligible for Medicaid

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**An encounter is face to face contact between a user and a provider who exercises independent judgment in the provision of services to the individual (UDS Table Definition).

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #2

Measure: 85%* of at-risk** children who were screened for blood lead between 18 and 30 months of age

Goal: To prevent childhood lead poisoning through early identification of lead exposure

Definition: **Numerator-**
Of those in the denominator, number of children screened for blood lead by capillary or venous on or after their 18-month birthday and prior to their 30-month birthday.

Denominator-
Number of at-risk** children who reached age 30 months during the reporting period. If discharged prior to 30 months, do not include in denominator.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**At risk = During the reporting period, the children were 18-29 months of age, and fit at least one of the following criteria:

- "Low income" (less than 185% poverty guidelines)
- Over 185% and resided in a town considered needing "Universal" screening per NH Childhood Lead Poisoning Prevention Program
- Over 185%, resided in a town considered "Target" and had a positive response to the risk questionnaire
- Refugee children -A refugee is defined as a person outside of his or her country of nationality who is unable or unwilling to return because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion (U.S. Citizenship and Immigration Services definition).

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #3

Measure: 71%* of children age two to nineteen years receiving primary care preventive health services with a Body Mass Index (BMI) percentile greater than or equal to the 85%ile with documented discussion of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Goal: To increase the percent of children receiving primary care preventive health services who have an elevated BMI percentile who receive guidance about promoting a healthier lifestyle.

Definition: **Numerator-**
Of those in the denominator, the number of children who had documentation in their medical record of there being discussion at least once during the reporting period of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Denominator-
Number of children who turned twenty-four months during or before the reporting period, up to the age of nineteen years, with one or more well child visit after their twenty-fourth month of age within the reporting year, and had an age and gender appropriate BMI percentile greater than or equal to the 85 % percentile at least once during the reporting period.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

Rationale: Children between the 85th – 94th percentiles BMI are encouraged to have 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks. (Discussion of the importance of family meal time, limiting eating out, consuming a healthy breakfast, preparing own foods, and promotion of breastfeeding is also encouraged.) American Academy of Pediatrics' guidance for Prevention and Treatment of Childhood Overweight and Obesity, (http://www.aap.org/obesity/health_professionals.html), from AAP Policy Statement: *Prevention of Pediatric Overweight and Obesity* and the AAP endorsed Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Children and Adolescent Overweight and Obesity, 2007.

*Target based on 2012 & 2013 Data Trend Table averages.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) #4

Measure: 75%* of eligible** infants and children with client record documentation of enrollment in WIC

Goal: To increase access to nutrition education, breastfeeding support, and healthy food through enrollment in the WIC Nutrition Program

Definition: **Numerator** -
Of those in the denominator, the number of infants and children who, as of the last well child visit during the reporting period, had client record documentation that infant or child was enrolled in WIC.

Denominator -
Unduplicated number of infants and children less than 5 years of age, enrolled in the agency, during the reporting period, who were eligible** for WIC.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**WIC Eligibility Requirements:

- Infants, and children up to their fifth birthday
- Must be income eligible (income guidelines are up to 185% of federal gross income, and are based on family size)

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #5

Measure: 23%* of infants who were exclusively** breastfed for the first three months, at their four month well baby visit

Goal: To provide optimum nutrition to infants in their first three months of life

Definition: **Numerator -**
Of those in the denominator, the number of infants who had client record documentation that the infant had been exclusively breastfed for their first three months when checked at their four month well baby visit.

Denominator -
Number of infants who received one or more visits during or before the reporting period and were seen for a four-month well baby visit during the reporting period.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

Benmarks: 2011 PedNSS (WIC) exclusive at 3 months: NH 22.9%, National (2010) 10.7%
2013 CDC Report Card (NIS, provisional 2010 births): NH 49.5%, National 37.7%
Healthy People 2020 goal: 44%

Rationale: The AAP recommends exclusive breastfeeding for about 6 months, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant, a recommendation concurred to by the World Health Organization and the Institute of Medicine. (American Academy of Pediatrics Policy Statement on Breastfeeding and the Use of Human Milk, 2012)

*Target based on 2012 & 2013 Data Trend Table averages.
**Exclusive means breast milk only, no supplemental formula, cereal/baby food, or water/fluids.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE: ADULT

PERFORMANCE MEASURES DEFINITIONS

State Fiscal Year 2015

Primary Care: Adult Performance Measure #1

Measure:* 58%** of adult patients 18 – 85 years of age diagnosed with hypertension will have a blood pressure measurement less than 140/90*** mm at the time of their last measurement.

Goal: To ensure patients diagnosed with hypertension are adequately controlled.

Definition: **Numerator-** Number of patients from the denominator with blood pressure measurement less than 140/90 mm at the time of their last measurement.

Denominator- Number of patients age 18 – 85 with diagnosed hypertension must have been diagnosed with hypertension 6 or more months before the measurement date. (Excludes pregnant women and patients with End Stage Renal Disease.)

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

*Measure based on the National Quality Forum 0018

**Health People 2020 National Target is 61.2%

***Both the numerator and denominator must be less that 140/90 mm

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE CLINICAL
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Primary Care Clinical Adolescent (PC-C) Performance Measure #1

Measure: 61%* of adolescents aged 11-21 years received an annual health maintenance visits in the past 12 months.

Goal: To enhance adolescent health by assuring annual, recommended, adolescent well -visits.

Definition:

Numerator-
Number of adolescents in the denominator who received an annual health maintenance "well" visit during the reporting year.

Denominator-
Total number of adolescents aged 11-21 years who were enrolled in the primary care clinic as primary care clients during the reporting year period.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

***Target based on 2012 & 2013 Data Trend Table averages.**

Primary Care Clinical Prenatal (PC-C) Performance Measure #2

Measure: 31%* of women and adolescent girls aged 15-44 take multi-vitamins with folic acid.

Goal: To enhance pregnancy outcomes by reducing neural tube defects.

Definition:

Numerator-
The number of women and adolescent girls aged 15-44 who take a multi-vitamin with folic acid.

Denominator-
The number of women and adolescent girls aged 15-44 who were seen in primary care for a well visit in the past year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

***Target based on 2012 & 2013 Data Trend Table averages.**

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE - FINANCIAL
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Primary Care (PC) Performance Measure #1

Measure: Patient Payor Mix

Goal: To allow monitoring of payment method trends at State funded primary care sites.

Definition: Patients enrolled in Medicare, Medicaid, Commercial insurance, or uninsured.

Data Source: Provided by agency

Primary Care (PC) Performance Measure #2

Measure: Accounts Receivables (AR) Days

Goal: To allow monitoring of financial sustainability trends at State funded primary care sites.

Definition: AR Days: Net Patient Accounts Receivable **multiplied by** 365 **divided by** Net Patient Revenue

Data Source: Provided by agency

Primary Care (PC) Performance Measure #3

Measure: Current Ratio

Goal: To allow monitoring of financial sustainability trends at State funded primary care sites.

Definition: Current Ratio = Current Assets **divided by** Current Liabilities

Data Source: Provided by agency

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRENATAL
PERFORMANCE MEASURES DEFINITIONS
State Fiscal Year 2015

Prenatal (PN) Performance Measure #1

Measure: 85%* of pregnant women who are enrolled in the agency's prenatal program will begin prenatal care during the first trimester of pregnancy.

Goal: To enhance pregnancy outcomes by assuring early entrance into prenatal care.

Definition:

Numerator-
Number of women in the denominator who had a documented prenatal visit during the first trimester (on or before 13.6 weeks gestation).

Denominator-
Number of women enrolled in the agency prenatal program who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

* Target based on 2012 & 2013 Data Trend Table averages.

Prenatal (PN) Performance Measure #2

Measure: 20%* of pregnant women who are identified as cigarette smokers will be referred to QuitWorks-New Hampshire.

Goal: To reduce tobacco use during pregnancy through focused tobacco use cessation activities at public health prenatal clinics.

Definition:

Numerator-
Number of women in the denominator who received at least one referral to QuitWorks-New Hampshire during pregnancy.

A referral is defined as signing the patient up for QuitWorks-NH via phone, fax, or EMR. It is not defined as discussing QuitWorks-NH with the patient and encouraging her to sign up.

Denominator-
Number of women enrolled in the agency prenatal program and identified as tobacco users who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

*Target set in consultation with the NH Tobacco Program & FY13 Data Trend Table average.

Prenatal (PN) Performance Measure #3

Measure: 79%* of pregnant women will be screened, using a formal valid screening tool, for alcohol and other substance use during every trimester they are enrolled in the prenatal program.

Goal: To reduce prenatal substance use through systematic screening and identification.

Definition: **Numerator-** Number of women in the denominator who were screened for substance and alcohol use, using a formal and valid screening tool, during each trimester that they were enrolled in the prenatal program.

Denominator- Number of women enrolled in the agency prenatal program and who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

* Target based on 2012 & 2013 Data Trend Table averages.

Exhibit B-1 (2014) -Amendment 1
Budget

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: Manchester Community Health Center

Budget Request for: MCH Primary Care
(Name of RFP)

Budget Period: SFY 2014

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages	$ 71,392.00	$ -	$ 71,392.00	
2. Employee Benefits	$ -	$ -	$ -	
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	$ -	$ -	$ -	
13. Other (specific details mandatory):	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
TOTAL	**$ 71,392.00**	**$ -**	**$ 71,392.00**	

Indirect As A Percent of Direct 0.0%

Contractor Initials: [signature]

Date: 3/12/14

Exhibit B-1 (2015) -Amendment 1
Budget

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: Manchester Community Health Center

Budget Request for: MCH Primary Care & BCCP
(Name of RFP)

Budget Period: SFY 2015

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages	$ 370,261.00	$ -	$ 370,261.00	0
2. Employee Benefits	$ -	$ -	$ -	0
3. Consultants	$ -	$ -	$ -	0
4. Equipment:	$ -	$ -	$ -	0
Rental	$ -	$ -	$ -	0
Repair and Maintenance	$ -	$ -	$ -	0
Purchase/Depreciation	$ -	$ -	$ -	0
5. Supplies:	$ -	$ -	$ -	0
Educational	$ -	$ -	$ -	0
Lab	$ -	$ -	$ -	0
Pharmacy	$ -	$ -	$ -	0
Medical	$ -	$ -	$ -	0
Office	$ -	$ -	$ -	0
6. Travel	$ -	$ -	$ -	0
7. Occupancy	$ -	$ -	$ -	0
8. Current Expenses	$ -	$ -	$ -	0
Telephone	$ -	$ -	$ -	0
Postage	$ -	$ -	$ -	0
Subscriptions	$ -	$ -	$ -	0
Audit and Legal	$ -	$ -	$ -	0
Insurance	$ -	$ -	$ -	0
Board Expenses	$ -	$ -	$ -	0
9. Software	$ -	$ -	$ -	0
10. Marketing/Communications	$ -	$ -	$ -	0
11. Staff Education and Training	$ -	$ -	$ -	0
12. Subcontracts/Agreements	$ 37,376.00	$ -	$ 37,376.00	0
13. Other (specific details mandatory):	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
	$ -	$ -	$ -	0
TOTAL	**$ 407,637.00**	**$ -**	**$ 407,637.00**	0

Indirect As A Percent of Direct 0.0%

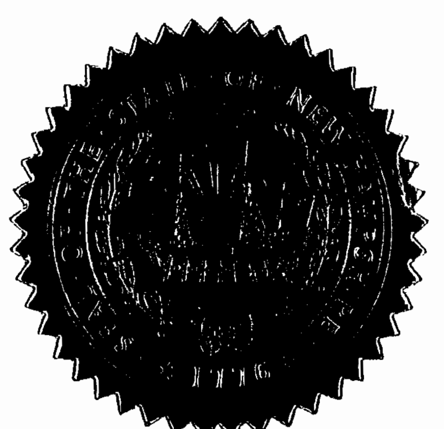
Contractor Initials: VL

Date: 3/12/14

State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that MANCHESTER COMMUNITY HEALTH CENTER is a New Hampshire nonprofit corporation formed May 7, 1992. I further certify that it is in good standing as far as this office is concerned, having filed the return(s) and paid the fees required by law.



In TESTIMONY WHEREOF, I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 20th day of May A.D. 2013

Wm Gardner

William M. Gardner
Secretary of State

WITHOUT SEAL

CERTIFICATE OF VOTE

I, Anthony J. Chismark, of Manchester Community Health Center, do hereby certify that:

1. I am the duly elected Board President of Manchester Community Health Center;

2. The following are true copies of two resolutions duly adopted at a meeting of the Board of Directors of the corporation, duly held on March 4, 2014;

   RESOLVED: That this corporation enters into contracts with the State of New Hampshire, acting through its Department of Health and Human Services, Division of Public Health Services.

   RESOLVED: That the President / CEO is hereby authorized on behalf of this corporation to enter into said contracts with the State and to execute any and all documents, agreements, and other instruments; and any amendments, revisions, or modifications thereto, as he/she may deem necessary, desirable, or appropriate. Kris McCracken is the duly elected President / CEO of the corporation.

3. The foregoing resolutions have not been amended or revoked and remain in full force and effect as of March 12, 2014.

IN WITNESS WHEREOF, I have hereunto set my hand as the Board President of the corporation this 12th day of March, 2014.

[signature]
Board President

STATE OF New Hampshire

COUNTY OF Hillsborough

The foregoing instrument was acknowledged before me this 12 day of March, 2014 by Anthony Chismark.

[signature]
Notary Public/Justice of the Peace
My Commission Expires:

AMANDA BRUNO
Notary Public - New Hampshire
My Commission Expires June 20, 2017

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 3/6/2014

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 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
USI INSURANCE SERVICES LLC
PO BOX 6360
MANCHESTER, NH 03108

CONTACT NAME:
PHONE (A/C, No, Ext): (877) 463-2723 FAX (A/C, No): 866-828-2424
E-MAIL ADDRESS: Certificate@hanover.com

INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A :	Hanover Insurance Co	22292
INSURER B :	Allmerica Financial Benefit	41840
INSURER C :		
INSURER D :		
INSURER E :		
INSURER F :		

INSURED
MANCHESTER COMMUNITY HEALTH CENTER
145 HOLLIS STREET
MANCHESTER, NH 03101

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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT X LOC			OHV A208788 00	02/15/2014	02/15/2015	EACH OCCURRENCE	$ 2,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 2,000,000
							MED EXP (Any one person)	$ 10,000
							PERSONAL & ADV INJURY	$ 2,000,000
							GENERAL AGGREGATE	$ 4,000,000
							PRODUCTS - COMP/OP AGG	$ 4,000,000
								$
A	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS X HIRED AUTOS X NON-OWNED AUTOS			OHV A208788 00	02/15/2014	02/15/2015	COMBINED SINGLE LIMIT (Ea accident)	$ 2,000,000
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
A	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DED RETENTION $			OHV A208788 00	02/15/2014	02/15/2015	EACH OCCURRENCE	$ 2,000,000
							AGGREGATE	$ 2,000,000
								$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N: Y (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		W2V 9461019 02	02/15/2014	02/15/2015	X WC STATU-TORY LIMITS OTH-ER	
							E.L. EACH ACCIDENT	$ 500,000
							E.L. DISEASE - EA EMPLOYEE	$ 500,000
							E.L. DISEASE - POLICY LIMIT	$ 500,000

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

CERTIFICATE HOLDER

DHHS
Contracts & Procurement Unit
129 Pleasant Street
Concord, NH 03301

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

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MANCHESTER COMMUNITY HEALTH CENTER

AUDITED FINANCIAL STATEMENTS

JUNE 30, 2013 AND 2012

BRAD BORBIDGE, P.A.
CERTIFIED PUBLIC ACCOUNTANTS
197 LOUDON ROAD, SUITE 350
CONCORD, NEW HAMPSHIRE 03301

TELEPHONE 603/224-0849
FAX 603/224-2397

Independent Auditor's Report on Financial Statements

Board of Directors
Manchester Community Health Center
Manchester, New Hampshire

We have audited the accompanying financial statements of Manchester Community Health Center as of June 30, 2013 and 2012 , the related statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the 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 entity'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 financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Manchester Community Health Center as of June 30, 2013 and 2012, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The accompanying schedule of expenditures of federal awards is presented for purposes of additional analysis as required by U.S. Office of Management and Budget Circular A-133, Audits of States, Local Governments, and Non-Profit Health Centers, and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the schedule of expenditures of federal awards is fairly stated in all material respects in relation to the financial statements as a whole.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards,* we have also issued our report dated November 19, 2013, on our consideration of the Association's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and important for assessing the results of our audit.

Concord, New Hampshire
November 19, 2013

MANCHESTER COMMUNITY HEALTH CENTER

BALANCE SHEETS

JUNE 30, 2013 AND 2012

ASSETS

	2013	2012
Current Assets		
Cash and cash equivalents	$ 354,377	$ 89,261
Investments	443,000	442,945
Patient accounts receivable, net of allowance for uncollectible accounts of $360,000 at June 30, 2013 and 2012	522,680	243,651
Other receivables	390,970	104,109
Pledges receivable, current	-	1,138
Due from third party payers	-	132,000
Prepaid expenses	52,833	71,473
Total Current Assets	1,763,860	1,084,577
Assets Limited As To Use	211,197	161,845
Property and Equipment, Net	2,847,044	2,844,364
TOTAL ASSETS	$ 4,822,101	$ 4,090,786

LIABILITIES AND NET ASSETS

	2013	2012
Current Liabilities		
Accounts payable and accrued expenses	$ 137,922	$ 96,172
Accrued payroll and related expenses	276,074	261,811
Advances from third party payers	319,224	-
Current maturities of long-term debt	21,300	22,450
Total Current Liabilities	754,520	380,433
Long-term Debt, Less Current Maturities	1,372,197	1,437,472
Total Liabilities	2,126,717	1,817,905
Net Assets		
Unrestricted	2,376,950	1,930,028
Temporarily restricted	318,434	342,853
Total Net Assets	2,695,384	2,272,881
TOTAL LIABILITIES AND NET ASSETS	$ 4,822,101	$ 4,090,786

(See accompanying notes to these financial statements)

MANCHESTER COMMUNITY HEALTH CENTER

STATEMENTS OF OPERATIONS

FOR THE YEARS ENDED JUNE 30, 2013 AND 2012

	2013	2012
Operating Revenue		
Patient service revenue	$ 3,855,463	$ 3,162,675
Provision for bad debts	(173,402)	(182,648)
Net patient service revenue	3,682,061	2,980,027
Grants and contracts	2,375,428	1,632,943
Other operating revenue	263,970	100,410
Net assets released from restrictions for operations	199,668	139,644
Total Operating Revenue	6,521,127	4,853,024
Operating Expenses		
Salaries and benefits	4,151,361	3,913,479
Other operating expenses	1,759,278	1,220,321
Depreciation	180,844	192,495
Interest expense	69,366	70,274
Total Operating Expenses	6,160,849	5,396,569
OPERATING INCOME (LOSS)	360,278	(543,545)
Other Revenue and Gains		
Investment income	9,740	359
Contributions	32,820	14,425
Total Other Revenue and Gains	42,560	14,784
EXCESS (DEFICIT) OF REVENUE OVER EXPENSES	402,838	(528,761)
Change in unrealized gain on investments	-	(308)
Change in unrealized gain on financial instrument	44,085	37,807
INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS	$ 446,923	$ (491,262)

(See accompanying notes to these financial statements)

MANCHESTER COMMUNITY HEALTH CENTER

STATEMENTS OF CHANGES IN NET ASSETS

FOR THE YEARS ENDED JUNE 30, 2013 AND 2012

	2013	2012
Unrestricted Net Assets:		
Excess (deficit) of revenue over expenses	$ 402,838	$ (528,761)
Change in unrealized gain on investments	-	(308)
Change in unrealized gain on financial instrument	44,085	37,807
Increase (Decrease) in Unrestricted Net Assets	446,923	(491,262)
Temporarily Restricted Net Assets:		
Contributions for operations	175,248	33,778
Grants for capital acquisition	-	27,000
Net assets released from restrictions for operations	(199,668)	(139,644)
Decrease in Temporarily Restricted Net Assets	(24,420)	(78,866)
Change in Net Assets	422,503	(570,128)
Net Assets, Beginning of Year	2,272,881	2,843,009
NET ASSETS, END OF YEAR	$ 2,695,384	$ 2,272,881

(See accompanying notes to these financial statements)

MANCHESTER COMMUNITY HEALTH CENTER

STATEMENTS OF CASH FLOWS

FOR THE YEARS ENDED JUNE 30, 2013 AND 2012

	2013	2012
Cash Flows From Operating Activities		
Change in net assets	$ 422,503	$ (570,128)
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Bad debt expense	173,402	182,648
Depreciation	180,844	192,495
Change in unrealized gain on investments	-	308
Change in unrealized gain on financial instrument	(44,085)	(37,807)
Restricted contributions for operations	(175,248)	(33,778)
Grants for capital acquisition	-	(27,000)
(Increase) decrease in the following assets:		
Patient accounts receivable	(452,431)	(102,741)
Other receivables	(286,861)	381,733
Pledges receivable	1,138	16,600
Due from third party payers	132,000	42,429
Prepaid expenses	18,640	(3,295)
Increase (decrease) in the following liabilities:		
Accounts payable and accrued expenses	41,750	(47,719)
Accrued payroll and related expenses	14,263	24,091
Advances from third party payers	319,224	-
Net Cash Provided by Operating Activities	345,139	17,836
Cash Flows From Investing Activities		
Purchase of investments	(55)	(50,282)
Proceeds from sales of investments	-	50,000
Capital expenditures	(183,524)	(29,637)
Net Cash Used by Investing Activities	(183,579)	(29,919)

MANCHESTER COMMUNITY HEALTH CENTER

STATEMENTS OF CASH FLOWS (CONTINUED)

FOR THE YEARS ENDED JUNE 30, 2013 AND 2012

	2013	2012
Cash Flows From Financing Activities		
Restricted contributions for operations	175,248	33,778
Grants for capital acquisition	-	27,000
(Increase) decrease in donor restricted assets	(49,352)	19,793
Payments on long-term debt	(22,340)	(21,241)
Net Cash Provided by Financing Activities	103,556	59,330
Net Increase in Cash and Cash Equivalents	265,116	47,247
Cash and Cash Equivalents, Beginning of Year	89,261	42,014
CASH AND CASH EQUIVALENTS, END OF YEAR	$ 354,377	$ 89,261
Supplemental Disclosures of Cash Flow Information:		
Cash paid for interest	$ 69,366	$ 70,274

(See accompanying notes to these financial statements)

Mission, Vision and Core Values

Mission

To improve the health and well-being of our patients and the communities we serve by leading the effort to eliminate health disparities by providing exceptional primary and preventive healthcare and support services which are accessible to all.

Vision

MCHC will become the provider of choice for comprehensive primary health care by achieving the triple aim of better health outcomes, better patient care, and lowered costs through using innovative care models and strong community partnerships. MCHC will meet our mission by using evidence-based care that is patient-centered, engages families, removes barriers, and promotes well-being and healthy lifestyles through patient empowerment and education.

Core Values

We will promote wellness, provide exceptional care, and offer outstanding services so that our patients achieve and maintain their best possible health. We will do this through fostering an environment of respect, integrity and caring for all stakeholders in our organization.

ADOPTED: 01/28/2014

MANCHESTER
COMMUNITY
HEALTH CENTER

145 HOLLIS STREET
MANCHESTER, NH 03101

TEL 603-626-9500
FAX 603-626-0899
www.mchc-nh.org

Board of Director's List

Anthony Chismark
President
Term: 3 years

Dominique A. Rust
Treasurer
Term: 3 years

David Cuzzi
Vice President
Term: 3 years

Gerri Provost
Secretary
Term: 3 years

Mukhtar Idhow
Director
Term: 3 years

Robert Kuhl
Director
Term: 3 years

Maria Mariano
Director
Term: 3 years

Germano Martins
Director
Term: 3 years

Myra Nixon
Director
Term 3 years

Andru Volinsky
Director
Term: 3 years

Idowu Edokupo
Director
Term: 3 years

Tulasi Pokhrel
Director
Term: 3 years

Don Walega
Director
Term: 3 years

Toni Pappas
Director
Term: 3 years

145 HOLLIS STREET
MANCHESTER, NH 03101

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Germano Martins
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Myra Nixon
Director
Term 3 years

Andru Volinsky
Director
Term: 3 years

Idowu Edokupo
Director
Term: 3 years

Tulasi Pokhrel
Director
Term: 3 years

Don Walega
Director
Term: 3 years

Toni Pappas
Director
Term: 3 years

KEY ADMINISTRATIVE PERSONNEL

NH Department of Health and Human Services

Contractor Name: Manchester Community Health Center

Name of Bureau/Section: MCH Primary Care

BUDGET PERIOD: SFY 14

Program Area: MCH Primary Care

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Muir, Gavin	CMO/Family Practice Physician	$260,561	0.00%	$0.00
McCracken, Kristen	CEO/President	$150,010	0.00%	$0.00
Croteau, Michele	CFO	$96,907	0.00%	$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$0.00**

KEY ADMINISTRATIVE PERSONNEL

NH Department of Health and Human Services

Contractor Name: Manchester Community Health Center

Name of Bureau/Section: MCH Primary Care & BCCP

BUDGET PERIOD: SFY 15

Program Area: MCH Primary Care Services

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Muir, Gavin	CMO/Family Practice Physician	$263,494	0.00%	$0.00
McCracken, Kristen	CEO/President	$150,739	0.00%	$0.00
Croteau, Michele	CFO	$98,752	0.00%	$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$0.00**

Program Area: Breast and Cervical Cancer Program Services

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Muir, Gavin	CMO/Family Practice Physician	$263,494	0.00%	$0.00
McCracken, Kristen	CEO/President	$150,739	0.00%	$0.00
Croteau, Michele	CFO	$98,752	0.00%	$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$0.00**

J. GAVIN MUIR

Manchester Community Health Center
145 Hollis Street Manchester, NH 03101
(603) 935-5223
gmuir@mchc-nh.org

EDUCATION

PRINCETON UNIVERSITY, Princeton, NJ
M.S. in Ecology and Evolutionary Biology, 1991
Senior Thesis: "The Mating and Grazing Habits of Feral Horses on Shackleford Banks"

TEMPLE UNIVERSITY SCHOOL OF MEDICINE, Philadelphia, PA
M.D. 1995

SOUTHERN COLORADO FAMILY MEDICINE RESIDENCY,
Pueblo, CO, July 1995- June 1998

EXPERIENCE

MANCHESTER COMMUNITY HEALTH CENTER, Manchester, NH
Chief Medical Officer/ Family Practice Physician, September 2013-current

Family Practice Physician, March 2011- September 2013

Medical Director, September 2000 - March 2011

Family Practice Physician, August 1998 – September 2000

ELLIOT HOSPITAL, Manchester, NH
Medical Director of Peer Review, 2008 - present

ELLIOT HOSPITAL, Manchester, NH
Chair, Department of Medicine, 2006 - 2008

LICENSURE & CERTIFICATION

New Hampshire State Medical License	6/30/2012
DEA Certification	1/31/2012
ABFM Board Certified	12/31/2015

NALS/PALS/ALSO certified
Active Staff, Elliot Hospital, Manchester, NH

MEMBERSHIPS

The American Academy of Family Physicians
American Medical Association
New Hampshire Medical Society

AWARDS

New Hampshire Union Leader *Forty Under 40*. 2006
New Hampshire Academy of Family Physicians' Physician of the Year, 2013

Kristen McCracken, MBA

Objective

To work for an organization with a clear vision, philanthropic community involvement, well-respected leadership, a strong strategic plan, and a corporate culture that is motivating and inclusive.

Education

Undergraduate Degree: 1991 Mt. Holyoke College, Major: Psychology, Minor: Latin American Studies

Graduate Degree: 2000 Rivier College, MBA Health Care Administration

Summary of Qualifications

Areas of Experience:

- Community Health
- Primary Care
- Behavioral Health
- Electronic Medical Records
- Substance Abuse, HIV/AIDS
- Domestic Violence
- Rape Crisis
- Culturally Diverse Populations
- Federally Funded Programs
- Joint Commission Accreditation
- Fundraising
- Board of Directors

Skill Sets:

- Operations Management
- Strategic Planning
- Budget Development
- Grant Writing/Report Management
- Group Facilitation
- Regulatory Compliance
- Staff Supervision
- Project Management
- Quality Improvement/Data Mgmt.
- Community Collaboration
- Facilities Oversight
- Program Development

Professional experience

2013-Present: **President and CEO**- Manchester Community Health Center

- Oversee all service programs provided by MCHC to ensure that client needs are met and quality standards are maintained and monitored in an efficient, cost effective manner by: supervising program personnel; annually assessing relevance of current programs to community needs; achieving and maintaining appropriate accreditation and/or licenses for programs.
- Ensure that MCHC services are consistent with its mission, vision, and strategic plan to ensure that programming is relevant to existing and emerging client and community needs.
- With the Board Strategic Planning Committee, develop and assist with the planning, execution and evaluation of a fund raising program. Establish and maintain a rapport with corporate sponsors, major contributors, directors, volunteers, civic organizations, and other parties in which the Center does business.
- Recommend a staffing pattern to ensure efficient management and operation of all programs and activities.
- Serve as the primary staff resource for MCHC Board of Directors to ensure effective use of and communication with trustees.
- Ensure that MCHC activities are operated in a cost-effective, efficient manner to ensure ongoing financial stability
- Call and preside at regular meetings with staff to ensure adequate communication between staff, to give the opportunity to share ideas and concerns, to coordinate efforts, and to ensure appropriate standardization of policies and procedures.

- Recommend and communicate necessary policies and procedures to ensure adherence to management, program service, fiscal and accounting standards, and standards of good personnel procedures.

Michele M. Croteau
Certified Management Accountant

Experience

Financial Management in a Multi-Corporate, Multi-State, Multi-Location Environment
Not for Profit & Fund Accounting
Risk Management
Cash Flow Management
Short Term Investing
Financing Negotiations & Lease Purchasing
Bond Financing, BANs, QSCB, BABs
Budget / Project Planning & Management
Mergers
RFP & Bid Development
Medicare / CORF Cost Reports
Collective Bargaining
Board Level Presentations
GASB 34 & 45 Implementation
Audit Management
Design of Internal Controls
Single Audit Act Requirements
DOL Requirements
Grant Management /Federal Contracts
Direct Supervision of Various Departments:
  Accounts Payable, Accounting, Payroll
  Accounts Receivable, Purchasing
  Transportation, Food Service,
  Facility Management, Human Resources
TV, Radio, and Public Presentations
Capital Campaign Reporting
Cost Analysis
Software Research, Selection & Implementation
Process Walk Through & Design
Team Management
Team Facilitation
990 & 990t Preparation
State Charitable Trust Reports
Fixed Assets Management
Insurance Negotiations
Worker's & Unemployment Comp.
Conference Speaker

Software

Excel Spread Sheets / Graphs / Pivot Tables
Approach Database Word
Google Mail & Google Docs
Unifund / Pentamation / MUNIS
Outlook / Organizer / First Class
Crystal Report Writer
Power Point
Solomon & FRX Drilldown
Quickbooks & Quicken

Major Accomplishments – Concord School District (SAU#8)

Coordinated search, selection and implementation process for new financial / human resources software
Established a new chart of accounts to better meet District needs and comply with GAAP and State Handbook II guidelines
Introduced internal controls which successfully reduced the Management Letter comments by 100% from 38 to -0-
Obtained approval of $3.68m in Qualified School Construction Bond funding - savings of approx. $1m in interest
Created detailed financial model for costing all components of proposals during collective bargaining negotiations
Established a standardized procedure manual for use district-wide in the management of Student Activity Accounts
Established monthly process to export financial expenditure data for ease of analysis using Excel Pivot Tables
Refined budget process and created materials for Board presentation and public hearings
Positioned District to be able to bond $62.5m for a facility project independently; Secured Moody's rating of Aa2 in 2010
Issued $55m in bonds including Build America Bonds; Affirmed Aa2 Moody's rating; Secured first Standard & Poor's rating of AA-
  Saved $8.5m in interest expense on $55m bond issue through interest rebates

Major Accomplishments – SAU #19

Implementation of Annual Benefit Fairs
Negotiation of District Wide Copier Upgrade Plan
Staff Retention and Development
Implementation of Internal Controls
Financial Tracking / Reporting of Building Projects
Search and Selection of Finance/HR Software
District Savings Through:
* Resolution of Outstanding IRS Issues upon hire
* Implementation of Health Insurance Reconciliation
* Implementation of COBRA Tracking Process
* Bond Refunding resulting in $340k+ in savings
* Implementation of GASB 34 In-house / No Consultant Fees
* Negotiation of a 3-Year Rate Guarantee for Life & LTD Coverage
* Renegotiated a 66-Month Fixed Fee Copier Contract Resulting in $26K in Savings Over Prior Contract
* Improved Goffstown School District's Bond Rating from A3 in 1998 to A2 in 2001

Major Accomplishments – Easter Seal Society

Active in Financial Turnaround of Not-for-Profit Organization
Assisted in Merger of $5 Million NY Organization
Implemented Weekly Financial Information
Roll out of Drilldown Process & Networked Financial Information
Successful IRS Audits – No Adjustments
Conversion to Client / Server / Financial Software
Successful Financial & A-133 Audits
430% increase in Short Term Cash
Recipient of Awards for Outstanding Service

Michele M. Croteau

Certified Management Accountant

Relevant Work History

June 2012 – Present Manchester Community Health Center(MCHC) Manchester, NH

Chief Financial Officer – MCHC is a not-for-profit Federally Qualified Healthcare Center with 2 locations providing comprehensive primary care services with a focus on ensuring access to healthcare for the uninsured and underserved in the Greater Manchester Area. With an annual budget of $7m, MCHC provides family practice, pediatrics, obstetrics, podiatry, optometry, behavioral health, nutrition and health education, interpretation, transportation, and 403(b) pharmacy services for 8,800 active patients with 35,000 encounters and 220 deliveries annually. The CFO is responsible for all aspects of financial operations including leading, planning, organizing and overseeing financial operations. The CFO is a key member of the Senior Management team, serves as the MCHC representative to various external organizations, services on the Finance Committee (FC) of the Board of Directors and is responsible for financial reporting to the FC and the Board. The CFO is responsible for the recommendation of fiscal policy as well as the interpretation and application of fiscal policy as established by the Board of Directors.

December 2005 – June 2012 Concord School District SAU #8 Concord, NH

Business Administrator / Treasurer – The Concord School District is the 4th largest district in the State with approximately 4,900 students throughout 5 active elementary schools, 1 middle school and 1 high school, 1,000 staff, an operating budget of $70m plus $66.8m in construction budgets. This position supervises an office of 7 and is responsible for all financial operations, including but not limited to the processing of payroll, accounts payable, cash receipts, purchasing, budget development and tracking, financial reporting, internal controls, bid management, bond issuance and alternative financing arrangements, grant management, audit preparation, participation in risk management and insurance negotiations, and State reports. Additionally, this role functions as a member of the Executive Team, is responsible for supervision of the Food Service and Transportation departments, and is on the negotiating team for the Concord Education Association collective bargaining agreement.

October 1998 – December 2005 School Administrative Unit # 19 Goffstown, NH

Business Manager - The SAU served the school districts of Dunbarton, Goffstown, and New Boston including 6 schools, approximately 3,800 students and 500 staff. This position supervised an office of 5 and was responsible for all financial operations, including but not limited to the processing of 4 payrolls, accounts payable, cash receipts, purchasing, budget development and tracking, financial reporting, internal controls, bid management, bond issuance, grant management, audit preparation, review and negotiation of contractual documents, risk management and insurance negotiations. food service operations, State reports, and development of the annual district meeting warrants. Dunbarton's budget was approved via traditional Town Meeting, New Boston's was SB-2 non-Municipal Budget Act (no Budget Committee; Finance Committee advisory only), Goffstown was SB-2 Municipal Budget Act (Budget Committee approved budget for public vote) and the SAU's budget was approved via the SAU Board.

July 1986 – September 1998 Easter Seal Society of NH, Inc. Manchester, NH

July 1988 – September 1998 Controller (for Parent & Subsidiaries)

Corporate headquarters for a $29 million tri-state, multi-corporate not-for-profit organization employing approximately 1000 staff. Supervised departments including 13 staff responsible for 4 payrolls, purchasing, accounts payable, cash receipts, internal and external audits, grant reporting and management, budget development, financial statement preparation, general ledger chart of accounts structure, and new reports development. Provided cash management, investing of short term funds, negotiating and securing loans, cost analysis, and cost projections. Served as an authorized signer on all accounts.

Sept. 1992 – Sept. 1994 Controller & Information Systems Supervisor (including network management)

July 1986 – July 1988 Assistant Controller (Promoted)

1979 – 1986 Employment in accounting (Easter Seal Society) and computer programming.

Education

New Hampshire College	Bachelor in Management Advisory Services (Dual Degree – Accounting & Computer Science)
Certifications:	Certified Management Accountant, IMA; Certified Netware Administrator version 3.11, Novel
Credentials:	Business Administrator - Alternative IV Statement of Eligibility

Associations

NH ASBO – Immediate Past President (2007, 2008), President (2006), Vice President (2005), Executive Committee (2003, 2004)

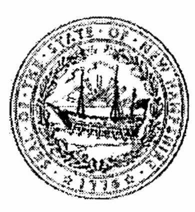
Institute of Management Accountants — IMA – Controllers Council (Past Member)

ASBO International — NH School Administrators Association

Other

Presenter: Budgeting – NH ASBO (2005); Budgeting – Tri-State ASBO (2005); RFP's – NH SAA (2005 Best Practices)
Competitive Bidding for Utilities - NH SAA (Best Practices)
Various presentations for aspiring school administrators – NH SAA

Board Member: NHTI Advisory Board (active; appointed summer 2010)
Founding Member of the John Stark General's Football Association; Treasurer (term expired)



STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

29 HAZEN DRIVE, CONCORD, NH 03301-6527
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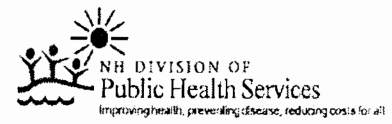

Nicholas A. Toumpas
Commissioner

José Thier Montero
Director

May 2, 2012

APPROVED G&C ______
DATE ______
APPROVED G&C # 132
DATE 6/20/12
NOT APPROVED ______

His Excellency, Governor John H. Lynch
and the Honorable Executive Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Public Health Services, Bureau of Population Health and Community Services, Maternal and Child Health Section, to enter into an agreement with Manchester Community Health Center (Vendor #157274-B001), 145 Hollis Street, Manchester, New Hampshire 03101, in an amount not to exceed $572,396.00, to provide primary care services and breast and cervical cancer screening, to be effective July 1, 2012 or date of Governor and Executive Council approval, whichever is later, through June 30, 2014. Funds are available in the following accounts for SFY 2013, and are anticipated to be available in SFY 2014 upon the availability and continued appropriation of funds in the future operating budgets.

05-95-90-902010-5190 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES, MATERNAL AND CHILD HEALTH

Fiscal Year	Class/Object	Class Title	Job Number	Total Amount
SFY 2013	102-500731	Contracts for Program Services	90080000	$239,002
SFY 2014	102-500731	Contracts for Program Services	90080000	$239,002
			Sub-Total	$478,004

05-95-90-902010-5659 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES, COMPREHENSIVE CANCER

Fiscal Year	Class/Object	Class Title	Job Number	Total Amount
SFY 2013	102-500731	Contracts for Program Services	90080081	$47,196
SFY 2014	102-500731	Contracts for Program Services	90080081	$47,196
			Sub-Total	$94,392
			Total	$572,396

EXPLANATION

Funds in this agreement will be used to provide breast and cervical cancer screening and office-based primary care services for low-income and uninsured families. This agreement provides funds for services as a last resort; contractor is required to make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid.

Primary health care services include preventive and episodic health care for acute and chronic health conditions for people of all ages, including pregnant women, children, adolescents, adults, and the elderly. Community health agencies that receive support through the Division of Public Health Services deliver primary and preventive health care services to underserved people who face barriers to accessing health care, due to issues such as a lack of insurance, inability to pay, language barriers, and geographic isolation. In addition to medical care, community health centers are unique among primary care providers for the array of patient-centered services they offer, including care coordination, translation, transportation, outreach, eligibility assistance, and health education. These services help individuals overcome barriers to getting the care they need and achieving their optimal health. One area of particular success has been in ensuring that eligible families maintain consistent enrollment in Medicaid for their children. Community health centers provide support for families in filling out applications and ensuring that children have continuity of care.

Community health agencies throughout New Hampshire have demonstrated success in meeting the health care needs of the uninsured and under-insured citizens of the state. Division of Public Health Services funded primary care providers participate in rigorous quality improvement efforts utilizing standard performance measures that focus attention on improving health outcomes for patients. For example, in State Fiscal Year 2011:

- 88% of eligible children served were enrolled in Medicaid/Healthy Kids Gold.
- 86% of children 24-35 months, served received the appropriate schedule of immunizations.
- 82% of infants born to women served received prenatal care beginning in the first trimester of pregnancy.

In addition, breast and cervical cancers continue to be ongoing public health issues for New Hampshire. The Division of Public Health Services, Breast and Cervical Cancer Screening Program provides support for breast and cervical cancer screening services that include clinical examinations, pap smears and referral for mammography. Through this program, women found to have abnormal screening results, following their testing, receive additional coverage for diagnostic work-up and, if necessary, have their care coordinated through the initiation of treatment.

Should Governor and Executive Council not authorize this Request, a minimum of 16,050 low-income individuals from the Greater Manchester area may not have access to primary care services, and eligible women may not receive recommended breast and cervical cancer screenings. A strong primary care infrastructure reduces costs for uncompensated care, improves health outcomes, and reduces health disparities. Additionally women that receive recommended breast and cervical cancer screenings are at lower risk of late diagnosis of breast and cervical cancers.

Manchester Community Health Center was selected for this project through a competitive bid process. A Request for Proposals was posted on the Department of Health and Human Services' web site from January 10, 2012 through February 16, 2012. In addition, a bidder's conference, conference call, and web conference were held on January 19, 2012 to alert agencies to this bid.

Thirteen proposals were received in response to the posting. Each proposal was scored by three professionals, who work internal and external to the Department of Health and Human Services. All reviewers have between three to twenty years experience either in clinical settings, providing community-based family support services, and managing agreements with vendors for various public health programs. Areas of specific expertise include maternal and child health; quality assurance and performance improvement; chronic and communicable diseases and public health infrastructure. The reviewers used a standardized form to score agencies' relevant experience and capacity to carry out the activities outlined in the proposal. Reviewers look for realistic targets when scoring performance measures in addition to detailed workplans including evaluation components. Budgets were reviewed to be reasonable, justified and consistent with the intent of the program goals and outcomes. There were no competing applications within each of the separate service areas. Scores were averaged and all proposals were recommended for funding. In those instances where scores were less than ideal, agency specific remedial actions were recommended and completed. Some primary care agencies are being funded at levels higher than they requested. Agencies were instructed to develop budgets based on previous allocations. While some proposed budgets higher than what was available for funding, others proposed budgets lower than what was available. There was an increase in breast and cervical cancer screening funds that bidders were unaware of when they drafted budgets. Adjustments were made accordingly for those agencies that proposed budgets at levels lower than available funds. This is a contract where that situation occurred. The Bid Summary is attached.

As referenced in the Request for Proposals, Renewals Section, this competitively procured Agreement has the option to renew for two additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties and approval of the Governor and Executive Council. These services were contracted previously with this agency in SFY 2011 and SFY 2012 in the amount of $903,136. This represents a decrease of $330,740. The decrease is due to budget reductions.

The performance measures used to measure the effectiveness of the agreement are attached.

Area served: Greater Manchester.

Source of Funds: 33.15% Federal Funds from US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau and 66.85% General Funds.

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

Respectfully submitted,

José Thier Montero, MD
Director

Approved by:
Nicholas A. Toumpas
Commissioner

JTM/PMT/sc

Primary Care Performance Measures

State Fiscal Year 2013

Primary Care Prenatal (PN) Performance Measure #1

Measure: Percent of infants born to women receiving prenatal care beginning in the first trimester of pregnancy.

Primary Care Prenatal (PN) Performance Measure #2

Measure: Percent of pregnant women identified as cigarette smokers that are referred to QuitWorks-New Hampshire.

Primary Care Prenatal (PN) Performance Measure #3

Measure: Percent of pregnant women who were screened, using a formal valid screening tool, for alcohol and other drug use during every trimester the patient was enrolled.

Primary Care Child Health Direct (CH – D) Performance Measure #1

Measure: Percent of eligible children enrolled in Medicaid

Primary Care Child Health Direct (CH – D) Performance Measure #2

Measure: Percent of at-risk children who were screened for blood lead between 18 and 30 months of age

Primary Care Child Health Direct (CH – D) Performance Measure #3

Measure: Percent of children age two to nineteen years receiving primary care preventive health services with a Body Mass Index (BMI) percentile greater than or equal to the 85th percentile with documented discussion of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Primary Care Child Health Direct (CH – D) Performance Measure #4

Measure: Percent of eligible infants and children with client record documentation of enrollment in Women Infant Children Program.

Primary Care Child Health Direct (CH – D) Performance Measure #5

Measure: Percent of infants who were exclusively breastfed for the first three months, at their four month well baby visit.

Primary Care Financial (PC) Performance Measure #1

Measure: Patient Payor Mix

Primary Care Financial (PC) Performance Measure #2

Measure: Accounts Receivables (AR) Days

Primary Care Financial (PC) Performance Measure #3

Measure: Current Ratio

Primary Care Performance Measures

State Fiscal Year 2013

Primary Care Clinical Adolescent (PC-C) Performance Measure #1

Measure: Percent of adolescents aged 10-21 years who received annual health maintenance visits in the past 12 months.

Primary Care Clinical Prenatal (PC-C) Performance Measure #2

Measure: Percent of women and adolescent girls aged 15-44 who take a multi-vitamin with folic acid.

Subject: Primary Care Services

AGREEMENT

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

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name NH Department of Health and Human Services Division of Public Health Services		**1.2 State Agency Address** 29 Hazen Drive Concord, NH 03301-6504	
1.3 Contractor Name Manchester Community Health Center		**1.4 Contractor Address** 145 Hollis Street Manchester, New Hampshire 03101	
1.5 Contractor Phone Number 603-935-5213	**1.6 Account Number** 010-090-5190-102-500731 010-090-5659-102-500731	**1.7 Completion Date** June 30, 2014	**1.8 Price Limitation** $572,396
1.9 Contracting Officer for State Agency Joan H. Ascheim, Bureau Chief		**1.10 State Agency Telephone Number** 603-271-4501	
1.11 Contractor Signature [signature]		**1.12 Name and Title of Contractor Signatory** Edward G. George President/CEO	

1.13 Acknowledgement: State of NH, County of Hillsborough

On 4/3/12, before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.

1.13.1 Signature of Notary Public or Justice of the Peace

[Seal] CECILIA M. SKERRY NOTARY PUBLIC Commission Expires 05-12-2015 NEW HAMPSHIRE

[signature]

1.13.2 Name and Title of Notary or Justice of the Peace

Cecilia M. Skerry

1.14 State Agency Signature [signature]	**1.15 Name and Title of State Agency Signatory** Joan H. Ascheim, Bureau Chief

1.16 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)*

By: Director, On:

1.17 Approval by the Attorney General (Form, Substance and Execution)

By: Jeanne P. Herrick, Attorney On: 14 May 2012

1.18 Approval by the Governor and Executive Council

By: On:

Exhibit A

Scope of Services

Primary Care Services

CONTRACT PERIOD: July 1, 2012 or date of G&C approval, whichever is later, through June 30, 2014

CONTRACTOR NAME: Manchester Community Health Center

ADDRESS: 145 Hollis Street
Manchester, New Hampshire 03101
President/Chief Executive Officer: Edward George
TELEPHONE: 603-935-5213

The Contractor shall:

I. General Provisions

A) Eligibility and Income Determination

1. Office-based primary care services will be provided to low-income individuals and families (defined as ≤ 185% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), in the State of New Hampshire.

2. Breast and Cervical Cancer screening services will be provided to low-income (defined as ≤ 250% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), New Hampshire women age 18 – 64, *uninsured or underinsured*.

3. The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing if, at any time, the practice is closed to new patients, or maintains a wait list for new patients, or any other mechanism is used that limits access for new patients for more than a one month period.

4. The Contractor shall document annually, for each client enrolled in the program, family income and family size, and calculate percentage of the federal poverty level. If calculations indicate that the client may be eligible for enrollment in Medicaid, the Contractor shall complete with the client the most recent version of the 800P form.

5. The Contractor shall implement, and post in a public and conspicuous location, a sliding fee payment schedule, approved in advance by the Division of Public Health Services (DPHS), for low-income patients. Signage must state that no client will be denied services for inability to pay.

   a. As an alternative, the contractor may post, in a public and conspicuous location, a notice to clients that a sliding fee scale is available and that no client will be denied services for inability to pay. The sliding fee scale must be updated annually based on USDHHS Poverty guidelines as published in the Federal Register, submitted to and approved by DPHS *prior to implementation.*

6. The primary care contract entered into here shall be the payer of last resort. The contractor shall make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid, for all reimbursable services rendered.

Contractor Initials: EG
Date: 4/2/12

B) Numbers Served

1. The contract funds shall be expended to provide the above services to a minimum of 8,025 users annually with 37,930 medical encounters, as defined in the Data and Reporting Requirements. Breast and Cervical Cancer Screening for eligible women, as defined by the Breast and Cervical Cancer Program (BCCP), shall be provided to 310 women annually and billed directly to the BCCP. Clinical service reimbursements shall not exceed the Medicare rate.

C) **Culturally and Linguistically Appropriate Standards of Care**

The Department of Health and Human Services (DHHS) recognizes that culture and language have considerable impact on how consumers access and respond to public health services. Culturally and linguistically diverse populations experience barriers in efforts to access health services. To ensure equal access to quality health services, the Division of Public Health Services (DPHS) expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.

2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.

3. *Provide* clients of limited English proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.

4. Offer consumers a forum through which clients have the opportunity to provide feedback to providers and organizations regarding cultural and linguistic issues that may deserve response.

5. The contractor shall maintain a program policy that sets forth compliance with Title VI, Language Efficiency and Proficiency Citation 45 CFR 80.3(b) (2). The policy shall describe the way in which the items listed above were addressed and shall indicate the circumstances in which interpretation services are provided and the method of providing service (e.g. trained interpreter, staff person who speaks the language of the client, language line).

D) **State and Federal Laws**

The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. The Contractor shall report all cases of communicable diseases according to New Hampshire RSA 141-C and He-P 301, adopted 6/3/08.

2. Persons employed by the contractor shall comply with the reporting requirements of New Hampshire RSA 169:C, Child Protection Act; RSA 161:F46, Protective Services to Adults, RSA 631:6, Assault and Related Offences and RSA 130:A, Lead Paint Poisoning and Control.

3. Immunizations shall be conducted in accordance with RSA 141-C and the Immunization Rules promulgated hereunder.

E) **Relevant Policies and Guidelines**

1. The Contractor shall design and provide the services described above to meet the unique and identified health needs of the populations within the contracted service area.

Contractor Initials: [initials]
Date: 4/3/17

2. Primary Care funds shall be targeted to populations in need. Populations in need are defined as follows:

   a) uninsured;

   b) under-insured;

   c) families and individuals with significant psychosocial and economic risk, including low income status;

   d) all life cycles including perinatal, child, adolescent, adult, and elderly who meet one or more of the above criteria.

3. The Contractor shall design and implement systems of governance, administration, financial management, information management, and clinical services which are adequate to assure the provision of contracted services, and to meet the data and reporting requirements. These systems shall meet the most current minimum standards described in at least one of the following: Health Resources and Services Administration (HRSA) Office of Performance Review protocols, Joint Commission on Accreditation of Health Care Organizations (JCAHO), Accreditation Association for Ambulatory Healthcare (AAAHC), Community Health Accreditation Program (CHAP), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey.

4. *The Contractor shall have an agency emergency preparedness and response plan in accordance with HRSA Health Center Emergency Management Program Expectations, Document #2007-15 or most recent version. Such plan shall also include a Continuity of Operations plan.*

5. The Contractor shall carry out the work as described in the performance Workplan submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

6. No Workplan is required by the Breast and Cervical Cancer Program (BCCP). The contractor shall be required to respond to the Quality Improvement Feedback Report twice a year.

7. The Contractor shall carry out the work as described in the Supplemental Funding Form submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

F) Publications Funded Under Contract

1. The DHHS and/or its funders will retain COPYRIGHT ownership for any and all original materials produced with DHHS contract funding, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports.

2. All documents (written, video, audio, *electronic*) produced, reproduced, or purchased under the contract shall have prior approval from DPHS before printing, production, distribution, or use.

3. The Contractor shall credit DHHS on all materials produced under this contract following the instructions outlined in Exhibit C (14).

G) Subcontractors

1. If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing *and approve the subcontractual agreement,* prior to initiation of the subcontract.

Contractor Initials: [signature]
Date: 1/3/12

2. In addition, the original DPHS contractor will remain liable for all requirements included in this Exhibit and carried out by subcontractors.

II. Minimal Standards of Core Services

A) Service Requirements

1. *Medical Home*

   The Contractor shall provide a Medical Home that:

   a) *Facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family.*

   b) *Provides care facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.*

2. Primary Care Services

   The Contractor shall provide office-based primary care services to populations in need who reside in the contractor's service area. Primary care services shall include:

   a) Health care provided by a New Hampshire licensed MD, DO, APRN, or PA, including diagnosis and treatment of acute and chronic illnesses within the scope of family practice; preventive services, screenings, and health education according to established, documented state or national guidelines; assessment of need for social and nutrition services, and appropriate referrals to health, *oral health*, and behavioral health specialty providers.

   b) *Referral to the WIC Nutrition Program for all eligible pregnant women, infants and children.*

   c) In-hospital care for conditions within the scope of family practice must be provided at a hospital, within the agency service area, through a staff clinician with full hospital privileges, or in the alternative, through a formal referral and admissions procedure available to clients on a 24 hour/7 day a week basis.

   d) Access to a healthcare provider, directly or by referral or subcontract, by telephone twenty-four hours per day, seven days per week.

   e) Assessment of psychosocial risk for all clients at least annually and for children at scheduled preventive care visits, including, at a minimum, age appropriate assessment of safety in the home, domestic violence, adequacy of food and housing, care and welfare of children, transportation needs, and provision of necessary social services to address the priority needs and safety issues of clients and families.

   f) Falls prevention screening for patients 65 years and older using the algorithm and guidelines of the American Geriatrics Society.

   g) Behavioral health care directly or by referral to an agency or provider with a sliding fee scale.

   h) *Nutrition assessment for all clients as part of the health maintenance visit.* Therapeutic nutrition services shall be provided *as indicated* directly or by referral to an agency or provider with a sliding fee scale. These services shall be recorded in the medical record.

   i) Formal arrangements with a local hospital for emergency care must be in place and reviewed annually.

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j) Home health care directly or by referral to an agency or provider with a sliding fee scale.

k) Assisted living and skilled nursing facility care by referral.

l) *Oral screening annually for all clients 19 years and older to note obvious dental decay and soft tissue abnormalities with a reminder to the patient that poor oral health impacts total health.*

m) *Diagnosis and management of pediatric and adult patients with asthma provided according to National Heart Lung Blood Institute, National Asthma Education and Prevention Program, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, 2007.*

2. Breast and Cervical Cancer Screening

a) Women age 18 to 64 who are eligible for Breast and Cervical Cancer Program (BCCP) services according to income (equal to or under 250% of poverty, underinsured/uninsured) *and insurance status* criteria shall be provided the following services:

i. cervical cancer screening including a pelvic examination and Pap smear;
ii. annual breast cancer screening including a clinical breast exam, mammogram and,
iii. referrals for diagnostic and treatment services based on screening results,
iv. case management services.

b) All referrals under this provision shall be to approved certified laboratory, pathology, radiology, and surgical services. Mammography units shall be accredited by the American College of Radiology, and must be FDA certified under MQSA. Laboratories shall be CLIA certified.

c) All services shall be provided in accordance with the Breast and Cervical Cancer Program (BCCP) Policy and Procedure Manual.

d) Follow-up and tracking of all tests done, and referrals made shall be provided in accordance with the minimum standards outlined in the Breast and Cervical Cancer Program Policy and Procedure Manual.

e) All services for women enrolled in the Breast and Cervical Cancer Program (BCCP) shall be billed directly to the BCCP in accordance with protocols established by the Breast and Cervical Cancer Program.

3. Reproductive Health Services

The Contractor shall provide prenatal, interconceptional and preconception medical care, social services, nutrition services, education, and nursing care to all women of childbearing age. Preconceptional care includes the preconception, interconceptional, and postpartum periods in women's health. It is recommended that preconceptional and interconceptional care visits focus on maintaining or achieving the optimal health of the mother, lowering the risk of future adverse pregnancy outcomes, the family's future plans, and how additional children fit into that plan. Preconceptional counseling may be done during an office, group or home visit.

a) In the event prenatal care is not provided directly by the Contractor a formal Memorandum/a of Agreement for coordinated referral to an appropriately qualified provider must be maintained.

b) Prenatal care shall, at minimum, be provided in accordance with the Guidelines for Perinatal Care, sixth or most current edition, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and /or the Centers for Disease Control.

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Date: 4/3/12

c) Age appropriate reproductive health care shall, at a minimum, be provided in accordance with the American College of Obstetricians and Gynecologists, or the USDHHS Centers for Disease Control (CDC) current guidelines.

d) *Pregnant women enrolled in the WIC Nutrition Program shall be referred to WIC for breastfeeding education and referral to the WIC Nutrition Program peer counselors.*

e. Family planning counseling for prevention of subsequent pregnancy following an infant's birth shall be discussed with the infant's mother *at the first postpartum visit and at the infant's 2-month visit and other visits as appropriate.* Rationale for birth intervals of 18-24 months shall be presented.

f) A referral to a Title X Family Planning Clinic or other reproductive health care provider shall be made as appropriate.

4. Services for Children and Adolescents

The Contractor shall provide as a minimum, comprehensive and age-appropriate health care, screenings, and health education according to the American Academy of Pediatrics' most recent periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent. Children and adolescent visits shall include:

a) Blood lead testing shall be performed in accordance with "New Hampshire Childhood Lead Poisoning Screening and Management Guidelines", issued by the New Hampshire Department of Health and Human Services, 2009 or subsequent revisions.

b) All children enrolled in either Healthy Kids-Gold or the Women, Infant, and Children (WIC) Program and/or who are $\leq$ 185% poverty, regardless of town of residence, are required to have a blood lead test at ages one and two years. All children ages three to six years who have not been previously tested shall have a capillary or venous blood lead test performed.

c) All children shall be screened for iron deficiency anemia as outlined in the Centers for Disease Control and Prevention document "Recommendations to Prevent and Control Iron Deficiency in the United States (4/2/98)".

d) Age-appropriate anticipatory guidance, dietary guidance, and *feeding practice counseling* for optimal oral health shall be provided at each well child visit according to the American Academy of Pediatrics' periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent edition. Starting at age 6 months, it is recommended that all children receive an oral health assessment at every well child visit.

e) Supplemental fluoride shall be prescribed as needed based upon the fluoride levels in the child's *drinking* water supply. The fluoride dosage regimen accepted by the American Academy of Pediatrics shall be followed. No fluoride shall be prescribed without obtaining water from private wells or noting the presence or absence of fluoride in the public water supply. *Supplemental fluoride may include bottled water containing fluoride and topical applications such as varnishes.*

f) *For infants enrolled in the WIC Nutrition Program, parents shall be referred to WIC for breastfeeding support and referral to the WIC Nutrition Program peer counselors.*

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5. Sexually Transmitted Infections

Primary Care Services shall provide age appropriate screening and treatment of sexually transmitted infections.

a) Treatment for sexually transmitted infections shall be provided according to the United States Centers for Disease Control Sexually Transmitted Diseases Treatment Guidelines, 2010 or subsequent revisions.

b) All clients, including women, shall be offered HIV testing following the most current recommendations of the United States Centers for Disease Control.

c) The contractor shall be responsible for ensuring referral to appropriate treatment services for any woman found to screen positive.

d) Appropriate risk reduction counseling shall be provided based on client needs.

6. Substance Use Services

a) A substance use screening history using a formal, validated screening tool shall be obtained for all clients as soon after entry into care as possible. Substance use counseling *or other substance abuse intervention, treatment, or recovery services* by an appropriately credentialed provider shall be provided on-site, or by referral, to clients with identified needs for these services. ***For these identified clients, ongoing primary care services should include follow up monitoring relative to substance abuse.***

b) All clients, including pregnant women, identified as smokers shall receive counseling *using the 5A's (ask, advise, assess, assist, and arrange) treatment available through the NH Tobacco Helpline* as cited in the US Public Health Services report "Tobacco Use and Dependence", 2008, or "Smoking Cessation During Pregnancy: *A Clinician's Guide to Helping Pregnant Women Quit Smoking*", American College of Obstetricians and Gynecologists, 2011. *With prior approval, agencies may also opt to participate in the DPHS best practice initiative of the 2A's and R (ask, advise and refer)*.

7. Immunizations

a) The Contractor shall adhere to the most current version of the "Recommended Adult Immunization Schedule United States", approved by the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

b) The Contractor shall administer vaccines according to the most current version of the *"Recommended Immunization Schedule for Persons Aged 0 Through 6 Years - United States", and "Recommended Immunization Schedule for Persons Aged 7 Through 18 Years – United States"* approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians, based upon availability of vaccine from the New Hampshire Immunization Program.

8. Prenatal Genetic Screening

a) A genetic screening history shall be obtained on all prenatal clients as soon after entry into care as possible.

b) All pregnant women should be offered voluntary genetic screening for fetal chromosomal abnormalities at the appropriate time following recommendations found in the American College of Obstetricians and Gynecologists' "Screening for Fetal Chromosomal

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Abnormalities (2007)" or more recent guidelines. The Contractor shall be responsible for ensuring referral to appropriate genetic testing and counseling for any woman found to have a positive screening test.

9. Additional Requirements

   a) The Contractor's Medical Director shall participate in the development and approval of specific guidelines for medical care that supplement minimal clinical standards. Supplemental guidelines should be reviewed, signed, and dated annually, and updated as indicated.

   b) Contractors considering clinical or sociological research using clients as subjects must adhere to the legal requirements governing human subjects research. Contractors must inform the DPHS, MCHS prior to initiating any research related to this contract.

   c) *The Contractor shall provide information to all employees annually about the Medical Reserve Corps Unit within their Public Health Region to enhance recruitment.*

   d) *The Contractor shall provide information to all employees annually regarding the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) managed by the NH Department of Health and Human Services' Emergency Services Unit, to enhance recruitment.*

B) Staffing Provisions

The Contractor shall have, at minimum, the following staff positions:

a) executive director

b) fiscal director

c) registered nurse

d) clinical coordinator

e) medical service director

f) nutritionist *(on site or by referral)*

g) social worker

Staff positions required to provide direct services on-site include:

a) registered nurse

b) clinical coordinator

c) social worker

1. Qualifications

   All health and allied health professionals shall have the appropriate New Hampshire licenses whether directly employed, contracted, or subcontracted.

   In addition the following minimum qualifications shall be met for:

   a) Registered Nurse

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Date: 4/3/12

a. A registered nurse licensed in the state of New Hampshire, Bachelor's degree preferred. Minimum of one-year experience in a community health setting.

b) Nutritionists:

a. A Bachelor's degree in nutritional sciences or dietetics, or a Master's degree in nutritional sciences, nutrition education, or public health nutrition or current Registered Dietitian status in accordance with the Commission on dietetic Registration of the American Dietetic Association.

b. Individuals who perform functions similar to a nutritionist but do not meet the above qualifications shall not use the title of nutritionist.

c) Social Workers shall have:

a. A Bachelor's or Master's degree in social work or Bachelor's or Master's degree in a related social science or human behavior field. A minimum of one year of experience in a community health or social services setting is preferred.

b. Individuals who perform functions similar to a social worker but do not meet the above qualifications shall not use the title of social worker.

d) Clinical Coordinators shall be:

a. A registered nurse (RN), physician, physician assistant, or nurse practitioner with a license to practice in New Hampshire.

b. The coordinator is a clinical position that oversees and takes responsibility for the clinical and administrative functions of each program.

c. The coordinator may be responsible for more than one MCH funded program.

2. New Hires

The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing within one month of hire when a new administrator, clinical coordinator, or any staff person essential to carrying out contracted services is hired to work in the program. A resume of the employee shall accompany the aforesaid notification.

3. Vacancies

a) The Contractor must notify the MCHS in writing if any critical position is vacant for more than one month, or if at any time funded under this contract does not have adequate staffing to perform all required services for more than one month. This may be done through a budget revision.

b) Before an agency hires new program personnel that do not meet the required staff qualifications, the agency shall notify the MCHS in writing requesting a waiver of the applicable staffing requirements. The Section may grant waivers based on the need of the program, individuals' experience, and additional training.

C) Coordination of Services

1. The Contractor shall coordinate, where possible, with other service providers within the contractor's community. At a minimum, such collaboration shall include interagency referrals and coordination of care.

2. The Contractor shall participate in activities *in the Public Health Region in which they provide services* as appropriate. These activities enhance the integration of community-based public health

Contractor Initials: [signature]

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prevention and health care initiatives that are being implemented by the contractor and may include community needs assessments, public health performance assessments, and/or the development of regional health improvement plans.

3. The Contractor agrees to *participate* in and coordinate public health activities as requested by the Division of Public Health Services during any *disease outbreak* and/or *emergency*, natural or man made, affecting the public's health.

4. The Contractor is responsible for case management of the client enrolled in the program and for program follow-up activities. Case management services shall promote effective and efficient organization and utilization of resources to assure access to necessary comprehensive medical, nutritional, and social services for clients.

5. The Contractor shall assure that *appropriate, responsive, and timely* referrals and linkages for other needed services are made, carried through, and documented. Such services shall include, but not be limited to: dental services, genetic counseling, high risk prenatal services, mental health, social services, including domestic violence crisis centers, substance abuse services; and family planning services, Early Supports and Services Program, local WIC/CSF Program, Home Visiting New Hampshire Programs and health and social service agencies which serve children and families in need of those services.

D) Meetings and Trainings

The contractor will be responsible for sending staff to meetings and training required by the MCHS program, including but not limited to:

1. MCHS Agency Directors' meetings

2. Prenatal and Child Health Coordinators' meetings

3. MCHS Agency Medical Services Directors' meetings

III. Quality or Performance Improvement (QI/PI)

A) Workplans

1. Performance Workplans are required for this program and are used to monitor achievement of standard measures of performance of the services provided under this contract. The workplans are a key component of the RHPCS and the MCHS performance-based contracting system and of this contract. Outcomes shall be reported by clinical site.

2. Performance Workplans and Workplan Outcome reports according to the schedule and instructions provided by the MCHS. The MCHS shall notify the Contractor at least 30 days in advance of any changes in the submission schedule.

3. The Contractor shall incorporate required and developmental performance measures, defined by the MCHS into the agency's Performance Workplan. Reports on Workplan Progress/Outcomes shall detail the Performance Workplan plans and activities that monitor and evaluate the agency's progress toward performance measure targets.

4. The Contractor shall comply with modifications and/or additions to the workplan and annual report format as requested by RHPCS and MCHS. MCHS will provide the contractor with reasonable notice of such changes.

5. Agencies contracting for Primary Care Services must submit the workplans for Primary Care *Clinical and Financial*, Child Health, and Prenatal Care.

Contractor Initials: [signature]
Date: 4/3/17

B) Additional Reporting requirements

In addition to Performance Workplans, the Contractor shall submit to MCHS the following data and information listed below which are used to monitor program performance:

1. In years when contracts or amendments are not required, the DPHS Budget Form, Budget Justification, Sources of Revenue and Program Staff list forms must be completed according to the relevant instructions and submitted as requested by DPHS and, at minimum, by April 30 of each year.

2. The Sources of Revenue report must be resubmitted at any point when changes in revenue threaten the ability of the agency to carry out the planned program.

3. Completed Uniform Data Set (UDS) tables reflecting program performance in the previous calendar year, by March 31 of each year.

4. The Perinatal Client Data Form (PCDF) shall be submitted electronically according to the instructions set forth by the MCHS.

5. A copy of the agency's updated Sliding Fee Scale including the amount(s) of any client fees and the schedule of discounts must be submitted by March 31st of each year. The agency's sliding fee scale must be updated annually based on the US DHHS Poverty guidelines as published in the Federal Register.

6. An annual summary of program-specific patient satisfaction results obtained during the prior contract period and the method by which the results were obtained shall be submitted annually as an addendum to the Workplan Outcome/Progress reports.

C) On-site reviews

1. The contractor shall allow a team or person authorized by the Division of Public Health Services to periodically review the contractor's systems of governance, administration, data collection and submission, clinical and financial management, and delivery of education services in order to assure systems are adequate to provide the contracted services.
2. Reviews shall include client record reviews to measure compliance with this exhibit.
3. The contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.
4. On-Site reviews may be waived or abbreviated at the discretion of MCHS, upon submission of satisfactory reports of reviews such as Health Services Resources Administration (HRSA): Office of Performance Review (OPR), or reviews from nationally accreditation organizations such as the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), Medicare, the Community Health Accreditation Program (CHAP), Accreditation Association for Ambulatory Healthcare (AAAHC), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey. Abbreviated reviews will focus on any deficiencies found in previous reviews, issues of compliance with this exhibit, and actions to strengthen performance as outlined in the agency Performance Workplan.

Contractor Initials: [signature]

Date: 4/3/17

State of New Hampshire
Department of Health and Human Services
Amendment #1 to the
Mid-State Health Center

This 1st Amendment to the Mid-State Health Center contract (hereinafter referred to as "Amendment One") dated this 13th day of March, 2014, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Mid-State Health Center (hereinafter referred to as "the Contractor"), a corporation with a place of business at 101 Boulder Point Drive, Suite 1, Plymouth, New Hampshire 03264.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on June 20, 2012, 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, the State and the Contractor have agreed to make changes to the scope of work, payment schedules and terms and conditions of the contract; and

WHEREAS, pursuant to the General Provisions, Paragraph 18, the State may modify the scope of work and the payment schedule of the contract by written agreement of the parties;

WHEREAS, the Department desires to provide additional primary health care services for preventive and episodic health care for acute and chronic health conditions for people of all ages.

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 as follows:

To amend as follows:

- Form P-37, to change:
  Block 1.7 to read: June 30, 2015
  Block 1.8 to read: $444,862

- Exhibit A, Scope of Services to add:
  Exhibit A – Amendment 1

- Exhibit B, Purchase of Services, Contract Price, to add:

  Paragraph 1.1 to Paragraph 1:
  The contract price shall increase by $35,001 for SFY 2014 and $175,511 for SFY 2015.

  Paragraph 1.2 to Paragraph 1:
  Funding is available as follows:
- $35,001 from 05-95-90-902010-5190-102-500731, 100% General Funds;
- $175,511 from 05-95-90-902010-5190-102-500731, 6.7% Federal Funds from the US Department of Health and Human Services Administration, Maternal and Child Health Bureau, CFDA #93.994 and 93.3% General Funds;

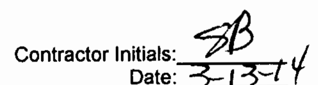
Contractor Initials: SB
Date: 3-13-14

- Add Paragraph 8
- 8. Notwithstanding paragraph 18 of the General Provisions P-37, an amendment limited to adjustments to amounts between and among account numbers, within the price limitation, may be made by written agreement of both parties and may be made without obtaining approval of the Governor and Executive Council.

- Budget, to add:
  Exhibit B-1 (2014) - Amendment 1,
  Exhibit B-1 (2015) - Amendment 1

This amendment shall be in effect July 1, 2013, effective upon the date of Governor and Executive Council approval.

Contractor Initials: SB
Date: 3-13-14



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

3/28/14
Date

Brook Dupee
Bureau Chief

Mid-State Health Center

March 13, 2014
Date

Sharon Beaty, CEO
Name: Sharon Beaty
Title: CEO

Acknowledgement:

State of New Hampshire County of Grafton on March 13, 2014, before the undersigned officer, personally appeared the person identified above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.

Laura Welch
Signature of Notary Public or Justice of the Peace

LAURA WELCH
Notary Public-New Hampshire
My Commission Expires
March 16, 2016

Name and Title of Notary or Justice of the Peace

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

OFFICE OF THE ATTORNEY GENERAL

4-3-14
Date

Name: Rosemary Wiant
Title: Asst Attorney General

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:

Contractor Initials: SB
Date: 3-13-14

EXHIBIT A – AMENDMENT 1

Scope of Services

The Department desires to continue the relationship with the primary care agencies to provide additional primary health care services for preventive and episodic health care for acute and chronic health conditions for people of all ages.

I. General Provisions

A) Eligibility and Income Determination

1. Office-based primary care services will be provided to low-income individuals and families (defined as ≤ 185% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), in the State of New Hampshire.

2. The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing if, at any time, the practice is closed to new patients, or maintains a wait list for new patients, or any other mechanism is used that limits access for new patients for more than a one month period.

3. The Contractor shall document annually, for each client enrolled in the program, family income and family size, and calculate percentage of the federal poverty level. If calculations indicate that the client may be eligible for enrollment in Medicaid, the Contractor shall complete with the client the most recent version of the 800P form.

4. The Contractor shall implement, and post in a public and conspicuous location, a sliding fee payment schedule, approved in advance by the Division of Public Health Services (DPHS), for low-income patients. Signage must state that no client will be denied services for inability to pay.

   a. As an alternative, the contractor may post, in a public and conspicuous location, a notice to clients that a sliding fee scale is available and that no client will be denied services for inability to pay. The sliding fee scale must be updated annually based on USDHHS Poverty guidelines as published in the Federal Register, submitted to and approved by DPHS prior to implementation.

5. The primary care contract entered into here shall be the payer of last resort. The contractor shall make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid, for all reimbursable services rendered.

B) Numbers Served

1. The contract funds shall be expended to provide the above services to a minimum of 1000 users annually with 4000 medical encounters, as defined in the Data and Reporting Requirements. Clinical service reimbursements shall not exceed the Medicare rate.

C) Culturally and Linguistically Appropriate Standards of Care

The Department of Health and Human Services (DHHS) recognizes that culture and language have considerable impact on how consumers access and respond to public health services. Culturally and linguistically diverse populations experience barriers in efforts to access health services. To ensure equal access to quality health services, the Division of Public Health Services (DPHS) expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.
2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.
3. Provide clients of limited English proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understandl and participate in the care or in the services provided to them without language assistance.
4. Offer consumers a forum through which clients have the opportunity to provide feedback to providers and organizations regarding cultural and linguistic issues that may deserve response.
5. The contractor shall maintain a program policy that sets forth compliance with Title VI, Language Efficiency and Proficiency Citation 45 CFR 80.3(b) (2). The policy shall describe the way in which the items listed above were addressed and shall indicate the circumstances in which interpretation services are provided and the method of providing service (e.g. trained interpreter, staff person who speaks the language of the client, language line).

D) State and Federal Laws

The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. The Contractor shall report all cases of communicable diseases according to New Hampshire RSA 141-C and He-P 301, adopted 6/3/08.
2. Persons employed by the contractor shall comply with the reporting requirements of New Hampshire RSA 169:C, Child Protection Act; RSA 161:F46, Protective Services to Adults, RSA 631:6, Assault and Related Offences and RSA 130:A, Lead Paint Poisoning and Control.
3. Immunizations shall be conducted in accordance with RSA 141-C and the Immunization Rules promulgated hereunder.

E) Relevant Policies and Guidelines

1. The Contractor shall design and provide the services described above to meet the unique and identified health needs of the populations within the contracted service area.

2. Primary Care funds shall be targeted to populations in need. Populations in need are defined as follows:

   a) uninsured;

   b) under-insured;

   c) families and individuals with significant psychosocial and economic risk, including low income status;

   d) all life cycles including perinatal, child, adolescent, adult, and elderly who meet one or more of the above criteria.

3. The Contractor shall design and implement systems of governance, administration, financial management, information management, and clinical services which are adequate to assure the provision of contracted services, and to meet the data and reporting requirements. These systems shall meet the most current minimum standards described in at least one of the following: Health Resources and Services Administration (HRSA) Office of Performance Review protocols, Joint Commission on Accreditation of Health Care Organizations (JCAHO), Accreditation Association for Ambulatory Healthcare (AAAHC), Community Health Accreditation Program (CHAP), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey.

4. The Contractor shall have an agency emergency preparedness and response plan in accordance with HRSA Health Center Emergency Management Program Expectations, Document #2007-15 or most recent version. Such plan shall also include a Continuity of Operations plan.

5. The Contractor shall carry out the work as described in the performance Workplan submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

6. No Workplan is required by the Breast and Cervical Cancer Program (BCCP). The contractor shall be required to respond to the Quality Improvement Feedback Report twice a year.

7. The Contractor shall carry out the work as described in the Supplemental Funding Form submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

F) Publications Funded Under Contract

1. The DHHS and/or its funders will retain COPYRIGHT ownership for any and all original materials produced with DHHS contract funding, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports.

2. All documents (written, video, audio, electronic) produced, reproduced, or purchased under the contract shall have prior approval from DPHS before printing, production, distribution, or use.

3. The Contractor shall credit DHHS on all materials produced under this contract following the instructions outlined in Exhibit C (14).

G) Subcontractors

If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing and approve the subcontractual agreement, prior to initiation of the subcontract.

1. If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing and approve the subcontractual agreement, prior to initiation of the subcontract.

2. In addition, the original DPHS contractor will remain liable for all requirements included in this Exhibit and carried out by subcontractors.

II. Minimal Standards of Core Services

A. Service Requirements

1. Medical Home

   The Contractor shall provide a Medical Home that:

   a) Facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family.

   b) Provides care facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

2. Primary Care Services

   The Contractor shall provide office-based primary care services to populations in need who reside in the contractor's service area. Primary care services shall include:

EXHIBIT A – AMENDMENT 1

a) Health care provided by a New Hampshire licensed MD, DO, APRN, or PA, including diagnosis and treatment of acute and chronic illnesses within the scope of family practice; preventive services, screenings, and health education according to established, documented state or national guidelines; assessment of need for social and nutrition services, and appropriate referrals to health, oral health, and behavioral health specialty providers.

b) Referral to the WIC Nutrition Program for all eligible pregnant women, infants and children.

c) In-hospital care for conditions within the scope of family practice must be provided at a hospital, within the agency service area, through a staff clinician with full hospital privileges, or in the alternative, through a formal referral and admissions procedure available to clients on a 24 hour/7 day a week basis.

d) Access to a healthcare provider, directly or by referral or subcontract, by telephone twenty-four hours per day, seven days per week.

e) Assessment of psychosocial risk for all clients at least annually and for children at scheduled preventive care visits, including, at a minimum, age appropriate assessment of safety in the home, domestic violence, adequacy of food and housing, care and welfare of children, transportation needs, and provision of necessary social services to address the priority needs and safety issues of clients and families.

f) Falls prevention screening for patients 65 years and older using the algorithm and guidelines of the American Geriatrics Society.

g) Behavioral health care directly or by referral to an agency or provider with a sliding fee scale.

h) Nutrition assessment for all clients as part of the health maintenance visit. Therapeutic nutrition services shall be provided as indicated directly or by referral to an agency or provider with a sliding fee scale. These services shall be recorded in the medical record.

i) Formal arrangements with a local hospital for emergency care must be in place and reviewed annually.

j) Home health care directly or by referral to an agency or provider with a sliding fee scale.

k) Assisted living and skilled nursing facility care by referral.

l) Oral screening annually for all clients 21 years and older to note obvious dental decay and soft tissue abnormalities with a reminder to the patient that poor oral health impacts total health.

m) Diagnosis and management of pediatric and adult patients with asthma provided according to National Heart Lung Blood Institute, National Asthma Education and Prevention Program, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, 2007.

3. Reproductive Health Services

The Contractor shall provide prenatal, interconceptional and preconception medical care, social services, nutrition services, education, and nursing care to all women of childbearing age. Preconceptional care includes the preconception, interconceptional, and postpartum periods in women's health. It is recommended that preconceptional and interconceptional care visits focus on maintaining or achieving the optimal health of the mother, lowering the risk of future adverse pregnancy outcomes, the family's future plans, and how additional children fit into that plan. Preconceptional counseling may be done during an office, group or home visit.

a) In the event prenatal care is not provided directly by the Contractor a formal Memorandum/a of Agreement for coordinated referral to an appropriately qualified provider must be maintained.

b) Prenatal care shall, at minimum, be provided in accordance with the Guidelines for Perinatal Care, sixth or most current edition, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and /or the Centers for Disease Control.

c) Age appropriate reproductive health care shall, at a minimum, be provided in accordance with the American College of Obstetricians and Gynecologists, or the USDHHS Centers for Disease Control (CDC) current guidelines.

d) Pregnant women enrolled in the WIC Nutrition Program shall be referred to WIC for breastfeeding education and referral to the WIC Nutrition Program peer counselors.

e. Family planning counseling for prevention of subsequent pregnancy following an infant's birth shall be discussed with the infant's mother at the first postpartum visit and at the infant's 2-month visit and other visits as appropriate. Rationale for birth intervals of 18-24 months shall be presented.

f) A referral to a Title X Family Planning Clinic or other reproductive health care provider shall be made as appropriate.

4. Services for Children and Adolescents

The Contractor shall provide as a minimum, comprehensive and age-appropriate health care, screenings, and health education according to the American Academy of Pediatrics' most recent periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of

Infants, Children, and Adolescents", Third Edition or most recent. Children and adolescent visits shall include:

a) The World Health Organization (WHO) growth charts shall be used to monitor growth for infants and children birth up to age 2 years. The Centers for Disease Control and Prevention (CDC) growth charts shall be used for children age 2 years and older.

b) Blood lead testing shall be performed in accordance with "New Hampshire Childhood Lead Poisoning Screening and Management Guidelines", issued by the New Hampshire Department of Health and Human Services, 2009 or subsequent revisions.

c) All children enrolled in either Medicaid, Head Start, or the Women, Infant, and Children (WIC) Program and/or who are ≤ 185%_poverty, regardless of town of residence, are required to have a blood lead test at ages one and two years. All children ages three to six years who have not been previously tested shall have a blood lead test performed.

d) All children shall be screened for iron deficiency anemia as outlined in the Centers for Disease Control and Prevention document "Recommendations to Prevent and Control Iron Deficiency in the United States (4/2/98)".

e) Age-appropriate anticipatory guidance, dietary guidance, and *feeding practice counseling* for optimal oral health shall be provided at each well child visit according to the American Academy of Pediatrics' periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent edition. Starting at age 6 months, it is recommended that all children receive an oral health assessment at every well child visit, and a referral for the child's first visit to the dentist by age one as recommended by the American Academy of Pediatrics and the American Academy of Pediatric Dentistry.

f) Supplemental fluoride shall be prescribed as needed based upon the fluoride levels in the child's drinking water supply. The fluoride dosage regimen accepted by the American Academy of Pediatrics shall be followed. No fluoride shall be prescribed without obtaining water from private wells or noting the presence or absence of fluoride in the public water supply. Supplemental fluoride may include bottled water containing fluoride and topical applications such as varnishes.

g) For infants enrolled in the WIC Nutrition Program, parents shall be referred to WIC for breastfeeding support and referral to the WIC Nutrition Program peer counselors.

5. Sexually Transmitted Infections

Primary Care Services shall provide age appropriate screening and treatment of sexually transmitted infections.

a) Treatment for sexually transmitted infections shall be provided according to the United States Centers for Disease Control Sexually Transmitted Diseases Treatment Guidelines, 2010 or subsequent revisions.

b) All clients, including women, shall be offered HIV testing following the most current recommendations of the United States Centers for Disease Control.

c) The contractor shall be responsible for ensuring referral to appropriate treatment services for any woman found to screen positive.

d) Appropriate risk reduction counseling shall be provided based on client needs.

6. Substance Use Services

   a) A substance use screening history using a formal, validated screening tool shall be obtained for all clients as soon after entry into care as possible. Substance use counseling or other substance abuse intervention, treatment, or recovery services by an appropriately credentialed provider shall be provided on-site, or by referral, to clients with identified needs for these services. For these identified clients, ongoing primary care services should include follow up monitoring relative to substance abuse.

   b) All clients, including pregnant women, identified as smokers shall receive counseling using the 5A's (ask, advise, assess, assist, and arrange) treatment available through the NH Tobacco Helpline as cited in the US Public Health Services report "Tobacco Use and Dependence", 2008, or "Smoking Cessation During Pregnancy: A Clinician's Guide to Helping Pregnant Women Quit Smoking", American College of Obstetricians and Gynecologists, 2011. With prior approval, agencies may also opt to participate in the DPHS best practice initiative of the 2A's and R (ask, advise and refer).

7. Immunizations

   a) The Contractor shall adhere to the most current version of the "Recommended Adult Immunization Schedule for Adults (19 years and older) by Age and Medical Condition - United States", approved by the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

   b) The Contractor shall administer vaccines according to the most current version of the "Recommended Immunization Schedule for Persons Aged 0 Through 6 Years - United States", and "Recommended Immunization Schedule for Persons Aged 7 Through 18 Years – United States" approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians, based upon availability of vaccine from the New Hampshire Immunization Program.

8. Prenatal Genetic Screening

a) A genetic screening history shall be obtained on all prenatal clients as soon after entry into care as possible.

b) All pregnant women should be offered voluntary genetic screening for fetal chromosomal abnormalities at the appropriate time following recommendations found in the American College of Obstetricians and Gynecologists' "Screening for Fetal Chromosomal Abnormalities (2007)" or more recent guidelines. The Contractor shall be responsible for ensuring referral to appropriate genetic testing and counseling for any woman found to have a positive screening test.

9. Additional Requirements

a) The Contractor's Medical Director shall participate in the development and approval of specific guidelines for medical care that supplement minimal clinical standards. Supplemental guidelines should be reviewed, signed, and dated annually, and updated as indicated.

b) Contractors considering clinical or sociological research using clients as subjects must adhere to the legal requirements governing human subjects research. Contractors must inform the DPHS, MCHS prior to initiating any research related to this contract.

c) The Contractor shall provide information to all employees annually about the Medical Reserve Corps Unit within their Public Health Region to enhance recruitment.

d) The Contractor shall provide information to all employees annually regarding the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) managed by the NH Department of Health and Human Services' Emergency Services Unit, to enhance recruitment.

B) Staffing Provisions

The Contractor shall have, at minimum, the following staff positions:

a) executive director

b) fiscal director

c) registered nurse

d) clinical coordinator

e) medical service director

f) nutritionist (on site or by referral)

g) social worker

Staff positions required to provide direct services on-site include:

a) registered nurse

b) clinical coordinator

c) social worker

1. Qualifications

All health and allied health professionals shall have the appropriate New Hampshire licenses whether directly employed, contracted, or subcontracted.

In addition the following minimum qualifications shall be met for:

a) Registered Nurse
   a. A registered nurse licensed in the state of New Hampshire, Bachelor's degree preferred. Minimum of one-year experience in a community health setting.

b) Nutritionists:
   a. A Bachelor's degree in nutritional sciences or dietetics, or a Master's degree in nutritional sciences, nutrition education, or public health nutrition or current Registered Dietitian status in accordance with the Commission on dietetic Registration of the American Dietetic Association.
   b. Individuals who perform functions similar to a nutritionist but do not meet the above qualifications shall not use the title of nutritionist.

c) Social Workers shall have:
   a. A Bachelor's or Master's degree in social work or Bachelor's or Master's degree in a related social science or human behavior field. A minimum of one year of experience in a community health or social services setting is preferred.
   b. Individuals who perform functions similar to a social worker but do not meet the above qualifications shall not use the title of social worker.

d) Clinical Coordinators shall be:
   a. A registered nurse (RN), physician, physician assistant, or nurse practitioner with a license to practice in New Hampshire.
   b. The coordinator is a clinical position that oversees and takes responsibility for the clinical and administrative functions of each program.
   c. The coordinator may be responsible for more than one MCH funded program.

2. New Hires

The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing within one month of hire when a new administrator, clinical coordinator, or any staff person essential to carrying out contracted services is hired to work in the program. A resume of the employee shall accompany the aforesaid notification.

3. Vacancies

a) The Contractor must notify the MCHS in writing if any critical position is vacant for more than one month, or if at any time funded under this contract does not have adequate staffing to perform all required services for more than one month. This may be done through a budget revision.

b) Before an agency hires new program personnel that do not meet the required staff qualifications, the agency shall notify the MCHS in writing requesting a waiver of the applicable staffing requirements. The Section may grant waivers based on the need of the program, individuals' experience, and additional training.

C) Coordination of Services

1. The Contractor shall coordinate, where possible, with other service providers within the contractor's community. At a minimum, such collaboration shall include interagency referrals and coordination of care.

2. The Contractor shall participate in activities in the Public Health Region in which they provide services as appropriate. These activities enhance the integration of community-based public health prevention and health care initiatives that are being implemented by the contractor and may include community needs assessments, public health performance assessments, and/or the development of regional health improvement plans.

3. The Contractor agrees to participate in and coordinate public health activities as requested by the Division of Public Health Services during any disease outbreak and/or emergency, natural or man-made, affecting the public's health.

4. The Contractor is responsible for case management of the client enrolled in the program and for program follow-up activities. Case management services shall promote effective and efficient organization and utilization of resources to assure access to necessary comprehensive medical, nutritional, and social services for clients.

5. The Contractor shall assure that appropriate, responsive, and timely referrals and linkages for other needed services are made, carried through, and documented. Such services shall include, but not be limited to: dental services, genetic counseling, high risk prenatal services, mental health, social services, including domestic violence crisis centers, substance abuse services; and family planning services, Early Supports and Services Program, local WIC/CSF Program, Home Visiting New Hampshire Programs and health and social service agencies which serve children and families in need of those services.

D) Meetings and Trainings

The contractor will be responsible for sending staff to meetings and training required by the MCHS program, including but not limited to:

1. MCHS Agency Directors' meetings

2. Prenatal and Child Health Coordinators' meetings

3. MCHS Agency Medical Services Directors' meetings

III. Quality or Performance Improvement (QI/PI)

A) Workplans

1. Performance Workplans are required for this program and are used to monitor achievement of standard measures of performance of the services provided under this contract. The workplans are a key component of the RHPCS and the MCHS performance-based contracting system and of this contract. Outcomes shall be reported by clinical site.

2. Performance Workplans and Workplan Outcome reports according to the schedule and instructions provided by the MCHS. The MCHS shall notify the Contractor at least 30 days in advance of any changes in the submission schedule.

3. The Contractor shall incorporate required and developmental performance measures, defined by the MCHS into the agency's Performance Workplan. Reports on Workplan Progress/Outcomes shall detail the Performance Workplan plans and activities that monitor and evaluate the agency's progress toward performance measure targets.

4. The Contractor shall comply with modifications and/or additions to the workplan and annual report format as requested by RHPCS and MCHS. MCHS will provide the contractor with reasonable notice of such changes.

5. Agencies contracting for Primary Care Services must submit the workplans for Primary Care Clinical and Financial, Child Health, and Prenatal Care.

B) Additional Reporting requirements

In addition to Performance Workplans, the Contractor shall submit to MCHS the following data and information listed below which are used to monitor program performance:

1. In years when contracts or amendments are not required, the DPHS Budget Form, Budget Justification, Sources of Revenue and Program Staff list forms must be

completed according to the relevant instructions and submitted as requested by DPHS and, at minimum, by April 30 of each year.

2. The Sources of Revenue report must be resubmitted at any point when changes in revenue threaten the ability of the agency to carry out the planned program.

3. Completed Uniform Data Set (UDS) tables reflecting program performance in the previous calendar year, by March 31 of each year.

4. The Perinatal Client Data Form (PCDF) shall be submitted electronically according to the instructions set forth by the MCHS.

5. A copy of the agency's updated Sliding Fee Scale including the amount(s) of any client fees and the schedule of discounts must be submitted by March 31st of each year. The agency's sliding fee scale must be updated annually based on the US DHHS Poverty guidelines as published in the Federal Register.

6. An annual summary of program-specific patient satisfaction results obtained during the prior contract period and the method by which the results were obtained shall be submitted annually as an addendum to the Workplan Outcome/Progress reports.

C) On-site reviews

1. The contractor shall allow a team or person authorized by the Division of Public Health Services to periodically review the contractor's systems of governance, administration, data collection and submission, clinical and financial management, and delivery of education services in order to assure systems are adequate to provide the contracted services.

2. Reviews shall include client record reviews to measure compliance with this exhibit.

3. The contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.

4. On-Site reviews may be waived or abbreviated at the discretion of MCHS, upon submission of satisfactory reports of reviews such as Health Services Resources Administration (HRSA): Office of Performance Review (OPR), or reviews from nationally accreditation organizations such as the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), Medicare, the Community Health Accreditation Program (CHAP), Accreditation Association for Ambulatory Healthcare (AAAHC), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey. Abbreviated reviews will focus on any deficiencies found in previous reviews, issues of compliance with this exhibit, and actions to strengthen performance as outlined in the agency Performance Workplan.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE CHILD HEALTH DIRECT CARE SERVICES
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Please note, for all measures, the following should be used **unless otherwise indicated:**

- Less than 19 years of age
- Served within the scope of this MCH contract during State Fiscal Year 2015 (July 1, 2014 – June 30, 2015)
- Each client can only be counted once (unduplicated)

Child Health Direct (CH – D) Performance Measure #1

Measure: 92%* of eligible children will be enrolled in Medicaid

Goal: To increase access to health care for children through the provision of health insurance

Definition: **Numerator-**
Of those in the denominator, the number of children enrolled in Medicaid.

Denominator-
Number of children who meet all of the following criteria:

- Less than 19 years of age
- Had 3 or more visits/encounters** during the reporting period
- As of the last visit during the reporting period were eligible for Medicaid

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**An encounter is face to face contact between a user and a provider who exercises independent judgment in the provision of services to the individual (UDS Table Definition).

Child Health Direct (CH – D) Performance Measure #2

Measure: 85%* of at-risk** children who were screened for blood lead between 18 and 30 months of age

Goal: To prevent childhood lead poisoning through early identification of lead exposure

Definition: **Numerator-**
Of those in the denominator, number of children screened for blood lead by capillary or venous on or after their 18-month birthday and prior to their 30-month birthday.

Denominator-
Number of at-risk** children who reached age 30 months during the reporting period. If discharged prior to 30 months, do not include in denominator.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**At risk = During the reporting period, the children were 18-29 months of age, and fit at least one of the following criteria:

- "Low income" (less than 185% poverty guidelines)
- Over 185% and resided in a town considered needing "Universal" screening per NH Childhood Lead Poisoning Prevention Program
- Over 185%, resided in a town considered "Target" and had a positive response to the risk questionnaire
- Refugee children -A refugee is defined as a person outside of his or her country of nationality who is unable or unwilling to return because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion (U.S. Citizenship and Immigration Services definition).

Child Health Direct (CH – D) Performance Measure #3

Measure: 71%* of children age two to nineteen years receiving primary care preventive health services with a Body Mass Index (BMI) percentile greater than or equal to the 85%ile with documented discussion of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Goal: To increase the percent of children receiving primary care preventive health services who have an elevated BMI percentile who receive guidance about promoting a healthier lifestyle.

Definition: **Numerator-**
Of those in the denominator, the number of children who had documentation in their medical record of there being discussion at least once during the reporting period of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Denominator-
Number of children who turned twenty-four months during or before the reporting period, up to the age of nineteen years, with one or more well child visit after their twenty-fourth month of age within the reporting year, and had an age and gender appropriate BMI percentile greater than or equal to the 85 % percentile at least once during the reporting period.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

Rationale: Children between the 85th – 94th percentiles BMI are encouraged to have 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks. (Discussion of the importance of family meal time, limiting eating out, consuming a healthy breakfast, preparing own foods, and promotion of breastfeeding is also encouraged.) American Academy of Pediatrics' guidance for Prevention and Treatment of Childhood Overweight and Obesity, (http://www.aap.org/obesity/health_professionals.html), from AAP Policy Statement: *Prevention of Pediatric Overweight and Obesity* and the AAP endorsed Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Children and Adolescent Overweight and Obesity, 2007.

*Target based on 2012 & 2013 Data Trend Table averages.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) #4

Measure: 75%* of eligible** infants and children with client record documentation of enrollment in WIC

Goal: To increase access to nutrition education, breastfeeding support, and healthy food through enrollment in the WIC Nutrition Program

Definition: **Numerator -**
Of those in the denominator, the number of infants and children who, as of the last well child visit during the reporting period, had client record documentation that infant or child was enrolled in WIC.

Denominator -
Unduplicated number of infants and children less than 5 years of age, enrolled in the agency, during the reporting period, who were eligible** for WIC.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**WIC Eligibility Requirements:

- Infants, and children up to their fifth birthday
- Must be income eligible (income guidelines are up to 185% of federal gross income, and are based on family size)

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #5

Measure: 23%* of infants who were exclusively** breastfed for the first three months, at their four month well baby visit

Goal: To provide optimum nutrition to infants in their first three months of life

Definition: **Numerator -**
Of those in the denominator, the number of infants who had client record documentation that the infant had been exclusively breastfed for their first three months when checked at their four month well baby visit.

Denominator -
Number of infants who received one or more visits during or before the reporting period and were seen for a four-month well baby visit during the reporting period.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

Benmarks: 2011 PedNSS (WIC) exclusive at 3 months: NH 22.9%, National (2010) 10.7%
2013 CDC Report Card (NIS, provisional 2010 births): NH 49.5%, National 37.7%
Healthy People 2020 goal: 44%

Rationale: The AAP recommends exclusive breastfeeding for about 6 months, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant, a recommendation concurred to by the World Health Organization and the Institute of Medicine. (American Academy of Pediatrics Policy Statement on Breastfeeding and the Use of Human Milk, 2012)

*Target based on 2012 & 2013 Data Trend Table averages.
**Exclusive means breast milk only, no supplemental formula, cereal/baby food, or water/fluids.

PRIMARY CARE: ADULT

PERFORMANCE MEASURES DEFINITIONS

State Fiscal Year 2015

Primary Care: Adult Performance Measure #1

Measure:* 58%** of adult patients 18 – 85 years of age diagnosed with hypertension will have a blood pressure measurement less than 140/90*** mm at the time of their last measurement.

Goal: To ensure patients diagnosed with hypertension are adequately controlled.

Definition: **Numerator-** Number of patients from the denominator with blood pressure measurement less than 140/90 mm at the time of their last measurement.

Denominator- Number of patients age 18 – 85 with diagnosed hypertension must have been diagnosed with hypertension 6 or more months before the measurement date. (Excludes pregnant women and patients with End Stage Renal Disease.)

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

*Measure based on the National Quality Forum 0018

**Health People 2020 National Target is 61.2%

***Both the numerator and denominator must be less that 140/90 mm

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE CLINICAL
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Primary Care Clinical Adolescent (PC-C) Performance Measure #1

Measure: 61%* of adolescents aged 11-21 years received an annual health maintenance visits in the past 12 months.

Goal: To enhance adolescent health by assuring annual, recommended, adolescent well -visits.

Definition:

Numerator-
Number of adolescents in the denominator who received an annual health maintenance "well" visit during the reporting year.

Denominator-
Total number of adolescents aged 11-21 years who were enrolled in the primary care clinic as primary care clients during the reporting year period.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

***Target based on 2012 & 2013 Data Trend Table averages.**

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Primary Care Clinical Prenatal (PC-C) Performance Measure #2

Measure: 31%* of women and adolescent girls aged 15-44 take multi-vitamins with folic acid.

Goal: To enhance pregnancy outcomes by reducing neural tube defects.

Definition:

Numerator-
The number of women and adolescent girls aged 15-44 who take a multi-vitamin with folic acid.

Denominator-
The number of women and adolescent girls aged 15-44 who were seen in primary care for a well visit in the past year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

***Target based on 2012 & 2013 Data Trend Table averages.**

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE - FINANCIAL
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Primary Care (PC) Performance Measure #1

Measure: Patient Payor Mix

Goal: To allow monitoring of payment method trends at State funded primary care sites.

Definition: Patients enrolled in Medicare, Medicaid, Commercial insurance, or uninsured.

Data Source: Provided by agency

Primary Care (PC) Performance Measure #2

Measure: Accounts Receivables (AR) Days

Goal: To allow monitoring of financial sustainability trends at State funded primary care sites.

Definition: AR Days: Net Patient Accounts Receivable **multiplied by** 365 **divided by** Net Patient Revenue

Data Source: Provided by agency

Primary Care (PC) Performance Measure #3

Measure: Current Ratio

Goal: To allow monitoring of financial sustainability trends at State funded primary care sites.

Definition: Current Ratio = Current Assets **divided by** Current Liabilities

Data Source: Provided by agency

PRENATAL
PERFORMANCE MEASURES DEFINITIONS
State Fiscal Year 2015

Prenatal (PN) Performance Measure #1

Measure: 85%* of pregnant women who are enrolled in the agency's prenatal program will begin prenatal care during the first trimester of pregnancy.

Goal: To enhance pregnancy outcomes by assuring early entrance into prenatal care.

Definition:

Numerator-
Number of women in the denominator who had a documented prenatal visit during the first trimester (on or before 13.6 weeks gestation).

Denominator-
Number of women enrolled in the agency prenatal program who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

* Target based on 2012 & 2013 Data Trend Table averages.

Prenatal (PN) Performance Measure #2

Measure: 20%* of pregnant women who are identified as cigarette smokers will be referred to QuitWorks-New Hampshire.

Goal: To reduce tobacco use during pregnancy through focused tobacco use cessation activities at public health prenatal clinics.

Definition:

Numerator-
Number of women in the denominator who received at least one referral to QuitWorks-New Hampshire during pregnancy.

A referral is defined as signing the patient up for QuitWorks-NH via phone, fax, or EMR. It is not defined as discussing QuitWorks-NH with the patient and encouraging her to sign up.

Denominator-
Number of women enrolled in the agency prenatal program and identified as tobacco users who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

*Target set in consultation with the NH Tobacco Program & FY13 Data Trend Table average.

Prenatal (PN) Performance Measure #3

Measure: 79%* of pregnant women will be screened, using a formal valid screening tool, for alcohol and other substance use during every trimester they are enrolled in the prenatal program.

Goal: To reduce prenatal substance use through systematic screening and identification.

Definition: **Numerator-** Number of women in the denominator who were screened for substance and alcohol use, using a formal and valid screening tool, during each trimester that they were enrolled in the prenatal program.

Denominator- Number of women enrolled in the agency prenatal program and who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

* Target based on 2012 & 2013 Data Trend Table averages.

Exhibit B-1 (2014) - Amendment 1
Budget

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: Mid-State Health Center

Budget Request for: MCH Primary Care
(Name of RFP)

Budget Period: SFY 2014

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages	$ 28,000.80	$ -	$ 28,000.80	
2. Employee Benefits	$ 7,000.20	$ -	$ 7,000.20	
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	$ -	$ -	$ -	
13. Other (specific details mandatory):	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
TOTAL	**$ 35,001.00**	**$ -**	**$ 35,001.00**	

Indirect As A Percent of Direct 0.0%

Contractor Initials: SB

Date: 3-13-14

Exhibit B-1 (2015) - Amendment 1
Budget

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: Mid-State Health Center

Budget Request for: MCH Primary Care
(Name of RFP)

Budget Period: SFY 2015

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages	$ 140,408.80	$ -	$ 140,408.80	
2. Employee Benefits	$ 35,102.20	$ -	$ 35,102.20	
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	$ -	$ -	$ -	
13. Other (specific details mandatory):	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
TOTAL	**$ 175,511.00**	**$ -**	**$ 175,511.00**	

Indirect As A Percent of Direct 0.0%

Contractor Initials: SB

Date: 3-13-14

State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that Mid-State Health Center is a New Hampshire nonprofit corporation formed January 9, 1998. I further certify that it is in good standing as far as this office is concerned, having filed the return(s) and paid the fees required by law.

In TESTIMONY WHEREOF, I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 15th day of April A.D. 2013

SEAL OF THE STATE OF NEW HAMPSHIRE 1776

William M. Gardner
Secretary of State

WITHOUT SEAL

CERTIFICATE OF VOTE/AUTHORITY

I, Robin J. Fisk, of Mid-State Health Center do hereby certify that:

1. I am the duly elected Vice Chair of the Board of Mid-State Health Center;

2. The following are true copies of two resolutions duly adopted at a meeting of the Board of Directors of the Corporation, duly held on April 23, 2013.

   RESOLVED: That this corporation enters into a contract with the State of New Hampshire, acting through its Department of Health and Human Services, Division of Public Health Services.

   RESOLVED: That the Chief Executive Officer and/or Board President is hereby authorized on behalf of this corporation to enter into said contract with the State and to execute any and all documents, agreements, and other instruments; and any amendments, revisions, or modifications thereto, as he/she may deem necessary, desirable, or appropriate. Sharon Beaty is the duly elected Chief Executive Officer of the corporation. Jim Dalley is the duly elected Board President of the corporation.

3. The foregoing resolutions have not been amended or revoked and remain in full force and effect as of March 13, 2014.

IN WITNESS WHEREOF, I have hereunto set my hand as the 13th Board V.P of the Midstate Health Center the 13th day of March, 2014

[signature]

STATE OF New Hampshire
COUNTY OF Grafton

The foregoing instrument was acknowledged before me this 13th day of March, 2014 by Robin J Fisk.

CATHLEEN M. SLEEPER STATE OF NEW HAMPSHIRE NOTARY PUBLIC MY COMMISSION EXPIRES MARCH

[signature]

Notary Public/Justice of the Peace
My Commission Expires:

Client#: 5846 MIDSTATE

ACORD™ **CERTIFICATE OF LIABILITY INSURANCE**

DATE (MM/DD/YYYY) 3/12/2014

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 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
William Gallagher Associates
470 Atlantic Avenue
Boston, MA 02210

CONTACT NAME:
PHONE (A/C, No, Ext): FAX (A/C, No):
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : ProSelect Insurance Company	
INSURER B : New Hampshire Employers Insuran	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Mid-State Health Center
101 Boulder Point Drive
Suite 1
Plymouth, NH 03264

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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC			212105PPL7	10/01/2013	10/01/2014	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$1,000,000 $50,000 $5,000 $1,000,000 $3,000,000 $3,000,000 $
	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS HIRED AUTOS NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ $ $ $ $
	UMBRELLA LIAB OCCUR EXCESS LIAB CLAIMS-MADE DED RETENTION $						EACH OCCURRENCE AGGREGATE	$ $ $
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		ECC60040000792013A	10/01/2013	10/01/2014	X WC STATU-TORY LIMITS OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $500,000 $500,000 $500,000

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

CERTIFICATE HOLDER

DHHS
Contracts & Procurement Unit
129 Pleasant Street
Concord, NH 03301

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

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MCD

MID-STATE HEALTH CENTER AND SUBSIDIARY

Consolidated Financial Statements and Independent Auditors' Report

As of and for the Years Ended
June 30, 2013 and 2012

Independent Auditors' Report

To the Board of Trustees of
Mid-State Health Center and Subsidiary:

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Mid-State Health Center and its subsidiary, which comprise the consolidated statements of financial position as of June 30, 2013 and 2012, and the related consolidated statements of activities and changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these 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.

Auditor's Responsibility

Our responsibility is to express an opinion on these 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 the auditor's 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, the auditor considers internal control relevant to the entity'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 entity'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 Mid-State Health Center and its subsidiary as of June 30, 2013 and 2012, and the results of their operations, changes in net assets and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplemental consolidating information is presented on pages 20-25 for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Tyler, Simms and St. Sauveur, CPAs, P.C.

Lebanon, New Hampshire
November 13, 2013

MID-STATE HEALTH CENTER AND SUBSIDIARY

Consolidated Statements of Financial Position

As of June 30, 2013 and 2012

	2013	2012
Assets		
Current assets		
Cash and cash equivalents	$ 771,305	$ 625,970
Patient accounts receivable, net	389,029	386,786
Estimated third-party settlements	35,000	35,000
Community benefit grant receivable	-	106,244
Grants and state contracts receivable	391,025	242,393
Prepaid expenses and other receivable	209,052	159,868
Total current assets	1,795,411	1,556,261
Property and equipment, net	4,470,183	4,272,178
Other assets		
Deferred financing costs	1,931	23,594
Other assets	2,751	3,667
Total other assets	4,682	27,261
Total assets	$ 6,270,276	$ 5,855,700
Liabilities		
Current liabilities		
Line of credit - SMH (Note 10)	$ 75,000	$ 75,000
Accounts payable	312,129	261,310
Construction payable	34,955	-
Accrued expenses and other current liabilities	86,885	110,084
Accrued payroll and related expenses	179,785	155,009
Accrued earned time	256,704	228,230
Current portion of long-term debt	113,926	87,928
Current portion of capital lease obligations	6,628	27,430
Deferred grants and state contract revenue	322,871	208,175
Total current liabilities	1,388,883	1,153,166
Long-term debt, less current portion	3,568,108	3,385,162
Capital lease obligations, less current portion	9,761	10,394
Total liabilities	4,966,752	4,548,722
Commitments and contingencies (See Notes)		
Net assets		
Unrestricted	519,915	500,265
Temporarily restricted	783,609	806,713
Total net assets	1,303,524	1,306,978
Total liabilities and net assets	$ 6,270,276	$ 5,855,700

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

MID-STATE HEALTH CENTER AND SUBSIDIARY

Consolidated Statements of Activities and Changes in Net Assets

For the Years Ended June 30, 2013 and 2012

	2013	2012
Changes in unrestricted net assets		
Unrestricted revenue, gains and other support		
Net patient service revenue	$ 5,062,724	$ 4,921,553
Community Benefit Grant	228,000	328,000
Other grant and state contract revenue	387,597	374,861
Other operating revenue	930,556	851,218
Total unrestricted revenue, gains and other support	6,608,877	6,475,632
Expenses		
Salaries and wages	3,952,349	3,713,052
Employee benefits	845,074	777,887
Insurance	98,084	102,631
Professional fees	311,437	269,530
Supplies and expenses	1,003,119	954,518
Depreciation and amortization	183,861	200,476
Interest expense	219,366	210,146
Total expenses	6,613,290	6,228,240
Increase (decrease) in net assets from operating activities	(4,413)	247,392
Non-operating gains		
Gain on disposal of fixed assets	959	100
Net assets released from restrictions used for property and equipment	23,104	23,104
Gain on involuntary conversion	-	20,576
Total non-operating gains	24,063	43,780
Increase in unrestricted net assets	19,650	291,172
Changes in temporarily restricted net assets		
Net assets released from restrictions	(23,104)	(23,104)
Decrease in temporarily restricted net assets	(23,104)	(23,104)
Change in net assets	(3,454)	268,068
Net assets, beginning of year	1,306,978	1,038,910
Net assets, end of year	$ 1,303,524	$ 1,306,978

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

MID-STATE HEALTH CENTER AND SUBSIDIARY

Consolidated Statements of Cash Flows

For the Years Ended June 30, 2013 and 2012

	2013	2012
Cash flows from operating activities		
Change in net assets	$ (3,454)	$ 268,068
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	183,861	200,476
Amortization reflected as interest	21,663	21,664
Provision for bad debts	367,681	363,014
Gain on disposal of fixed assets	(959)	(100)
Gain on involuntary conversion	-	(20,576)
Community benefit grant - debt forgiveness	-	(77,639)
(Increase) decrease in the following assets:		
Patient accounts receivable	(369,924)	(362,875)
Community benefit grant receivable	106,244	(80,411)
Grants and state contracts receivable	(148,632)	23,896
Prepaid expenses and other receivable	(49,184)	(15,335)
Increase (decrease) in the following liabilities:		
Accounts payable	50,819	(13,708)
Construction payable	34,955	-
Accrued payroll and related expenses	24,776	(69,232)
Accrued earned time	28,474	12,649
Accrued other expenses	(23,199)	62,738
Deferred grants and state contract revenue	114,696	(733)
Net cash provided by operating activities	337,817	311,896
Cash flows from investing activities		
Purchases of property and equipment	(220,859)	(94,269)
Proceeds from sale of asset	-	20,576
Net cash used in investing activities	(220,859)	(73,693)
Cash flows from financing activities		
Payments on capital leases	(28,567)	(55,613)
Payments on long-term debt	(93,156)	(81,683)
Proceeds on long-term debt	150,100	-
Net cash provided by (used in) financing activities	28,377	(137,296)
Net increase in cash and cash equivalents	145,335	100,907
Cash and cash equivalents, beginning of year	625,970	525,063
Cash and cash equivalents, end of year	$ 771,305	$ 625,970

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

MID-STATE HEALTH CENTER AND SUBSIDIARY

Consolidated Statements of Cash Flows (continued)

For the Years Ended June 30, 2013 and 2012

Supplemental Disclosures of Cash Flow Information

	2013	2012
Cash payments for:		
Interest	$ 197,436	$ 203,171
State taxes	$ 2,610	$ -

Supplemental Disclosure of Non-Cash Transactions

During 2013 and 2012, the Organization purchased certain equipment through the issuance of capital leases totaling $7,132 and $16,836, respectively.

During 2013, the Organization purchased land through the issuance of a long-term note payable in the amount of $152,000.

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

Where your care comes together.

Family, Internal and Pediatric Medicine • Behavioral Health Services
www.midstatehealth.org

Mission Statement

Mid-State Health Center provides sound primary care to the community, accessible to all regardless of the ability to pay.

Vision for the Future

- ✧ Patients are satisfied, knowledgeable and involved in their healthcare.
- ✧ Mid-State Health Center has developed collaborative relationships with the medical community.
- ✧ Facilities are comfortable, functional and accessible.
- ✧ Working environment is characterized by professional behavior, mutual respect and focused on finding solutions to problems.
- ✧ Mid-State operates in a manner that results in financial stability, enhances efficiency, respects the importance of the working environment and supports a premier teaching experience.

Core Values

- ✧ Employees and providers are held to high ethical and professional standards.
- ✧ Committed to creating a healthier community.
- ✧ Respects the privacy of the provider-patient relationship.
- ✧ Continuing education is supported at all levels of the organization.
- ✧ Provides high-quality primary care.
- ✧ Recognizes the importance of employees' need to lead healthy and balanced lives.
- ✧ Respects and considers the opinions of all stakeholders.
- ✧ Board members are actively involved, interested and committed to the success of Mid-State Health Center.

Plymouth Office: 101 Boulder Point Drive • PH (603) 536-4000 • FAX (603) 536-4001
Bristol Office: 859 Lake Street • PH (603) 744-6200 • FAX (603) 744-9024
Mailing Address: 101 Boulder Point Drive • Suite 1 • Plymouth, NH 03264

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www.midstatehealth.org

Mid-State Health Center
Board of Directors
2013-2014

Carol Bears
Voting Member — Term Exp: 6/30/15

Ann Blair
Secretary — Term Exp: 6/30/15

Mary Cooney
Voting Member — Term Exp: 6/30/16

James Dalley
President — Term Exp: 6/30/16

Linda Dauer
Treasurer — Term Exp: 6/30/16

Patricia Field
Voting Member — Term Exp: 6/30/14

Robin Fisk
Vice President — Term Exp: 6/30/14

Robert MacLeod
Voting Member — Term Exp: 6/30/16

Timothy Naro
Voting Member — Term Exp: 6/30/14

Non-Voting Members:

Diane Arsenault, MD, FAAFP, Physician
Tonya Warren, PsyD, Behavioral Health Director
Frederick S. Kelsey, MD, FACP, Medical Director
Sharon Beaty, MBA, CMPE, Chief Executive Officer

Plymouth Office: 101 Boulder Point Drive • PH (603) 536-4000 • FAX (603) 536-4001
Bristol Office: 859 Lake Street • PH (603) 744-6200 • FAX (603) 744-9024
Mailing Address: 101 Boulder Point Drive • Suite 1 • Plymouth, NH 03264

KEY ADMINISTRATIVE PERSONNEL

NH Department of Health and Human Services

Contractor Name: Mid-State Health Center

Name of Bureau/Section: MCH Primary Care

BUDGET PERIOD: SFY 14

Program Area: MCH Primary Care

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Sharon Beaty	CEO	$159,994	1.25%	$1,999.92
William Sweeney	CFO	$121,118	2.50%	$3,027.95
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$5,027.87**

BUDGET PERIOD: SFY 15

Program Area: MCH Primary Care

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Sharon Beaty	CEO	$166,400	5.00%	$8,320.00
William Sweeney	CFO	$124,738	10.00%	$12,473.80
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$20,793.80**

Sharon Beaty

Career Objective

To apply administrative and financial expertise in the health-care industry, encouraging positive relationships between a growing physician community and its associated medical system, and promoting capabilities of service providers to treat patients effectively while improving financial viability and profitability

Credentials

FACMPE, Fellow of the American College of Medical Practice Executives
Master of Business Administration, Baylor University Bachelor of Science in Chemistry, Texas Tech University

Summary of Qualifications

Expertise in strategic planning, financial management and analysis and contract negotiations with providers and managed-care entities. Administrative skills, specifically in management of medical facilities. Experience in operations, finance, and billing including regulatory compliance and legislative issues. Understanding of ancillary services and procedures. Knowledge of Medicare/ Medicaid and third-party-payor billing/ filing requirements. Computer literacy, both software and hardware. Communication and personnel management expertise.

Professional Experience

October 2002 to Present

Chief Executive Officer, Mid-State Health Center, Plymouth, New Hampshire. Direct operations for three clinic sites including strategic planning, marketing, budgeting, contracting and physician management. Develop programs for physician recruitment and retention as well as physician compensation plans. Provide venues for financial reporting and analysis and improvement of revenue streams while assuring access to care for local populations. Attained FQHC Look-Alike status and planned for new facility.

October 1999 to October 2002

Vice President for Business Development, Central Kansas Medical Center, Great Bend, Kansas (as of April 2001) Direct all hospital-owned and contracted practices, strategic planning, marketing, managed-care contracting, billing, and accounts receivable. Responsibilities include direction of outlying operations for multiple specialists, labs, radiology, pathology, and physician recruitment. Develop strategies for physician retention and provision of administrative support and expertise for local physician groups, including contract negotiation. . To expand availability of primary care, recently opened an additional family practice, including acquisition of facility and installation of paperless medical record system.

Director of Clinics and Physician Recruitment, Central Kansas Medical Center, Great Bend, Kansas Administered hospital-owned rural health practices, including strategic planning, marketing, managed-care contracting, billing and accounts receivable. Developed outlying operations for multiple specialists. Act as physician recruiter, developing strategies for physician retention and providing administrative support and expertise for local physician groups, including contract negotiation. Improved internal medicine practice, reducing losses by 55% in first year, with projection of 10% profit (above physician salaries) for coming budget

year. Developed hospital-owned family practice in adjacent community, remodeling building to house practice and separate specialty clinic.

January 1998 to October 1999

Administrator, Abilene Lung Physicians, Abilene, Texas Full responsibility for management of practice including long-term planning, managed care contracting, accounts receivable, accounts payable, maintenance of computer software (including formatting and design of system) and hardware, payroll, personnel, and retirement planning. Served as consultant to other physician groups concerning billing and insurance claims, as well as cost reporting for rural health clinics.

July 1994 to December 1997

Administrator, Rolling Plains Rural Health Clinic and Rolling Plains Physicians Office, Sweetwater, Texas Merged six individual physician practices, including two nurse practitioners, full-reference laboratory, radiology department, and forty employees. Developed and installed systems for billing, collections, and personnel management, including provisions for rural health clinic status, cost reporting and billing. Increased revenues by more than 80% in two and one-half years while maintaining profitability of above 50%. Oversaw all aspects of design and construction of new facility, from initial planning to transition management, including development of financing package and all contracting.

May 1981 to July 1994

Private consultant for professional offices Consulted for professional practices including medical practices: Researched needs for software and hardware. Purchased and installed computer systems. Evaluated office management performance and recommended and implemented solutions for office problems or limitations. Served on the elected board of the Nolan County Hospital District, 1991-1993.

September 1979 to May 1981

Research Assistant, Center for Private Enterprise and Entrepreneurship, Hankamer School of Business, Baylor University, Waco, Texas. Interviewed and surveyed national sample of entrepreneurs and their lifetime experiences while pursuing graduate studies.

January 1974 to September 1979

Laboratory Director, **Rolling Plains Memorial Hospital, Sweetwater, Texas** Served on Joint Commission Accreditation Committee, and assisted hospital administrator with public relations. Recognized future needs for administrative expertise that would be required for medical service industry to adapt to a new era. Resigned to acquire MBA.

Memberships and Interests

Fellow in American College of Medical Practice Executives, Medical Group Management Association, National Assoc. of Rural Health Clinics, Rotary International, former member of Taylor County Board of American Heart Association, former board member of West Texas Girl Scout Council, enjoy skiing and scuba diving as well as musical interests and community theatre.

William Sweeney

Objective

Seeking a challenging and rewarding job in finance and accounting within a medical office context.

Education

5/1997 Plymouth State College Plymouth, NH

Bachelor's of Science in Accounting

- Graduated Cum Laude with a 3.33 GPA on a 4.0 scale.
- Minor in Mathematics

Professional experience

1/1997-Present Mid-State Health Center Plymouth, NH

Chief Financial Officer

- Prepare financial statements, reconcile bank account and compile provider productivity which is used to calculate their salary. Experience with billing office and hospital charges for PCP office, management of employees, use of MS Office, and some technical support ability; bill all hospital and home visit claims for 10 providers, supervise business office staff, assist reception staff to ensure proper charge entry for office visits, and answer coding questions from providers, receptionists, and other business office personnel. Download and transmit all insurance claims and patient statements to a clearinghouse. Created a hospital procedures form for out of office procedures.

References

Available upon request.

Awards received

- Dean's list, spring semester 1994
- President's list, fall semester 1994
- Dean's list, spring semester 1995
- Certificate of Merit, May 1995
- Certificate of Merit, May 1996
- Certificate of Attendance: Troubleshooting, Maintaining & Upgrading PCs

Nicholas A. Toumpas
Commissioner

José Thier Montero
Director

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

29 HAZEN DRIVE, CONCORD, NH 03301-6527
603-271-4517 1-800-852-3345 Ext. 4517
Fax: 603-271-4519 TDD Access: 1-800-735-2964

May 10, 2012

APPRO
DATE
APPROVED G&C # 126
DATE 6/20/12
NOT APPROVED

His Excellency, Governor John H. Lynch
and the Honorable Executive Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Public Health Services, Bureau of Population Health and Community Services, Maternal and Child Health Section, to enter into an agreement with Mid-State Health Center (Vendor #158055-B001), 101 Boulder Point Drive, Suite 1, Plymouth, New Hampshire 03264, in an amount not to exceed $234,350.00, to provide primary care services, to be effective July 1, 2012 or date of Governor and Executive Council approval, whichever is later, through June 30, 2014. Funds are available in the following account for SFY 2013, and are anticipated to be available in SFY 2014 upon the availability and continued appropriation of funds in the future operating budget.

05-95-90-902010-5190 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES, MATERNAL AND CHILD HEALTH

Fiscal Year	Class/Object	Class Title	Job Number	Total Amount
SFY 2013	102-500731	Contracts for Program Services	90080000	$117,175
SFY 2014	102-500731	Contracts for Program Services	90080000	$117,175
			Total	$234,350

EXPLANATION

Funds in this agreement will be used to provide office-based primary care services for low-income and uninsured families. This agreement provides funds for services as a last resort; contractor is required to make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid.

Primary health care services include preventive and episodic health care for acute and chronic health conditions for people of all ages, including pregnant women, children, adolescents, adults, and the elderly. Community health agencies that receive support through the Division of Public Health Services deliver primary and preventive health care services to underserved people who face barriers to accessing health care, due to issues such as a lack of insurance, inability to pay, language barriers, and geographic isolation. In addition to medical care, community health centers are unique among primary care providers for the array of patient-centered services they offer, including care coordination, translation, transportation, outreach, eligibility assistance, and health education. These services help individuals overcome barriers to getting the care they need and achieving their

optimal health. One area of particular success has been in ensuring that eligible families maintain consistent enrollment in Medicaid for their children. Community health centers provide support for families in filling out applications and ensuring that children have continuity of care.

Community health agencies throughout New Hampshire have demonstrated success in meeting the health care needs of the uninsured and under-insured citizens of the state. Division of Public Health Services funded primary care providers participate in rigorous quality improvement efforts utilizing standard performance measures that focus attention on improving health outcomes for patients. For example, in State Fiscal Year 2011:

- 88% of eligible children served were enrolled in Medicaid/Healthy Kids Gold.
- 86% of children 24-35 months, served received the appropriate schedule of immunizations.
- 82% of infants born to women served received prenatal care beginning in the first trimester of pregnancy.

Should Governor and Executive Council not authorize this Request, a minimum of 1,450 low-income individuals from the following areas Alexandria, Ashland, Bridgewater, Bristol, Campton, Danbury, Dorchester, Ellsworth, Groton, Hebron, Holderness, New Hampton, Plymouth, Rumney, Thornton, Wentworth and Woodstock may not have access to primary care services. A strong primary care infrastructure reduces costs for uncompensated care, improves health outcomes, and reduces health disparities.

Mid-State Health Center was selected for this project through a competitive bid process. A Request for Proposals was posted on the Department of Health and Human Services' web site from January 10, 2012 through February 16, 2012. In addition, a bidder's conference, conference call, and web conference were held on January 19, 2012 to alert agencies to this bid.

Thirteen proposals were received in response to the posting. Each proposal was scored by three professionals, who work internal and external to the Department of Health and Human Services. All reviewers have between three to twenty years experience either in clinical settings, providing community-based family support services, and managing agreements with vendors for various public health programs. Areas of specific expertise include maternal and child health; quality assurance and performance improvement; chronic and communicable diseases and public health infrastructure. The reviewers used a standardized form to score agencies' relevant experience and capacity to carry out the activities outlined in the proposal. Reviewers look for realistic targets when scoring performance measures in addition to detailed workplans including evaluation components. Budgets were reviewed to be reasonable, justified and consistent with the intent of the program goals and outcomes. There were no competing applications within each of the separate service areas. Scores were averaged and all proposals were recommended for funding. In those instances where scores were less than ideal, agency specific remedial actions were recommended and completed. The Bid Summary is attached.

As referenced in the Request for Proposals, Renewals Section, this competitively procured Agreement has the option to renew for two additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties and approval of the Governor and Executive Council. These services were contracted previously with this agency in SFY 2011 and SFY 2012 in the amount of $397,700. This represents a decrease of $163,350. The decrease is due to budget reductions.

The performance measures used to measure the effectiveness of the agreement are attached.

Area served: Alexandria, Ashland, Bridgewater, Bristol, Campton, Danbury, Dorchester, Ellsworth, Groton, Hebron, Holderness, New Hampton, Plymouth, Rumney, Thornton, Wentworth and Woodstock.

Source of Funds: 19.95% Federal Funds from US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau and 80.05% General Funds.

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

Respectfully submitted,

José Thier Montero, MD
Director

Approved by:
Nicholas A. Toumpas
Commissioner

JTM/PMT/sc

Primary Care Performance Measures

State Fiscal Year 2013

Primary Care Prenatal (PN) Performance Measure #1

Measure: Percent of infants born to women receiving prenatal care beginning in the first trimester of pregnancy.

Primary Care Prenatal (PN) Performance Measure #2

Measure: Percent of pregnant women identified as cigarette smokers that are referred to QuitWorks-New Hampshire.

Primary Care Prenatal (PN) Performance Measure #3

Measure: Percent of pregnant women who were screened, using a formal valid screening tool, for alcohol and other drug use during every trimester the patient was enrolled.

Primary Care Child Health Direct (CH – D) Performance Measure #1

Measure: Percent of eligible children enrolled in Medicaid

Primary Care Child Health Direct (CH – D) Performance Measure #2

Measure: Percent of at-risk children who were screened for blood lead between 18 and 30 months of age

Primary Care Child Health Direct (CH – D) Performance Measure #3

Measure: Percent of children age two to nineteen years receiving primary care preventive health services with a Body Mass Index (BMI) percentile greater than or equal to the 85th percentile with documented discussion of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Primary Care Child Health Direct (CH – D) Performance Measure #4

Measure: Percent of eligible infants and children with client record documentation of enrollment in Women Infant Children Program.

Primary Care Child Health Direct (CH – D) Performance Measure #5

Measure: Percent of infants who were exclusively breastfed for the first three months, at their four month well baby visit.

Primary Care Financial (PC) Performance Measure #1

Measure: Patient Payor Mix

Primary Care Financial (PC) Performance Measure #2

Measure: Accounts Receivables (AR) Days

Primary Care Financial (PC) Performance Measure #3

Measure: Current Ratio

Primary Care Performance Measures

State Fiscal Year 2013

Primary Care Clinical Adolescent (PC-C) Performance Measure #1

Measure: Percent of adolescents aged 10-21 years who received annual health maintenance visits in the past 12 months.

Primary Care Clinical Prenatal (PC-C) Performance Measure #2

Measure: Percent of women and adolescent girls aged 15-44 who take a multi-vitamin with folic acid.

FORM NUMBER P-37 (version 1/09)

Subject: Primary Care Services

AGREEMENT

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

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name NH Department of Health and Human Services Division of Public Health Services		**1.2 State Agency Address** 29 Hazen Drive Concord, NH 03301-6504	
1.3 Contractor Name Mid-State Health Center		**1.4 Contractor Address** 101 Boulder Point Drive Suite 1 Plymouth, New Hampshire 03264	
1.5 Contractor Phone Number 603-536-4099	**1.6 Account Number** 010-090-5190-102-500731	**1.7 Completion Date** June 30, 2014	**1.8 Price Limitation** $234,350
1.9 Contracting Officer for State Agency Joan H. Ascheim, Bureau Chief		**1.10 State Agency Telephone Number** 603-271-4501	
1.11 Contractor Signature Sharon Beaty		**1.12 Name and Title of Contractor Signatory** Sharon Beaty, CEO	
1.13 Acknowledgement: State of NH, County of Grafton On 4/4/12 before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.			
1.13.1 Signature of Notary Public or Justice of the Peace Pamela J Plummer [Seal]			
1.13.2 Name and Title of Notary or Justice of the Peace PAMELA J PLUMMER Notary Public-New Hampshire My Commission Expires March 16, 2016			
1.14 State Agency Signature [signature]		**1.15 Name and Title of State Agency Signatory** Joan H. Ascheim, Bureau Chief	
1.16 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)* By:		Director, On:	
1.17 Approval by the Attorney General (Form, Substance and Execution) By: Jeanne P. Herrick Jeanne P. Herrick, Attorney		On: 29 May 2012	
1.18 Approval by the Governor and Executive Council By:		On:	

NH Department of Health and Human Services

Exhibit A

Scope of Services

Primary Care Services

CONTRACT PERIOD: July 1, 2012 or date of G&C approval, whichever is later, through June 30, 2014

CONTRACTOR NAME: Mid-State Health Center

ADDRESS: 101 Boulder Point Drive, Suite 1
Plymouth, New Hampshire 03264
Chief Executive Officer: Sharon Beaty
TELEPHONE: 603-536-4099

The Contractor shall:

I. General Provisions

A) Eligibility and Income Determination

1. Office-based primary care services will be provided to low-income individuals and families (defined as $\leq$ 185% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), in the State of New Hampshire.

2. The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing if, at any time, the practice is closed to new patients, or maintains a wait list for new patients, or any other mechanism is used that limits access for new patients for more than a one month period.

3. The Contractor shall document annually, for each client enrolled in the program, family income and family size, and calculate percentage of the federal poverty level. If calculations indicate that the client may be eligible for enrollment in Medicaid, the Contractor shall complete with the client the most recent version of the 800P form.

4. The Contractor shall implement, and post in a public and conspicuous location, a sliding fee payment schedule, approved in advance by the Division of Public Health Services (DPHS), for low-income patients. Signage must state that no client will be denied services for inability to pay.

   a. As an alternative, the contractor may post, in a public and conspicuous location, a notice to clients that a sliding fee scale is available and that no client will be denied services for inability to pay. The sliding fee scale must be updated annually based on USDHHS Poverty guidelines as published in the Federal Register, submitted to and approved by DPHS ***prior to implementation.***

5. The primary care contract entered into here shall be the payer of last resort. The contractor shall make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid, for all reimbursable services rendered.

Contractor Initials: SB
Date: 6-5-12

B) Numbers Served

1. The contract funds shall be expended to provide the above services to a minimum of 725 users annually with 3184 medical encounters, as defined in the Data and Reporting Requirements. Clinical service reimbursements shall not exceed the Medicare rate.

C) **Culturally and Linguistically Appropriate Standards of Care**

The Department of Health and Human Services (DHHS) recognizes that culture and language have considerable impact on how consumers access and respond to public health services. Culturally and linguistically diverse populations experience barriers in efforts to access health services. To ensure equal access to quality health services, the Division of Public Health Services (DPHS) expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.

2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.

3. *Provide* clients of limited English proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.

4. Offer consumers a forum through which clients have the opportunity to provide feedback to providers and organizations regarding cultural and linguistic issues that may deserve response.

5. The contractor shall maintain a program policy that sets forth compliance with Title VI, Language Efficiency and Proficiency Citation 45 CFR 80.3(b) (2). The policy shall describe the way in which the items listed above were addressed and shall indicate the circumstances in which interpretation services are provided and the method of providing service (e.g. trained interpreter, staff person who speaks the language of the client, language line).

D) **State and Federal Laws**

The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. The Contractor shall report all cases of communicable diseases according to New Hampshire RSA 141-C and He-P 301, adopted 6/3/08.

2. Persons employed by the contractor shall comply with the reporting requirements of New Hampshire RSA 169:C, Child Protection Act; RSA 161:F46, Protective Services to Adults, RSA 631:6, Assault and Related Offences and RSA 130:A, Lead Paint Poisoning and Control.

3. Immunizations shall be conducted in accordance with RSA 141-C and the Immunization Rules promulgated hereunder.

E) **Relevant Policies and Guidelines**

1. The Contractor shall design and provide the services described above to meet the unique and identified health needs of the populations within the contracted service area.

2. Primary Care funds shall be targeted to populations in need. Populations in need are defined as follows:

Contractor Initials: OB
Date: 6-5-12

a) uninsured;

b) under-insured;

c) families and individuals with significant psychosocial and economic risk, including low income status;

d) all life cycles including perinatal, child, adolescent, adult, and elderly who meet one or more of the above criteria.

3. The Contractor shall design and implement systems of governance, administration, financial management, information management, and clinical services which are adequate to assure the provision of contracted services, and to meet the data and reporting requirements. These systems shall meet the most current minimum standards described in at least one of the following: Health Resources and Services Administration (HRSA) Office of Performance Review protocols, Joint Commission on Accreditation of Health Care Organizations (JCAHO), Accreditation Association for Ambulatory Healthcare (AAAHC), Community Health Accreditation Program (CHAP), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey.

4. *The Contractor shall have an agency emergency preparedness and response plan in accordance with HRSA Health Center Emergency Management Program Expectations, Document #2007-15 or most recent version. Such plan shall also include a Continuity of Operations plan.*

5. The Contractor shall carry out the work as described in the performance Workplan submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

6. The Contractor shall carry out the work as described in the Supplemental Funding Form submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

F) Publications Funded Under Contract

1. The DHHS and/or its funders will retain COPYRIGHT ownership for any and all original materials produced with DHHS contract funding, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports.

2. All documents (written, video, audio, *electronic*) produced, reproduced, or purchased under the contract shall have prior approval from DPHS before printing, production, distribution, or use.

3. The Contractor shall credit DHHS on all materials produced under this contract following the instructions outlined in Exhibit C (14).

G) Subcontractors

1. If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing *and approve the subcontractual agreement*, prior to initiation of the subcontract.

Contractor Initials: SB
Date: 1-5-12

2. In addition, the original DPHS contractor will remain liable for all requirements included in this Exhibit and carried out by subcontractors.

II. Minimal Standards of Core Services

A) Service Requirements

1. *Medical Home*

The Contractor shall provide a Medical Home that:

a) *Facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family.*

b) *Provides care facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.*

2. Primary Care Services

The Contractor shall provide office-based primary care services to populations in need who reside in the contractor's service area. Primary care services shall include:

a) Health care provided by a New Hampshire licensed MD, DO, APRN, or PA, including diagnosis and treatment of acute and chronic illnesses within the scope of family practice; preventive services, screenings, and health education according to established, documented state or national guidelines; assessment of need for social and nutrition services, and appropriate referrals to health, *oral health*, and behavioral health specialty providers.

b) *Referral to the WIC Nutrition Program for all eligible pregnant women, infants and children.*

c) In-hospital care for conditions within the scope of family practice must be provided at a hospital, within the agency service area, through a staff clinician with full hospital privileges, or in the alternative, through a formal referral and admissions procedure available to clients on a 24 hour/7 day a week basis.

d) Access to a healthcare provider, directly or by referral or subcontract, by telephone twenty-four hours per day, seven days per week.

e) Assessment of psychosocial risk for all clients at least annually and for children at scheduled preventive care visits, including, at a minimum, age appropriate assessment of safety in the home, domestic violence, adequacy of food and housing, care and welfare of children, transportation needs, and provision of necessary social services to address the priority needs and safety issues of clients and families.

f) Falls prevention screening for patients 65 years and older using the algorithm and guidelines of the American Geriatrics Society.

g) Behavioral health care directly or by referral to an agency or provider with a sliding fee scale.

h) *Nutrition assessment for all clients as part of the health maintenance visit.* Therapeutic nutrition services shall be provided *as indicated* directly or by referral to an agency or provider with a sliding fee scale. These services shall be recorded in the medical record.

i) Formal arrangements with a local hospital for emergency care must be in place and reviewed annually.

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j) Home health care directly or by referral to an agency or provider with a sliding fee scale.

k) Assisted living and skilled nursing facility care by referral.

l) *Oral screening annually for all clients 19 years and older to note obvious dental decay and soft tissue abnormalities with a reminder to the patient that poor oral health impacts total health.*

m) *Diagnosis and management of pediatric and adult patients with asthma provided according to National Heart Lung Blood Institute, National Asthma Education and Prevention Program, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, 2007.*

n) *Breast and cervical cancer screening directly or by referral to an agency or provider with a sliding fee scale using screening guidelines from a nationally accepted organization.*

3. Reproductive Health Services

The Contractor shall provide prenatal, interconceptional and preconception medical care, social services, nutrition services, education, and nursing care to all women of childbearing age. Preconceptional care includes the preconception, interconceptional, and postpartum periods in women's health. It is recommended that preconceptional and interconceptional care visits focus on maintaining or achieving the optimal health of the mother, lowering the risk of future adverse pregnancy outcomes, the family's future plans, and how additional children fit into that plan. Preconceptional counseling may be done during an office, group or home visit.

a) In the event prenatal care is not provided directly by the Contractor a formal Memorandum/a of Agreement for coordinated referral to an appropriately qualified provider must be maintained.

b) Prenatal care shall, at minimum, be provided in accordance with the Guidelines for Perinatal Care, sixth or most current edition, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and /or the Centers for Disease Control.

c) Age appropriate reproductive health care shall, at a minimum, be provided in accordance with the American College of Obstetricians and Gynecologists, or the USDHHS Centers for Disease Control (CDC) current guidelines.

d) *Pregnant women enrolled in the WIC Nutrition Program shall be referred to WIC for breastfeeding education and referral to the WIC Nutrition Program peer counselors.*

e) Family planning counseling for prevention of subsequent pregnancy following an infant's birth shall be discussed with the infant's mother *at the first postpartum visit and at the infant's 2-month visit and other visits as appropriate.* Rationale for birth intervals of 18-24 months shall be presented.

f) A referral to a Title X Family Planning Clinic or other reproductive health care provider shall be made as appropriate.

4. Services for Children and Adolescents

The Contractor shall provide as a minimum, comprehensive and age-appropriate health care, screenings, and health education according to the American Academy of Pediatrics' most recent periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent. Children and adolescent visits shall include:

Contractor Initials: SB
Date: 6-5-12

a) Blood lead testing shall be performed in accordance with "New Hampshire Childhood Lead Poisoning Screening and Management Guidelines", issued by the New Hampshire Department of Health and Human Services, 2009 or subsequent revisions.

b) All children enrolled in either Healthy Kids-Gold or the Women, Infant, and Children (WIC) Program and/or who are ≤ 185%_poverty, regardless of town of residence, are required to have a blood lead test at ages one and two years. All children ages three to six years who have not been previously tested shall have a capillary or venous blood lead test performed.

c) All children shall be screened for iron deficiency anemia as outlined in the Centers for Disease Control and Prevention document "Recommendations to Prevent and Control Iron Deficiency in the United States (4/2/98)".

d) Age-appropriate anticipatory guidance, dietary guidance, and *feeding practice counseling* for optimal oral health shall be provided at each well child visit according to the American Academy of Pediatrics' periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent edition. Starting at age 6 months, it is recommended that all children receive an oral health assessment at every well child visit.

e) Supplemental fluoride shall be prescribed as needed based upon the fluoride levels in the child's *drinking* water supply. The fluoride dosage regimen accepted by the American Academy of Pediatrics shall be followed. No fluoride shall be prescribed without obtaining water from private wells or noting the presence or absence of fluoride in the public water supply. ***Supplemental fluoride may include bottled water containing fluoride and topical applications such as varnishes.***

f) ***For infants enrolled in the WIC Nutrition Program, parents shall be referred to WIC for breastfeeding support and referral to the WIC Nutrition Program peer counselors.***

5. Sexually Transmitted Infections

Primary Care Services shall provide age appropriate screening and treatment of sexually transmitted infections.

a) Treatment for sexually transmitted infections shall be provided according to the United States Centers for Disease Control Sexually Transmitted Diseases Treatment Guidelines, 2010 or subsequent revisions.

b) All clients, including women, shall be offered HIV testing following the most current recommendations of the United States Centers for Disease Control.

c) The contractor shall be responsible for ensuring referral to appropriate treatment services for any woman found to screen positive.

d) Appropriate risk reduction counseling shall be provided based on client needs.

6. Substance Use Services

a) A substance use screening history using a formal, validated screening tool shall be obtained for all clients as soon after entry into care as possible. Substance use counseling *or other substance abuse intervention, treatment, or recovery services* by an appropriately credentialed provider shall be provided on-site, or by referral, to clients with identified needs for these services. *For these identified clients, ongoing primary care services should include follow up monitoring relative to substance abuse.*

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b) All clients, including pregnant women, identified as smokers shall receive counseling *using the 5A's (ask, advise, assess, assist, and arrange) treatment available through the NH Tobacco Helpline* as cited in the US Public Health Services report "Tobacco Use and Dependence", 2008, or "Smoking Cessation During Pregnancy: *A Clinician's Guide to Helping Pregnant Women Quit Smoking*", American College of Obstetricians and Gynecologists, 2011. *With prior approval, agencies may also opt to participate in the DPHS best practice initiative of the 2A's and R (ask, advise and refer).*

7. Immunizations

a) The Contractor shall adhere to the most current version of the "Recommended Adult Immunization Schedule United States", approved by the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

b) The Contractor shall administer vaccines according to the most current version of the *"Recommended Immunization Schedule for Persons Aged 0 Through 6 Years - United States", and "Recommended Immunization Schedule for Persons Aged 7 Through 18 Years – United States"* approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians, based upon availability of vaccine from the New Hampshire Immunization Program.

8. Prenatal Genetic Screening

a) A genetic screening history shall be obtained on all prenatal clients as soon after entry into care as possible.

b) All pregnant women should be offered voluntary genetic screening for fetal chromosomal abnormalities at the appropriate time following recommendations found in the American College of Obstetricians and Gynecologists' "Screening for Fetal Chromosomal Abnormalities (2007)" or more recent guidelines. The Contractor shall be responsible for ensuring referral to appropriate genetic testing and counseling for any woman found to have a positive screening test.

9. Additional Requirements

a) The Contractor's Medical Director shall participate in the development and approval of specific guidelines for medical care that supplement minimal clinical standards. Supplemental guidelines should be reviewed, signed, and dated annually, and updated as indicated.

b) Contractors considering clinical or sociological research using clients as subjects must adhere to the legal requirements governing human subjects research. Contractors must inform the DPHS, MCHS prior to initiating any research related to this contract.

c) *The Contractor shall provide information to all employees annually about the Medical Reserve Corps Unit within their Public Health Region to enhance recruitment.*

d) *The Contractor shall provide information to all employees annually regarding the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) managed by the NH Department of Health and Human Services' Emergency Services Unit, to enhance recruitment.*

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B) **Staffing Provisions**

The Contractor shall have, at minimum, the following staff positions:

a) executive director

b) fiscal director

c) registered nurse

d) clinical coordinator

e) medical service director

f) nutritionist *(on site or by referral)*

g) social worker

Staff positions required to provide direct services on-site include:

a) registered nurse

b) clinical coordinator

c) social worker

1. Qualifications

All health and allied health professionals shall have the appropriate New Hampshire licenses whether directly employed, contracted, or subcontracted.

In addition the following minimum qualifications shall be met for:

a) Registered Nurse

   a. A registered nurse licensed in the state of New Hampshire, Bachelor's degree preferred. Minimum of one-year experience in a community health setting.

b) Nutritionists:

   a. A Bachelor's degree in nutritional sciences or dietetics, or a Master's degree in nutritional sciences, nutrition education, or public health nutrition or current Registered Dietitian status in accordance with the Commission on dietetic Registration of the American Dietetic Association.

   b. Individuals who perform functions similar to a nutritionist but do not meet the above qualifications shall not use the title of nutritionist.

c) Social Workers shall have:

   a. A Bachelor's or Master's degree in social work or Bachelor's or Master's degree in a related social science or human behavior field. A minimum of one year of experience in a community health or social services setting is preferred.

   b. Individuals who perform functions similar to a social worker but do not meet the above qualifications shall not use the title of social worker.

d) Clinical Coordinators shall be:

   a. A registered nurse (RN), physician, physician assistant, or nurse practitioner with a license to practice in New Hampshire.

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Date: 6-5-12

b. The coordinator is a clinical position that oversees and takes responsibility for the clinical and administrative functions of each program.

c. The coordinator may be responsible for more than one MCH funded program.

2. New Hires

The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing within one month of hire when a new administrator, clinical coordinator, or any staff person essential to carrying out contracted services is hired to work in the program. A resume of the employee shall accompany the aforesaid notification.

3. Vacancies

a) The Contractor must notify the MCHS in writing if any critical position is vacant for more than one month, or if at any time funded under this contract does not have adequate staffing to perform all required services for more than one month. This may be done through a budget revision.

b) Before an agency hires new program personnel that do not meet the required staff qualifications, the agency shall notify the MCHS in writing requesting a waiver of the applicable staffing requirements. The Section may grant waivers based on the need of the program, individuals' experience, and additional training.

C) Coordination of Services

1. The Contractor shall coordinate, where possible, with other service providers within the contractor's community. At a minimum, such collaboration shall include interagency referrals and coordination of care.

2. The Contractor shall participate in activities *<u>in the Public Health Region in which they provide services</u>* as appropriate. These activities enhance the integration of community-based public health prevention and health care initiatives that are being implemented by the contractor and may include community needs assessments, public health performance assessments, and/or the development of regional health improvement plans.

3. The Contractor agrees to *<u>participate</u>* in and coordinate public health activities as requested by the Division of Public Health Services during any *<u>disease outbreak</u>* and/or *<u>emergency</u>*, natural or man made, affecting the public's health.

4. The Contractor is responsible for case management of the client enrolled in the program and for program follow-up activities. Case management services shall promote effective and efficient organization and utilization of resources to assure access to necessary comprehensive medical, nutritional, and social services for clients.

5. The Contractor shall assure that *<u>appropriate, responsive, and timely</u>* referrals and linkages for other needed services are made, carried through, and documented. Such services shall include, but not be limited to: dental services, genetic counseling, high risk prenatal services, mental health, social services, including domestic violence crisis centers, substance abuse services; and family planning services, Early Supports and Services Program, local WIC/CSF Program, Home Visiting New Hampshire Programs and health and social service agencies which serve children and families in need of those services.

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Date: 6-5-12

D) Meetings and Trainings

The contractor will be responsible for sending staff to meetings and training required by the MCHS program, including but not limited to:

1. MCHS Agency Directors' meetings
2. Prenatal and Child Health Coordinators' meetings
3. MCHS Agency Medical Services Directors' meetings

III. Quality or Performance Improvement (QI/PI)

A) Workplans

1. Performance Workplans are required for this program and are used to monitor achievement of standard measures of performance of the services provided under this contract. The workplans are a key component of the RHPCS and the MCHS performance-based contracting system and of this contract. Outcomes shall be reported by clinical site.

2. Submit Performance Workplans and Workplan Outcome reports according to the schedule and instructions provided by the MCHS. The MCHS shall notify the Contractor at least 30 days in advance of any changes in the submission schedule.

3. The Contractor shall incorporate required and developmental performance measures, defined by the MCHS into the agency's Performance Workplan. Reports on Workplan Progress/Outcomes shall detail the Performance Workplan plans and activities that monitor and evaluate the agency's progress toward performance measure targets.

4. The Contractor shall comply with modifications and/or additions to the workplan and annual report format as requested by RHPCS and MCHS. MCHS will provide the contractor with reasonable notice of such changes.

5. Agencies contracting for Primary Care Services must submit the workplans for Primary Care *Clinical and Financial*, Child Health, and Prenatal Care.

B) Additional Reporting requirements

In addition to Performance Workplans, the Contractor shall submit to MCHS the following data and information listed below which are used to monitor program performance:

1. In years when contracts or amendments are not required, the DPHS Budget Form, Budget Justification, Sources of Revenue and Program Staff list forms must be completed according to the relevant instructions and submitted as requested by DPHS and, at minimum, by April 30 of each year.

2. The Sources of Revenue report must be resubmitted at any point when changes in revenue threaten the ability of the agency to carry out the planned program.

3. Completed Uniform Data Set (UDS) tables reflecting program performance in the previous calendar year, by March 31 of each year.

4. The Perinatal Client Data Form (PCDF) shall be submitted electronically according to the instructions set forth by the MCHS.

Contractor Initials: SB
Date: 6-5-12

5. A copy of the agency's updated Sliding Fee Scale including the amount(s) of any client fees and the schedule of discounts must be submitted by March 31st of each year. The agency's sliding fee scale must be updated annually based on the US DHHS Poverty guidelines as published in the Federal Register.

6. An annual summary of program-specific patient satisfaction results obtained during the prior contract period and the method by which the results were obtained shall be submitted annually as an addendum to the Workplan Outcome/Progress reports.

C) On-site reviews

1. The contractor shall allow a team or person authorized by the Division of Public Health Services to periodically review the contractor's systems of governance, administration, data collection and submission, clinical and financial management, and delivery of education services in order to assure systems are adequate to provide the contracted services.
2. Reviews shall include client record reviews to measure compliance with this exhibit.
3. The contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.
4. On-Site reviews may be waived or abbreviated at the discretion of MCHS, upon submission of satisfactory reports of reviews such as Health Services Resources Administration (HRSA): Office of Performance Review (OPR), or reviews from nationally accreditation organizations such as the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), Medicare, the Community Health Accreditation Program (CHAP), Accreditation Association for Ambulatory Healthcare (AAAHC), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey. Abbreviated reviews will focus on any deficiencies found in previous reviews, issues of compliance with this exhibit, and actions to strengthen performance as outlined in the agency Performance Workplan.

Contractor Initials: SB
Date: 10-5-12

State of New Hampshire
Department of Health and Human Services
Amendment #1 to the
The New London Hospital Association, Inc.

This 1st Amendment to The New London Hospital Association, Inc., contract (hereinafter referred to as "Amendment One") dated this 25th day of March, 2014, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and The New London Hospital Association, Inc., (hereinafter referred to as "the Contractor"), a corporation with a place of business at 273 County Road, New London, New Hampshire 03257.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on June 20, 2012, 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, the State and the Contractor have agreed to make changes to the scope of work, payment schedules and terms and conditions of the contract; and

WHEREAS, pursuant to the General Provisions, Paragraph 18, the State may modify the scope of work and the payment schedule of the contract by written agreement of the parties;

WHEREAS, the Department desires to provide additional primary health care services for preventive and episodic health care for acute and chronic health conditions for people of all ages.

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 as follows:

To amend as follows:

- Form P-37, to change:
  Block 1.7 to read: June 30, 2015
  Block 1.8 to read: $587,923

- Exhibit A, Scope of Services to add:
  Exhibit A – Amendment 1

- Exhibit B, Purchase of Services, Contract Price, to add:

  Paragraph 1.1 to Paragraph 1:
  The contract price shall increase by $39,566 for SFY 2014 and $225,093 for SFY 2015.

  Paragraph 1.2 to Paragraph 1:
  Funding is available as follows:
- $39,566 from 05-95-90-902010-5190-102-500731, 100% General Funds;
- $198,401 from 05-95-90-902010-5190-102-500731, 6.7% Federal Funds from the US Department of Health and Human Services Administration, Maternal and Child Health Bureau, CFDA #93.994 and 93.3% General Funds;

Contractor Initials: BPK
Date: 3/25/14

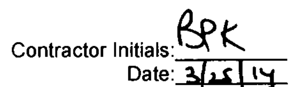
- $26,692 from 05-95-90-902010-5659-102-500731, 100% Federal Funds from the US Department of Health and Human Services, Centers for Disease Control and Prevention, CFDA #93.283;

  Add Paragraph 8
  8. Notwithstanding paragraph 18 of the General Provisions P-37, an amendment limited to adjustments to amounts between and among account numbers, within the price limitation, may be made by written agreement of both parties and may be made without obtaining approval of the Governor and Executive Council.

- Budget, to add:
  Exhibit B-1 (2014) - Amendment 1,
  Exhibit B-1 (2015) - Amendment 1

This amendment shall be in effect July 1, 2013, effective upon the date of Governor and Executive Council approval.

Contractor Initials: BPK
Date: 3/25/14



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

4/28/14
Date

Brook Dupee
Bureau Chief

The New London Hospital Association, Inc.

3/25/14
Date

Name: Bruce P. King
Title: President & CEO

Acknowledgement:

State of New Hampshire, County of Merrimack on March 25, 2014, before the undersigned officer, personally appeared the person identified above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.

Signature of Notary Public or Justice of the Peace

ERICA M. BELISLE, Notary Public
My Commission Expires March 30, 2016

Name and Title of Notary or Justice of the Peace

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

OFFICE OF THE ATTORNEY GENERAL

4-3-14
Date

Name: Rosemary Wiant
Title: Asst Attorney General

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:

Contractor Initials: RPK
Date: 3/25/14

EXHIBIT A – AMENDMENT 1

Scope of Services

The Department desires to continue the relationship with the primary care agencies to provide additional primary health care services for preventive and episodic health care for acute and chronic health conditions for people of all ages.

I. General Provisions

A) Eligibility and Income Determination

1. Office-based primary care services will be provided to low-income individuals and families (defined as ≤ 185% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), in the State of New Hampshire.

2. Breast and Cervical Cancer screening services will be provided to low-income (defined as ≤ 250% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), New Hampshire women age 21– 64, uninsured or underinsured. BCCP changes.

3. The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing if, at any time, the practice is closed to new patients, or maintains a wait list for new patients, or any other mechanism is used that limits access for new patients for more than a one month period.

4. The Contractor shall document annually, for each client enrolled in the program, family income and family size, and calculate percentage of the federal poverty level. If calculations indicate that the client may be eligible for enrollment in Medicaid, the Contractor shall complete with the client the most recent version of the 800P form.

5. The Contractor shall implement, and post in a public and conspicuous location, a sliding fee payment schedule, approved in advance by the Division of Public Health Services (DPHS), for low-income patients. Signage must state that no client will be denied services for inability to pay.

   a. As an alternative, the contractor may post, in a public and conspicuous location, a notice to clients that a sliding fee scale is available and that no client will be denied services for inability to pay. The sliding fee scale must be updated annually based on USDHHS Poverty guidelines as published in the Federal Register, submitted to and approved by DPHS prior to implementation.

6. The primary care contract entered into here shall be the payer of last resort. The contractor shall make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid, for all reimbursable services rendered.

EXHIBIT A – AMENDMENT 1

B) Numbers Served

1. The contract funds shall be expended to provide the above services to a minimum of 150 users annually with 450 medical encounters, as defined in the Data and Reporting Requirements. Breast and Cervical Cancer Screening for eligible women, as defined by the Breast and Cervical Cancer Program (BCCP), shall be provided to 70 women annually and billed directly to the BCCP. Clinical service reimbursements shall not exceed the Medicare rate.

C) Culturally and Linguistically Appropriate Standards of Care

The Department of Health and Human Services (DHHS) recognizes that culture and language have considerable impact on how consumers access and respond to public health services. Culturally and linguistically diverse populations experience barriers in efforts to access health services. To ensure equal access to quality health services, the Division of Public Health Services (DPHS) expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.

2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.

3. Provide clients of limited English proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.

4. Offer consumers a forum through which clients have the opportunity to provide feedback to providers and organizations regarding cultural and linguistic issues that may deserve response.

5. The contractor shall maintain a program policy that sets forth compliance with Title VI, Language Efficiency and Proficiency Citation 45 CFR 80.3(b) (2). The policy shall describe the way in which the items listed above were addressed and shall indicate the circumstances in which interpretation services are provided and the method of providing service (e.g. trained interpreter, staff person who speaks the language of the client, language line).

D) State and Federal Laws

The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. The Contractor shall report all cases of communicable diseases according to New Hampshire RSA 141-C and He-P 301, adopted 6/3/08.

2. Persons employed by the contractor shall comply with the reporting requirements of New Hampshire RSA 169:C, Child Protection Act; RSA 161:F46, Protective Services to Adults, RSA 631:6, Assault and Related Offences and RSA 130:A, Lead Paint Poisoning and Control.

3. Immunizations shall be conducted in accordance with RSA 141-C and the Immunization Rules promulgated hereunder.

E) Relevant Policies and Guidelines

1. The Contractor shall design and provide the services described above to meet the unique and identified health needs of the populations within the contracted service area.

2. Primary Care funds shall be targeted to populations in need. Populations in need are defined as follows:

   a) uninsured;

   b) under-insured;

   c) families and individuals with significant psychosocial and economic risk, including low income status;

   d) all life cycles including perinatal, child, adolescent, adult, and elderly who meet one or more of the above criteria.

3. The Contractor shall design and implement systems of governance, administration, financial management, information management, and clinical services which are adequate to assure the provision of contracted services, and to meet the data and reporting requirements. These systems shall meet the most current minimum standards described in at least one of the following: Health Resources and Services Administration (HRSA) Office of Performance Review protocols, Joint Commission on Accreditation of Health Care Organizations (JCAHO), Accreditation Association for Ambulatory Healthcare (AAAHC), Community Health Accreditation Program (CHAP), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey.

4. The Contractor shall have an agency emergency preparedness and response plan in accordance with HRSA Health Center Emergency Management Program Expectations, Document #2007-15 or most recent version. Such plan shall also include a Continuity of Operations plan.

5. The Contractor shall carry out the work as described in the performance Workplan submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

6. No Workplan is required by the Breast and Cervical Cancer Program (BCCP). The contractor shall be required to respond to the Quality Improvement Feedback Report twice a year.

7. The Contractor shall carry out the work as described in the Supplemental Funding Form submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

F) Publications Funded Under Contract

1. The DHHS and/or its funders will retain COPYRIGHT ownership for any and all original materials produced with DHHS contract funding, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports.

2. All documents (written, video, audio, electronic) produced, reproduced, or purchased under the contract shall have prior approval from DPHS before printing, production, distribution, or use.

3. The Contractor shall credit DHHS on all materials produced under this contract following the instructions outlined in Exhibit C (14).

G) Subcontractors

If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing and approve the subcontractual agreement, prior to initiation of the subcontract.

1. If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing and approve the subcontractual agreement, prior to initiation of the subcontract.

2. In addition, the original DPHS contractor will remain liable for all requirements included in this Exhibit and carried out by subcontractors.

II. <u>Minimal Standards of Core Services</u>

A. Service Requirements

1. Medical Home

   The Contractor shall provide a Medical Home that:

   a) Facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family.

b) Provides care facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

2. Primary Care Services

The Contractor shall provide office-based primary care services to populations in need who reside in the contractor's service area. Primary care services shall include:

a) Health care provided by a New Hampshire licensed MD, DO, APRN, or PA, including diagnosis and treatment of acute and chronic illnesses within the scope of family practice; preventive services, screenings, and health education according to established, documented state or national guidelines; assessment of need for social and nutrition services, and appropriate referrals to health, oral health, and behavioral health specialty providers.

b) Referral to the WIC Nutrition Program for all eligible pregnant women, infants and children.

c) In-hospital care for conditions within the scope of family practice must be provided at a hospital, within the agency service area, through a staff clinician with full hospital privileges, or in the alternative, through a formal referral and admissions procedure available to clients on a 24 hour/7 day a week basis.

d) Access to a healthcare provider, directly or by referral or subcontract, by telephone twenty-four hours per day, seven days per week.

e) Assessment of psychosocial risk for all clients at least annually and for children at scheduled preventive care visits, including, at a minimum, age appropriate assessment of safety in the home, domestic violence, adequacy of food and housing, care and welfare of children, transportation needs, and provision of necessary social services to address the priority needs and safety issues of clients and families.

f) Falls prevention screening for patients 65 years and older using the algorithm and guidelines of the American Geriatrics Society.

g) Behavioral health care directly or by referral to an agency or provider with a sliding fee scale.

h) Nutrition assessment for all clients as part of the health maintenance visit. Therapeutic nutrition services shall be provided as indicated directly or by referral to an agency or provider with a sliding fee scale. These services shall be recorded in the medical record.

i) Formal arrangements with a local hospital for emergency care must be in place and reviewed annually.

j) Home health care directly or by referral to an agency or provider with a sliding fee scale.

k) Assisted living and skilled nursing facility care by referral.

l) Oral screening annually for all clients 21 years and older to note obvious dental decay and soft tissue abnormalities with a reminder to the patient that poor oral health impacts total health.

m) Diagnosis and management of pediatric and adult patients with asthma provided according to National Heart Lung Blood Institute, National Asthma Education and Prevention Program, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, 2007.

3. Breast and Cervical Cancer Screening

a) Women age 21 to 64 who are eligible for Breast and Cervical Cancer Program (BCCP) services according to income (equal to or under 250% of poverty, underinsured/uninsured) and insurance status criteria shall be provided the following services, following USPSTF screening recommendations:

i. cervical cancer screening including a pelvic examination and Pap smear;
ii. breast cancer screening including a clinical breast exam, mammogram and,
iii. referrals for diagnostic and treatment services based on screening results,
iv. case management services.

b) All referrals under this provision shall be to approved certified laboratory, pathology, radiology, and surgical services. Mammography units shall be accredited by the American College of Radiology, and must be FDA certified under MQSA. Laboratories shall be CLIA certified.

c) All services shall be provided in accordance with the Breast and Cervical Cancer Program (BCCP) Policy and Procedure Manual.

d) Follow-up and tracking of all tests done, and referrals made shall be provided in accordance with the minimum standards outlined in the Breast and Cervical Cancer Program Policy and Procedure Manual.

e) All services for women enrolled in the Breast and Cervical Cancer Program (BCCP) shall be billed directly to the BCCP in accordance with protocols established by the Breast and Cervical Cancer Program.

f) The Contractor shall provide the NH Breast and Cervical Cancer Program with breast and cervical cancer screening rates for all women served by the practice as requested, but not more than twice per SFY.

g) The contractor shall work with the NH Breast and Cervical Cancer Program staff to increase the breast and cervical cancer screening rates among all women serviced by the practice.

4. Reproductive Health Services

The Contractor shall provide prenatal, interconceptional and preconception medical care, social services, nutrition services, education, and nursing care to all women of childbearing age. Preconceptional care includes the preconception, interconceptional, and postpartum periods in women's health. It is recommended that preconceptional and interconceptional care visits focus on maintaining or achieving the optimal health of the mother, lowering the risk of future adverse pregnancy outcomes, the family's future plans, and how additional children fit into that plan. Preconceptional counseling may be done during an office, group or home visit.

a) In the event prenatal care is not provided directly by the Contractor a formal Memorandum/a of Agreement for coordinated referral to an appropriately qualified provider must be maintained.

b) Prenatal care shall, at minimum, be provided in accordance with the Guidelines for Perinatal Care, sixth or most current edition, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and /or the Centers for Disease Control.

c) Age appropriate reproductive health care shall, at a minimum, be provided in accordance with the American College of Obstetricians and Gynecologists, or the USDHHS Centers for Disease Control (CDC) current guidelines.

d) Pregnant women enrolled in the WIC Nutrition Program shall be referred to WIC for breastfeeding education and referral to the WIC Nutrition Program peer counselors.

e. Family planning counseling for prevention of subsequent pregnancy following an infant's birth shall be discussed with the infant's mother at the first postpartum visit and at the infant's 2-month visit and other visits as appropriate. Rationale for birth intervals of 18-24 months shall be presented.

f) A referral to a Title X Family Planning Clinic or other reproductive health care provider shall be made as appropriate.

5. Services for Children and Adolescents

The Contractor shall provide as a minimum, comprehensive and age-appropriate health care, screenings, and health education according to the American Academy of Pediatrics' most recent periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent. Children and adolescent visits shall include:

a) The World Health Organization (WHO) growth charts shall be used to monitor growth for infants and children birth up to age 2 years. The Centers for Disease Control and Prevention (CDC) growth charts shall be used for children age 2 years and older.

b) Blood lead testing shall be performed in accordance with "New Hampshire Childhood Lead Poisoning Screening and Management Guidelines", issued by the New Hampshire Department of Health and Human Services, 2009 or subsequent revisions.

c) All children enrolled in either Medicaid, Head Start, or the Women, Infant, and Children (WIC) Program and/or who are ≤ 185%_poverty, regardless of town of residence, are required to have a blood lead test at ages one and two years. All children ages three to six years who have not been previously tested shall have a blood lead test performed.

d) All children shall be screened for iron deficiency anemia as outlined in the Centers for Disease Control and Prevention document "Recommendations to Prevent and Control Iron Deficiency in the United States (4/2/98)".

e) Age-appropriate anticipatory guidance, dietary guidance, and *feeding practice counseling* for optimal oral health shall be provided at each well child visit according to the American Academy of Pediatrics' periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent edition. Starting at age 6 months, it is recommended that all children receive an oral health assessment at every well child visit, and a referral for the child's first visit to the dentist by age one as recommended by the American Academy of Pediatrics and the American Academy of Pediatric Dentistry.

f) Supplemental fluoride shall be prescribed as needed based upon the fluoride levels in the child's drinking water supply. The fluoride dosage regimen accepted by the American Academy of Pediatrics shall be followed. No fluoride shall be prescribed without obtaining water from private wells or noting the presence or absence of fluoride in the public water supply. Supplemental fluoride may include bottled water containing fluoride and topical applications such as varnishes.

g) For infants enrolled in the WIC Nutrition Program, parents shall be referred to WIC for breastfeeding support and referral to the WIC Nutrition Program peer counselors.

6. Sexually Transmitted Infections

Primary Care Services shall provide age appropriate screening and treatment of sexually transmitted infections.

a) Treatment for sexually transmitted infections shall be provided according to the United States Centers for Disease Control Sexually Transmitted Diseases Treatment Guidelines, 2010 or subsequent revisions.

b) All clients, including women, shall be offered HIV testing following the most current recommendations of the United States Centers for Disease Control.

c) The contractor shall be responsible for ensuring referral to appropriate treatment services for any woman found to screen positive.

d) Appropriate risk reduction counseling shall be provided based on client needs.

7. Substance Use Services

a) A substance use screening history using a formal, validated screening tool shall be obtained for all clients as soon after entry into care as possible. Substance use counseling or other substance abuse intervention, treatment, or recovery services by an appropriately credentialed provider shall be provided on-site, or by referral, to clients with identified needs for these services. For these identified clients, ongoing primary care services should include follow up monitoring relative to substance abuse.

b) All clients, including pregnant women, identified as smokers shall receive counseling using the 5A's (ask, advise, assess, assist, and arrange) treatment available through the NH Tobacco Helpline as cited in the US Public Health Services report "Tobacco Use and Dependence", 2008, or "Smoking Cessation During Pregnancy: A Clinician's Guide to Helping Pregnant Women Quit Smoking", American College of Obstetricians and Gynecologists, 2011. With prior approval, agencies may also opt to participate in the DPHS best practice initiative of the 2A's and R (ask, advise and refer).

8. Immunizations

a) The Contractor shall adhere to the most current version of the "Recommended Adult Immunization Schedule for Adults (19 years and older) by Age and Medical Condition - United States", approved by the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

b) The Contractor shall administer vaccines according to the most current version of the "Recommended Immunization Schedule for Persons Aged 0 Through 6 Years - United States", and "Recommended Immunization Schedule for Persons Aged 7 Through 18 Years – United States" approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians, based upon availability of vaccine from the New Hampshire Immunization Program.

9. Prenatal Genetic Screening

a) A genetic screening history shall be obtained on all prenatal clients as soon after entry into care as possible.

b) All pregnant women should be offered voluntary genetic screening for fetal chromosomal abnormalities at the appropriate time following recommendations found in the American College of Obstetricians and Gynecologists' "Screening for Fetal Chromosomal Abnormalities (2007)" or more recent guidelines. The Contractor shall be responsible for ensuring referral to appropriate genetic testing and counseling for any woman found to have a positive screening test.

10. Additional Requirements

a) The Contractor's Medical Director shall participate in the development and approval of specific guidelines for medical care that supplement minimal clinical standards. Supplemental guidelines should be reviewed, signed, and dated annually, and updated as indicated.

b) Contractors considering clinical or sociological research using clients as subjects must adhere to the legal requirements governing human subjects research. Contractors must inform the DPHS, MCHS prior to initiating any research related to this contract.

c) The Contractor shall provide information to all employees annually about the Medical Reserve Corps Unit within their Public Health Region to enhance recruitment.

d) The Contractor shall provide information to all employees annually regarding the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) managed by the NH Department of Health and Human Services' Emergency Services Unit, to enhance recruitment.

B) Staffing Provisions

The Contractor shall have, at minimum, the following staff positions:

a) executive director

b) fiscal director

c) registered nurse

d) clinical coordinator

e) medical service director

f) nutritionist (on site or by referral)

g) social worker

Staff positions required to provide direct services on-site include:

a) registered nurse

b) clinical coordinator

c) social worker

1. Qualifications

All health and allied health professionals shall have the appropriate New Hampshire licenses whether directly employed, contracted, or subcontracted.

In addition the following minimum qualifications shall be met for:

a) Registered Nurse
   a. A registered nurse licensed in the state of New Hampshire, Bachelor's degree preferred. Minimum of one-year experience in a community health setting.

b) Nutritionists:
   a. A Bachelor's degree in nutritional sciences or dietetics, or a Master's degree in nutritional sciences, nutrition education, or public health nutrition or current Registered Dietitian status in accordance with the Commission on dietetic Registration of the American Dietetic Association.
   b. Individuals who perform functions similar to a nutritionist but do not meet the above qualifications shall not use the title of nutritionist.

c) Social Workers shall have:
   a. A Bachelor's or Master's degree in social work or Bachelor's or Master's degree in a related social science or human behavior field. A minimum of one year of experience in a community health or social services setting is preferred.
   b. Individuals who perform functions similar to a social worker but do not meet the above qualifications shall not use the title of social worker.

d) Clinical Coordinators shall be:
   a. A registered nurse (RN), physician, physician assistant, or nurse practitioner with a license to practice in New Hampshire.
   b. The coordinator is a clinical position that oversees and takes responsibility for the clinical and administrative functions of each program.
   c. The coordinator may be responsible for more than one MCH funded program.

2. New Hires

The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing within one month of hire when a new administrator, clinical coordinator, or any staff person essential to carrying out contracted services is hired to work in the program. A resume of the employee shall accompany the aforesaid notification.

3. Vacancies

   a) The Contractor must notify the MCHS in writing if any critical position is vacant for more than one month, or if at any time funded under this contract does not have adequate staffing to perform all required services for more than one month. This may be done through a budget revision.

   b) Before an agency hires new program personnel that do not meet the required staff qualifications, the agency shall notify the MCHS in writing requesting a waiver of the applicable staffing requirements. The Section may grant waivers based on the need of the program, individuals' experience, and additional training.

C) Coordination of Services

1. The Contractor shall coordinate, where possible, with other service providers within the contractor's community. At a minimum, such collaboration shall include interagency referrals and coordination of care.

2. The Contractor shall participate in activities in the Public Health Region in which they provide services as appropriate. These activities enhance the integration of community-based public health prevention and health care initiatives that are being implemented by the contractor and may include community needs assessments, public health performance assessments, and/or the development of regional health improvement plans.

3. The Contractor agrees to participate in and coordinate public health activities as requested by the Division of Public Health Services during any disease outbreak and/or emergency, natural or man-made, affecting the public's health.

4. The Contractor is responsible for case management of the client enrolled in the program and for program follow-up activities. Case management services shall promote effective and efficient organization and utilization
   of resources to assure access to necessary comprehensive medical, nutritional, and social services for clients.

5. The Contractor shall assure that appropriate, responsive, and timely referrals and linkages for other needed services are made, carried through, and documented. Such services shall include, but not be limited to: dental services, genetic counseling, high risk prenatal services, mental health, social services, including domestic violence crisis centers, substance abuse services; and family planning services, Early Supports and Services Program, local WIC/CSF Program, Home Visiting New Hampshire Programs and health and social service agencies which serve children and families in need of those services.

D) Meetings and Trainings

The contractor will be responsible for sending staff to meetings and training required by the MCHS program, including but not limited to:

1. MCHS Agency Directors' meetings
2. Prenatal and Child Health Coordinators' meetings
3. MCHS Agency Medical Services Directors' meetings

III. Quality or Performance Improvement (QI/PI)

A) Workplans

1. Performance Workplans are required for this program and are used to monitor achievement of standard measures of performance of the services provided under this contract. The workplans are a key component of the RHPCS and the MCHS performance-based contracting system and of this contract. Outcomes shall be reported by clinical site.
2. Performance Workplans and Workplan Outcome reports according to the schedule and instructions provided by the MCHS. The MCHS shall notify the Contractor at least 30 days in advance of any changes in the submission schedule.
3. The Contractor shall incorporate required and developmental performance measures, defined by the MCHS into the agency's Performance Workplan. Reports on Workplan Progress/Outcomes shall detail the Performance Workplan plans and activities that monitor and evaluate the agency's progress toward performance measure targets.
4. The Contractor shall comply with modifications and/or additions to the workplan and annual report format as requested by RHPCS and MCHS. MCHS will provide the contractor with reasonable notice of such changes.
5. Agencies contracting for Primary Care Services must submit the workplans for Primary Care Clinical and Financial, Child Health, and Prenatal Care.

B) Additional Reporting requirements

In addition to Performance Workplans, the Contractor shall submit to MCHS the following data and information listed below which are used to monitor program performance:

1. In years when contracts or amendments are not required, the DPHS Budget Form, Budget Justification, Sources of Revenue and Program Staff list forms must be

completed according to the relevant instructions and submitted as requested by DPHS and, at minimum, by April 30 of each year.

2. The Sources of Revenue report must be resubmitted at any point when changes in revenue threaten the ability of the agency to carry out the planned program.

3. Completed Uniform Data Set (UDS) tables reflecting program performance in the previous calendar year, by March 31 of each year.

4. The Perinatal Client Data Form (PCDF) shall be submitted electronically according to the instructions set forth by the MCHS.

5. A copy of the agency's updated Sliding Fee Scale including the amount(s) of any client fees and the schedule of discounts must be submitted by March 31st of each year. The agency's sliding fee scale must be updated annually based on the US DHHS Poverty guidelines as published in the Federal Register.

6. An annual summary of program-specific patient satisfaction results obtained during the prior contract period and the method by which the results were obtained shall be submitted annually as an addendum to the Workplan Outcome/Progress reports.

C) On-site reviews

1. The contractor shall allow a team or person authorized by the Division of Public Health Services to periodically review the contractor's systems of governance, administration, data collection and submission, clinical and financial management, and delivery of education services in order to assure systems are adequate to provide the contracted services.

2. Reviews shall include client record reviews to measure compliance with this exhibit.

3. The contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.

4. On-Site reviews may be waived or abbreviated at the discretion of MCHS, upon submission of satisfactory reports of reviews such as Health Services Resources Administration (HRSA): Office of Performance Review (OPR), or reviews from nationally accreditation organizations such as the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), Medicare, the Community Health Accreditation Program (CHAP), Accreditation Association for Ambulatory Healthcare (AAAHC), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey. Abbreviated reviews will focus on any deficiencies found in previous reviews, issues of compliance with this exhibit, and actions to strengthen performance as outlined in the agency Performance Workplan.

Contractor Initials BR/KC

Date 3/26/14

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE CHILD HEALTH DIRECT CARE SERVICES
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Please note, for all measures, the following should be used **unless otherwise indicated:**

- Less than 19 years of age
- Served within the scope of this MCH contract during State Fiscal Year 2015 (July 1, 2014 – June 30, 2015)
- Each client can only be counted once (unduplicated)

Child Health Direct (CH – D) Performance Measure #1

Measure: 92%* of eligible children will be enrolled in Medicaid

Goal: To increase access to health care for children through the provision of health insurance

Definition: **Numerator-**
Of those in the denominator, the number of children enrolled in Medicaid.

Denominator-
Number of children who meet all of the following criteria:

- Less than 19 years of age
- Had 3 or more visits/encounters** during the reporting period
- As of the last visit during the reporting period were eligible for Medicaid

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**An encounter is face to face contact between a user and a provider who exercises independent judgment in the provision of services to the individual (UDS Table Definition).

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #2

Measure: 85%* of at-risk** children who were screened for blood lead between 18 and 30 months of age

Goal: To prevent childhood lead poisoning through early identification of lead exposure

Definition: **Numerator-**
Of those in the denominator, number of children screened for blood lead by capillary or venous on or after their 18-month birthday and prior to their 30-month birthday.

Denominator-
Number of at-risk** children who reached age 30 months during the reporting period. If discharged prior to 30 months, do not include in denominator.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**At risk = During the reporting period, the children were 18-29 months of age, and fit at least one of the following criteria:

- "Low income" (less than 185% poverty guidelines)
- Over 185% and resided in a town considered needing "Universal" screening per NH Childhood Lead Poisoning Prevention Program
- Over 185%, resided in a town considered "Target" and had a positive response to the risk questionnaire
- Refugee children -A refugee is defined as a person outside of his or her country of nationality who is unable or unwilling to return because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion (U.S. Citizenship and Immigration Services definition).

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #3

Measure: 71%* of children age two to nineteen years receiving primary care preventive health services with a Body Mass Index (BMI) percentile greater than or equal to the 85%ile with documented discussion of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Goal: To increase the percent of children receiving primary care preventive health services who have an elevated BMI percentile who receive guidance about promoting a healthier lifestyle.

Definition: **Numerator-**
Of those in the denominator, the number of children who had documentation in their medical record of there being discussion at least once during the reporting period of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Denominator-
Number of children who turned twenty-four months during or before the reporting period, up to the age of nineteen years, with one or more well child visit after their twenty-fourth month of age within the reporting year, and had an age and gender appropriate BMI percentile greater than or equal to the 85 % percentile at least once during the reporting period.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

Rationale: Children between the 85th – 94th percentiles BMI are encouraged to have 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks. (Discussion of the importance of family meal time, limiting eating out, consuming a healthy breakfast, preparing own foods, and promotion of breastfeeding is also encouraged.) American Academy of Pediatrics' guidance for Prevention and Treatment of Childhood Overweight and Obesity, (http://www.aap.org/obesity/health_professionals.html), from AAP Policy Statement: *Prevention of Pediatric Overweight and Obesity* and the AAP endorsed Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Children and Adolescent Overweight and Obesity, 2007.

*Target based on 2012 & 2013 Data Trend Table averages.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) #4

Measure: 75%* of eligible** infants and children with client record documentation of enrollment in WIC

Goal: To increase access to nutrition education, breastfeeding support, and healthy food through enrollment in the WIC Nutrition Program

Definition: **Numerator -**
Of those in the denominator, the number of infants and children who, as of the last well child visit during the reporting period, had client record documentation that infant or child was enrolled in WIC.

Denominator -
Unduplicated number of infants and children less than 5 years of age, enrolled in the agency, during the reporting period, who were eligible** for WIC.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**WIC Eligibility Requirements:

- Infants, and children up to their fifth birthday
- Must be income eligible (income guidelines are up to 185% of federal gross income, and are based on family size)

Child Health Direct (CH – D) Performance Measure #5

Measure: 23%* of infants who were exclusively** breastfed for the first three months, at their four month well baby visit

Goal: To provide optimum nutrition to infants in their first three months of life

Definition: **Numerator -**
Of those in the denominator, the number of infants who had client record documentation that the infant had been exclusively breastfed for their first three months when checked at their four month well baby visit.

Denominator -
Number of infants who received one or more visits during or before the reporting period and were seen for a four-month well baby visit during the reporting period.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

Benmarks: 2011 PedNSS (WIC) exclusive at 3 months: NH 22.9%, National (2010) 10.7%
2013 CDC Report Card (NIS, provisional 2010 births): NH 49.5%, National 37.7%
Healthy People 2020 goal: 44%

Rationale: The AAP recommends exclusive breastfeeding for about 6 months, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant, a recommendation concurred to by the World Health Organization and the Institute of Medicine. (American Academy of Pediatrics Policy Statement on Breastfeeding and the Use of Human Milk, 2012)

*Target based on 2012 & 2013 Data Trend Table averages.
**Exclusive means breast milk only, no supplemental formula, cereal/baby food, or water/fluids.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE: ADULT

PERFORMANCE MEASURES DEFINITIONS

State Fiscal Year 2015

Primary Care: Adult Performance Measure #1

Measure:* 58%** of adult patients 18 – 85 years of age diagnosed with hypertension will have a blood pressure measurement less than 140/90*** mm at the time of their last measurement.

Goal: To ensure patients diagnosed with hypertension are adequately controlled.

Definition: **Numerator-** Number of patients from the denominator with blood pressure measurement less than 140/90 mm at the time of their last measurement.

Denominator- Number of patients age 18 – 85 with diagnosed hypertension must have been diagnosed with hypertension 6 or more months before the measurement date. (Excludes pregnant women and patients with End Stage Renal Disease.)

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

*Measure based on the National Quality Forum 0018

**Health People 2020 National Target is 61.2%

***Both the numerator and denominator must be less that 140/90 mm

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE CLINICAL
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Primary Care Clinical Adolescent (PC-C) Performance Measure #1

Measure: 61%* of adolescents aged 11-21 years received an annual health maintenance visits in the past 12 months.

Goal: To enhance adolescent health by assuring annual, recommended, adolescent well -visits.

Definition:

Numerator-
Number of adolescents in the denominator who received an annual health maintenance "well" visit during the reporting year.

Denominator-
Total number of adolescents aged 11-21 years who were enrolled in the primary care clinic as primary care clients during the reporting year period.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

***Target based on 2012 & 2013 Data Trend Table averages.**

Primary Care Clinical Prenatal (PC-C) Performance Measure #2

Measure: 31%* of women and adolescent girls aged 15-44 take multi-vitamins with folic acid.

Goal: To enhance pregnancy outcomes by reducing neural tube defects.

Definition:

Numerator-
The number of women and adolescent girls aged 15-44 who take a multi-vitamin with folic acid.

Denominator-
The number of women and adolescent girls aged 15-44 who were seen in primary care for a well visit in the past year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

***Target based on 2012 & 2013 Data Trend Table averages.**

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE - FINANCIAL
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Primary Care (PC) Performance Measure #1

Measure: Patient Payor Mix

Goal: To allow monitoring of payment method trends at State funded primary care sites.

Definition: Patients enrolled in Medicare, Medicaid, Commercial insurance, or uninsured.

Data Source: Provided by agency

Primary Care (PC) Performance Measure #2

Measure: Accounts Receivables (AR) Days

Goal: To allow monitoring of financial sustainability trends at State funded primary care sites.

Definition: AR Days: Net Patient Accounts Receivable **multiplied by** 365 **divided by** Net Patient Revenue

Data Source: Provided by agency

Primary Care (PC) Performance Measure #3

Measure: Current Ratio

Goal: To allow monitoring of financial sustainability trends at State funded primary care sites.

Definition: Current Ratio = Current Assets **divided by** Current Liabilities

Data Source: Provided by agency

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRENATAL
PERFORMANCE MEASURES DEFINITIONS
State Fiscal Year 2015

Prenatal (PN) Performance Measure #1

Measure: 85%* of pregnant women who are enrolled in the agency's prenatal program will begin prenatal care during the first trimester of pregnancy.

Goal: To enhance pregnancy outcomes by assuring early entrance into prenatal care.

Definition:

Numerator-
Number of women in the denominator who had a documented prenatal visit during the first trimester (on or before 13.6 weeks gestation).

Denominator-
Number of women enrolled in the agency prenatal program who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

* Target based on 2012 & 2013 Data Trend Table averages.

Prenatal (PN) Performance Measure #2

Measure: 20%* of pregnant women who are identified as cigarette smokers will be referred to QuitWorks-New Hampshire.

Goal: To reduce tobacco use during pregnancy through focused tobacco use cessation activities at public health prenatal clinics.

Definition:

Numerator-
Number of women in the denominator who received at least one referral to QuitWorks-New Hampshire during pregnancy.

A referral is defined as signing the patient up for QuitWorks-NH via phone, fax, or EMR. It is not defined as discussing QuitWorks-NH with the patient and encouraging her to sign up.

Denominator-
Number of women enrolled in the agency prenatal program and identified as tobacco users who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

*Target set in consultation with the NH Tobacco Program & FY13 Data Trend Table average.

Prenatal (PN) Performance Measure #3

Measure: 79%* of pregnant women will be screened, using a formal valid screening tool, for alcohol and other substance use during every trimester they are enrolled in the prenatal program.

Goal: To reduce prenatal substance use through systematic screening and identification.

Definition: **Numerator-** Number of women in the denominator who were screened for substance and alcohol use, using a formal and valid screening tool, during each trimester that they were enrolled in the prenatal program.

Denominator- Number of women enrolled in the agency prenatal program and who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

* Target based on 2012 & 2013 Data Trend Table averages.

Exhibit B-1 (2014) -Amendment 1
Budget

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: The New London Hospital, Inc.

Budget Request for: MCH Primary Care
(Name of RFP)

Budget Period: SFY 2014

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages	$ 1,245.20	$ -	$ 1,245.20	
2. Employee Benefits	$ 302.07	$ -	$ 302.07	
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	$ -	$ -	$ -	
13. Other (specific details mandatory):	$ -	$ -	$ -	
Healthcare services for grant eligible	$ 38,018.73	$ -	$ 38,018.73	
patients	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
TOTAL	**$ 39,566.00**	**$ -**	**$ 39,566.00**	
Indirect As A Percent of Direct		0.0%		

Contractor Initials: BEK

Date: 3/25/13

Exhibit B-1 (2015) -Amendment 1
Budget

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: The New London Hospital, Inc.

Budget Request for: MCH Primary Care & BCCP
(Name of RFP)

Budget Period: SFY 2015

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages	$ 67,641.60	$ -	$ 67,641.60	0
2. Employee Benefits	$ 20,067.78	$ -	$ 20,067.78	0
3. Consultants	$ -	$ -	$ -	0
4. Equipment:	$ -	$ -	$ -	0
Rental	$ -	$ -	$ -	0
Repair and Maintenance	$ -	$ -	$ -	0
Purchase/Depreciation	$ -	$ -	$ -	0
5. Supplies:	$ -	$ -	$ -	0
Educational	$ -	$ -	$ -	0
Lab	$ -	$ -	$ -	0
Pharmacy	$ -	$ -	$ -	0
Medical	$ -	$ -	$ -	0
Office	$ -	$ -	$ -	0
6. Travel	$ -	$ -	$ -	0
7. Occupancy	$ -	$ -	$ -	0
8. Current Expenses	$ -	$ -	$ -	0
Telephone	$ -	$ -	$ -	0
Postage	$ -	$ -	$ -	0
Subscriptions	$ -	$ -	$ -	0
Audit and Legal	$ -	$ -	$ -	0
Insurance	$ -	$ -	$ -	0
Board Expenses	$ -	$ -	$ -	0
9. Software	$ -	$ -	$ -	0
10. Marketing/Communications	$ -	$ -	$ -	0
11. Staff Education and Training	$ 3,346.60	$ -	$ 3,346.60	0
12. Subcontracts/Agreements	$ -	$ -	$ -	0
13. Other (specific details mandatory):	$ -	$ -	$ -	0
Healthcare services for grant eligible	$ 110,691.62	$ -	$ 110,691.62	0
patients	$ -	$ -	$ -	0
Clinical Services	$ 13,145.40	$ -	$ 13,145.40	0
Case Management	$ 10,200.00	$ -	$ 10,200.00	0
0	$ -	$ -	$ -	0
TOTAL	**$ 225,093.00**	**$ -**	**$ 225,093.00**	0

Indirect As A Percent of Direct 0.0%

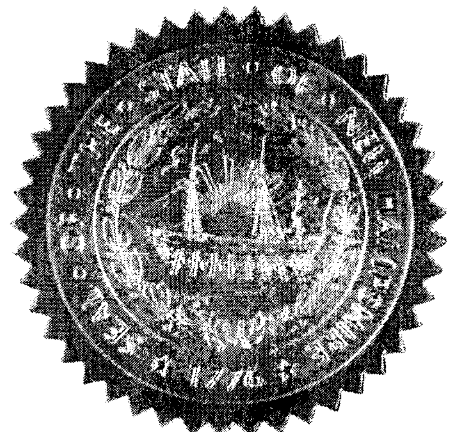
Contractor Initials: BPK

Date: 3/25/13

State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that New London Hospital is a New Hampshire trade name registered on May 6, 2005 and that THE NEW LONDON HOSPITAL ASSOCIATION, INC. presently own(s) this trade name. I further certify that it is in good standing as far as this office is concerned, having paid the fees required by law.



In TESTIMONY WHEREOF, I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 12th day of March, A.D. 2014

William M. Gardner
Secretary of State

THE NEW LONDON HOSPITAL ASSOCIATION, INC.

Secretary's Certificate

The undersigned, being the duly elected and authorized Secretary of *The New London Hospital Association, Inc.*, a New Hampshire non-profit, voluntary corporation (the "Corporation"), hereby certifies as follows:

1. That the following resolutions were duly adopted by the Board of Trustees of the Corporation at a meeting duly noticed and held on March 13, 2014, and that such resolutions have not been amended or rescinded:

RESOLVED: That The New London Hospital Association, Inc. (the "Corporation") enter into a first amendment (the "Amendment") to a contract between the Corporation and the State of New Hampshire, acting through its Department of Health and Human Services, as approved by the Governor and Executive Council on June 20, 2012 and pertaining to the provision by the Corporation of certain health care services in Sullivan County (the "Contract"), as presented to the Board of Trustees and which modifies the term, contract price and scope of services, and related provisions, of the Contract.

FURTHER
RESOLVED: That each of the President, Bruce P. King, and the Chief Financial Officer, Donald Griffin, acting singly and on behalf of the Corporation, is hereby authorized to execute and deliver the Amendment and any and all other documentation which may be necessary or desirable, in his sole discretion, to effect the Amendment.

2. That the following are the current President and Chief Financial Officer, respectively, of the Corporation, duly qualified and elected to the office beside his name, and that the signature below is the true and genuine signature of such President and Chief Financial Officer:

Name:	Office:	Signature:
Bruce P. King	President	[signature]
Donald Griffin	Chief Financial Officer	[signature]

EXECUTED this 25th day of March, 2014.

[signature]
Secretary, Board of Trustees

STATE OF New Hampshire

COUNTY OF Merrimack

On this the 25 day of March, 2014, before me, Erica M. Belisle, the undersigned officer,

personally appeared Stanley Cundey, Jr., who acknowledge/himself to be the Secretary, Board of Trustees (Title), of The New London Hospital Association, Inc. (Name of the Corporation), a corporation, and that he, as such Secretary, Board of Trustees (Title) being authorized to do so, executed the foregoing instrument for the purposes therein contained, by signing the name of the corporation by himself as Stanley Cundey, Jr.

IN WITNESS WHEREOF I hereunto set my hand and official seal.

[signature]
Notary Public/Justice of the Peace

My Commission expires: ERICA M. BELISLE, Notary Public My Commission Expires March 30, 2016

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 03/06/2014

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 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 1-617-531-6000
Integro USA Inc.
dba Integro Insurance Brokers
Two Financial Center
60 South Street, Suite 800
Boston, MA 02111

CONTACT NAME:
PHONE (A/C, No, Ext):
FAX (A/C, No):
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : LEXINGTON INS CO	19437
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
New London Hospital Association, Inc.

273 County Road

New London, NH 03257

COVERAGES

CERTIFICATE NUMBER: 38724004 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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY			6795757	10/01/13	10/01/14	EACH OCCURRENCE	$ 1,000,000
	X COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 50,000
	CLAIMS-MADE X OCCUR						MED EXP (Any one person)	$ 5,000
							PERSONAL & ADV INJURY	$ 1,000,000
							GENERAL AGGREGATE	$ 3,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$ 1,000,000
	X POLICY PRO-JECT LOC							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
A	UMBRELLA LIAB OCCUR			6975756	10/01/13	10/01/14	EACH OCCURRENCE	$ 1,000,000
	X EXCESS LIAB X CLAIMS-MADE						AGGREGATE	$ 1,000,000
	DED RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						WC STATU-TORY LIMITS OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	N/A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	HEALTHCARE PROFESSIONAL LIABILITY (CLAIMS MADE)			6795757	10/01/13	10/01/14	Each Medical Incid.	1,000,000
							Aggregate	3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
RE: Agreement with DHHS for the Sullivan County Grant program

CERTIFICATE HOLDER

State of New Hampshire
DHHS - Contracts and Procurement Unit

129 Pleasant Street

Concord, NH 03301
USA

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

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Client#: 241432 NEWLONDONH1

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 3/03/2014

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 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
HUB International New England, LLC
136 Turnpike Road, Suite 105
Southborough, MA 01772
508 303-9470

CONTACT NAME: Amanda Keaveney
PHONE (A/C, No, Ext): 508-303-9471 FAX (A/C, No): 508-303-9476
E-MAIL ADDRESS: amanda.keaveney@hubinternational.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : New Hampshire Employers Ins. Co	
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
New London Hospital Assoc., Inc
Kieran Kays
273 County Road
New London, NH 03257

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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	GENERAL LIABILITY COMMERCIAL GENERAL LIABILITY CLAIMS-MADE / OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY / PRO-JECT / LOC						EACH OCCURRENCE	$
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
							GENERAL AGGREGATE	$
							PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS / SCHEDULED AUTOS HIRED AUTOS / NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident)	$
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB / OCCUR EXCESS LIAB / CLAIMS-MADE DED / RETENTION $						EACH OCCURRENCE	$
							AGGREGATE	$
								$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		ECC60040000802013A	10/01/2013	10/01/2014	X WC STATU-TORY LIMITS / OTH-ER	
							E.L. EACH ACCIDENT	$500,000
							E.L. DISEASE - EA EMPLOYEE	$500,000
							E.L. DISEASE - POLICY LIMIT	$500,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
Sullivan County Grant Program

CERTIFICATE HOLDER
DHHS
Contracts and Procurement Unit
129 Pleasant Street
Concord, NH 03301

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

AUTHORIZED REPRESENTATIVE

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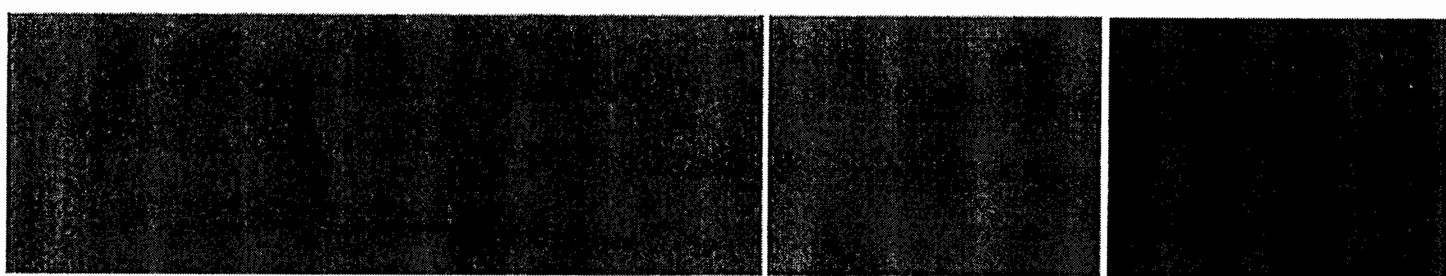


THE NEW LONDON HOSPITAL ASSOCIATION, INC. AND SUBSIDIARIES

CONSOLIDATED FINANCIAL STATEMENTS

and

ADDITIONAL INFORMATION

September 30, 2013 and 2012

With Independent Auditor's Report

INDEPENDENT AUDITOR'S REPORT

Board of Trustees
The New London Hospital Association, Inc. and Subsidiaries

Report on the Financial Statements

We have audited the accompanying consolidated financial statements of The New London Hospital Association, Inc. and Subsidiaries (the Association), which comprise the consolidated balance sheets as of September 30, 2013 and 2012, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; 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.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with U.S. generally accepted auditing standards. 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 the auditor's 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, the auditor considers internal control relevant to the entity'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 entity'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 The New London Hospital Association, Inc. and Subsidiaries as of September 30, 2013 and 2012, and the results of their operations, changes in their net assets and their cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

Other Matter

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. Schedules 1 and 2 are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits 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 U.S. generally accepted auditing standards. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Berry Dunn McNeil & Parker, LLC

Portland, Maine
December 30, 2013

THE NEW LONDON HOSPITAL ASSOCIATION, INC. AND SUBSIDIARIES

Consolidated Balance Sheets

September 30, 2013 and 2012

ASSETS

	2013	2012
Current assets		
Cash and cash equivalents	**$ 3,430,516**	$ 8,086,485
Assets limited as to use	**363,051**	370,031
Patient accounts receivable, net of allowance for uncollectible accounts of $1,729,044 and $967,628 in 2013 and 2012, respectively	**6,492,848**	6,450,190
Pledges receivable, net	**76,803**	199,008
Other accounts receivable, net	**279,452**	604,000
Supplies	**1,022,833**	988,908
Prepaid expenses	**815,350**	463,088
Total current assets	**12,480,853**	17,161,710
Assets limited as to use		
By Trustees	**12,569,428**	10,860,135
Under bond indenture	**363,051**	370,031
	12,932,479	11,230,166
Less current portion	**363,051**	370,031
	12,569,428	10,860,135
Long-term investments	**537,846**	564,745
Deferred compensation plan assets	**1,475,875**	1,193,226
Beneficial interest in perpetual trust	**1,678,649**	1,629,122
Property and equipment, net	**32,235,902**	30,514,558
Deferred financing costs, net of amortization	**292,506**	303,792
Pledges receivable, net of current portion	**8,916**	22,522
Other assets	**6,066**	6,066
Total assets	**$61,286,041**	$ 62,255,876

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

LIABILITIES AND NET ASSETS

	2013	2012
Current liabilities		
Current portion of long-term debt	**$ 386,675**	$ 370,534
Current portion of capital lease obligation	**466,902**	448,795
Accounts payable and accrued expenses	**4,560,099**	3,620,509
Accrued salaries, wages, and related amounts	**1,840,732**	1,680,883
Estimated third-party payor settlements	**3,471,988**	4,600,763
Current portion of charitable gift annuities	**4,930**	10,172
Other current liabilities	**20,000**	20,000
Total current liabilities	**10,751,326**	10,751,656
Deferred compensation	**1,475,875**	1,193,226
Long-term debt, excluding current portion	**15,563,063**	15,956,067
Capital lease obligations, excluding current portion	**949,854**	721,127
Interest rate swap	**3,095,722**	4,773,651
Charitable gift annuities, excluding current portion	**17,103**	11,994
Total liabilities	**31,852,943**	33,407,721
Commitments and contingencies (Notes 11, 12, and 13)		
Net assets		
Unrestricted	**26,994,789**	26,441,123
Temporarily restricted	**385,793**	404,043
Permanently restricted	**2,052,516**	2,002.989
Total net assets	**29,433,098**	28,848,155
Total liabilities and net assets	**$ 61,286,041**	$ 62,255,876

THE NEW LONDON HOSPITAL ASSOCIATION, INC. AND SUBSIDIARIES

Consolidated Statements of Operations

Years Ended September 30, 2013 and 2012

	2013	2012
Unrestricted revenues, gains, and other support		
Patient service revenue (net of contractual allowances and discounts)	**$ 52,989,644**	$ 54,962,775
Less provisions for bad debts	**2,458,172**	2,941,149
Net patient service revenue	**50,531,472**	52,021,626
Other operating revenue	**3,165,356**	3,996,710
Net assets released from restrictions used for operations	**107,009**	78,975
Total revenues, gains, and other support	**53,803,837**	56,097,311
Expenses		
Salaries and benefits	**32,782,844**	32,111,069
Supplies and other	**10,299,608**	9,488,370
Purchased services	**7,167,865**	6,321,293
Depreciation and amortization	**3,410,503**	3,679,563
Medicaid enhancement tax	**2,197,391**	2,194,918
Interest	**764,216**	914,542
Total expenses	**56,622,427**	54,709,755
Operating (loss) income	**(2,818,590)**	1,387,556
Nonoperating gains (losses)		
Investment income	**303,062**	261,498
Contributions and program support	**653,760**	1,200,100
Other nonoperating expenses	**(211,779)**	-
Unrealized gain (loss) on interest rate swap	**1,677,929**	(167,747)
Realized and unrealized gains on investments	**898,968**	1,111,581
Nonoperating gains, net	**3,321,940**	2,405,432
Excess of revenues, gains, and other support over expenses and nonoperating gains	**503,350**	3,792,988
Net assets released from restrictions used for purchase of property and equipment	**50,316**	27,422
Increase in unrestricted net assets	**$ 553,666**	$ 3,820,410

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

THE NEW LONDON HOSPITAL ASSOCIATION, INC. AND SUBSIDIARIES

Consolidated Statements of Changes in Net Assets

Years Ended September 30, 2013 and 2012

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Balances, October 1, 2011	$ 22,620,713	$ 307,685	$ 1,890,475	$ 24,818,873
Excess of revenues, gains, and other support under expenses and nonoperating gains	3,792,988	-	-	3,792,988
Restricted bequests and contributions	-	202,755	-	202,755
Net assets released from restrictions used for operations		(78,975)	-	(78,975)
Net assets released from restrictions used for purchase of property and equipment	27,422	(27,422)	-	-
Change in beneficial interest in perpetual trust	-	-	112,514	112,514
Increase in net assets	3,820,410	96,358	112,514	4,029,282
Balances, September 30, 2012	26,441,123	404,043	2,002,989	28,848,155
Excess of revenues, gains, and other support over expenses and nonoperating gains	**503,350**	**-**	**-**	**503,350**
Restricted bequests and contributions	**-**	**139,075**	**-**	**139,075**
Net assets released from restrictions used for operations	**-**	**(107,009)**	**-**	**(107,009)**
Net assets released from restrictions used for purchase of property and equipment	**50,316**	**(50,316)**	**-**	**-**
Change in beneficial interest in perpetual trust	**-**	**-**	**49,527**	**49,527**
Increase (decrease) in net assets	**553,666**	**(18,250)**	**49,527**	**584,943**
Balances, September 30, 2013	**$ 26,994,789**	**$ 385,793**	**$ 2,052,516**	**$ 29,433,098**

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

THE NEW LONDON HOSPITAL ASSOCIATION, INC. AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years Ended September 30, 2013 and 2012

	2013	2012
Cash flows from operating activities		
Change in net assets	$ **584,943**	$ 4,029,282
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	**3,410,503**	3,679,563
Provision for bad debts	**2,458,172**	2,941,149
Unrealized (gain) loss on interest rate swap	**(1,677,929)**	167,747
Loss (gain) on sale of equipment	**204,529**	(3,000)
Net realized and unrealized gains on investments	**(898,968)**	(1,111,581)
Net unrealized gain on beneficial interest in perpetual trust	**(49,527)**	(112,514)
Restricted contributions	**(139,075)**	(202,755)
Increase (decrease) in cash resulting from a change in:		
Patient accounts receivable	**(2,500,830)**	(2,477,314)
Pledges receivable, net	**135,811**	346,899
Estimated third-party payor settlements	**(1,128,775)**	1,589,088
Supplies and prepaid expenses	**(213,984)**	119,403
Other accounts receivable, net	**324,548**	(551,599)
Accounts payable and accrued expenses	**939,590**	697,379
Accrued salaries, wages, and related amounts	**159,849**	113,540
Charitable gift annuities	**(133)**	(10,172)
Net cash provided by operating activities	**1,608,724**	9,215,115
Cash flows from investing activities		
Purchases of property and equipment	**(4,748,402)**	(1,895,265)
Proceeds from sale of property and equipment	**7,250**	3,000
Proceeds from sale of investments	**7,743,770**	4,670,286
Purchase of investments	**(8,520,216)**	(7,151,687)
Net cash used by investing activities	**(5,517,598)**	(4,373,666)
Cash flows from financing activities		
Payments on long-term debt	**(390,093)**	(874,727)
Net payments on line of credit	**-**	(2,000,000)
Payment on capital lease obligations	**(496,077)**	(507,184)
Restricted gifts received	**139,075**	202,755
Net cash used by financing activities	**(747,095)**	(3,179,156)
Net (decrease) increase in cash and cash equivalents	**(4,655,969)**	1,662,293
Cash and cash equivalents, beginning of year	**8,086,485**	6,424,192
Cash and cash equivalents, end of year	$ **3,430,516**	$ 8,086,485
Noncash transaction - equipment under loan obligation	$ **13,230**	$ 155,022
Noncash transaction - equipment under capital lease obligations	$ **742,911**	$ 401,614

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

THE NEW LONDON HOSPITAL ASSOCIATION, INC.

VISION STATEMENT

New London Hospital is a community hospital committed to safe quality care in a patient and family centered care environment resulting in a healthier community.

MISSION STATEMENT

New London Hospital provides safe quality care for every patient, every time in partnership with patients, families and healthcare providers.

VALUES

- Care and respect for all people
- Partnership with patients and families
- Informed decision-making
- Integrity
- Commitment to continuous improvement
- Service excellence
- Compassion
- Accountability
- Commitment to our community
- Transparent communication
- Teamwork
- Financial responsibility
- Charity care

PATIENT AND FAMILY CENTERED PHILOSOPHY OF CARE

Every patient at New London Hospital is part of a unique family unit with its own strengths and capabilities. We respect the importance of the family, as defined by the patient, and encourage family involvement and support in patient care. We believe in partnering with each patient and family to give the highest quality of care to each patient. Our philosophy of care includes these values:

- View families as partners who contribute to the well being of patients
- The patient's family, as defined by the patient, is an important part of the healthcare team.
- Support quality of care and patient satisfaction by partnering with patients and families for all levels of care
- Respect for the diversity of patient families
- Share complete and unbiased information with patients and families, with the patient's consent
- Provide a healing environment for patients and families

THE NEW LONDON HOSPITAL ASSOCIATION, INC.
BOARD OF TRUSTEES
Effective October 24, 2013

OFFICERS:		
	Chair	Anne Holmes
	Vice Chair	Susan Reeves
	Secretary	Chris Cundey
	Treasurer	David Marshall
	President & CEO	Bruce P. King

TRUSTEES:

Name	Position
John R. Butterly, MD	Trustee
Celeste C. Cook	Trustee
Stanley I. Cundey, Jr., (Chris)	Trustee
Karen E. Ebel	Trustee
Kris Eschbach, DO	Medical Staff President/Ex-Officio
John C. Ferries	Trustee
Peter E. Hager	Trustee
Anne B. Holmes	Trustee
Daniel Jantzen	Trustee
Carolyn Kerrigan, MD	Trustee
Bruce P. King	President & CEO/Ex-Officio
John (Jack) Kirk, MD	Medical Staff President-Elect/Ex-Officio
Stephen J. LeBlanc	Trustee
Douglas W. Lyon	Trustee
David E. Marshall	Trustee
Jane Rastallis	Trustee
Susan A. Reeves	Trustee
Robert M. Rex (Bob)	Trustee

KEY ADMINISTRATIVE PERSONNEL

NH Department of Health and Human Services

Contractor Name: The New London Hospital Association, Inc

Name of Bureau/Section: MCH Primary Care

BUDGET PERIOD: SFY 14

Program Area: MCH Primary Care

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Bruce P. King	CEO	$310,000	0.00%	$0.00
Donald Griffin	CFO	$145,683	0.00%	$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$0.00**

KEY ADMINISTRATIVE PERSONNEL

NH Department of Health and Human Services

Contractor Name: The New London Hospital Association, Inc

Name of Bureau/Section: MCH Primary Care & BCCP

BUDGET PERIOD: SFY 15

Program Area: MCH Primary Care Services

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Bruce P. King	CEO	$310,000	0.00%	$0.00
Donald Griffin	CFO	$145,683	0.00%	$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$0.00**

Program Area: Breast and Cervical Cancer Program Services

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Bruce P. King	CEO	$310,000	0.00%	
Donald Griffin	CFO	$145,683	0.00%	
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$0.00**

BRUCE P. KING, FHFMA, MPH

SENIOR EXECUTIVE

35 years of successful experience providing fiscal, strategic and operations leadership in uniquely challenging situations.

Results oriented leader with strong track record of performance in turnaround and healthcare organizations. Utilize analysis, insights and team approach to drive organizational improvements and implementation of best practices with focus on quality patient care. Capable of resolving multiple and complex issues.

PROFESSIONAL EXPERIENCE

NEW LONDON HOSPITAL ❖ NEW LONDON, NH
PRESIDENT AND CEO 2003-PRESENT

Under management contract with Dartmouth-Hitchcock Medical Center, President and CEO of a 25 bed Critical Access Hospital with embedded 58 bed nursing home and 4 lines of business (Hospital, Physician Practices, Nursing Home, Ambulance) serving 15 towns and a population of 31K. Provide fiscal, strategic and operational leadership to improve quality patient care, satisfaction while also improving operating results.

- Established new and expanded clinical programs in the areas of cardiology, oncology, orthopedics, neurology, neurosurgery, pre/post natal care, sleep lab, pediatrics, 24/7 acute care hospitalist, nursing home hospitalist, chaplaincy and dermatology.
- Achievement of a 225% increase of net revenue from FY '03 – FY '11.
- Successfully reversed years of operating losses resulting in operating gains for 6 out of past 9 years.
- Planned, developed, financed and completed a $21M, 48,000 square foot addition, 20,000 square foot renovation "on-time and on-budget".
- Successfully fund-raised more than one-third of the total project financing exceeding targeted goals by raising $7.7M.
- Acquired and implemented an electronic medical record (EMR) from McKesson, utilizing a USDA loan-grant program; achieved Meaningful Use, Phase I. Recently named "Most Wired" from AHA/Health Forum.
- NLH and personal awards for outstanding performance from the Institute of Healthcare Improvement (IHI), Harvard Pilgrim Health Care (HPHC), NH Economic Development, State of New Hampshire Immunization Program, New Hampshire Hospital Association (NHHA) for Trustee and Physician leadership, and Center for Medicare/Medicaid (CMS) 5-star rating, named NH Grass Roots Champion for 2011.
- Coordinated the establishment of a picture archiving and communication system (PACS) for four different hospitals and related radiologist group.

DARTMOUTH-HITCHCOCK MEDICAL CENTER ❖ LEBANON, NH
VICE PRESIDENT, CONTRACTING AND NETWORK DEVELOPMENT 1994-2003

- Instrumental in the establishment of the Dartmouth-Hitchcock Alliance network organization.
- Responsible for the negotiation of major payer contracts for MHMH, DH Clinic, and DHA Organizations

DARTMOUTH-HITCHCOCK MEDICAL CENTER ❖ LEBANON, NH
VICE PRESIDENT, FISCAL SERVICES 1987-1994

- Oversight for the budget, reimbursement, and patient accounting functions of MHMH.
- Involved in the planning, financing, and move of DHMC to a new campus.

KPMG PEAT, MARWICK ❖ BOSTON, MA
SENIOR CONSULTANT 1983-1987

ST. ELIZABETH'S HOSPITAL OF BOSTON ❖ BRIGHTON, MA 1981-1983
ASSISTANT CONTROLLER

MASSACHUSETTS DEPT. OF MENTAL HEALTH ❖ MEDFIELD, MA
TREASURER 1977-1981

EDUCATION

Boston University, 1991 ❖ Master of Science
University of Massachusetts, 1977 ❖ Bachelor of Science

BOARDS AND MEMBERSHIPS (partial listing)

Board of Directors, Past Chair ❖ New Hampshire Hospital Association
Board of Trustees ❖ New England Life Care (NELC)
Board of Trustees ❖ Crotched Mountain Rehabilitation Center
Board of Directors ❖ American Thrombosis & Hemostasis Network
Treasurer ❖ State of New Hampshire Health Plan
Alternate Delegate ❖ AHA Regional Policy Board
Appointee for Region 1 ❖ MCHB-HTC
Member, Advisory Board ❖ Ledyard National Bank
Member and past Chair ❖ Rural Health Coalition
Instructor in Community and Family Medicine ❖ Dartmouth Medical School
Past President ❖ NH/VT Chapter of Healthcare Financing Management Association (HFMA)
Past Member of National Advisory Council ❖ HFMA
Past Member of Board of Trustees ❖ Foundation for Healthy Communities
Past Member ❖ Quality and Patient Safety of Combined Subcommittee of NHHA and FHC

Revised: 3/12/12

DONALD J. GRIFFIN, CPA

POSITION HISTORY

THE NEW LONDON HOSPITAL ASSOCIATION, INC., New London, NH
Chief Financial Officer January, 2011 to present
Sr. Director, Controller June, 2004 – January, 2011

New London Hospital (NLHA) is a Critical Access Hospital and member of the New England Alliance for Health. NLHA has annual gross patient service revenue of approximately $97 million: $74 million in the hospital division, $15 million in physician practices, and $8 million in the nursing home.

Responsibilities include:

- Direct and analyze studies of general economic, business, and financial conditions and their impact on the organization's policies and procedures. Recommend appropriate actions and strategies to respond to projected economic trends and/or regulatory changes.
- Oversee the organization's long-term and short-term financial process. Coordinate and control the organization's short-term cash activities in accordance with established financial polices and objectives.
- Direct and participate in the development of accounting, admission, credit/collection, and internal control policies and systems, and address related policy/system issues.
- Direct and control the organization's cash and investment management activities and decisions.
- Oversee and direct treasury, budgeting, audit, tax, accounting, materiel management, facilities, real estate, and insurance activities of the organization.
- Oversee and direct procedures and systems necessary to maintain proper records and to afford adequate accounting controls and services.
- Appraise the organization's financial position and provide regular financial and operating reports to leadership and Board of Trustees.
- Analyze, consolidate, and direct all cost accounting procedures, together with other statistical and routine reports. Provide advice and guidance as necessary, in preparing and analyzing financial reports and executing appropriate responsive actions.
- Work with appropriate investment managers in coordinating fund transfers and monitoring investment performance.
- Participate in the analysis of the financial implications of proposed capital projects and expenditures, and recommend the execution of appropriate measures to respond to projected economic trends and/or regulatory changes.
- Ensure that accurate information is provided on a timely basis and assist, as needed, in facilitating the efficient conduct of external audits, examinations, and related financial objectives.
- Ensure that all financial reporting and practices are compliant with all Hospital policies and auditable accounting standards, and that all other regulatory requirements are met.

THE MENTAL HEALTH CENTER OF GREATER MANCHESTER, NH April 2002 to June 2004
Vice President, Chief Financial Officer for New Hampshire's largest mental health center, annually serving over 8,000 clients and generating over $20 million in revenue. Responsible for all financial matters, including supervision of the Billing and Accounting Departments. Actively worked with the CEO, COO, and CMO in the strategic planning process.

NORTRAX EQUIPMENT COMPANY, Concord, NH 2000 to 2002
Regional Controller for this retailer of construction equipment with 11 branches throughout the northeast and $140 million in sales. The headquarters for this company relocated to NY in 2002.

BLUE CROSS/BLUE SHIELD OF NEW HAMPSHIRE, Manchester, NH 1990-1999
Vice President, Controller for New Hampshire's largest health insurer with over $300 million in annual revenue.

POSITON HISTORY (continued)

NUMERICA FINANCIAL CORP., Manchester, NH 1988-1989
Vice President, Controller for this bank holding company with over $1billion in assets.

CHUBB LIFE AMERICA, Concord, NH 1986-1988
Assistant Vice President of Financial Reporting for this consolidated group of five life insurance companies with over $1.75 billion in assets and over $500 million in annual revenue.

- Duties included preparation of the monthly financial statements, and the SEC Reporting: 10K, 10Q, and Management Discussion and Analysis.

NORTHEAST CONSOLIDATED SERVICES, Concord, NH 1983-1986
Director of Internal Auditing for this subsidiary of Blue Cross and Blue Shield of NH and VT.

- Performed and directed internal audits throughout the company to verify that processes were controlled and efficient. Presented written and oral reports to managers, the CEO, and the Board of Directors.

EDUCATION

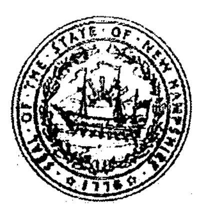
Bentley College
Certificate of Accounting. Graduated with highest honors, cumulative average of 3.91.
Bentley College
Completed 50% of the MBA program prior to relocating to Bow, NH.
University of Massachusetts
Bachelor of Science, Member of Dean's list.

Continuing Professional Education

- Courses and seminars qualifying for the NHCPA annual CPE requirement (a minimum of 40hrs/yr), including:
  Specialized courses, such as Preparing the Medicare Cost Report, Physician Practices Management, Hospital Contracting with Third Party Payers, Patient Financial Services, Long-Term Care Alternatives, Measurement and Statistics for Making Improvements, NAIC Model Investment Laws and Holding Company Act, Health Organization Risk Based Capital, Facilitating Process Improvement Teams, Process Flowcharting, Legal Toolkit for Business Owners, Derivative Investments, FAS 109 Accounting for Income Taxes, various management seminars, and various software system and application seminars and training sessions.
- Passed the examinations for the Health Financial Management Association Core and Financial Programs. Attend several HFMA sponsored CPE courses every year.
- Annual auditing and GAAP updates sponsored and/or approved by the NH Society of CPA's.
- Annual accounting and tax conferences sponsored by BCBC Association.
- Graduate level Financial Management courses.

CERTIFICATIONS AND AFFILIATIONS

- Certified Healthcare Financial Professional through the Healthcare Financial Mgmnt Assoc. (HFMA).
- Member of the American Institute of Certified Public Accountants and NH Society of CPAs.
- Passed all four parts of the three-day Uniform CPA Exam in the first attempt.
- Former Treasurer of the NH Association for the Blind. Consulted on the selection and implementation of a MAS 90 general ledger and financial reporting system during my tenure.



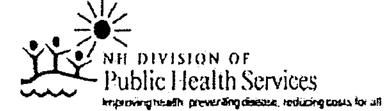
Nicholas A. Toumpas
Commissioner

José Thier Montero
Director

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

29 HAZEN DRIVE, CONCORD, NH 03301-6527
603-271-4517 1-800-852-3345 Ext. 4517
Fax: 603-271-4519 TDD Access: 1-800-735-2964



May 15, 2012

APPROVED G&C #129
DATE 6/20/12
NOT APPROVED

His Excellency, Governor John H. Lynch
and the Honorable Executive Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Public Health Services, Bureau of Population Health and Community Services, Maternal and Child Health Section, to enter into an agreement with The New London Hospital Association, Inc. (Vendor #177167-R005), 273 County Road, New London, New Hampshire 03257, in an amount not to exceed $323,264.00, to provide primary care services and breast and cervical cancer screening, to be effective July 1, 2012 or date of Governor and Executive Council approval, whichever is later, through June 30, 2014. Funds are available in the following accounts for SFY 2013, and are anticipated to be available in SFY 2014 upon the availability and continued appropriation of funds in the future operating budgets.

05-95-90-902010-5190 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES, MATERNAL AND CHILD HEALTH

Fiscal Year	Class/Object	Class Title	Job Number	Total Amount
SFY 2013	102-500731	Contracts for Program Services	90080000	$132,457
SFY 2014	102-500731	Contracts for Program Services	90080000	$132,457
			Sub-Total	$264,914

05-95-90-902010-5659 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES, COMPREHENSIVE CANCER

Fiscal Year	Class/Object	Class Title	Job Number	Total Amount
SFY 2013	102-500731	Contracts for Program Services	90080081	$29,175
SFY 2014	102-500731	Contracts for Program Services	90080081	$29,175
			Sub-Total	$58,350
			Total	$323,264

EXPLANATION

Funds in this agreement will be used to provide breast and cervical cancer screening and office-based primary care services for low-income and uninsured families. This agreement provides funds for services as a last resort; contractor is required to make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid.

Primary health care services include preventive and episodic health care for acute and chronic health conditions for people of all ages, including pregnant women, children, adolescents, adults, and the elderly. Community health agencies that receive support through the Division of Public Health Services deliver primary and preventive health care services to underserved people who face barriers to accessing health care, due to issues such as a lack of insurance, inability to pay, language barriers, and geographic isolation. In addition to medical care, community health centers are unique among primary care providers for the array of patient-centered services they offer, including care coordination, translation, transportation, outreach, eligibility assistance, and health education. These services help individuals overcome barriers to getting the care they need and achieving their optimal health. One area of particular success has been in ensuring that eligible families maintain consistent enrollment in Medicaid for their children. Community health centers provide support for families in filling out applications and ensuring that children have continuity of care.

Community health agencies throughout New Hampshire have demonstrated success in meeting the health care needs of the uninsured and under-insured citizens of the state. Division of Public Health Services funded primary care providers participate in rigorous quality improvement efforts utilizing standard performance measures that focus attention on improving health outcomes for patients. For example, in State Fiscal Year 2011:

- 88% of eligible children served were enrolled in Medicaid/Healthy Kids Gold.
- 86% of children 24-35 months, served received the appropriate schedule of immunizations.
- 82% of infants born to women served received prenatal care beginning in the first trimester of pregnancy.

In addition, breast and cervical cancers continue to be ongoing public health issues for New Hampshire. The Division of Public Health Services, Breast and Cervical Cancer Screening Program provides support for breast and cervical cancer screening services that include clinical examinations, pap smears and referral for mammography. Through this program, women found to have abnormal screening results, following their testing, receive additional coverage for diagnostic work-up and, if necessary, have their care coordinated through the initiation of treatment.

Should Governor and Executive Council not authorize this Request, a minimum of 500 low-income individuals in Sullivan County may not have access to primary care services, and eligible women may not receive recommended breast and cervical cancer screenings. A strong primary care infrastructure reduces costs for uncompensated care, improves health outcomes, and reduces health disparities. Additionally women that receive recommended breast and cervical cancer screenings are at lower risk of late diagnosis of breast and cervical cancers.

The New London Hospital Association, Inc. was selected for this project through a competitive bid process. A Request for Proposals was posted on the Department of Health and Human Services' web site from January 10, 2012 through February 16, 2012. In addition, a bidder's conference, conference call, and web conference were held on January 19, 2012 to alert agencies to this bid.

Thirteen proposals were received in response to the posting. Each proposal was scored by three professionals, who work internal and external to the Department of Health and Human Services. All reviewers have between three to twenty years experience either in clinical settings, providing community-based family support services, and managing agreements with vendors for various public health programs. Areas of specific expertise include maternal and child health; quality assurance and performance improvement; chronic and communicable diseases and public health infrastructure. The reviewers used a standardized form to score agencies' relevant experience and capacity to carry out the activities outlined in the proposal. Reviewers look for realistic targets when scoring performance measures in addition to detailed workplans including evaluation components. Budgets were reviewed to be reasonable, justified and consistent with the intent of the program goals and outcomes. There were no competing applications within each of the separate service areas. Scores were averaged and all proposals were recommended for funding. In those instances where scores were less than ideal, agency specific remedial actions were recommended and completed. Some primary care agencies are being funded at levels higher than they requested. Agencies were instructed to develop budgets based on previous allocations. While some proposed budgets higher than what was available for funding, others proposed budgets lower than what was available. There was an increase in breast and cervical cancer screening funds that bidders were unaware of when they drafted budgets. Adjustments were made accordingly for those agencies that proposed budgets at levels lower than available funds. This is a contract where that situation occurred. The Bid Summary is attached.

As referenced in the Request for Proposals, Renewals Section, this competitively procured Agreement has the option to renew for two additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties and approval of the Governor and Executive Council. These services were contracted previously with this agency in SFY 2011 and SFY 2012 in the amount of $547,604. This represents a decrease of $224,340. The decrease is due to budget reductions.

The performance measures used to measure the effectiveness of the agreement are attached.

Area served: Sullivan County.

Source of Funds: 34.40% Federal Funds from US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau and 65.60% General Funds.

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

Respectfully submitted,

José Thier Montero, MD
Director

Approved by: Nicholas A. Toumpas
Commissioner

JTM/PMT/sc

Primary Care Performance Measures

State Fiscal Year 2013

<u>Primary Care Prenatal (PN) Performance Measure #1</u>

Measure: Percent of infants born to women receiving prenatal care beginning in the first trimester of pregnancy.

<u>Primary Care Prenatal (PN) Performance Measure #2</u>

Measure: Percent of pregnant women identified as cigarette smokers that are referred to QuitWorks-New Hampshire.

<u>Primary Care Prenatal (PN) Performance Measure #3</u>

Measure: Percent of pregnant women who were screened, using a formal valid screening tool, for alcohol and other drug use during every trimester the patient was enrolled.

<u>Primary Care Child Health Direct (CH – D) Performance Measure #1</u>

Measure: Percent of eligible children enrolled in Medicaid

<u>Primary Care Child Health Direct (CH – D) Performance Measure #2</u>

Measure: Percent of at-risk children who were screened for blood lead between 18 and 30 months of age

<u>Primary Care Child Health Direct (CH – D) Performance Measure #3</u>

Measure: Percent of children age two to nineteen years receiving primary care preventive health services with a Body Mass Index (BMI) percentile greater than or equal to the 85th percentile with documented discussion of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

<u>Primary Care Child Health Direct (CH – D) Performance Measure #4</u>

Measure: Percent of eligible infants and children with client record documentation of enrollment in Women Infant Children Program.

<u>Primary Care Child Health Direct (CH – D) Performance Measure #5</u>

Measure: Percent of infants who were exclusively breastfed for the first three months, at their four month well baby visit.

<u>Primary Care Financial (PC) Performance Measure #1</u>

Measure: Patient Payor Mix

<u>Primary Care Financial (PC) Performance Measure #2</u>

Measure: Accounts Receivables (AR) Days

<u>Primary Care Financial (PC) Performance Measure #3</u>

Measure: Current Ratio

Primary Care Performance Measures

State Fiscal Year 2013

Primary Care Clinical Adolescent (PC-C) Performance Measure #1

Measure: Percent of adolescents aged 10-21 years who received annual health maintenance visits in the past 12 months.

Primary Care Clinical Prenatal (PC-C) Performance Measure #2

Measure: Percent of women and adolescent girls aged 15-44 who take a multi-vitamin with folic acid.

Subject: Primary Care Services

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

1. IDENTIFICATION.

1.1 State Agency Name NH Department of Health and Human Services Division of Public Health Services		**1.2 State Agency Address** 29 Hazen Drive Concord, NH 03301-6504	
1.3 Contractor Name The New London Hospital Association, Inc.		**1.4 Contractor Address** 273 County Road New London, New Hampshire 03257	
1.5 Contractor Phone Number 603-526-5512	**1.6 Account Number** 010-090-5190-102-500731 010-090-5659-102-500731	**1.7 Completion Date** June 30, 2014	**1.8 Price Limitation** $323,264
1.9 Contracting Officer for State Agency Joan H. Ascheim, Bureau Chief		**1.10 State Agency Telephone Number** 603-271-4501	
1.11 Contractor Signature Bruce P. King		**1.12 Name and Title of Contractor Signatory** Bruce P. King, President & CEO	
1.13 Acknowledgement: State of NH, **County of** Merrimack On 4/5/12, before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.			
1.13.1 Signature of Notary Public or Justice of the Peace [Seal] Coua Early		COUA L. EARLY Notary Public - New Hampshire My Commission Expires December 8, 2015	
1.13.2 Name and Title of Notary or Justice of the Peace Coua Early, Notary			
1.14 State Agency Signature [signature]		**1.15 Name and Title of State Agency Signatory** Joan H. Ascheim, Bureau Chief	
1.16 Approval by the N.H. Department of Administration, Division of Personnel ***(if applicable)*** By:		Director, On:	
1.17 Approval by the Attorney General (Form, Substance and Execution) By: Jeanne P. Herrick, Attorney		On: 29 May 2012	
1.18 Approval by the Governor and Executive Council By:		On:	

NH Department of Health and Human Services

Exhibit A

Scope of Services

Primary Care Services

CONTRACT PERIOD: July 1, 2012 or date of G&C approval, whichever is later, through June 30, 2014

CONTRACTOR NAME: The New London Hospital Association, Inc.

ADDRESS: 273 County Road
New London, New Hampshire 03257
President and Chief Executive Officer: Bruce King
TELEPHONE: 603-526-5512

The Contractor shall:

I. General Provisions

A) Eligibility and Income Determination

1. Office-based primary care services will be provided to low-income individuals and families (defined as ≤ 185% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), in the State of New Hampshire.

2. Breast and Cervical Cancer screening services will be provided to low-income (defined as ≤ 250% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), New Hampshire women age 18 – 64, *uninsured or underinsured.*

3. The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing if, at any time, the practice is closed to new patients, or maintains a wait list for new patients, or any other mechanism is used that limits access for new patients for more than a one month period.

4. The Contractor shall document annually, for each client enrolled in the program, family income and family size, and calculate percentage of the federal poverty level. If calculations indicate that the client may be eligible for enrollment in Medicaid, the Contractor shall complete with the client the most recent version of the 800P form.

5. The Contractor shall implement, and post in a public and conspicuous location, a sliding fee payment schedule, approved in advance by the Division of Public Health Services (DPHS), for low-income patients. Signage must state that no client will be denied services for inability to pay.

   a. As an alternative, the contractor may post, in a public and conspicuous location, a notice to clients that a sliding fee scale is available and that no client will be denied services for inability to pay. The sliding fee scale must be updated annually based on USDHHS Poverty guidelines as published in the Federal Register, submitted to and approved by DPHS *prior to implementation.*

6. The primary care contract entered into here shall be the payer of last resort. The contractor shall make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid, for all reimbursable services rendered.

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B) Numbers Served

1. The contract funds shall be expended to provide the above services to a minimum of 250 users annually with 500 medical encounters, as defined in the Data and Reporting Requirements. Breast and Cervical Cancer Screening for eligible women, as defined by the Breast and Cervical Cancer Program (BCCP), shall be provided to 125 women annually and billed directly to the BCCP. Clinical service reimbursements shall not exceed the Medicare rate.

C) Culturally and Linguistically Appropriate Standards of Care

The Department of Health and Human Services (DHHS) recognizes that culture and language have considerable impact on how consumers access and respond to public health services. Culturally and linguistically diverse populations experience barriers in efforts to access health services. To ensure equal access to quality health services, the Division of Public Health Services (DPHS) expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.
2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.
3. *Provide* clients of limited English proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.
4. Offer consumers a forum through which clients have the opportunity to provide feedback to providers and organizations regarding cultural and linguistic issues that may deserve response.
5. The contractor shall maintain a program policy that sets forth compliance with Title VI, Language Efficiency and Proficiency Citation 45 CFR 80.3(b) (2). The policy shall describe the way in which the items listed above were addressed and shall indicate the circumstances in which interpretation services are provided and the method of providing service (e.g. trained interpreter, staff person who speaks the language of the client, language line).

D) State and Federal Laws

The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. The Contractor shall report all cases of communicable diseases according to New Hampshire RSA 141-C and He-P 301, adopted 6/3/08.
2. Persons employed by the contractor shall comply with the reporting requirements of New Hampshire RSA 169:C, Child Protection Act; RSA 161:F46, Protective Services to Adults, RSA 631:6, Assault and Related Offences and RSA 130:A, Lead Paint Poisoning and Control.
3. Immunizations shall be conducted in accordance with RSA 141-C and the Immunization Rules promulgated hereunder.

E) Relevant Policies and Guidelines

1. The Contractor shall design and provide the services described above to meet the unique and identified health needs of the populations within the contracted service area.

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2. Primary Care funds shall be targeted to populations in need. Populations in need are defined as follows:

   a) uninsured;

   b) under-insured;

   c) families and individuals with significant psychosocial and economic risk, including low income status;

   d) all life cycles including perinatal, child, adolescent, adult, and elderly who meet one or more of the above criteria.

3. The Contractor shall design and implement systems of governance, administration, financial management, information management, and clinical services which are adequate to assure the provision of contracted services, and to meet the data and reporting requirements. These systems shall meet the most current minimum standards described in at least one of the following: Health Resources and Services Administration (HRSA) Office of Performance Review protocols, Joint Commission on Accreditation of Health Care Organizations (JCAHO), Accreditation Association for Ambulatory Healthcare (AAAHC), Community Health Accreditation Program (CHAP), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey.

4. *The Contractor shall have an agency emergency preparedness and response plan in accordance with HRSA Health Center Emergency Management Program Expectations, Document #2007-15 or most recent version. Such plan shall also include a Continuity of Operations plan.*

5. The Contractor shall carry out the work as described in the performance Workplan submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

6. No Workplan is required by the Breast and Cervical Cancer Program (BCCP). The contractor shall be required to respond to the Quality Improvement Feedback Report twice a year.

7. The Contractor shall carry out the work as described in the Supplemental Funding Form submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

F) **Publications Funded Under Contract**

1. The DHHS and/or its funders will retain COPYRIGHT ownership for any and all original materials produced with DHHS contract funding, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports.

2. All documents (written, video, audio, *electronic*) produced, reproduced, or purchased under the contract shall have prior approval from DPHS before printing, production, distribution, or use.

3. The Contractor shall credit DHHS on all materials produced under this contract following the instructions outlined in Exhibit C (14).

G) **Subcontractors**

1. If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing *and approve the subcontractual agreement*, prior to initiation of the subcontract.

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2. In addition, the original DPHS contractor will remain liable for all requirements included in this Exhibit and carried out by subcontractors.

II. Minimal Standards of Core Services

A) Service Requirements

1. *Medical Home*

The Contractor shall provide a Medical Home that:

a) *Facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family.*

b) *Provides care facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.*

2. Primary Care Services

The Contractor shall provide office-based primary care services to populations in need who reside in the contractor's service area. Primary care services shall include:

a) Health care provided by a New Hampshire licensed MD, DO, APRN, or PA, including diagnosis and treatment of acute and chronic illnesses within the scope of family practice; preventive services, screenings, and health education according to established, documented state or national guidelines; assessment of need for social and nutrition services, and appropriate referrals to health, *oral health*, and behavioral health specialty providers.

b) *Referral to the WIC Nutrition Program for all eligible pregnant women, infants and children.*

c) In-hospital care for conditions within the scope of family practice must be provided at a hospital, within the agency service area, through a staff clinician with full hospital privileges, or in the alternative, through a formal referral and admissions procedure available to clients on a 24 hour/7 day a week basis.

d) Access to a healthcare provider, directly or by referral or subcontract, by telephone twenty-four hours per day, seven days per week.

e) Assessment of psychosocial risk for all clients at least annually and for children at scheduled preventive care visits, including, at a minimum, age appropriate assessment of safety in the home, domestic violence, adequacy of food and housing, care and welfare of children, transportation needs, and provision of necessary social services to address the priority needs and safety issues of clients and families.

f) Falls prevention screening for patients 65 years and older using the algorithm and guidelines of the American Geriatrics Society.

g) Behavioral health care directly or by referral to an agency or provider with a sliding fee scale.

h) *Nutrition assessment for all clients as part of the health maintenance visit.* Therapeutic nutrition services shall be provided *as indicated* directly or by referral to an agency or provider with a sliding fee scale. These services shall be recorded in the medical record.

i) Formal arrangements with a local hospital for emergency care must be in place and reviewed annually.

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j) Home health care directly or by referral to an agency or provider with a sliding fee scale.

k) Assisted living and skilled nursing facility care by referral.

l) *Oral screening annually for all clients 19 years and older to note obvious dental decay and soft tissue abnormalities with a reminder to the patient that poor oral health impacts total health.*

m) *Diagnosis and management of pediatric and adult patients with asthma provided according to National Heart Lung Blood Institute, National Asthma Education and Prevention Program, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, 2007.*

2. Breast and Cervical Cancer Screening

a) Women age 18 to 64 who are eligible for Breast and Cervical Cancer Program (BCCP) services according to income (equal to or under 250% of poverty, underinsured/uninsured) *and insurance status* criteria shall be provided the following services:

i. cervical cancer screening including a pelvic examination and Pap smear;
ii. annual breast cancer screening including a clinical breast exam, mammogram and,
iii. referrals for diagnostic and treatment services based on screening results,
iv. case management services.

b) All referrals under this provision shall be to approved certified laboratory, pathology, radiology, and surgical services. Mammography units shall be accredited by the American College of Radiology, and must be FDA certified under MQSA. Laboratories shall be CLIA certified.

c) All services shall be provided in accordance with the Breast and Cervical Cancer Program (BCCP) Policy and Procedure Manual.

d) Follow-up and tracking of all tests done, and referrals made shall be provided in accordance with the minimum standards outlined in the Breast and Cervical Cancer Program Policy and Procedure Manual.

e) All services for women enrolled in the Breast and Cervical Cancer Program (BCCP) shall be billed directly to the BCCP in accordance with protocols established by the Breast and Cervical Cancer Program.

3. Reproductive Health Services

The Contractor shall provide prenatal, interconceptional and preconception medical care, social services, nutrition services, education, and nursing care to all women of childbearing age. Preconceptional care includes the preconception, interconceptional, and postpartum periods in women's health. It is recommended that preconceptional and interconceptional care visits focus on maintaining or achieving the optimal health of the mother, lowering the risk of future adverse pregnancy outcomes, the family's future plans, and how additional children fit into that plan. Preconceptional counseling may be done during an office, group or home visit.

a) In the event prenatal care is not provided directly by the Contractor a formal Memorandum/a of Agreement for coordinated referral to an appropriately qualified provider must be maintained.

b) Prenatal care shall, at minimum, be provided in accordance with the Guidelines for Perinatal Care, sixth or most current edition, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and /or the Centers for Disease Control.

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c) Age appropriate reproductive health care shall, at a minimum, be provided in accordance with the American College of Obstetricians and Gynecologists, or the USDHHS Centers for Disease Control (CDC) current guidelines.

d) *Pregnant women enrolled in the WIC Nutrition Program shall be referred to WIC for breastfeeding education and referral to the WIC Nutrition Program peer counselors.*

e. Family planning counseling for prevention of subsequent pregnancy following an infant's birth shall be discussed with the infant's mother *at the first postpartum visit and at the infant's 2-month visit and other visits as appropriate.* Rationale for birth intervals of 18-24 months shall be presented.

f) A referral to a Title X Family Planning Clinic or other reproductive health care provider shall be made as appropriate.

4. Services for Children and Adolescents

The Contractor shall provide as a minimum, comprehensive and age-appropriate health care, screenings, and health education according to the American Academy of Pediatrics' most recent periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent. Children and adolescent visits shall include:

a) Blood lead testing shall be performed in accordance with "New Hampshire Childhood Lead Poisoning Screening and Management Guidelines", issued by the New Hampshire Department of Health and Human Services, 2009 or subsequent revisions.

b) All children enrolled in either Healthy Kids-Gold or the Women, Infant, and Children (WIC) Program and/or who are $\leq$ 185% poverty, regardless of town of residence, are required to have a blood lead test at ages one and two years. All children ages three to six years who have not been previously tested shall have a capillary or venous blood lead test performed.

c) All children shall be screened for iron deficiency anemia as outlined in the Centers for Disease Control and Prevention document "Recommendations to Prevent and Control Iron Deficiency in the United States (4/2/98)".

d) Age-appropriate anticipatory guidance, dietary guidance, and *feeding practice counseling* for optimal oral health shall be provided at each well child visit according to the American Academy of Pediatrics' periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent edition. Starting at age 6 months, it is recommended that all children receive an oral health assessment at every well child visit.

e) Supplemental fluoride shall be prescribed as needed based upon the fluoride levels in the child's *drinking* water supply. The fluoride dosage regimen accepted by the American Academy of Pediatrics shall be followed. No fluoride shall be prescribed without obtaining water from private wells or noting the presence or absence of fluoride in the public water supply. *Supplemental fluoride may include bottled water containing fluoride and topical applications such as varnishes.*

f) *For infants enrolled in the WIC Nutrition Program, parents shall be referred to WIC for breastfeeding support and referral to the WIC Nutrition Program peer counselors.*

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5. Sexually Transmitted Infections

Primary Care Services shall provide age appropriate screening and treatment of sexually transmitted infections.

a) Treatment for sexually transmitted infections shall be provided according to the United States Centers for Disease Control Sexually Transmitted Diseases Treatment Guidelines, 2010 or subsequent revisions.

b) All clients, including women, shall be offered HIV testing following the most current recommendations of the United States Centers for Disease Control.

c) The contractor shall be responsible for ensuring referral to appropriate treatment services for any woman found to screen positive.

d) Appropriate risk reduction counseling shall be provided based on client needs.

6. Substance Use Services

a) A substance use screening history using a formal, validated screening tool shall be obtained for all clients as soon after entry into care as possible. Substance use counseling *or other substance abuse intervention, treatment, or recovery services* by an appropriately credentialed provider shall be provided on-site, or by referral, to clients with identified needs for these services. *For these identified clients, ongoing primary care services should include follow up monitoring relative to substance abuse.*

b) All clients, including pregnant women, identified as smokers shall receive counseling *using the 5A's (ask, advise, assess, assist, and arrange) treatment available through the NH Tobacco Helpline* as cited in the US Public Health Services report "Tobacco Use and Dependence", 2008, or "Smoking Cessation During Pregnancy: *A Clinician's Guide to Helping Pregnant Women Quit Smoking*", American College of Obstetricians and Gynecologists, 2011. *With prior approval, agencies may also opt to participate in the DPHS best practice initiative of the 2A's and R (ask, advise and refer).*

7. Immunizations

a) The Contractor shall adhere to the most current version of the "Recommended Adult Immunization Schedule United States", approved by the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

b) The Contractor shall administer vaccines according to the most current version of the *"Recommended Immunization Schedule for Persons Aged 0 Through 6 Years - United States", and "Recommended Immunization Schedule for Persons Aged 7 Through 18 Years – United States"* approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians, based upon availability of vaccine from the New Hampshire Immunization Program.

8. Prenatal Genetic Screening

a) A genetic screening history shall be obtained on all prenatal clients as soon after entry into care as possible.

b) All pregnant women should be offered voluntary genetic screening for fetal chromosomal abnormalities at the appropriate time following recommendations found in the American College of Obstetricians and Gynecologists' "Screening for Fetal Chromosomal

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Abnormalities (2007)" or more recent guidelines. The Contractor shall be responsible for ensuring referral to appropriate genetic testing and counseling for any woman found to have a positive screening test.

9. Additional Requirements

   a) The Contractor's Medical Director shall participate in the development and approval of specific guidelines for medical care that supplement minimal clinical standards. Supplemental guidelines should be reviewed, signed, and dated annually, and updated as indicated.

   b) Contractors considering clinical or sociological research using clients as subjects must adhere to the legal requirements governing human subjects research. Contractors must inform the DPHS, MCHS prior to initiating any research related to this contract.

   c) *The Contractor shall provide information to all employees annually about the Medical Reserve Corps Unit within their Public Health Region to enhance recruitment.*

   d) *The Contractor shall provide information to all employees annually regarding the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) managed by the NH Department of Health and Human Services' Emergency Services Unit, to enhance recruitment.*

B) Staffing Provisions

The Contractor shall have, at minimum, the following staff positions:

a) executive director

b) fiscal director

c) registered nurse

d) clinical coordinator

e) medical service director

f) nutritionist *(on site or by referral)*

g) social worker

Staff positions required to provide direct services on-site include:

a) registered nurse

b) clinical coordinator

c) social worker

1. Qualifications

   All health and allied health professionals shall have the appropriate New Hampshire licenses whether directly employed, contracted, or subcontracted.

   In addition the following minimum qualifications shall be met for:

   a) Registered Nurse

a. A registered nurse licensed in the state of New Hampshire, Bachelor's degree preferred. Minimum of one-year experience in a community health setting.

b) Nutritionists:

a. A Bachelor's degree in nutritional sciences or dietetics, or a Master's degree in nutritional sciences, nutrition education, or public health nutrition or current Registered Dietitian status in accordance with the Commission on dietetic Registration of the American Dietetic Association.

b. Individuals who perform functions similar to a nutritionist but do not meet the above qualifications shall not use the title of nutritionist.

c) Social Workers shall have:

a. A Bachelor's or Master's degree in social work or Bachelor's or Master's degree in a related social science or human behavior field. A minimum of one year of experience in a community health or social services setting is preferred.

b. Individuals who perform functions similar to a social worker but do not meet the above qualifications shall not use the title of social worker.

d) Clinical Coordinators shall be:

a. A registered nurse (RN), physician, physician assistant, or nurse practitioner with a license to practice in New Hampshire.

b. The coordinator is a clinical position that oversees and takes responsibility for the clinical and administrative functions of each program.

c. The coordinator may be responsible for more than one MCH funded program.

2. New Hires

The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing within one month of hire when a new administrator, clinical coordinator, or any staff person essential to carrying out contracted services is hired to work in the program. A resume of the employee shall accompany the aforesaid notification.

3. Vacancies

a) The Contractor must notify the MCHS in writing if any critical position is vacant for more than one month, or if at any time funded under this contract does not have adequate staffing to perform all required services for more than one month. This may be done through a budget revision.

b) Before an agency hires new program personnel that do not meet the required staff qualifications, the agency shall notify the MCHS in writing requesting a waiver of the applicable staffing requirements. The Section may grant waivers based on the need of the program, individuals' experience, and additional training.

C) Coordination of Services

1. The Contractor shall coordinate, where possible, with other service providers within the contractor's community. At a minimum, such collaboration shall include interagency referrals and coordination of care.

2. The Contractor shall participate in activities *in the Public Health Region in which they provide services* as appropriate. These activities enhance the integration of community-based public health

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prevention and health care initiatives that are being implemented by the contractor and may include community needs assessments, public health performance assessments, and/or the development of regional health improvement plans.

3. The Contractor agrees to *participate* in and coordinate public health activities as requested by the Division of Public Health Services during any *disease outbreak* and/or *emergency*, natural or man made, affecting the public's health.

4. The Contractor is responsible for case management of the client enrolled in the program and for program follow-up activities. Case management services shall promote effective and efficient organization and utilization of resources to assure access to necessary comprehensive medical, nutritional, and social services for clients.

5. The Contractor shall assure that *appropriate, responsive, and timely* referrals and linkages for other needed services are made, carried through, and documented. Such services shall include, but not be limited to: dental services, genetic counseling, high risk prenatal services, mental health, social services, including domestic violence crisis centers, substance abuse services; and family planning services, Early Supports and Services Program, local WIC/CSF Program, Home Visiting New Hampshire Programs and health and social service agencies which serve children and families in need of those services.

D) Meetings and Trainings

The contractor will be responsible for sending staff to meetings and training required by the MCHS program, including but not limited to:

1. MCHS Agency Directors' meetings

2. Prenatal and Child Health Coordinators' meetings

3. MCHS Agency Medical Services Directors' meetings

III. Quality or Performance Improvement (QI/PI)

A) Workplans

1. Performance Workplans are required for this program and are used to monitor achievement of standard measures of performance of the services provided under this contract. The workplans are a key component of the RHPCS and the MCHS performance-based contracting system and of this contract. Outcomes shall be reported by clinical site.

2. Submit Performance Workplans and Workplan Outcome reports according to the schedule and instructions provided by the MCHS. The MCHS shall notify the Contractor at least 30 days in advance of any changes in the submission schedule.

3. The Contractor shall incorporate required and developmental performance measures, defined by the MCHS into the agency's Performance Workplan. Reports on Workplan Progress/Outcomes shall detail the Performance Workplan plans and activities that monitor and evaluate the agency's progress toward performance measure targets.

4. The Contractor shall comply with modifications and/or additions to the workplan and annual report format as requested by RHPCS and MCHS. MCHS will provide the contractor with reasonable notice of such changes.

5. Agencies contracting for Primary Care Services must submit the workplans for Primary Care *Clinical and Financial*, Child Health, and Prenatal Care.

B) Additional Reporting requirements

In addition to Performance Workplans, the Contractor shall submit to MCHS the following data and information listed below which are used to monitor program performance:

1. In years when contracts or amendments are not required, the DPHS Budget Form, Budget Justification, Sources of Revenue and Program Staff list forms must be completed according to the relevant instructions and submitted as requested by DPHS and, at minimum, by April 30 of each year.
2. The Sources of Revenue report must be resubmitted at any point when changes in revenue threaten the ability of the agency to carry out the planned program.
3. Completed Uniform Data Set (UDS) tables reflecting program performance in the previous calendar year, by March 31 of each year.
4. The Perinatal Client Data Form (PCDF) shall be submitted electronically according to the instructions set forth by the MCHS.
5. A copy of the agency's updated Sliding Fee Scale including the amount(s) of any client fees and the schedule of discounts must be submitted by March 31st of each year. The agency's sliding fee scale must be updated annually based on the US DHHS Poverty guidelines as published in the Federal Register.
6. An annual summary of program-specific patient satisfaction results obtained during the prior contract period and the method by which the results were obtained shall be submitted annually as an addendum to the Workplan Outcome/Progress reports.

C) **On-site reviews**

1. The contractor shall allow a team or person authorized by the Division of Public Health Services to periodically review the contractor's systems of governance, administration, data collection and submission, clinical and financial management, and delivery of education services in order to assure systems are adequate to provide the contracted services.
2. Reviews shall include client record reviews to measure compliance with this exhibit.
3. The contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.
4. On-Site reviews may be waived or abbreviated at the discretion of MCHS, upon submission of satisfactory reports of reviews such as Health Services Resources Administration (HRSA): Office of Performance Review (OPR), or reviews from nationally accreditation organizations such as the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), Medicare, the Community Health Accreditation Program (CHAP), Accreditation Association for Ambulatory Healthcare (AAAHC), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey. Abbreviated reviews will focus on any deficiencies found in previous reviews, issues of compliance with this exhibit, and actions to strengthen performance as outlined in the agency Performance Workplan.

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Date: 4/5/11

State of New Hampshire
Department of Health and Human Services
Amendment #1 to the
Weeks Medical Center

This 1st Amendment to the Weeks Medical Center contract (hereinafter referred to as "Amendment One") dated this 7TH day of MARCH, 2014, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Weeks Medical Center (hereinafter referred to as "the Contractor"), a corporation with a place of business at 170 Middle Street, Lancaster, New Hampshire 03584.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on July 11, 2012, 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, the State and the Contractor have agreed to make changes to the scope of work, payment schedules and terms and conditions of the contract; and

WHEREAS, pursuant to the General Provisions, Paragraph 18, the State may modify the scope of work and the payment schedule of the contract by written agreement of the parties;

WHEREAS, the Department desires to provide additional primary health care services for preventive and episodic health care for acute and chronic health conditions for people of all ages.

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 as follows:

To amend as follows:

- Form P-37, to change:
  Block 1.7 to read: June 30, 2015
  Block 1.8 to read: $292,483

- Exhibit A, Scope of Services to add:
  Exhibit A – Amendment 1

- Exhibit B, Purchase of Services, Contract Price, to add:

  Paragraph 1.1 to Paragraph 1:
  The contract price shall increase by $20,652 for SFY 2014 and $113,557 for SFY 2015.

  Paragraph 1.2 to Paragraph 1:
  Funding is available as follows:
- $20,652 from 05-95-90-902010-5190-102-500731, 100% General Funds;
- $103,557 from 05-95-90-902010-5190-102-500731, 6.7% Federal Funds from the US Department of Health and Human Services Administration, Maternal and Child Health Bureau, CFDA #93.994 and 93.3% General Funds;

Contractor Initials: [initials]
Date: 3/7/14

- $10,000 from 05-95-90-901010-7965-102-500731, 100% General Funds.

  Add Paragraph 8
  8. Notwithstanding paragraph 18 of the General Provisions P-37, an amendment limited to adjustments to amounts between and among account numbers, within the price limitation, may be made by written agreement of both parties and may be made without obtaining approval of the Governor and Executive Council.

- Budget, to add:
  Exhibit B-1 (2014) - Amendment 1,
  Exhibit B-1 (2015) - Amendment 1

This amendment shall be in effect July 1, 2013, effective upon the date of Governor and Executive Council approval.

Contractor Initials: [signature]
Date: 3/7/14

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

3/20/2014
Date

Brook Dupee
Bureau Chief

Weeks Medical Center

3/7/14
Date

Name: SCOTT HOWE
Title: CEO

Acknowledgement:

State of NEW HAMPSHIRE, County of Coos on MARCH 7 2014, before the undersigned officer, personally appeared the person identified above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.

Kathy St. Onge
Signature of Notary Public or Justice of the Peace

KATHY ST. ONGE, NOTARY
Name and Title of Notary or Justice of the Peace

KATHY ST. ONGE, Notary Public
My Commission Expires June 22, 2016

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

OFFICE OF THE ATTORNEY GENERAL

4-3-14
Date

Name: Rosemary Wiant
Title: Asst. Attorney General

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:

Contractor Initials:
Date: 3/7/14

EXHIBIT A – AMENDMENT 1

Scope of Services

The Department desires to continue the relationship with the primary care agencies to provide additional primary health care services for preventive and episodic health care for acute and chronic health conditions for people of all ages.

I. General Provisions

A) Eligibility and Income Determination

1. Office-based primary care services will be provided to low-income individuals and families (defined as ≤ 185% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), in the State of New Hampshire.

2. The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing if, at any time, the practice is closed to new patients, or maintains a wait list for new patients, or any other mechanism is used that limits access for new patients for more than a one month period.

3. The Contractor shall document annually, for each client enrolled in the program, family income and family size, and calculate percentage of the federal poverty level. If calculations indicate that the client may be eligible for enrollment in Medicaid, the Contractor shall complete with the client the most recent version of the 800P form.

4. The Contractor shall implement, and post in a public and conspicuous location, a sliding fee payment schedule, approved in advance by the Division of Public Health Services (DPHS), for low-income patients. Signage must state that no client will be denied services for inability to pay.

   a. As an alternative, the contractor may post, in a public and conspicuous location, a notice to clients that a sliding fee scale is available and that no client will be denied services for inability to pay. The sliding fee scale must be updated annually based on USDHHS Poverty guidelines as published in the Federal Register, submitted to and approved by DPHS prior to implementation.

5. The primary care contract entered into here shall be the payer of last resort. The contractor shall make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid, for all reimbursable services rendered.

B) Numbers Served

1. The contract funds shall be expended to provide the above services to a minimum of 800 users annually with 2000 medical encounters, as defined in the Data and Reporting Requirements. Clinical service reimbursements shall not exceed the Medicare rate.

EXHIBIT A – AMENDMENT 1

C) Culturally and Linguistically Appropriate Standards of Care

The Department of Health and Human Services (DHHS) recognizes that culture and language have considerable impact on how consumers access and respond to public health services. Culturally and linguistically diverse populations experience barriers in efforts to access health services. To ensure equal access to quality health services, the Division of Public Health Services (DPHS) expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.

2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.

3. Provide clients of limited English proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.

4. Offer consumers a forum through which clients have the opportunity to provide feedback to providers and organizations regarding cultural and linguistic issues that may deserve response.

5. The contractor shall maintain a program policy that sets forth compliance with Title VI, Language Efficiency and Proficiency Citation 45 CFR 80.3(b) (2). The policy shall describe the way in which the items listed above were addressed and shall indicate the circumstances in which interpretation services are provided and the method of providing service (e.g. trained interpreter, staff person who speaks the language of the client, language line).

D) State and Federal Laws

The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. The Contractor shall report all cases of communicable diseases according to New Hampshire RSA 141-C and He-P 301, adopted 6/3/08.

2. Persons employed by the contractor shall comply with the reporting requirements of New Hampshire RSA 169:C, Child Protection Act; RSA 161:F46, Protective Services to Adults, RSA 631:6, Assault and Related Offences and RSA 130:A, Lead Paint Poisoning and Control.

3. Immunizations shall be conducted in accordance with RSA 141-C and the Immunization Rules promulgated hereunder.

E) Relevant Policies and Guidelines

1. The Contractor shall design and provide the services described above to meet the unique and identified health needs of the populations within the contracted service area.

2. Primary Care funds shall be targeted to populations in need. Populations in need are defined as follows:

   a) uninsured;

   b) under-insured;

   c) families and individuals with significant psychosocial and economic risk, including low income status;

   d) all life cycles including perinatal, child, adolescent, adult, and elderly who meet one or more of the above criteria.

3. The Contractor shall design and implement systems of governance, administration, financial management, information management, and clinical services which are adequate to assure the provision of contracted services, and to meet the data and reporting requirements. These systems shall meet the most current minimum standards described in at least one of the following: Health Resources and Services Administration (HRSA) Office of Performance Review protocols, Joint Commission on Accreditation of Health Care Organizations (JCAHO), Accreditation Association for Ambulatory Healthcare (AAAHC), Community Health Accreditation Program (CHAP), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey.

4. The Contractor shall have an agency emergency preparedness and response plan in accordance with HRSA Health Center Emergency Management Program Expectations, Document #2007-15 or most recent version. Such plan shall also include a Continuity of Operations plan.

5. The Contractor shall carry out the work as described in the performance Workplan submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

6. No Workplan is required by the Breast and Cervical Cancer Program (BCCP). The contractor shall be required to respond to the Quality Improvement Feedback Report twice a year.

7. The Contractor shall carry out the work as described in the Supplemental Funding Form submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

 Contractor Initials ____

Date 3/7/14

F) Publications Funded Under Contract

1. The DHHS and/or its funders will retain COPYRIGHT ownership for any and all original materials produced with DHHS contract funding, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports.

2. All documents (written, video, audio, electronic) produced, reproduced, or purchased under the contract shall have prior approval from DPHS before printing, production, distribution, or use.

3. The Contractor shall credit DHHS on all materials produced under this contract following the instructions outlined in Exhibit C (14).

G) Subcontractors

If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing and approve the subcontractual agreement, prior to initiation of the subcontract.

1. If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing and approve the subcontractual agreement, prior to initiation of the subcontract.

2. In addition, the original DPHS contractor will remain liable for all requirements included in this Exhibit and carried out by subcontractors.

II. <u>Minimal Standards of Core Services</u>

A. Service Requirements

1. Medical Home

   The Contractor shall provide a Medical Home that:

   a) Facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family.

   b) Provides care facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

2. Primary Care Services

   The Contractor shall provide office-based primary care services to populations in need who reside in the contractor's service area. Primary care services shall include:

a) Health care provided by a New Hampshire licensed MD, DO, APRN, or PA, including diagnosis and treatment of acute and chronic illnesses within the scope of family practice; preventive services, screenings, and health education according to established, documented state or national guidelines; assessment of need for social and nutrition services, and appropriate referrals to health, oral health, and behavioral health specialty providers.

b) Referral to the WIC Nutrition Program for all eligible pregnant women, infants and children.

c) In-hospital care for conditions within the scope of family practice must be provided at a hospital, within the agency service area, through a staff clinician with full hospital privileges, or in the alternative, through a formal referral and admissions procedure available to clients on a 24 hour/7 day a week basis.

d) Access to a healthcare provider, directly or by referral or subcontract, by telephone twenty-four hours per day, seven days per week.

e) Assessment of psychosocial risk for all clients at least annually and for children at scheduled preventive care visits, including, at a minimum, age appropriate assessment of safety in the home, domestic violence, adequacy of food and housing, care and welfare of children, transportation needs, and provision of necessary social services to address the priority needs and safety issues of clients and families.

f) Falls prevention screening for patients 65 years and older using the algorithm and guidelines of the American Geriatrics Society.

g) Behavioral health care directly or by referral to an agency or provider with a sliding fee scale.

h) Nutrition assessment for all clients as part of the health maintenance visit. Therapeutic nutrition services shall be provided as indicated directly or by referral to an agency or provider with a sliding fee scale. These services shall be recorded in the medical record.

i) Formal arrangements with a local hospital for emergency care must be in place and reviewed annually.

j) Home health care directly or by referral to an agency or provider with a sliding fee scale.

k) Assisted living and skilled nursing facility care by referral.

l) Oral screening annually for all clients 21 years and older to note obvious dental decay and soft tissue abnormalities with a reminder to the patient that poor oral health impacts total health.

m) Diagnosis and management of pediatric and adult patients with asthma provided according to National Heart Lung Blood Institute, National Asthma Education and Prevention Program, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, 2007.

3. Reproductive Health Services

The Contractor shall provide prenatal, interconceptional and preconception medical care, social services, nutrition services, education, and nursing care to all women of childbearing age. Preconceptional care includes the preconception, interconceptional, and postpartum periods in women's health. It is recommended that preconceptional and interconceptional care visits focus on maintaining or achieving the optimal health of the mother, lowering the risk of future adverse pregnancy outcomes, the family's future plans, and how additional children fit into that plan. Preconceptional counseling may be done during an office, group or home visit.

a) In the event prenatal care is not provided directly by the Contractor a formal Memorandum/a of Agreement for coordinated referral to an appropriately qualified provider must be maintained.

b) Prenatal care shall, at minimum, be provided in accordance with the Guidelines for Perinatal Care, sixth or most current edition, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and /or the Centers for Disease Control.

c) Age appropriate reproductive health care shall, at a minimum, be provided in accordance with the American College of Obstetricians and Gynecologists, or the USDHHS Centers for Disease Control (CDC) current guidelines.

d) Pregnant women enrolled in the WIC Nutrition Program shall be referred to WIC for breastfeeding education and referral to the WIC Nutrition Program peer counselors.

e. Family planning counseling for prevention of subsequent pregnancy following an infant's birth shall be discussed with the infant's mother at the first postpartum visit and at the infant's 2-month visit and other visits as appropriate. Rationale for birth intervals of 18-24 months shall be presented.

f) A referral to a Title X Family Planning Clinic or other reproductive health care provider shall be made as appropriate.

4. Services for Children and Adolescents

The Contractor shall provide as a minimum, comprehensive and age-appropriate health care, screenings, and health education according to the American Academy of Pediatrics' most recent periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of

Infants, Children, and Adolescents", Third Edition or most recent. Children and adolescent visits shall include:

a) The World Health Organization (WHO) growth charts shall be used to monitor growth for infants and children birth up to age 2 years. The Centers for Disease Control and Prevention (CDC) growth charts shall be used for children age 2 years and older.

b) Blood lead testing shall be performed in accordance with “New Hampshire Childhood Lead Poisoning Screening and Management Guidelines”, issued by the New Hampshire Department of Health and Human Services, 2009 or subsequent revisions.

c) All children enrolled in either Medicaid, Head Start, or the Women, Infant, and Children (WIC) Program and/or who are ≤ 185%_poverty, regardless of town of residence, are required to have a blood lead test at ages one and two years. All children ages three to six years who have not been previously tested shall have a blood lead test performed.

d) All children shall be screened for iron deficiency anemia as outlined in the Centers for Disease Control and Prevention document “Recommendations to Prevent and Control Iron Deficiency in the United States (4/2/98)”.

e) Age-appropriate anticipatory guidance, dietary guidance, and *feeding practice counseling* for optimal oral health shall be provided at each well child visit according to the American Academy of Pediatrics' periodicity schedule “Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent edition. Starting at age 6 months, it is recommended that all children receive an oral health assessment at every well child visit, and a referral for the child's first visit to the dentist by age one as recommended by the American Academy of Pediatrics and the American Academy of Pediatric Dentistry.

f) Supplemental fluoride shall be prescribed as needed based upon the fluoride levels in the child’s drinking water supply. The fluoride dosage regimen accepted by the American Academy of Pediatrics shall be followed. No fluoride shall be prescribed without obtaining water from private wells or noting the presence or absence of fluoride in the public water supply. Supplemental fluoride may include bottled water containing fluoride and topical applications such as varnishes.

g) For infants enrolled in the WIC Nutrition Program, parents shall be referred to WIC for breastfeeding support and referral to the WIC Nutrition Program peer counselors.

5. Sexually Transmitted Infections

Primary Care Services shall provide age appropriate screening and treatment of sexually transmitted infections.

a) Treatment for sexually transmitted infections shall be provided according to the United States Centers for Disease Control Sexually Transmitted Diseases Treatment Guidelines, 2010 or subsequent revisions.

b) All clients, including women, shall be offered HIV testing following the most current recommendations of the United States Centers for Disease Control.

c) The contractor shall be responsible for ensuring referral to appropriate treatment services for any woman found to screen positive.

d) Appropriate risk reduction counseling shall be provided based on client needs.

6. Substance Use Services

a) A substance use screening history using a formal, validated screening tool shall be obtained for all clients as soon after entry into care as possible. Substance use counseling or other substance abuse intervention, treatment, or recovery services by an appropriately credentialed provider shall be provided on-site, or by referral, to clients with identified needs for these services. For these identified clients, ongoing primary care services should include follow up monitoring relative to substance abuse.

b) All clients, including pregnant women, identified as smokers shall receive counseling using the 5A's (ask, advise, assess, assist, and arrange) treatment available through the NH Tobacco Helpline as cited in the US Public Health Services report "Tobacco Use and Dependence", 2008, or "Smoking Cessation During Pregnancy: A Clinician's Guide to Helping Pregnant Women Quit Smoking", American College of Obstetricians and Gynecologists, 2011. With prior approval, agencies may also opt to participate in the DPHS best practice initiative of the 2A's and R (ask, advise and refer).

7. Immunizations

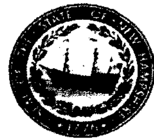
a) The Contractor shall adhere to the most current version of the "Recommended Adult Immunization Schedule for Adults (19 years and older) by Age and Medical Condition - United States", approved by the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

b) The Contractor shall administer vaccines according to the most current version of the "Recommended Immunization Schedule for Persons Aged 0 Through 6 Years - United States", and "Recommended Immunization Schedule for Persons Aged 7 Through 18 Years – United States" approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians, based upon availability of vaccine from the New Hampshire Immunization Program.

8. Prenatal Genetic Screening

Contractor Initials [initials]

Date 3/7/14



a) A genetic screening history shall be obtained on all prenatal clients as soon after entry into care as possible.

b) All pregnant women should be offered voluntary genetic screening for fetal chromosomal abnormalities at the appropriate time following recommendations found in the American College of Obstetricians and Gynecologists' "Screening for Fetal Chromosomal Abnormalities (2007)" or more recent guidelines. The Contractor shall be responsible for ensuring referral to appropriate genetic testing and counseling for any woman found to have a positive screening test.

9. Additional Requirements

a) The Contractor's Medical Director shall participate in the development and approval of specific guidelines for medical care that supplement minimal clinical standards. Supplemental guidelines should be reviewed, signed, and dated annually, and updated as indicated.

b) Contractors considering clinical or sociological research using clients as subjects must adhere to the legal requirements governing human subjects research. Contractors must inform the DPHS, MCHS prior to initiating any research related to this contract.

c) The Contractor shall provide information to all employees annually about the Medical Reserve Corps Unit within their Public Health Region to enhance recruitment.

d) The Contractor shall provide information to all employees annually regarding the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) managed by the NH Department of Health and Human Services' Emergency Services Unit, to enhance recruitment.

B) Staffing Provisions

The Contractor shall have, at minimum, the following staff positions:

a) executive director

b) fiscal director

c) registered nurse

d) clinical coordinator

e) medical service director

f) nutritionist (on site or by referral)

g) social worker

Staff positions required to provide direct services on-site include:

a) registered nurse

b) clinical coordinator

c) social worker

1. Qualifications

All health and allied health professionals shall have the appropriate New Hampshire licenses whether directly employed, contracted, or subcontracted.

In addition the following minimum qualifications shall be met for:

a) Registered Nurse
   a. A registered nurse licensed in the state of New Hampshire, Bachelor's degree preferred. Minimum of one-year experience in a community health setting.

b) Nutritionists:
   a. A Bachelor's degree in nutritional sciences or dietetics, or a Master's degree in nutritional sciences, nutrition education, or public health nutrition or current Registered Dietitian status in accordance with the Commission on dietetic Registration of the American Dietetic Association.
   b. Individuals who perform functions similar to a nutritionist but do not meet the above qualifications shall not use the title of nutritionist.

c) Social Workers shall have:
   a. A Bachelor's or Master's degree in social work or Bachelor's or Master's degree in a related social science or human behavior field. A minimum of one year of experience in a community health or social services setting is preferred.
   b. Individuals who perform functions similar to a social worker but do not meet the above qualifications shall not use the title of social worker.

d) Clinical Coordinators shall be:
   a. A registered nurse (RN), physician, physician assistant, or nurse practitioner with a license to practice in New Hampshire.
   b. The coordinator is a clinical position that oversees and takes responsibility for the clinical and administrative functions of each program.
   c. The coordinator may be responsible for more than one MCH funded program.

2. New Hires

The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing within one month of hire when a new administrator, clinical coordinator, or any staff person essential to carrying out contracted services is hired to work in the program. A resume of the employee shall accompany the aforesaid notification.

3. Vacancies

   a) The Contractor must notify the MCHS in writing if any critical position is vacant for more than one month, or if at any time funded under this contract does not have adequate staffing to perform all required services for more than one month. This may be done through a budget revision.

   b) Before an agency hires new program personnel that do not meet the required staff qualifications, the agency shall notify the MCHS in writing requesting a waiver of the applicable staffing requirements. The Section may grant waivers based on the need of the program, individuals' experience, and additional training.

C) Coordination of Services

1. The Contractor shall coordinate, where possible, with other service providers within the contractor's community. At a minimum, such collaboration shall include interagency referrals and coordination of care.

2. The Contractor shall participate in activities in the Public Health Region in which they provide services as appropriate. These activities enhance the integration of community-based public health prevention and health care initiatives that are being implemented by the contractor and may include community needs assessments, public health performance assessments, and/or the development of regional health improvement plans.

3. The Contractor agrees to participate in and coordinate public health activities as requested by the Division of Public Health Services during any disease outbreak and/or emergency, natural or man-made, affecting the public's health.

4. The Contractor is responsible for case management of the client enrolled in the program and for program follow-up activities. Case management services shall promote effective and efficient organization and utilization of resources to assure access to necessary comprehensive medical, nutritional, and social services for clients.

5. The Contractor shall assure that appropriate, responsive, and timely referrals and linkages for other needed services are made, carried through, and documented. Such services shall include, but not be limited to: dental services, genetic counseling, high risk prenatal services, mental health, social services, including domestic violence crisis centers, substance abuse services; and family planning services, Early Supports and Services Program, local WIC/CSF Program, Home Visiting New Hampshire Programs and health and social service agencies which serve children and families in need of those services.

D) Meetings and Trainings

The contractor will be responsible for sending staff to meetings and training required by the MCHS program, including but not limited to:

1. MCHS Agency Directors' meetings
2. Prenatal and Child Health Coordinators' meetings
3. MCHS Agency Medical Services Directors' meetings

III. Quality or Performance Improvement (QI/PI)

A) Workplans

1. Performance Workplans are required for this program and are used to monitor achievement of standard measures of performance of the services provided under this contract. The workplans are a key component of the RHPCS and the MCHS performance-based contracting system and of this contract. Outcomes shall be reported by clinical site.
2. Performance Workplans and Workplan Outcome reports according to the schedule and instructions provided by the MCHS. The MCHS shall notify the Contractor at least 30 days in advance of any changes in the submission schedule.
3. The Contractor shall incorporate required and developmental performance measures, defined by the MCHS into the agency's Performance Workplan. Reports on Workplan Progress/Outcomes shall detail the Performance Workplan plans and activities that monitor and evaluate the agency's progress toward performance measure targets.
4. The Contractor shall comply with modifications and/or additions to the workplan and annual report format as requested by RHPCS and MCHS. MCHS will provide the contractor with reasonable notice of such changes.
5. Agencies contracting for Primary Care Services must submit the workplans for Primary Care Clinical and Financial, Child Health, and Prenatal Care.

B) Additional Reporting requirements

In addition to Performance Workplans, the Contractor shall submit to MCHS the following data and information listed below which are used to monitor program performance:

1. In years when contracts or amendments are not required, the DPHS Budget Form, Budget Justification, Sources of Revenue and Program Staff list forms must be

completed according to the relevant instructions and submitted as requested by DPHS and, at minimum, by April 30 of each year.

2. The Sources of Revenue report must be resubmitted at any point when changes in revenue threaten the ability of the agency to carry out the planned program.

3. Completed Uniform Data Set (UDS) tables reflecting program performance in the previous calendar year, by March 31 of each year.

4. The Perinatal Client Data Form (PCDF) shall be submitted electronically according to the instructions set forth by the MCHS.

5. A copy of the agency's updated Sliding Fee Scale including the amount(s) of any client fees and the schedule of discounts must be submitted by March 31st of each year. The agency's sliding fee scale must be updated annually based on the US DHHS Poverty guidelines as published in the Federal Register.

6. An annual summary of program-specific patient satisfaction results obtained during the prior contract period and the method by which the results were obtained shall be submitted annually as an addendum to the Workplan Outcome/Progress reports.

C) On-site reviews

1. The contractor shall allow a team or person authorized by the Division of Public Health Services to periodically review the contractor's systems of governance, administration, data collection and submission, clinical and financial management, and delivery of education services in order to assure systems are adequate to provide the contracted services.
2. Reviews shall include client record reviews to measure compliance with this exhibit.
3. The contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.

4. On-Site reviews may be waived or abbreviated at the discretion of MCHS, upon submission of satisfactory reports of reviews such as Health Services Resources Administration (HRSA): Office of Performance Review (OPR), or reviews from nationally accreditation organizations such as the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), Medicare, the Community Health Accreditation Program (CHAP), Accreditation Association for Ambulatory Healthcare (AAAHC), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey. Abbreviated reviews will focus on any deficiencies found in previous reviews, issues of compliance with this exhibit, and actions to strengthen performance as outlined in the agency Performance Workplan.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE CHILD HEALTH DIRECT CARE SERVICES
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Please note, for all measures, the following should be used **unless otherwise indicated:**

- Less than 19 years of age
- Served within the scope of this MCH contract during State Fiscal Year 2015 (July 1, 2014 – June 30, 2015)
- Each client can only be counted once (unduplicated)

Child Health Direct (CH – D) Performance Measure #1

Measure: 92%* of eligible children will be enrolled in Medicaid

Goal: To increase access to health care for children through the provision of health insurance

Definition: **Numerator-**
Of those in the denominator, the number of children enrolled in Medicaid.

Denominator-
Number of children who meet all of the following criteria:

- Less than 19 years of age
- Had 3 or more visits/encounters** during the reporting period
- As of the last visit during the reporting period were eligible for Medicaid

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**An encounter is face to face contact between a user and a provider who exercises independent judgment in the provision of services to the individual (UDS Table Definition).

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #2

Measure: 85%* of at-risk** children who were screened for blood lead between 18 and 30 months of age

Goal: To prevent childhood lead poisoning through early identification of lead exposure

Definition: **Numerator-**
Of those in the denominator, number of children screened for blood lead by capillary or venous on or after their 18-month birthday and prior to their 30-month birthday.

Denominator-
Number of at-risk** children who reached age 30 months during the reporting period. If discharged prior to 30 months, do not include in denominator.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**At risk = During the reporting period, the children were 18-29 months of age, and fit at least one of the following criteria:

- "Low income" (less than 185% poverty guidelines)
- Over 185% and resided in a town considered needing "Universal" screening per NH Childhood Lead Poisoning Prevention Program
- Over 185%, resided in a town considered "Target" and had a positive response to the risk questionnaire
- Refugee children -A refugee is defined as a person outside of his or her country of nationality who is unable or unwilling to return because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion (U.S. Citizenship and Immigration Services definition).

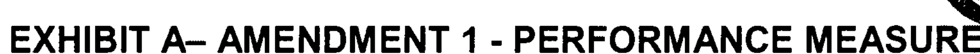


EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #3

Measure: 71%* of children age two to nineteen years receiving primary care preventive health services with a Body Mass Index (BMI) percentile greater than or equal to the 85%ile with documented discussion of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Goal: To increase the percent of children receiving primary care preventive health services who have an elevated BMI percentile who receive guidance about promoting a healthier lifestyle.

Definition: **Numerator-**
Of those in the denominator, the number of children who had documentation in their medical record of there being discussion at least once during the reporting period of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Denominator-
Number of children who turned twenty-four months during or before the reporting period, up to the age of nineteen years, with one or more well child visit after their twenty-fourth month of age within the reporting year, and had an age and gender appropriate BMI percentile greater than or equal to the 85 % percentile at least once during the reporting period.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

Rationale: Children between the 85th – 94th percentiles BMI are encouraged to have 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks. (Discussion of the importance of family meal time, limiting eating out, consuming a healthy breakfast, preparing own foods, and promotion of breastfeeding is also encouraged.) American Academy of Pediatrics' guidance for Prevention and Treatment of Childhood Overweight and Obesity, (http://www.aap.org/obesity/health_professionals.html), from AAP Policy Statement: *Prevention of Pediatric Overweight and Obesity* and the AAP endorsed Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Children and Adolescent Overweight and Obesity, 2007.

*Target based on 2012 & 2013 Data Trend Table averages.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) #4

Measure: 75%* of eligible** infants and children with client record documentation of enrollment in WIC

Goal: To increase access to nutrition education, breastfeeding support, and healthy food through enrollment in the WIC Nutrition Program

Definition: **Numerator -**
Of those in the denominator, the number of infants and children who, as of the last well child visit during the reporting period, had client record documentation that infant or child was enrolled in WIC.

Denominator -
Unduplicated number of infants and children less than 5 years of age, enrolled in the agency, during the reporting period, who were eligible** for WIC.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**WIC Eligibility Requirements:

- Infants, and children up to their fifth birthday
- Must be income eligible (income guidelines are up to 185% of federal gross income, and are based on family size)

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #5

Measure: 23%* of infants who were exclusively** breastfed for the first three months, at their four month well baby visit

Goal: To provide optimum nutrition to infants in their first three months of life

Definition: **Numerator -**
Of those in the denominator, the number of infants who had client record documentation that the infant had been exclusively breastfed for their first three months when checked at their four month well baby visit.

Denominator -
Number of infants who received one or more visits during or before the reporting period and were seen for a four-month well baby visit during the reporting period.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

Benmarks: 2011 PedNSS (WIC) exclusive at 3 months: NH 22.9%, National (2010) 10.7%
2013 CDC Report Card (NIS, provisional 2010 births): NH 49.5%, National 37.7%
Healthy People 2020 goal: 44%

Rationale: The AAP recommends exclusive breastfeeding for about 6 months, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant, a recommendation concurred to by the World Health Organization and the Institute of Medicine. (American Academy of Pediatrics Policy Statement on Breastfeeding and the Use of Human Milk, 2012)

*Target based on 2012 & 2013 Data Trend Table averages.
**Exclusive means breast milk only, no supplemental formula, cereal/baby food, or water/fluids.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE: ADULT

PERFORMANCE MEASURES DEFINITIONS

State Fiscal Year 2015

Primary Care: Adult Performance Measure #1

Measure:* 58%** of adult patients 18 – 85 years of age diagnosed with hypertension will have a blood pressure measurement less than 140/90*** mm at the time of their last measurement.

Goal: To ensure patients diagnosed with hypertension are adequately controlled.

Definition: **Numerator-** Number of patients from the denominator with blood pressure measurement less than 140/90 mm at the time of their last measurement.

Denominator- Number of patients age 18 – 85 with diagnosed hypertension must have been diagnosed with hypertension 6 or more months before the measurement date. (Excludes pregnant women and patients with End Stage Renal Disease.)

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

*Measure based on the National Quality Forum 0018

**Health People 2020 National Target is 61.2%

***Both the numerator and denominator must be less that 140/90 mm

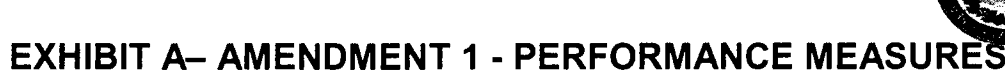


EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE CLINICAL
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Primary Care Clinical Adolescent (PC-C) Performance Measure #1

Measure: 61%* of adolescents aged 11-21 years received an annual health maintenance visits in the past 12 months.

Goal: To enhance adolescent health by assuring annual, recommended, adolescent well -visits.

Definition:

Numerator-
Number of adolescents in the denominator who received an annual health maintenance "well" visit during the reporting year.

Denominator-
Total number of adolescents aged 11-21 years who were enrolled in the primary care clinic as primary care clients during the reporting year period.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

***Target based on 2012 & 2013 Data Trend Table averages.**

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Primary Care Clinical Prenatal (PC-C) Performance Measure #2

Measure: 31%* of women and adolescent girls aged 15-44 take multi-vitamins with folic acid.

Goal: To enhance pregnancy outcomes by reducing neural tube defects.

Definition:

Numerator-
The number of women and adolescent girls aged 15-44 who take a multi-vitamin with folic acid.

Denominator-
The number of women and adolescent girls aged 15-44 who were seen in primary care for a well visit in the past year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

***Target based on 2012 & 2013 Data Trend Table averages.**

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE - FINANCIAL
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Primary Care (PC) Performance Measure #1

Measure: Patient Payor Mix

Goal: To allow monitoring of payment method trends at State funded primary care sites.

Definition: Patients enrolled in Medicare, Medicaid, Commercial insurance, or uninsured.

Data Source: Provided by agency

Primary Care (PC) Performance Measure #2

Measure: Accounts Receivables (AR) Days

Goal: To allow monitoring of financial sustainability trends at State funded primary care sites.

Definition: AR Days: Net Patient Accounts Receivable **multiplied by** 365 **divided by** Net Patient Revenue

Data Source: Provided by agency

Primary Care (PC) Performance Measure #3

Measure: Current Ratio

Goal: To allow monitoring of financial sustainability trends at State funded primary care sites.

Definition: Current Ratio = Current Assets **divided by** Current Liabilities

Data Source: Provided by agency

PRENATAL
PERFORMANCE MEASURES DEFINITIONS
State Fiscal Year 2015

Prenatal (PN) Performance Measure #1

Measure: 85%* of pregnant women who are enrolled in the agency's prenatal program will begin prenatal care during the first trimester of pregnancy.

Goal: To enhance pregnancy outcomes by assuring early entrance into prenatal care.

Definition:

Numerator-
Number of women in the denominator who had a documented prenatal visit during the first trimester (on or before 13.6 weeks gestation).

Denominator-
Number of women enrolled in the agency prenatal program who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

* Target based on 2012 & 2013 Data Trend Table averages.

Prenatal (PN) Performance Measure #2

Measure: 20%* of pregnant women who are identified as cigarette smokers will be referred to QuitWorks-New Hampshire.

Goal: To reduce tobacco use during pregnancy through focused tobacco use cessation activities at public health prenatal clinics.

Definition:

Numerator-
Number of women in the denominator who received at least one referral to QuitWorks-New Hampshire during pregnancy.

A referral is defined as signing the patient up for QuitWorks-NH via phone, fax, or EMR. It is not defined as discussing QuitWorks-NH with the patient and encouraging her to sign up.

Denominator-
Number of women enrolled in the agency prenatal program and identified as tobacco users who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

*Target set in consultation with the NH Tobacco Program & FY13 Data Trend Table average.

Prenatal (PN) Performance Measure #3

Measure: 79%* of pregnant women will be screened, using a formal valid screening tool, for alcohol and other substance use during every trimester they are enrolled in the prenatal program.

Goal: To reduce prenatal substance use through systematic screening and identification.

Definition: **Numerator-** Number of women in the denominator who were screened for substance and alcohol use, using a formal and valid screening tool, during each trimester that they were enrolled in the prenatal program.

Denominator- Number of women enrolled in the agency prenatal program and who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

* Target based on 2012 & 2013 Data Trend Table averages.

Exhibit B-1 (2014) -Amendment 1
Budget

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: Weeks Medical Center

Budget Request for: MCH Primary Care
(Name of RFP)

Budget Period: SFY 2014

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages	$ 20,652.00	$ -	$ 20,652.00	
2. Employee Benefits	$ -	$ -	$ -	
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	$ -	$ -	$ -	
13. Other (specific details mandatory):	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
TOTAL	**$ 20,652.00**	**$ -**	**$ 20,652.00**	

Indirect As A Percent of Direct 0.0%

Contractor Initials: [initials]

Date: 3/7/14

Exhibit B-1 (2015) -Amendment 1
Budget

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: Weeks Medical Center

Budget Request for: MCH Primary Care & RHPC
(Name of RFP)

Budget Period: SFY 2015

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages	$ 113,557.00	$ -	$ 113,557.00	
2. Employee Benefits	$ -	$ -	$ -	
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	$ -	$ -	$ -	
13. Other (specific details mandatory):	$ -	$ -	$ -	
0	$ -	$ -	$ -	
0	$ -	$ -	$ -	
0	$ -	$ -	$ -	
0	$ -	$ -	$ -	
0	$ -	$ -	$ -	
0	$ -	$ -	$ -	
	$ -	$ -	$ -	
TOTAL	**$ 113,557.00**	**$ -**	**$ 113,557.00**	

Indirect As A Percent of Direct 0.0%

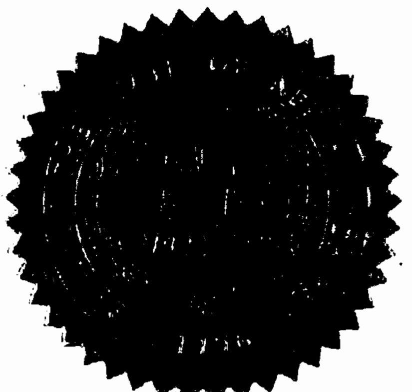
Contractor Initials: [signature]

Date: 3/7/14

State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that WEEKS MEDICAL CENTER is a New Hampshire nonprofit corporation formed December 22, 1919. I further certify that it is in good standing as far as this office is concerned, having filed the return(s) and paid the fees required by law.



In TESTIMONY WHEREOF, I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 26th day of April A.D. 2013

William M. Gardner
Secretary of State

WITHOUT SEAL

CERTIFICATE OF VOTE

I, David Atkinson, of Weeks Medical Center, do hereby certify that:

1. I am the duly elected Chairman of the Board of Trustees of Weeks Medical Center;
2. The following are true copies of two resolutions duly adopted at a meeting of the Board of Directors of the corporation, duly held on March 22, 2011;

   RESOLVED: That this corporation enters into a contract with the State of New Hampshire, acting through its Department of Health and Human Services, Division of Public Health Services.

   RESOLVED: That the Chief Executive Officer is hereby authorized on behalf of this corporation to enter into said contract with the State and to execute any and all documents, agreements, and other instruments; and any amendments, revisions, or modifications thereto, as he/she may deem necessary, desirable, or appropriate.

   Scott Howe is the duly elected Chief Executive Office of the corporation.
3. The foregoing resolutions have not been amended or revoked and remain in full force and effect as of March 7, 2014.

IN WITNESS WHEREOF, I have hereunto set my hand as the Chairman of the Board of Trustees of the corporation this 7th day of March, 2014

STATE OF New Hampshire

COUNTY OF Coos

The foregoing instrument was acknowledged before me this 7th day of March, 2014 by David Atkinson.

Notary Public/Justice of the Peace
My Commission Expires:

KATHY ST. ONGE, Notary Public
My Commission Expires June 22, 2016

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 03/13/2014

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 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 1-617-531-6000
Integro USA Inc.
dba Integro Insurance Brokers
Two Financial Center
60 South Street, Suite 800
Boston, MA 02111

CONTACT NAME:
PHONE (A/C, No, Ext): FAX (A/C, No):
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : LEXINGTON INS CO	19437
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Weeks Medical Center
173 Middle Street
Lancaster, NH 03584

COVERAGES **CERTIFICATE NUMBER:** 38792071 **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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY / PRO-JECT / LOC			6795757	10/01/13	10/01/14	EACH OCCURRENCE	$ 1,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 50,000
							MED EXP (Any one person)	$ 5,000
							PERSONAL & ADV INJURY	$ 1,000,000
							GENERAL AGGREGATE	$ 3,000,000
							PRODUCTS - COMP/OP AGG	$ 1,000,000
								$
	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS / SCHEDULED AUTOS HIRED AUTOS / NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident)	$
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
A	X UMBRELLA LIAB / OCCUR EXCESS LIAB / X CLAIMS-MADE DED / RETENTION $			6795756	10/01/13	10/01/14	EACH OCCURRENCE	$ 1,000,000
							AGGREGATE	$ 2,000,000
								$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A					WC STATU-TORY LIMITS / OTH-ER	
							E.L. EACH ACCIDENT	$
							E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	HEALTHCARE PROFESSIONAL LIABILITY (Claims Made)			6795757	10/01/13	10/01/14	Each Medical Incid	1,000,000
							Aggregate	3,000,000

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

Evidence of Insurance only
RE: NH DHHS Grant Application Fiscal Year 2014 and 2015

CERTIFICATE HOLDER

DHHS

Contracts and Procurement Unit
129 Pleasant Street
Concord, NH 03301
USA

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

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Eva.Gee@integrogroup.com_BOS
38792071

Client#: 48345 WEEKS1

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 03/13/2014

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.

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PRODUCER
Davis Towle Morrill & Everett
115 Airport Road
P O Box 1260
Concord, NH 03302-1260

CONTACT NAME:
PHONE (A/C, No, Ext): 603 225-6611 FAX (A/C, No): 603-225-7935
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : A.I.M. Mutual Insurance Co.	
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Weeks Medical Center
173 Middle St.
Lancaster, NH 03584

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

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INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	GENERAL LIABILITY COMMERCIAL GENERAL LIABILITY CLAIMS-MADE / OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY / PRO-JECT / LOC						EACH OCCURRENCE	$
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
							GENERAL AGGREGATE	$
							PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS / SCHEDULED AUTOS HIRED AUTOS / NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident)	$
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB / OCCUR EXCESS LIAB / CLAIMS-MADE DED / RETENTION $						EACH OCCURRENCE	$
							AGGREGATE	$
								$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		ECC4000173012014	01/01/2014	01/01/2015	WC STATU-TORY LIMITS / OTH-ER	
							E.L. EACH ACCIDENT	$500,000
							E.L. DISEASE - EA EMPLOYEE	$500,000
							E.L. DISEASE - POLICY LIMIT	$500,000

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

CERTIFICATE HOLDER

The Director
DHHS
Contracts & Procurement Unit
129 Pleasant St
Concord, NH 03301

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

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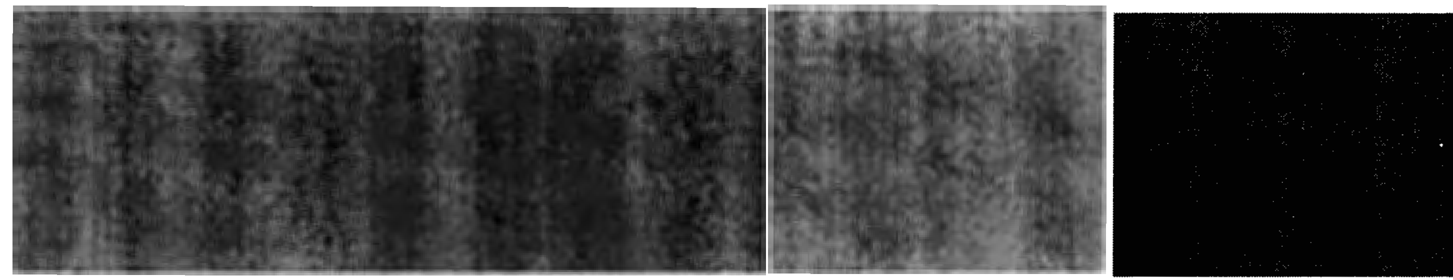
MES



FINANCIAL STATEMENTS

September 30, 2013 and 2012

With Independent Auditor's Report

INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees of
Weeks Medical Center

We have audited the accompanying financial statements of Weeks Medical Center (the Hospital), which comprise the balance sheets as of September 30, 2013 and 2012, and the related statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the 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 entity'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 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 financial statements referred to above present fairly, in all material respects, the financial position of Weeks Medical Center as of September 30, 2013 and 2012, and the results of its operations, changes in its net assets and its cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

Berry Dunn McNeil & Parker, LLC

Manchester, New Hampshire
December 19, 2013

WEEKS MEDICAL CENTER

Balance Sheets

September 30, 2013 and 2012

ASSETS

	2013	2012
Current assets		
Cash	**$ 4,275,053**	$ 2,546,377
Patient accounts receivable, net of allowances of $5,325,897 and $4,989,273 in 2013 and 2012, respectively	**5,218,935**	4,958,306
Other accounts receivable	**2,075,767**	1,158,596
Supplies	**785,686**	783,723
Prepaid expenses	**500,860**	235,949
Total current assets	**12,856,301**	9,682,951
Investments	**15,152,714**	13,858,867
Property and equipment, net	**16,025,201**	17,469,737
Deferred financing costs, net	**120,125**	127,226
Total assets	**$ 44,154,341**	$ 41,138,781

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

LIABILITIES AND NET ASSETS

	2013	2012
Current liabilities		
Current portion of long-term debt	$ 348,973	$ 340,653
Accounts payable and accrued expenses	1,062,684	2,261,531
Accrued salaries, wages and related accounts	2,392,582	2,218,906
Deferred revenue	1,669,231	430,596
Estimated third-party payor settlements	3,327,556	235,875
Total current liabilities	8,801,026	5,487,561
Long-term debt, less current portion	8,760,072	9,106,495
Interest rate swap	582,782	863,058
Total liabilities	18,143,880	15,457,114
Commitments and contingencies (Notes 4, 7, and 14)		
Net assets		
Unrestricted	24,416,246	24,131,764
Temporarily restricted	606,201	561,889
Permanently restricted	988,014	988,014
Total net assets	26,010,461	25,681,667
Total liabilities and net assets	$ 44,154,341	$ 41,138,781

WEEKS MEDICAL CENTER

Statements of Operations

Years Ended September 30, 2013 and 2012

	2013	2012
Unrestricted revenues, gains, and other support		
Patient service revenue (net of contractual allowances and discounts)	**$ 41,371,469**	$ 41,352,770
Provision for bad debts	**2,114,609**	2,009,760
Net patient service revenue	**39,256,860**	39,343,010
Net assets released from restrictions used for operations	**94,605**	84,822
Other operating revenue	**3,174,721**	1,768,133
Total unrestricted revenues, gains and other support	**42,526,186**	41,195,965
Expenses		
Salaries and wages	**15,835,382**	15,578,361
Employee benefits	**4,627,384**	4,533,779
Physician salaries and fees	**8,092,709**	7,024,032
Medicaid enhancement tax	**1,330,368**	1,306,776
Contract labor	**891,007**	402,577
Medical supplies	**4,412,934**	4,226,956
Other supplies and services	**4,614,505**	4,662,087
Utilities	**743,548**	830,462
Insurance	**328,563**	292,002
Depreciation and amortization	**2,536,594**	2,377,919
Interest	**458,132**	475,183
Total expenses	**43,871,126**	41,710,134
Operating loss	**(1,344,940)**	(514,169)
Nonoperating gains (losses)		
Contributions	**6,457**	47,424
Investment income, net	**1,315,687**	1,601,625
Unrealized gain (loss) on interest rate swap	**280,276**	(41,020)
Total nonoperating gains	**1,602,420**	1,608,029
Excess of revenues, gains, and other support over expenses and losses	**257,480**	1,093,860
Net assets released from restrictions for capital acquisitions	**27,002**	42,198
Increase in unrestricted net assets	**284,482**	1,136,058
Unrestricted net assets, beginning of year	**24,131,764**	22,995,706
Unrestricted net assets, end of year	**$ 24,416,246**	$ 24,131,764

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

WEEKS MEDICAL CENTER

Statement of Changes in Net Assets

Years Ended September 30, 2013 and 2012

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Balances, October 1, 2011	$ 22,995,706	$ 569,450	$ 916,914	$ 24,482,070
Excess of revenues, gains and other support over expenses and losses	1,093,860	-	-	1,093,860
Change in net unrealized gains on investments		30,835	-	30,835
Restricted investment income	-	20,258	-	20,258
Restricted contributions	-	93,366	46,100	139,466
Net assets released from restrictions used for operations		(84,822)	-	(84,822)
Net assets released from restrictions for capital acquisitions	42,198	(42,198)	-	-
Reclassification based on donor intent	-	(25,000)	25,000	-
Change in net assets	1,136,058	(7,561)	71,100	1,199,597
Balances, September 30, 2012	24,131,764	561,889	988,014	25,681,667
Excess of revenues, gains and other support over expenses and losses	**257,480**	**-**	**-**	**257,480**
Change in net unrealized gains on investments	**-**	**14,686**	**-**	**14,686**
Restricted investment income	**-**	**21,059**	**-**	**21,059**
Restricted contributions	**-**	**130,174**	**-**	**130,174**
Net assets released from restrictions used for operations	**-**	**(94,605)**	**-**	**(94,605)**
Net assets released from restrictions for capital acquisitions	**27,002**	**(27,002)**	**-**	**-**
Change in net assets	**284,482**	**44,312**	**-**	**328,794**
Balances, September 30, 2013	**$ 24,416,246**	**$ 606,201**	**$ 988,014**	**$ 26,010,461**

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

WEEKS MEDICAL CENTER

Statements of Cash Flows

Years Ended September 30, 2013 and 2012

	2013	2012
Cash flows from operating activities		
Change in net assets	$ 328,794	$ 1,199,597
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	2,536,594	2,377,919
(Gain) loss on sale of equipment	(7,954)	3,746
Provision for bad debts	2,114,609	2,009,760
Realized and unrealized gains on investments	(993,171)	(1,277,285)
Unrealized (gain) loss on interest rate swap	(280,276)	41,020
(Increase) decrease in		
Patient accounts receivable	(2,375,238)	(2,307,600)
Other accounts receivable	(917,171)	(168,762)
Supplies	(1,963)	26,722
Prepaid expenses	(264,911)	(64,902)
Estimated third-party payor settlements	-	(748,467)
Increase (decrease) in		
Accounts payable and accrued expenses	(1,198,847)	378,161
Accrued salaries, wages and related accounts	173,676	185,037
Deferred revenue	1,238,635	1,278,515
Estimated third-party settlements	3,091,681	-
Net cash provided by operating activities	3,444,458	2,933,461
Cash flows from investing activities		
Proceeds from sale of equipment	26,482	7,800
Purchases of property and equipment	(1,103,485)	(3,319,537)
Proceeds from sales of investments	3,951,091	3,180,018
Purchase of investments	(4,251,767)	(3,558,444)
Net cash used by investing activities	(1,377,679)	(3,690,163)
Cash flows from financing activities		
Repayments of long-term debt	(338,103)	(415,279)
Net cash used by financing activities	(338,103)	(415,279)
Net increase (decrease) in cash	1,728,676	(1,171,981)
Cash, beginning of year	2,546,377	3,718,358
Cash, end of year	$ 4,275,053	$ 2,546,377
Supplemental disclosure of cash flow information		
Cash paid for interest	$ 458,132	$ 475,183

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

Mission Statement

Weeks Medical Center's compassionate staff is committed to providing high quality and efficient health care services to ensure the well-being of our patients, families and communities.

In partnership with our communities, Weeks promotes health by;

- acknowledging that health is physical, spiritual and emotional
- emphasizing personal prevention, education and health information
- working closely with human services providers and local governments
- being closely involved with schools, businesses and churches
- actively participating in community organizations and activities
- learning about local health care needs through listening to all of our communities

Weeks strives to meet those health care needs by;

- matching our services to the needs of the individuals in our communities
- insuring timely access to health care
- providing as many services as possible locally
- delivering those services throughout our communities—in schools, businesses, homes, clinics—as well as in our modern, well-equipped Lancaster facility
- providing smoothly coordinated access to services which cannot be provided locally
- managing health care costs so that local access to health care is protected
- attracting and retaining highly trained, enthusiastic staff members
- satisfying the individuals we serve

Weeks Medical Center
Board of Trustees and Officers – 2014

Name	Office	Term	Term Expires
David Atkinson	President	2 years	December 2016
Scott Burns	Member-at-Large	2 years	December 2016
George Cook		2 years	December 2014
Dennis Couture		2 years	December 2015
Donald Crane	Treasurer	2 years	December 2014
Sarah Desrochers	Secretary	2 years	December 2016
William Everleth		2 years	December 2017
William Fischang		2 years	December 2016
Charlie Fitch		2 years	December 2015
Stanley Holz	Vice President	2 years	December 2016
Patrick Kelly		2 years	December 2016
Patsy Pilgrim		2 years	December 2015
Lisa Tetreault	Member at Large	2 years	December 2016
Keith Young (started 12/2012)		2 years	January 2015

Name	Office
Scott Howe	CEO
Celeste Pitts	CFO
Lars Nielson	Chief Medical Officer
Donna Walker	CNE
Mederic LeBlanc, MD	Medical Staff President

Honorary Members

Name	Office
Rebecca More	Honorary Trustee

Kathy.St.Onge@weeksmedical.org Administrative Assistant 788-5026 – W

Revised: 01/02/2014

KEY ADMINISTRATIVE PERSONNEL

NH Department of Health and Human Services

Contractor Name: Weeks Medical Center

Name of Bureau/Section: MCH Primary Care

BUDGET PERIOD: SFY 14

Program Area: MCH Primary Care

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Scott Howe	CEO	$234,000	0.00%	$0.00
Rona Glines	Director of Physician Services	$152,755	1.20%	$1,828.19
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$1,828.19**

KEY ADMINISTRATIVE PERSONNEL

NH Department of Health and Human Services

Contractor Name: Weeks Medical Center

Name of Bureau/Section: MCH Primary Care/Rural Health

BUDGET PERIOD: SFY 15

Program Area: MCH Primary Care Services

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Scott Howe	CEO	$234,000	0.00%	$0.00
Rona Glines	Director of Physician Services	$152,755	1.28%	$1,955.15
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$1,955.15**

Program Area: Rural Health and Primary Care Services

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Scott Howe	CEO		0.00%	$0.00
Rona Glines	Director of Physician Services	$152,838	0.00%	$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$0.00**

Scott W. Howe

Weeks Medical Center
173 Middle Street
Lancaster, New Hampshire 03584

Office (603) 788-5030

Experience

6/98 - Present | Weeks Medical Center | Lancaster, NH

Chief Executive Officer

- Responsible for overall management of hospital, physician office, home health and hospice services.
- Report to the Weeks Medical Center Board of Trustees

12/94 – 5/98 | Weeks Medical Center | Lancaster, NH

Chief Financial Officer

- Responsible for managing and reporting the financial affairs to the Weeks Medical Center Board of Trustees
- Worked with Department Heads to prepare and submit the annual budget to the Board of Trustees
- Managed the following departments: Data Processing, Accounting, Collections, Purchasing, Admitting, Switchboard, Dietary and Home Health

2/84 – 11/94 | Gifford Memorial Hospital | Randolph, VT

Vice President of Finance

- Responsible for managing and reporting the financial affairs to the hospital's Board of Directors
- Worked with Department Heads to prepare and submit the Hospital's annual budget to the Board of Directors
- Submitted the Hospital's budget to the State's Review Board including responding to questions at a public hearing
- Involved in developing the Hospital's diversification into Physician Offices, Home Care as a means to protect market share and respond to regulatory pressure
- Negotiated Managed Care contracts
- Managed the following departments: Data Processing, Accounting, Collections, Purchasing, Admitting, Switchboard and Physician Offices

8/80 – 2/84 Springfield Hospital Springfield, VT

Accounting Manager

- Managed all the accounting and financial statement preparation for this multi-corporate organization
- Responsible for completing Medicare and Medicaid cost reports
- Worked with departments in preparation of budgets
- Established the pricing structure for the for-profit commercial laboratory operated by the Hospital
- Managed the Hospital's Accounts Payables and Payrolls
- Created the accounting systems when the Hospital was reorganized into a multi-corporate structure

7/79 – 8/80 Kors, Inc. Rutland, VT

Accounting Manager

- Performed all the accounting functions for this High Density Polyethylene manufacturer
- Secured a current asset financing program with First National Bank of Boston
- Directed purchasing, billing, credit and collections

4/78 – 6/79 Southern Vermont College Bennington, VT

Accountant

- Performed all the purchasing, payroll and cash disbursements for the college

11/77 – 8/78 Southern Vermont College Bennington, VT

Bookstore Manager

- Responsible to insure the profitable operation of the Bookstore
- Supervised employees, ordered textbooks and supplies

Education

Southern Vermont College Bennington, VT

- May 1979 – Bachelor of Science
- Major: Accounting

Professional Memberships

American College of Healthcare Executives
Healthcare Financial Management Association

Civic Organizations

Northern Gateway Chamber of Commerce
Lancaster Rotary Club

Weeks Medical Center
170 Middle Street, Lancaster, NH
Telephone: 603-788-5098

Rona Glines

Objective

To obtain an administrative position within the health care field that will utilize my skills and experience.

Experience

1994-Present Weeks Medical Center Lancaster, NH

Director of Physician Services

- Responsible for Physician Services, Case Management, Health Information Management and Admitting/Communications.
- Integrated the functions of physician offices and other departments within the organization.
- Responsible for implementation of clinical and financial computer applications for the physician offices and Health Information Management.
- Responsible for implementing an enterprise-wide Department of Case Management.

1985–1994 Weeks Memorial Hospital Lancaster, NH

Patient Accounts Manager/Assistant Director of Fiscal Services

- Responsible for the day-to-day operation of the patient accounting department.
- Ensured adequate cash flow to meet organizational needs.
- Responsible for implementation and upgrade of computerized financial system.
- Assisted managers with completion of departmental budgets.

1980-1985 M&R Glines Auctions Lancaster, NH

Auctioneer/Appraiser

- Responsible for business management functions.
- Set-up and conducted auction sales.
- Performed estate and insurance appraisals for clients.

Education

1985 Plymouth State College Plymouth, NH

- B.S., Business Administration and Computer Science.
- Graduated Summa Cum Laude.

Interests

Antiques, Motorcycling, Skiing

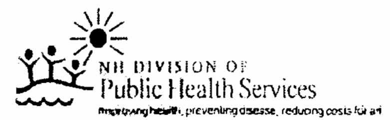
References

Available upon request.

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

29 HAZEN DRIVE, CONCORD, NH 03301-6527
603-271-4517 1-800-852-3345 Ext. 4517
Fax: 603-271-4519 TDD Access: 1-800-735-2964



Nicholas A. Toumpas
Commissioner

José Thier Montero
Director

May 10, 2012

APPROVED F/C
DATE
APPROVED G&C #31
DATE 7-11-12
NOT APPROVED

His Excellency, Governor John H. Lynch
and the Honorable Executive Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Public Health Services, Bureau of Population Health and Community Services, Maternal and Child Health Section, to enter into an agreement with Weeks Medical Center (Vendor #177171-R001), 170 Middle Street, Lancaster, New Hampshire 03584, in an amount not to exceed $158,274.00, to provide primary care services, to be effective July 1, 2012 or date of Governor and Executive Council approval, whichever is later, through June 30, 2014. Funds are available in the following accounts for SFY 2013, and are anticipated to be available in SFY 2014 upon the availability and continued appropriation of funds in the future operating budgets.

05-95-90-902010-5190 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES, MATERNAL AND CHILD HEALTH

Fiscal Year	Class/Object	Class Title	Job Number	Total Amount
SFY 2013	102-500731	Contracts for Program Services	90080000	$69,137
SFY 2014	102-500731	Contracts for Program Services	90080000	$69,137
			Sub-Total	$138,274

05-95-90-901010-5149 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF PUBLIC HEALTH SYSTEMS, POLICY AND PERFORMANCE, RURAL HEALTH AND PRIMARY CARE

Fiscal Year	Class/Object	Class Title	Job Number	Total Amount
SFY 2013	102-500731	Contracts for Program Services	90073001	$10,000
SFY 2014	102-500731	Contracts for Program Services	90073001	$10,000
			Sub-Total	$20,000
			Total	$158,274

EXPLANATION

Funds in this agreement will be used to provide office-based primary care services for low-income and uninsured families. This agreement provides funds for services as a last resort; contractor is required to make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid.

Primary health care services include preventive and episodic health care for acute and chronic health conditions for people of all ages, including pregnant women, children, adolescents, adults, and the elderly. Community health agencies that receive support through the Division of Public Health Services deliver primary and preventive health care services to underserved people who face barriers to accessing health care, due to issues such as a lack of insurance, inability to pay, language barriers, and geographic isolation. In addition to medical care, community health centers are unique among primary care providers for the array of patient-centered services they offer, including care coordination, translation, transportation, outreach, eligibility assistance, and health education. These services help individuals overcome barriers to getting the care they need and achieving their optimal health. One area of particular success has been in ensuring that eligible families maintain consistent enrollment in Medicaid for their children. Community health centers provide support for families in filling out applications and ensuring that children have continuity of care.

Community health agencies throughout New Hampshire have demonstrated success in meeting the health care needs of the uninsured and under-insured citizens of the state. Division of Public Health Services funded primary care providers participate in rigorous quality improvement efforts utilizing standard performance measures that focus attention on improving health outcomes for patients. For example, in State Fiscal Year 2011:

- 88% of eligible children served were enrolled in Medicaid/Healthy Kids Gold.
- 86% of children 24-35 months, served received the appropriate schedule of immunizations.
- 82% of infants born to women served received prenatal care beginning in the first trimester of pregnancy.

Should Governor and Executive Council not authorize this Request, a minimum of 1,600 low-income individuals from the following areas Carroll, Dalton, Groveton, Jefferson, Lancaster, North Stratford, Northumberland, Randolph, Stark, Stratford, Twin Mountain and Whitefield may not have access to primary care services. A strong primary care infrastructure reduces costs for uncompensated care, improves health outcomes, and reduces health disparities.

Weeks Medical Center was selected for this project through a competitive bid process. A Request for Proposals was posted on the Department of Health and Human Services' web site from January 10, 2012 through February 16, 2012. In addition, a bidder's conference, conference call, and web conference were held on January 19, 2012 to alert agencies to this bid.

Thirteen proposals were received in response to the posting. Each proposal was scored by three professionals, who work internal and external to the Department of Health and Human Services. All reviewers have between three to twenty years experience either in clinical settings, providing community-based family support services, and managing agreements with vendors for various public health programs. Areas of specific expertise include maternal and child health; quality assurance and performance improvement; chronic and communicable diseases and public health infrastructure. The reviewers used a standardized form to score agencies' relevant experience and capacity to carry out the activities outlined in the proposal. Reviewers look for realistic targets when scoring performance measures in addition to detailed workplans including evaluation components. Budgets were reviewed to be reasonable, justified and consistent with the intent of the program goals and outcomes. There were no competing applications within each of the separate service areas. Scores were

averaged and all proposals were recommended for funding. In those instances where scores were less than ideal, agency specific remedial actions were recommended and completed. The Bid Summary is attached.

As referenced in the Request for Proposals, Renewals Section, this competitively procured Agreement has the option to renew for two additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties and approval of the Governor and Executive Council. These services were contracted previously with this agency in SFY 2011 and SFY 2012 in the amount of $273,898. This represents a decrease of $115,624. The decrease is due to budget reductions.

The performance measures used to measure the effectiveness of the agreement are attached.

Area served: Carroll, Dalton, Groveton, Jefferson, Lancaster, North Stratford, Northumberland, Randolph, Stark, Stratford, Twin Mountain and Whitefield.

Source of Funds: 17.43% Federal Funds from US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau and 82.57% General Funds.

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

Respectfully submitted,

José Thier Montero, MD
Director

Approved by:
Nicholas A. Toumpas
Commissioner

JTM/PMT/sc

Primary Care Performance Measures

State Fiscal Year 2013

Primary Care Prenatal (PN) Performance Measure #1

Measure: Percent of infants born to women receiving prenatal care beginning in the first trimester of pregnancy.

Primary Care Prenatal (PN) Performance Measure #2

Measure: Percent of pregnant women identified as cigarette smokers that are referred to QuitWorks-New Hampshire.

Primary Care Prenatal (PN) Performance Measure #3

Measure: Percent of pregnant women who were screened, using a formal valid screening tool, for alcohol and other drug use during every trimester the patient was enrolled.

Primary Care Child Health Direct (CH – D) Performance Measure #1

Measure: Percent of eligible children enrolled in Medicaid

Primary Care Child Health Direct (CH – D) Performance Measure #2

Measure: Percent of at-risk children who were screened for blood lead between 18 and 30 months of age

Primary Care Child Health Direct (CH – D) Performance Measure #3

Measure: Percent of children age two to nineteen years receiving primary care preventive health services with a Body Mass Index (BMI) percentile greater than or equal to the 85th percentile with documented discussion of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Primary Care Child Health Direct (CH – D) Performance Measure #4

Measure: Percent of eligible infants and children with client record documentation of enrollment in Women Infant Children Program.

Primary Care Child Health Direct (CH – D) Performance Measure #5

Measure: Percent of infants who were exclusively breastfed for the first three months, at their four month well baby visit.

Primary Care Financial (PC) Performance Measure #1

Measure: Patient Payor Mix

Primary Care Financial (PC) Performance Measure #2

Measure: Accounts Receivables (AR) Days

Primary Care Financial (PC) Performance Measure #3

Measure: Current Ratio

Primary Care Performance Measures

State Fiscal Year 2013

Primary Care Clinical Adolescent (PC-C) Performance Measure #1

Measure: Percent of adolescents aged 10-21 years who received annual health maintenance visits in the past 12 months.

Primary Care Clinical Prenatal (PC-C) Performance Measure #2

Measure: Percent of women and adolescent girls aged 15-44 who take a multi-vitamin with folic acid.

Subject: Primary Care Services

AGREEMENT

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

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name NH Department of Health and Human Services Division of Public Health Services		**1.2 State Agency Address** 29 Hazen Drive Concord, NH 03301-6504	
1.3 Contractor Name Weeks Medical Center		**1.4 Contractor Address** 170 Middle Street Lancaster, New Hampshire 03584	
1.5 Contractor Phone Number 603-788-2521	**1.6 Account Number** 010-090-5190-120-500731 010-090-5149-102-500731	**1.7 Completion Date** June 30, 2014	**1.8 Price Limitation** $158,274
1.9 Contracting Officer for State Agency Joan H. Ascheim, Bureau Chief		**1.10 State Agency Telephone Number** 603-271-4501	
1.11 Contractor Signature [signature]		**1.12 Name and Title of Contractor Signatory** Scott Howe, Chief Executive Officer	
1.13 Acknowledgement: State of New Hampshire, County of Coos On March 28, 2012, before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.			
1.13.1 Signature of Notary Public or Justice of the Peace Kathy St. Onge [signature] [Seal] KATHY ST. ONGE, Notary Public My Commission Expires June 22, 2016			
1.13.2 Name and Title of Notary or Justice of the Peace			
1.14 State Agency Signature [signature]		**1.15 Name and Title of State Agency Signatory** Joan H. Ascheim, Bureau Chief	
1.16 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)* By:		Director, On:	
1.17 Approval by the Attorney General (Form, Substance and Execution) By: [signature] Jeanne P. Herrick, Attorney		On: 29 May 2012	
1.18 Approval by the Governor and Executive Council By:		On:	

NH Department of Health and Human Services

Exhibit A

Scope of Services

Primary Care Services

CONTRACT PERIOD: July 1, 2012 or date of G&C approval, whichever is later, through June 30, 2014

CONTRACTOR NAME: Weeks Medical Center

ADDRESS: 170 Middle Street
Lancaster, New Hampshire 03584
Grant Administrator: Patricia Cotter
TELEPHONE: 603-788-2521

The Contractor shall:

I. General Provisions

A) Eligibility and Income Determination

1. Office-based primary care services will be provided to low-income individuals and families (defined as $\leq$ 185% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), in the State of New Hampshire.

2. The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing if, at any time, the practice is closed to new patients, or maintains a wait list for new patients, or any other mechanism is used that limits access for new patients for more than a one month period.

3. The Contractor shall document annually, for each client enrolled in the program, family income and family size, and calculate percentage of the federal poverty level. If calculations indicate that the client may be eligible for enrollment in Medicaid, the Contractor shall complete with the client the most recent version of the 800P form.

4. The Contractor shall implement, and post in a public and conspicuous location, a sliding fee payment schedule, approved in advance by the Division of Public Health Services (DPHS), for low-income patients. Signage must state that no client will be denied services for inability to pay.

   a. As an alternative, the contractor may post, in a public and conspicuous location, a notice to clients that a sliding fee scale is available and that no client will be denied services for inability to pay. The sliding fee scale must be updated annually based on USDHHS Poverty guidelines as published in the Federal Register, submitted to and approved by DPHS *prior to implementation.*

5. The primary care contract entered into here shall be the payer of last resort. The contractor shall make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid, for all reimbursable services rendered.

B) Numbers Served

1. The contract funds shall be expended to provide the above services to a minimum of _800_ users annually with _2000_ medical encounters, as defined in the Data and Reporting Requirements. Clinical service reimbursements shall not exceed the Medicare rate.

C) **Culturally and Linguistically Appropriate Standards of Care**

The Department of Health and Human Services (DHHS) recognizes that culture and language have considerable impact on how consumers access and respond to public health services. Culturally and linguistically diverse populations experience barriers in efforts to access health services. To ensure equal access to quality health services, the Division of Public Health Services (DPHS) expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.

2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.

3. *Provide* clients of limited English proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.

4. Offer consumers a forum through which clients have the opportunity to provide feedback to providers and organizations regarding cultural and linguistic issues that may deserve response.

5. The contractor shall maintain a program policy that sets forth compliance with Title VI, Language Efficiency and Proficiency Citation 45 CFR 80.3(b) (2). The policy shall describe the way in which the items listed above were addressed and shall indicate the circumstances in which interpretation services are provided and the method of providing service (e.g. trained interpreter, staff person who speaks the language of the client, language line).

D) **State and Federal Laws**

The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. The Contractor shall report all cases of communicable diseases according to New Hampshire RSA 141-C and He-P 301, adopted 6/3/08.

2. Persons employed by the contractor shall comply with the reporting requirements of New Hampshire RSA 169:C, Child Protection Act; RSA 161:F46, Protective Services to Adults, RSA 631:6, Assault and Related Offences and RSA 130:A, Lead Paint Poisoning and Control.

3. Immunizations shall be conducted in accordance with RSA 141-C and the Immunization Rules promulgated hereunder.

E) **Relevant Policies and Guidelines**

1. The Contractor shall design and provide the services described above to meet the unique and identified health needs of the populations within the contracted service area.

2. Primary Care funds shall be targeted to populations in need. Populations in need are defined as follows:

a) uninsured;

b) under-insured;

c) families and individuals with significant psychosocial and economic risk, including low income status;

d) all life cycles including perinatal, child, adolescent, adult, and elderly who meet one or more of the above criteria.

3. The Contractor shall design and implement systems of governance, administration, financial management, information management, and clinical services which are adequate to assure the provision of contracted services, and to meet the data and reporting requirements. These systems shall meet the most current minimum standards described in at least one of the following: Health Resources and Services Administration (HRSA) Office of Performance Review protocols, Joint Commission on Accreditation of Health Care Organizations (JCAHO), Accreditation Association for Ambulatory Healthcare (AAAHC), Community Health Accreditation Program (CHAP), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey.

4. *The Contractor shall have an agency emergency preparedness and response plan in accordance with HRSA Health Center Emergency Management Program Expectations, Document #2007-15 or most recent version. Such plan shall also include a Continuity of Operations plan.*

5. The Contractor shall carry out the work as described in the performance Workplan submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

6. The Contractor shall carry out the work as described in the Supplemental Funding Form submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

F) Publications Funded Under Contract

1. The DHHS and/or its funders will retain COPYRIGHT ownership for any and all original materials produced with DHHS contract funding, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports.

2. All documents (written, video, audio, *electronic*) produced, reproduced, or purchased under the contract shall have prior approval from DPHS before printing, production, distribution, or use.

3. The Contractor shall credit DHHS on all materials produced under this contract following the instructions outlined in Exhibit C (14).

G) Subcontractors

1. If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing *and approve the subcontractual agreement,* prior to initiation of the subcontract.

Contractor Initials: ____

Date: 06/15/12

2. In addition, the original DPHS contractor will remain liable for all requirements included in this Exhibit and carried out by subcontractors.

II. Minimal Standards of Core Services

A) Service Requirements

1. *Medical Home*

The Contractor shall provide a Medical Home that:

a) *Facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family.*

b) ***Provides care facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.***

2. Primary Care Services

The Contractor shall provide office-based primary care services to populations in need who reside in the contractor's service area. Primary care services shall include:

a) Health care provided by a New Hampshire licensed MD, DO, APRN, or PA, including diagnosis and treatment of acute and chronic illnesses within the scope of family practice; preventive services, screenings, and health education according to established, documented state or national guidelines; assessment of need for social and nutrition services, and appropriate referrals to health, ***oral health***, and behavioral health specialty providers.

b) ***Referral to the WIC Nutrition Program for all eligible pregnant women, infants and children.***

c) In-hospital care for conditions within the scope of family practice must be provided at a hospital, within the agency service area, through a staff clinician with full hospital privileges, or in the alternative, through a formal referral and admissions procedure available to clients on a 24 hour/7 day a week basis.

d) Access to a healthcare provider, directly or by referral or subcontract, by telephone twenty-four hours per day, seven days per week.

e) Assessment of psychosocial risk for all clients at least annually and for children at scheduled preventive care visits, including, at a minimum, age appropriate assessment of safety in the home, domestic violence, adequacy of food and housing, care and welfare of children, transportation needs, and provision of necessary social services to address the priority needs and safety issues of clients and families.

f) Falls prevention screening for patients 65 years and older using the algorithm and guidelines of the American Geriatrics Society.

g) Behavioral health care directly or by referral to an agency or provider with a sliding fee scale.

h) *Nutrition assessment for all clients as part of the health maintenance visit.* Therapeutic nutrition services shall be provided *as indicated* directly or by referral to an agency or provider with a sliding fee scale. These services shall be recorded in the medical record.

i) Formal arrangements with a local hospital for emergency care must be in place and reviewed annually.

j) Home health care directly or by referral to an agency or provider with a sliding fee scale.

k) Assisted living and skilled nursing facility care by referral.

l) *Oral screening annually for all clients 19 years and older to note obvious dental decay and soft tissue abnormalities with a reminder to the patient that poor oral health impacts total health.*

m) *Diagnosis and management of pediatric and adult patients with asthma provided according to National Heart Lung Blood Institute, National Asthma Education and Prevention Program, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, 2007.*

n) *Breast and cervical cancer screening directly or by referral to an agency or provider with a sliding fee scale using screening guidelines from a nationally accepted organization.*

3. Reproductive Health Services

The Contractor shall provide prenatal, interconceptional and preconception medical care, social services, nutrition services, education, and nursing care to all women of childbearing age. Preconceptional care includes the preconception, interconceptional, and postpartum periods in women's health. It is recommended that preconceptional and interconceptional care visits focus on maintaining or achieving the optimal health of the mother, lowering the risk of future adverse pregnancy outcomes, the family's future plans, and how additional children fit into that plan. Preconceptional counseling may be done during an office, group or home visit.

a) In the event prenatal care is not provided directly by the Contractor a formal Memorandum/a of Agreement for coordinated referral to an appropriately qualified provider must be maintained.

b) Prenatal care shall, at minimum, be provided in accordance with the Guidelines for Perinatal Care, sixth or most current edition, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and /or the Centers for Disease Control.

c) Age appropriate reproductive health care shall, at a minimum, be provided in accordance with the American College of Obstetricians and Gynecologists, or the USDHHS Centers for Disease Control (CDC) current guidelines.

d) *Pregnant women enrolled in the WIC Nutrition Program shall be referred to WIC for breastfeeding education and referral to the WIC Nutrition Program peer counselors.*

e. Family planning counseling for prevention of subsequent pregnancy following an infant's birth shall be discussed with the infant's mother *at the first postpartum visit and at the infant's 2-month visit and other visits as appropriate.* Rationale for birth intervals of 18-24 months shall be presented.

f) A referral to a Title X Family Planning Clinic or other reproductive health care provider shall be made as appropriate.

4. Services for Children and Adolescents

The Contractor shall provide as a minimum, comprehensive and age-appropriate health care, screenings, and health education according to the American Academy of Pediatrics' most recent periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent. Children and adolescent visits shall include:

a) Blood lead testing shall be performed in accordance with "New Hampshire Childhood Lead Poisoning Screening and Management Guidelines", issued by the New Hampshire Department of Health and Human Services, 2009 or subsequent revisions.

b) All children enrolled in either Healthy Kids-Gold or the Women, Infant, and Children (WIC) Program and/or who are ≤ 185% poverty, regardless of town of residence, are required to have a blood lead test at ages one and two years. All children ages three to six years who have not been previously tested shall have a capillary or venous blood lead test performed.

c) All children shall be screened for iron deficiency anemia as outlined in the Centers for Disease Control and Prevention document "Recommendations to Prevent and Control Iron Deficiency in the United States (4/2/98)".

d) Age-appropriate anticipatory guidance, dietary guidance, and *feeding practice counseling* for optimal oral health shall be provided at each well child visit according to the American Academy of Pediatrics' periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent edition. Starting at age 6 months, it is recommended that all children receive an oral health assessment at every well child visit.

e) Supplemental fluoride shall be prescribed as needed based upon the fluoride levels in the child's *drinking* water supply. The fluoride dosage regimen accepted by the American Academy of Pediatrics shall be followed. No fluoride shall be prescribed without obtaining water from private wells or noting the presence or absence of fluoride in the public water supply. ***Supplemental fluoride may include bottled water containing fluoride and topical applications such as varnishes.***

f) ***For infants enrolled in the WIC Nutrition Program, parents shall be referred to WIC for breastfeeding support and referral to the WIC Nutrition Program peer counselors.***

5. Sexually Transmitted Infections

Primary Care Services shall provide age appropriate screening and treatment of sexually transmitted infections.

a) Treatment for sexually transmitted infections shall be provided according to the United States Centers for Disease Control Sexually Transmitted Diseases Treatment Guidelines, 2010 or subsequent revisions.

b) All clients, including women, shall be offered HIV testing following the most current recommendations of the United States Centers for Disease Control.

c) The contractor shall be responsible for ensuring referral to appropriate treatment services for any woman found to screen positive.

d) Appropriate risk reduction counseling shall be provided based on client needs.

6. Substance Use Services

a) A substance use screening history using a formal, validated screening tool shall be obtained for all clients as soon after entry into care as possible. Substance use counseling *or other substance abuse intervention, treatment, or recovery services* by an appropriately credentialed provider shall be provided on-site, or by referral, to clients with identified needs for these services. *For these identified clients, ongoing primary care services should include follow up monitoring relative to substance abuse.*

b) All clients, including pregnant women, identified as smokers shall receive counseling *using the 5A's (ask, advise, assess, assist, and arrange) treatment available through the NH Tobacco Helpline* as cited in the US Public Health Services report "Tobacco Use and Dependence", 2008, or "Smoking Cessation During Pregnancy: *A Clinician's Guide to Helping Pregnant Women Quit Smoking*", American College of Obstetricians and Gynecologists, 2011. *With prior approval, agencies may also opt to participate in the DPHS best practice initiative of the 2A's and R (ask, advise and refer).*

7. Immunizations

a) The Contractor shall adhere to the most current version of the "Recommended Adult Immunization Schedule United States", approved by the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

b) The Contractor shall administer vaccines according to the most current version of the *"Recommended Immunization Schedule for Persons Aged 0 Through 6 Years - United States", and "Recommended Immunization Schedule for Persons Aged 7 Through 18 Years – United States"* approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians, based upon availability of vaccine from the New Hampshire Immunization Program.

8. Prenatal Genetic Screening

a) A genetic screening history shall be obtained on all prenatal clients as soon after entry into care as possible.

b) All pregnant women should be offered voluntary genetic screening for fetal chromosomal abnormalities at the appropriate time following recommendations found in the American College of Obstetricians and Gynecologists' "Screening for Fetal Chromosomal Abnormalities (2007)" or more recent guidelines. The Contractor shall be responsible for ensuring referral to appropriate genetic testing and counseling for any woman found to have a positive screening test.

9. Additional Requirements

a) The Contractor's Medical Director shall participate in the development and approval of specific guidelines for medical care that supplement minimal clinical standards. Supplemental guidelines should be reviewed, signed, and dated annually, and updated as indicated.

b) Contractors considering clinical or sociological research using clients as subjects must adhere to the legal requirements governing human subjects research. Contractors must inform the DPHS, MCHS prior to initiating any research related to this contract.

c) *The Contractor shall provide information to all employees annually about the Medical Reserve Corps Unit within their Public Health Region to enhance recruitment.*

d) *The Contractor shall provide information to all employees annually regarding the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) managed by the NH Department of Health and Human Services' Emergency Services Unit, to enhance recruitment.*

B) **Staffing Provisions**

The Contractor shall have, at minimum, the following staff positions:

a) executive director

b) fiscal director

c) registered nurse

d) clinical coordinator

e) medical service director

f) nutritionist *(on site or by referral)*

g) social worker

Staff positions required to provide direct services on-site include:

a) registered nurse

b) clinical coordinator

c) social worker

1. Qualifications

All health and allied health professionals shall have the appropriate New Hampshire licenses whether directly employed, contracted, or subcontracted.

In addition the following minimum qualifications shall be met for:

a) Registered Nurse
   a. A registered nurse licensed in the state of New Hampshire, Bachelor's degree preferred. Minimum of one-year experience in a community health setting.

b) Nutritionists:
   a. A Bachelor's degree in nutritional sciences or dietetics, or a Master's degree in nutritional sciences, nutrition education, or public health nutrition or current Registered Dietitian status in accordance with the Commission on dietetic Registration of the American Dietetic Association.

   b. Individuals who perform functions similar to a nutritionist but do not meet the above qualifications shall not use the title of nutritionist.

c) Social Workers shall have:
   a. A Bachelor's or Master's degree in social work or Bachelor's or Master's degree in a related social science or human behavior field. A minimum of one year of experience in a community health or social services setting is preferred.

   b. Individuals who perform functions similar to a social worker but do not meet the above qualifications shall not use the title of social worker.

d) Clinical Coordinators shall be:

   a. A registered nurse (RN), physician, physician assistant, or nurse practitioner with a license to practice in New Hampshire.

b. The coordinator is a clinical position that oversees and takes responsibility for the clinical and administrative functions of each program.

c. The coordinator may be responsible for more than one MCH funded program.

2. New Hires

The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing within one month of hire when a new administrator, clinical coordinator, or any staff person essential to carrying out contracted services is hired to work in the program. A resume of the employee shall accompany the aforesaid notification.

3. Vacancies

a) The Contractor must notify the MCHS in writing if any critical position is vacant for more than one month, or if at any time funded under this contract does not have adequate staffing to perform all required services for more than one month. This may be done through a budget revision.

b) Before an agency hires new program personnel that do not meet the required staff qualifications, the agency shall notify the MCHS in writing requesting a waiver of the applicable staffing requirements. The Section may grant waivers based on the need of the program, individuals' experience, and additional training.

C) Coordination of Services

1. The Contractor shall coordinate, where possible, with other service providers within the contractor's community. At a minimum, such collaboration shall include interagency referrals and coordination of care.

2. The Contractor shall participate in activities *in the Public Health Region in which they provide services* as appropriate. These activities enhance the integration of community-based public health prevention and health care initiatives that are being implemented by the contractor and may include community needs assessments, public health performance assessments, and/or the development of regional health improvement plans.

3. The Contractor agrees to *participate* in and coordinate public health activities as requested by the Division of Public Health Services during any *disease outbreak* and/or *emergency*, natural or man made, affecting the public's health.

4. The Contractor is responsible for case management of the client enrolled in the program and for program follow-up activities. Case management services shall promote effective and efficient organization and utilization of resources to assure access to necessary comprehensive medical, nutritional, and social services for clients.

5. The Contractor shall assure that *appropriate, responsive, and timely* referrals and linkages for other needed services are made, carried through, and documented. Such services shall include, but not be limited to: dental services, genetic counseling, high risk prenatal services, mental health, social services, including domestic violence crisis centers, substance abuse services; and family planning services, Early Supports and Services Program, local WIC/CSF Program, Home Visiting New Hampshire Programs and health and social service agencies which serve children and families in need of those services.

Contractor Initials: ______

Date: 06/15/12

D) Meetings and Trainings

The contractor will be responsible for sending staff to meetings and training required by the MCHS program, including but not limited to:

1. MCHS Agency Directors' meetings
2. Prenatal and Child Health Coordinators' meetings
3. MCHS Agency Medical Services Directors' meetings

III. Quality or Performance Improvement (QI/PI)

A) Workplans

1. Performance Workplans are required for this program and are used to monitor achievement of standard measures of performance of the services provided under this contract. The workplans are a key component of the RHPCS and the MCHS performance-based contracting system and of this contract. Outcomes shall be reported by clinical site.

2. Submit Performance Workplans and Workplan Outcome reports according to the schedule and instructions provided by the MCHS. The MCHS shall notify the Contractor at least 30 days in advance of any changes in the submission schedule.

3. The Contractor shall incorporate required and developmental performance measures, defined by the MCHS into the agency's Performance Workplan. Reports on Workplan Progress/Outcomes shall detail the Performance Workplan plans and activities that monitor and evaluate the agency's progress toward performance measure targets.

4. The Contractor shall comply with modifications and/or additions to the workplan and annual report format as requested by RHPCS and MCHS. MCHS will provide the contractor with reasonable notice of such changes.

5. Agencies contracting for Primary Care Services must submit the workplans for Primary Care *Clinical and Financial*, Child Health, and Prenatal Care.

B) Additional Reporting requirements

In addition to Performance Workplans, the Contractor shall submit to MCHS the following data and information listed below which are used to monitor program performance:

1. In years when contracts or amendments are not required, the DPHS Budget Form, Budget Justification, Sources of Revenue and Program Staff list forms must be completed according to the relevant instructions and submitted as requested by DPHS and, at minimum, by April 30 of each year.

2. The Sources of Revenue report must be resubmitted at any point when changes in revenue threaten the ability of the agency to carry out the planned program.

3. Completed Uniform Data Set (UDS) tables reflecting program performance in the previous calendar year, by March 31 of each year.

4. The Perinatal Client Data Form (PCDF) shall be submitted electronically according to the instructions set forth by the MCHS.

5. A copy of the agency's updated Sliding Fee Scale including the amount(s) of any client fees and the schedule of discounts must be submitted by March 31st of each year. The agency's sliding fee

scale must be updated annually based on the US DHHS Poverty guidelines as published in the Federal Register.

6. An annual summary of <u>program-specific</u> patient satisfaction results obtained during the prior contract period and the method by which the results were obtained shall be submitted annually as an addendum to the Workplan Outcome/Progress reports.

C) On-site reviews

1. The contractor shall allow a team or person authorized by the Division of Public Health Services to periodically review the contractor's systems of governance, administration, data collection and submission, clinical and financial management, and delivery of education services in order to assure systems are adequate to provide the contracted services.
2. Reviews shall include client record reviews to measure compliance with this exhibit.
3. The contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.
4. On-Site reviews may be waived or abbreviated at the discretion of MCHS, upon submission of satisfactory reports of reviews such as Health Services Resources Administration (HRSA): Office of Performance Review (OPR), or reviews from nationally accreditation organizations such as the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), Medicare, the Community Health Accreditation Program (CHAP), Accreditation Association for Ambulatory Healthcare (AAAHC), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey. Abbreviated reviews will focus on any deficiencies found in previous reviews, issues of compliance with this exhibit, and actions to strengthen performance as outlined in the agency Performance Workplan.

Contractor Initials: ______

Date: 06/15/12

State of New Hampshire
Department of Health and Human Services
Amendment #1 to the
White Mountain Community Health Center

This 1st Amendment to the White Mountain Community Health Center contract (hereinafter referred to as "Amendment One") dated this 14 day of March, 2014, is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and White Mountain Community Health Center (hereinafter referred to as "the Contractor"), a corporation with a place of business at 298 White Mountain Highway, PO Box 2800, Conway, New Hampshire 03818.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on June 20, 2012, 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, the State and the Contractor have agreed to make changes to the scope of work, payment schedules and terms and conditions of the contract; and

WHEREAS, pursuant to the General Provisions, Paragraph 18, the State may modify the scope of work and the payment schedule of the contract by written agreement of the parties;

WHEREAS, the Department desires to provide additional primary health care services for preventive and episodic health care for acute and chronic health conditions for people of all ages.

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 as follows:

To amend as follows:

- Form P-37, to change:
  Block 1.7 to read: June 30, 2015
  Block 1.8 to read: $579,513

- Exhibit A, Scope of Services to add:
  Exhibit A – Amendment 1

- Exhibit B, Purchase of Services, Contract Price, to add:

  Paragraph 1.1 to Paragraph 1:
  The contract price shall increase by $40,300 for SFY 2014 and $223,645 for SFY 2015.

  Paragraph 1.2 to Paragraph 1:
  Funding is available as follows:
- $40,300 from 05-95-90-902010-5190-102-500731, 100% General Funds;
- $202,079 from 05-95-90-902010-5190-102-500731, 6.7% Federal Funds from the US Department of Health and Human Services Administration, Maternal and Child Health Bureau, CFDA #93.994 and 93.3% General Funds;

Contractor Initials: PMc
Date: 3-14-14

- $11,566 from 05-95-90-902010-5659-102-500731, 100% Federal Funds from the US Department of Health and Human Services, Centers for Disease Control and Prevention, CFDA #93.283;
- $10,000 from 05-95-90-901010-7965-102-500731, 100% General Funds.

Add Paragraph 8
8. Notwithstanding paragraph 18 of the General Provisions P-37, an amendment limited to adjustments to amounts between and among account numbers, within the price limitation, may be made by written agreement of both parties and may be made without obtaining approval of the Governor and Executive Council.

- Budget, to add:
  Exhibit B-1 (2014) - Amendment 1,
  Exhibit B-1 (2015) - Amendment 1

This amendment shall be in effect July 1, 2013, effective upon the date of Governor and Executive Council approval.

Contractor Initials: PMc
Date: 3-14-14

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

3/28/14
Date

Brook Dupee
Bureau Chief

White Mountain Community Health Center

3-14-14
Date

Name: Patricia McMurry
Title: Executive Director

Acknowledgement:

State of New Hampshire, County of Carroll on March 14, 2014, before the undersigned officer, personally appeared the person identified above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.

Signature of Notary Public or Justice of the Peace

Diane Brothers Notary Public
Name and Title of Notary or Justice of the Peace

DIANE BROTHERS
Notary Public - New Hampshire
My Commission Expires August 19, 2014

Contractor Initials: PM
Date: 3-14-14

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

OFFICE OF THE ATTORNEY GENERAL

4-3-14
Date

[signature]
Name: Rosemary Wiant
Title: Asst. Attorney General

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:

Contractor Initials: [initials]
Date: 3-14-14

EXHIBIT A – AMENDMENT 1

Scope of Services

The Department desires to continue the relationship with the primary care agencies to provide additional primary health care services for preventive and episodic health care for acute and chronic health conditions for people of all ages.

I. General Provisions

A) Eligibility and Income Determination

1. Office-based primary care services will be provided to low-income individuals and families (defined as ≤ 185% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), in the State of New Hampshire.

2. Breast and Cervical Cancer screening services will be provided to low-income (defined as ≤ 250% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), New Hampshire women age 21– 64, uninsured or underinsured. BCCP changes.

3. The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing if, at any time, the practice is closed to new patients, or maintains a wait list for new patients, or any other mechanism is used that limits access for new patients for more than a one month period.

4. The Contractor shall document annually, for each client enrolled in the program, family income and family size, and calculate percentage of the federal poverty level. If calculations indicate that the client may be eligible for enrollment in Medicaid, the Contractor shall complete with the client the most recent version of the 800P form.

5. The Contractor shall implement, and post in a public and conspicuous location, a sliding fee payment schedule, approved in advance by the Division of Public Health Services (DPHS), for low-income patients. Signage must state that no client will be denied services for inability to pay.

   a. As an alternative, the contractor may post, in a public and conspicuous location, a notice to clients that a sliding fee scale is available and that no client will be denied services for inability to pay. The sliding fee scale must be updated annually based on USDHHS Poverty guidelines as published in the Federal Register, submitted to and approved by DPHS prior to implementation.

6. The primary care contract entered into here shall be the payer of last resort. The contractor shall make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid, for all reimbursable services rendered.

EXHIBIT A – AMENDMENT 1

B) Numbers Served

1. The contract funds shall be expended to provide the above services to a minimum of 2,285 users annually with 8,598 medical encounters, as defined in the Data and Reporting Requirements. Breast and Cervical Cancer Screening for eligible women, as defined by the Breast and Cervical Cancer Program (BCCP), shall be provided to 65 women annually and billed directly to the BCCP. Clinical service reimbursements shall not exceed the Medicare rate.

C) Culturally and Linguistically Appropriate Standards of Care

The Department of Health and Human Services (DHHS) recognizes that culture and language have considerable impact on how consumers access and respond to public health services. Culturally and linguistically diverse populations experience barriers in efforts to access health services. To ensure equal access to quality health services, the Division of Public Health Services (DPHS) expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.
2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.
3. Provide clients of limited English proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.
4. Offer consumers a forum through which clients have the opportunity to provide feedback to providers and organizations regarding cultural and linguistic issues that may deserve response.
5. The contractor shall maintain a program policy that sets forth compliance with Title VI, Language Efficiency and Proficiency Citation 45 CFR 80.3(b) (2). The policy shall describe the way in which the items listed above were addressed and shall indicate the circumstances in which interpretation services are provided and the method of providing service (e.g. trained interpreter, staff person who speaks the language of the client, language line).

D) State and Federal Laws

The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. The Contractor shall report all cases of communicable diseases according to New Hampshire RSA 141-C and He-P 301, adopted 6/3/08.

2. Persons employed by the contractor shall comply with the reporting requirements of New Hampshire RSA 169:C, Child Protection Act; RSA 161:F46, Protective Services to Adults, RSA 631:6, Assault and Related Offences and RSA 130:A, Lead Paint Poisoning and Control.

3. Immunizations shall be conducted in accordance with RSA 141-C and the Immunization Rules promulgated hereunder.

E) Relevant Policies and Guidelines

1. The Contractor shall design and provide the services described above to meet the unique and identified health needs of the populations within the contracted service area.

2. Primary Care funds shall be targeted to populations in need. Populations in need are defined as follows:

   a) uninsured;

   b) under-insured;

   c) families and individuals with significant psychosocial and economic risk, including low income status;

   d) all life cycles including perinatal, child, adolescent, adult, and elderly who meet one or more of the above criteria.

3. The Contractor shall design and implement systems of governance, administration, financial management, information management, and clinical services which are adequate to assure the provision of contracted services, and to meet the data and reporting requirements. These systems shall meet the most current minimum standards described in at least one of the following: Health Resources and Services Administration (HRSA) Office of Performance Review protocols, Joint Commission on Accreditation of Health Care Organizations (JCAHO), Accreditation Association for Ambulatory Healthcare (AAAHC), Community Health Accreditation Program (CHAP), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey.

4. The Contractor shall have an agency emergency preparedness and response plan in accordance with HRSA Health Center Emergency Management Program Expectations, Document #2007-15 or most recent version. Such plan shall also include a Continuity of Operations plan.

5. The Contractor shall carry out the work as described in the performance Workplan submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

EXHIBIT A – AMENDMENT 1

6. No Workplan is required by the Breast and Cervical Cancer Program (BCCP). The contractor shall be required to respond to the Quality Improvement Feedback Report twice a year.

7. The Contractor shall carry out the work as described in the Supplemental Funding Form submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

F) Publications Funded Under Contract

1. The DHHS and/or its funders will retain COPYRIGHT ownership for any and all original materials produced with DHHS contract funding, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports.

2. All documents (written, video, audio, electronic) produced, reproduced, or purchased under the contract shall have prior approval from DPHS before printing, production, distribution, or use.

3. The Contractor shall credit DHHS on all materials produced under this contract following the instructions outlined in Exhibit C (14).

G) Subcontractors

If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing and approve the subcontractual agreement, prior to initiation of the subcontract.

1. If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing and approve the subcontractual agreement, prior to initiation of the subcontract.

2. In addition, the original DPHS contractor will remain liable for all requirements included in this Exhibit and carried out by subcontractors.

II. <u>Minimal Standards of Core Services</u>

A. Service Requirements

1. Medical Home

   The Contractor shall provide a Medical Home that:

   a) Facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family.

EXHIBIT A – AMENDMENT 1

b) Provides care facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

2. Primary Care Services

The Contractor shall provide office-based primary care services to populations in need who reside in the contractor's service area. Primary care services shall include:

a) Health care provided by a New Hampshire licensed MD, DO, APRN, or PA, including diagnosis and treatment of acute and chronic illnesses within the scope of family practice; preventive services, screenings, and health education according to established, documented state or national guidelines; assessment of need for social and nutrition services, and appropriate referrals to health, oral health, and behavioral health specialty providers.

b) Referral to the WIC Nutrition Program for all eligible pregnant women, infants and children.

c) In-hospital care for conditions within the scope of family practice must be provided at a hospital, within the agency service area, through a staff clinician with full hospital privileges, or in the alternative, through a formal referral and admissions procedure available to clients on a 24 hour/7 day a week basis.

d) Access to a healthcare provider, directly or by referral or subcontract, by telephone twenty-four hours per day, seven days per week.

e) Assessment of psychosocial risk for all clients at least annually and for children at scheduled preventive care visits, including, at a minimum, age appropriate assessment of safety in the home, domestic violence, adequacy of food and housing, care and welfare of children, transportation needs, and provision of necessary social services to address the priority needs and safety issues of clients and families.

f) Falls prevention screening for patients 65 years and older using the algorithm and guidelines of the American Geriatrics Society.

g) Behavioral health care directly or by referral to an agency or provider with a sliding fee scale.

h) Nutrition assessment for all clients as part of the health maintenance visit. Therapeutic nutrition services shall be provided as indicated directly or by referral to an agency or provider with a sliding fee scale. These services shall be recorded in the medical record.

i) Formal arrangements with a local hospital for emergency care must be in place and reviewed annually.

j) Home health care directly or by referral to an agency or provider with a sliding fee scale.

k) Assisted living and skilled nursing facility care by referral.

l) Oral screening annually for all clients 21 years and older to note obvious dental decay and soft tissue abnormalities with a reminder to the patient that poor oral health impacts total health.

m) Diagnosis and management of pediatric and adult patients with asthma provided according to National Heart Lung Blood Institute, National Asthma Education and Prevention Program, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, 2007.

3. Breast and Cervical Cancer Screening

a) Women age 21 to 64 who are eligible for Breast and Cervical Cancer Program (BCCP) services according to income (equal to or under 250% of poverty, underinsured/uninsured) and insurance status criteria shall be provided the following services, following USPSTF screening recommendations:

i. cervical cancer screening including a pelvic examination and Pap smear;
ii. breast cancer screening including a clinical breast exam, mammogram and,
iii. referrals for diagnostic and treatment services based on screening results,
iv. case management services.

b) All referrals under this provision shall be to approved certified laboratory, pathology, radiology, and surgical services. Mammography units shall be accredited by the American College of Radiology, and must be FDA certified under MQSA. Laboratories shall be CLIA certified.

c) All services shall be provided in accordance with the Breast and Cervical Cancer Program (BCCP) Policy and Procedure Manual.

d) Follow-up and tracking of all tests done, and referrals made shall be provided in accordance with the minimum standards outlined in the Breast and Cervical Cancer Program Policy and Procedure Manual.

e) All services for women enrolled in the Breast and Cervical Cancer Program (BCCP) shall be billed directly to the BCCP in accordance with protocols established by the Breast and Cervical Cancer Program.

f) The Contractor shall provide the NH Breast and Cervical Cancer Program with breast and cervical cancer screening rates for all women served by the practice as requested, but not more than twice per SFY.

EXHIBIT A – AMENDMENT 1

g) The contractor shall work with the NH Breast and Cervical Cancer Program staff to increase the breast and cervical cancer screening rates among all women serviced by the practice.

4. Reproductive Health Services

The Contractor shall provide prenatal, interconceptional and preconception medical care, social services, nutrition services, education, and nursing care to all women of childbearing age. Preconceptional care includes the preconception, interconceptional, and postpartum periods in women's health. It is recommended that preconceptional and interconceptional care visits focus on maintaining or achieving the optimal health of the mother, lowering the risk of future adverse pregnancy outcomes, the family's future plans, and how additional children fit into that plan. Preconceptional counseling may be done during an office, group or home visit.

a) In the event prenatal care is not provided directly by the Contractor a formal Memorandum/a of Agreement for coordinated referral to an appropriately qualified provider must be maintained.

b) Prenatal care shall, at minimum, be provided in accordance with the Guidelines for Perinatal Care, sixth or most current edition, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and /or the Centers for Disease Control.

c) Age appropriate reproductive health care shall, at a minimum, be provided in accordance with the American College of Obstetricians and Gynecologists, or the USDHHS Centers for Disease Control (CDC) current guidelines.

d) Pregnant women enrolled in the WIC Nutrition Program shall be referred to WIC for breastfeeding education and referral to the WIC Nutrition Program peer counselors.

e. Family planning counseling for prevention of subsequent pregnancy following an infant's birth shall be discussed with the infant's mother at the first postpartum visit and at the infant's 2-month visit and other visits as appropriate. Rationale for birth intervals of 18-24 months shall be presented.

f) A referral to a Title X Family Planning Clinic or other reproductive health care provider shall be made as appropriate.

5. Services for Children and Adolescents

The Contractor shall provide as a minimum, comprehensive and age-appropriate health care, screenings, and health education according to the American Academy of Pediatrics' most recent periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent. Children and adolescent visits shall include:

EXHIBIT A – AMENDMENT 1

a) The World Health Organization (WHO) growth charts shall be used to monitor growth for infants and children birth up to age 2 years. The Centers for Disease Control and Prevention (CDC) growth charts shall be used for children age 2 years and older.

b) Blood lead testing shall be performed in accordance with "New Hampshire Childhood Lead Poisoning Screening and Management Guidelines", issued by the New Hampshire Department of Health and Human Services, 2009 or subsequent revisions.

c) All children enrolled in either Medicaid, Head Start, or the Women, Infant, and Children (WIC) Program and/or who are ≤ 185%_poverty, regardless of town of residence, are required to have a blood lead test at ages one and two years. All children ages three to six years who have not been previously tested shall have a blood lead test performed.

d) All children shall be screened for iron deficiency anemia as outlined in the Centers for Disease Control and Prevention document "Recommendations to Prevent and Control Iron Deficiency in the United States (4/2/98)".

e) Age-appropriate anticipatory guidance, dietary guidance, and *feeding practice counseling* for optimal oral health shall be provided at each well child visit according to the American Academy of Pediatrics' periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent edition. Starting at age 6 months, it is recommended that all children receive an oral health assessment at every well child visit, and a referral for the child's first visit to the dentist by age one as recommended by the American Academy of Pediatrics and the American Academy of Pediatric Dentistry.

f) Supplemental fluoride shall be prescribed as needed based upon the fluoride levels in the child's drinking water supply. The fluoride dosage regimen accepted by the American Academy of Pediatrics shall be followed. No fluoride shall be prescribed without obtaining water from private wells or noting the presence or absence of fluoride in the public water supply. Supplemental fluoride may include bottled water containing fluoride and topical applications such as varnishes.

g) For infants enrolled in the WIC Nutrition Program, parents shall be referred to WIC for breastfeeding support and referral to the WIC Nutrition Program peer counselors.

6. Sexually Transmitted Infections

Primary Care Services shall provide age appropriate screening and treatment of sexually transmitted infections.

a) Treatment for sexually transmitted infections shall be provided according to the United States Centers for Disease Control Sexually Transmitted Diseases Treatment Guidelines, 2010 or subsequent revisions.

b) All clients, including women, shall be offered HIV testing following the most current recommendations of the United States Centers for Disease Control.

c) The contractor shall be responsible for ensuring referral to appropriate treatment services for any woman found to screen positive.

d) Appropriate risk reduction counseling shall be provided based on client needs.

7. Substance Use Services

a) A substance use screening history using a formal, validated screening tool shall be obtained for all clients as soon after entry into care as possible. Substance use counseling or other substance abuse intervention, treatment, or recovery services by an appropriately credentialed provider shall be provided on-site, or by referral, to clients with identified needs for these services. For these identified clients, ongoing primary care services should include follow up monitoring relative to substance abuse.

b) All clients, including pregnant women, identified as smokers shall receive counseling using the 5A's (ask, advise, assess, assist, and arrange) treatment available through the NH Tobacco Helpline as cited in the US Public Health Services report "Tobacco Use and Dependence", 2008, or "Smoking Cessation During Pregnancy: A Clinician's Guide to Helping Pregnant Women Quit Smoking", American College of Obstetricians and Gynecologists, 2011. With prior approval, agencies may also opt to participate in the DPHS best practice initiative of the 2A's and R (ask, advise and refer).

8. Immunizations

a) The Contractor shall adhere to the most current version of the "Recommended Adult Immunization Schedule for Adults (19 years and older) by Age and Medical Condition - United States", approved by the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

b) The Contractor shall administer vaccines according to the most current version of the "Recommended Immunization Schedule for Persons Aged 0 Through 6 Years - United States", and "Recommended Immunization Schedule for Persons Aged 7 Through 18 Years – United States" approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians, based upon availability of vaccine from the New Hampshire Immunization Program.

9. Prenatal Genetic Screening

EXHIBIT A – AMENDMENT 1

a) A genetic screening history shall be obtained on all prenatal clients as soon after entry into care as possible.

b) All pregnant women should be offered voluntary genetic screening for fetal chromosomal abnormalities at the appropriate time following recommendations found in the American College of Obstetricians and Gynecologists' "Screening for Fetal Chromosomal Abnormalities (2007)" or more recent guidelines. The Contractor shall be responsible for ensuring referral to appropriate genetic testing and counseling for any woman found to have a positive screening test.

10. Additional Requirements

a) The Contractor's Medical Director shall participate in the development and approval of specific guidelines for medical care that supplement minimal clinical standards. Supplemental guidelines should be reviewed, signed, and dated annually, and updated as indicated.

b) Contractors considering clinical or sociological research using clients as subjects must adhere to the legal requirements governing human subjects research. Contractors must inform the DPHS, MCHS prior to initiating any research related to this contract.

c) The Contractor shall provide information to all employees annually about the Medical Reserve Corps Unit within their Public Health Region to enhance recruitment.

d) The Contractor shall provide information to all employees annually regarding the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) managed by the NH Department of Health and Human Services' Emergency Services Unit, to enhance recruitment.

B) Staffing Provisions

The Contractor shall have, at minimum, the following staff positions:

a) executive director

b) fiscal director

c) registered nurse

d) clinical coordinator

e) medical service director

f) nutritionist (on site or by referral)

g) social worker

EXHIBIT A – AMENDMENT 1

Staff positions required to provide direct services on-site include:

a) registered nurse

b) clinical coordinator

c) social worker

1. Qualifications

All health and allied health professionals shall have the appropriate New Hampshire licenses whether directly employed, contracted, or subcontracted.

In addition the following minimum qualifications shall be met for:

a) Registered Nurse
   a. A registered nurse licensed in the state of New Hampshire, Bachelor's degree preferred. Minimum of one-year experience in a community health setting.

b) Nutritionists:
   a. A Bachelor's degree in nutritional sciences or dietetics, or a Master's degree in nutritional sciences, nutrition education, or public health nutrition or current Registered Dietitian status in accordance with the Commission on dietetic Registration of the American Dietetic Association.
   b. Individuals who perform functions similar to a nutritionist but do not meet the above qualifications shall not use the title of nutritionist.

c) Social Workers shall have:
   a. A Bachelor's or Master's degree in social work or Bachelor's or Master's degree in a related social science or human behavior field. A minimum of one year of experience in a community health or social services setting is preferred.
   b. Individuals who perform functions similar to a social worker but do not meet the above qualifications shall not use the title of social worker.

d) Clinical Coordinators shall be:
   a. A registered nurse (RN), physician, physician assistant, or nurse practitioner with a license to practice in New Hampshire.
   b. The coordinator is a clinical position that oversees and takes responsibility for the clinical and administrative functions of each program.
   c. The coordinator may be responsible for more than one MCH funded program.

2. New Hires

The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing within one month of hire when a new administrator, clinical coordinator, or any staff person essential to carrying out contracted services is hired to work in the program. A resume of the employee shall accompany the aforesaid notification.

3. Vacancies

a) The Contractor must notify the MCHS in writing if any critical position is vacant for more than one month, or if at any time funded under this contract does not have adequate staffing to perform all required services for more than one month. This may be done through a budget revision.

b) Before an agency hires new program personnel that do not meet the required staff qualifications, the agency shall notify the MCHS in writing requesting a waiver of the applicable staffing requirements. The Section may grant waivers based on the need of the program, individuals' experience, and additional training.

C) Coordination of Services

1. The Contractor shall coordinate, where possible, with other service providers within the contractor's community. At a minimum, such collaboration shall include interagency referrals and coordination of care.

2. The Contractor shall participate in activities in the Public Health Region in which they provide services as appropriate. These activities enhance the integration of community-based public health prevention and health care initiatives that are being implemented by the contractor and may include community needs assessments, public health performance assessments, and/or the development of regional health improvement plans.

3. The Contractor agrees to participate in and coordinate public health activities as requested by the Division of Public Health Services during any disease outbreak and/or emergency, natural or man-made, affecting the public's health.

4. The Contractor is responsible for case management of the client enrolled in the program and for program follow-up activities. Case management services shall promote effective and efficient organization and utilization of resources to assure access to necessary comprehensive medical, nutritional, and social services for clients.

5. The Contractor shall assure that appropriate, responsive, and timely referrals and linkages for other needed services are made, carried through, and documented. Such services shall include, but not be limited to: dental services, genetic counseling, high risk prenatal services, mental health, social services, including domestic violence crisis centers, substance abuse services; and family planning services, Early Supports and Services Program, local WIC/CSF Program, Home Visiting New Hampshire Programs and health and social service agencies which serve children and families in need of those services.

D) Meetings and Trainings

The contractor will be responsible for sending staff to meetings and training required by the MCHS program, including but not limited to:

1. MCHS Agency Directors' meetings

2. Prenatal and Child Health Coordinators' meetings

3. MCHS Agency Medical Services Directors' meetings

III. Quality or Performance Improvement (QI/PI)

A) Workplans

1. Performance Workplans are required for this program and are used to monitor achievement of standard measures of performance of the services provided under this contract. The workplans are a key component of the RHPCS and the MCHS performance-based contracting system and of this contract. Outcomes shall be reported by clinical site.

2. Performance Workplans and Workplan Outcome reports according to the schedule and instructions provided by the MCHS. The MCHS shall notify the Contractor at least 30 days in advance of any changes in the submission schedule.

3. The Contractor shall incorporate required and developmental performance measures, defined by the MCHS into the agency's Performance Workplan. Reports on Workplan Progress/Outcomes shall detail the Performance Workplan plans and activities that monitor and evaluate the agency's progress toward performance measure targets.

4. The Contractor shall comply with modifications and/or additions to the workplan and annual report format as requested by RHPCS and MCHS. MCHS will provide the contractor with reasonable notice of such changes.

5. Agencies contracting for Primary Care Services must submit the workplans for Primary Care Clinical and Financial, Child Health, and Prenatal Care.

B) Additional Reporting requirements

In addition to Performance Workplans, the Contractor shall submit to MCHS the following data and information listed below which are used to monitor program performance:

1. In years when contracts or amendments are not required, the DPHS Budget Form, Budget Justification, Sources of Revenue and Program Staff list forms must be

completed according to the relevant instructions and submitted as requested by DPHS and, at minimum, by April 30 of each year.

2. The Sources of Revenue report must be resubmitted at any point when changes in revenue threaten the ability of the agency to carry out the planned program.

3. Completed Uniform Data Set (UDS) tables reflecting program performance in the previous calendar year, by March 31 of each year.

4. The Perinatal Client Data Form (PCDF) shall be submitted electronically according to the instructions set forth by the MCHS.

5. A copy of the agency's updated Sliding Fee Scale including the amount(s) of any client fees and the schedule of discounts must be submitted by March 31st of each year. The agency's sliding fee scale must be updated annually based on the US DHHS Poverty guidelines as published in the Federal Register.

6. An annual summary of program-specific patient satisfaction results obtained during the prior contract period and the method by which the results were obtained shall be submitted annually as an addendum to the Workplan Outcome/Progress reports.

C) On-site reviews

1. The contractor shall allow a team or person authorized by the Division of Public Health Services to periodically review the contractor's systems of governance, administration, data collection and submission, clinical and financial management, and delivery of education services in order to assure systems are adequate to provide the contracted services.

2. Reviews shall include client record reviews to measure compliance with this exhibit.

3. The contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.

4. On-Site reviews may be waived or abbreviated at the discretion of MCHS, upon submission of satisfactory reports of reviews such as Health Services Resources Administration (HRSA): Office of Performance Review (OPR), or reviews from nationally accreditation organizations such as the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), Medicare, the Community Health Accreditation Program (CHAP), Accreditation Association for Ambulatory Healthcare (AAAHC), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey. Abbreviated reviews will focus on any deficiencies found in previous reviews, issues of compliance with this exhibit, and actions to strengthen performance as outlined in the agency Performance Workplan.

PRIMARY CARE CHILD HEALTH DIRECT CARE SERVICES
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Please note, for all measures, the following should be used **unless otherwise indicated:**

- Less than 19 years of age
- Served within the scope of this MCH contract during State Fiscal Year 2015 (July 1, 2014 – June 30, 2015)
- Each client can only be counted once (unduplicated)

Child Health Direct (CH – D) Performance Measure #1

Measure: 92%* of eligible children will be enrolled in Medicaid

Goal: To increase access to health care for children through the provision of health insurance

Definition: **Numerator-**
Of those in the denominator, the number of children enrolled in Medicaid.

Denominator-
Number of children who meet all of the following criteria:

- Less than 19 years of age
- Had 3 or more visits/encounters** during the reporting period
- As of the last visit during the reporting period were eligible for Medicaid

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**An encounter is face to face contact between a user and a provider who exercises independent judgment in the provision of services to the individual (UDS Table Definition).

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #2

Measure: 85%* of at-risk** children who were screened for blood lead between 18 and 30 months of age

Goal: To prevent childhood lead poisoning through early identification of lead exposure

Definition: **Numerator-**
Of those in the denominator, number of children screened for blood lead by capillary or venous on or after their 18-month birthday and prior to their 30-month birthday.

Denominator-
Number of at-risk** children who reached age 30 months during the reporting period. If discharged prior to 30 months, do not include in denominator.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**At risk = During the reporting period, the children were 18-29 months of age, and fit at least one of the following criteria:

- "Low income" (less than 185% poverty guidelines)
- Over 185% and resided in a town considered needing "Universal" screening per NH Childhood Lead Poisoning Prevention Program
- Over 185%, resided in a town considered "Target" and had a positive response to the risk questionnaire
- Refugee children -A refugee is defined as a person outside of his or her country of nationality who is unable or unwilling to return because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion (U.S. Citizenship and Immigration Services definition).

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #3

Measure: 71%* of children age two to nineteen years receiving primary care preventive health services with a Body Mass Index (BMI) percentile greater than or equal to the 85%ile with documented discussion of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Goal: To increase the percent of children receiving primary care preventive health services who have an elevated BMI percentile who receive guidance about promoting a healthier lifestyle.

Definition: **Numerator-**
Of those in the denominator, the number of children who had documentation in their medical record of there being discussion at least once during the reporting period of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Denominator-
Number of children who turned twenty-four months during or before the reporting period, up to the age of nineteen years, with one or more well child visit after their twenty-fourth month of age within the reporting year, and had an age and gender appropriate BMI percentile greater than or equal to the 85 % percentile at least once during the reporting period.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

Rationale: Children between the 85th – 94th percentiles BMI are encouraged to have 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks. (Discussion of the importance of family meal time, limiting eating out, consuming a healthy breakfast, preparing own foods, and promotion of breastfeeding is also encouraged.) American Academy of Pediatrics' guidance for Prevention and Treatment of Childhood Overweight and Obesity, (http://www.aap.org/obesity/health_professionals.html), from AAP Policy Statement: *Prevention of Pediatric Overweight and Obesity* and the AAP endorsed Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Children and Adolescent Overweight and Obesity, 2007.

*Target based on 2012 & 2013 Data Trend Table averages.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) #4

Measure: 75%* of eligible** infants and children with client record documentation of enrollment in WIC

Goal: To increase access to nutrition education, breastfeeding support, and healthy food through enrollment in the WIC Nutrition Program

Definition: **Numerator** -
Of those in the denominator, the number of infants and children who, as of the last well child visit during the reporting period, had client record documentation that infant or child was enrolled in WIC.

Denominator -
Unduplicated number of infants and children less than 5 years of age, enrolled in the agency, during the reporting period, who were eligible** for WIC.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

*Target based on 2012 & 2013 Data Trend Table averages.
**WIC Eligibility Requirements:

- Infants, and children up to their fifth birthday
- Must be income eligible (income guidelines are up to 185% of federal gross income, and are based on family size)

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Child Health Direct (CH – D) Performance Measure #5

Measure: 23%* of infants who were exclusively** breastfed for the first three months, at their four month well baby visit

Goal: To provide optimum nutrition to infants in their first three months of life

Definition: **Numerator -**
Of those in the denominator, the number of infants who had client record documentation that the infant had been exclusively breastfed for their first three months when checked at their four month well baby visit.

Denominator -
Number of infants who received one or more visits during or before the reporting period and were seen for a four-month well baby visit during the reporting period.

Data Source: Chart audit or query of 100% of the **total** population of patients as described in the denominator.

Benmarks: 2011 PedNSS (WIC) exclusive at 3 months: NH 22.9%, National (2010) 10.7%
2013 CDC Report Card (NIS, provisional 2010 births): NH 49.5%, National 37.7%
Healthy People 2020 goal: 44%

Rationale: The AAP recommends exclusive breastfeeding for about 6 months, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant, a recommendation concurred to by the World Health Organization and the Institute of Medicine. (American Academy of Pediatrics Policy Statement on Breastfeeding and the Use of Human Milk, 2012)

*Target based on 2012 & 2013 Data Trend Table averages.
**Exclusive means breast milk only, no supplemental formula, cereal/baby food, or water/fluids.

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE: ADULT

PERFORMANCE MEASURES DEFINITIONS

State Fiscal Year 2015

Primary Care: Adult Performance Measure #1

Measure:* 58%** of adult patients 18 – 85 years of age diagnosed with hypertension will have a blood pressure measurement less than 140/90*** mm at the time of their last measurement.

Goal: To ensure patients diagnosed with hypertension are adequately controlled.

Definition: **Numerator-** Number of patients from the denominator with blood pressure measurement less than 140/90 mm at the time of their last measurement.

Denominator- Number of patients age 18 – 85 with diagnosed hypertension must have been diagnosed with hypertension 6 or more months before the measurement date. (Excludes pregnant women and patients with End Stage Renal Disease.)

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

*Measure based on the National Quality Forum 0018

**Health People 2020 National Target is 61.2%

***Both the numerator and denominator must be less that 140/90 mm

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE CLINICAL
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Primary Care Clinical Adolescent (PC-C) Performance Measure #1

Measure: 61%* of adolescents aged 11-21 years received an annual health maintenance visits in the past 12 months.

Goal: To enhance adolescent health by assuring annual, recommended, adolescent well -visits.

Definition:

Numerator-
Number of adolescents in the denominator who received an annual health maintenance "well" visit during the reporting year.

Denominator-
Total number of adolescents aged 11-21 years who were enrolled in the primary care clinic as primary care clients during the reporting year period.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

***Target based on 2012 & 2013 Data Trend Table averages.**

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

Primary Care Clinical Prenatal (PC-C) Performance Measure #2

Measure: 31%* of women and adolescent girls aged 15-44 take multi-vitamins with folic acid.

Goal: To enhance pregnancy outcomes by reducing neural tube defects.

Definition:

Numerator-
The number of women and adolescent girls aged 15-44 who take a multi-vitamin with folic acid.

Denominator-
The number of women and adolescent girls aged 15-44 who were seen in primary care for a well visit in the past year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

***Target based on 2012 & 2013 Data Trend Table averages.**

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRIMARY CARE - FINANCIAL
PERFORMANCE MEASURE DEFINITIONS
Fiscal Year 2015

Primary Care (PC) Performance Measure #1

Measure: Patient Payor Mix

Goal: To allow monitoring of payment method trends at State funded primary care sites.

Definition: Patients enrolled in Medicare, Medicaid, Commercial insurance, or uninsured.

Data Source: Provided by agency

Primary Care (PC) Performance Measure #2

Measure: Accounts Receivables (AR) Days

Goal: To allow monitoring of financial sustainability trends at State funded primary care sites.

Definition: AR Days: Net Patient Accounts Receivable **multiplied by** 365 **divided by** Net Patient Revenue

Data Source: Provided by agency

Primary Care (PC) Performance Measure #3

Measure: Current Ratio

Goal: To allow monitoring of financial sustainability trends at State funded primary care sites.

Definition: Current Ratio = Current Assets **divided by** Current Liabilities

Data Source: Provided by agency

EXHIBIT A– AMENDMENT 1 - PERFORMANCE MEASURES

PRENATAL
PERFORMANCE MEASURES DEFINITIONS
State Fiscal Year 2015

Prenatal (PN) Performance Measure #1

Measure: 85%* of pregnant women who are enrolled in the agency's prenatal program will begin prenatal care during the first trimester of pregnancy.

Goal: To enhance pregnancy outcomes by assuring early entrance into prenatal care.

Definition:

Numerator-
Number of women in the denominator who had a documented prenatal visit during the first trimester (on or before 13.6 weeks gestation).

Denominator-
Number of women enrolled in the agency prenatal program who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

* Target based on 2012 & 2013 Data Trend Table averages.

Prenatal (PN) Performance Measure #2

Measure: 20%* of pregnant women who are identified as cigarette smokers will be referred to QuitWorks-New Hampshire.

Goal: To reduce tobacco use during pregnancy through focused tobacco use cessation activities at public health prenatal clinics.

Definition:

Numerator-
Number of women in the denominator who received at least one referral to QuitWorks-New Hampshire during pregnancy.

A referral is defined as signing the patient up for QuitWorks-NH via phone, fax, or EMR. It is not defined as discussing QuitWorks-NH with the patient and encouraging her to sign up.

Denominator-
Number of women enrolled in the agency prenatal program and identified as tobacco users who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

*Target set in consultation with the NH Tobacco Program & FY13 Data Trend Table average.

Prenatal (PN) Performance Measure #3

Measure: 79%* of pregnant women will be screened, using a formal valid screening tool, for alcohol and other substance use during every trimester they are enrolled in the prenatal program.

Goal: To reduce prenatal substance use through systematic screening and identification.

Definition: **Numerator-** Number of women in the denominator who were screened for substance and alcohol use, using a formal and valid screening tool, during each trimester that they were enrolled in the prenatal program.

Denominator- Number of women enrolled in the agency prenatal program and who gave birth during the reporting year.

Data Source: Chart audits or query of 100% of the **total** population of patients as described in the denominator.

* Target based on 2012 & 2013 Data Trend Table averages.

Exhibit B-1 (2014) -Amendment 1

Budget

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: White Mountain Community Health Center

Budget Request for: MCH Primary Care
(Name of RFP)

Budget Period: SFY 2014

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages	$ -	$ -	$ -	
2. Employee Benefits	$ -	$ -	$ -	
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	$ 40,300.00	$ -	$ 40,300.00	
13. Other (specific details mandatory):	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
TOTAL	**$ 40,300.00**	**$ -**	**$ 40,300.00**	

Indirect As A Percent of Direct 0.0%

Contractor Initials: [signature]

Date: 3-14-14

Exhibit B-1 (2015) -Amendment 1
Budget

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: White Mountain Community Health Center

Budget Request for: MCH Primary Care, BCCP & RHPC
(Name of RFP)

Budget Period: SFY 2015

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages	$ 143,668.00	$ -	$ 143,668.00	0
2. Employee Benefits	$ 20,602.00	$ -	$ 20,602.00	0
3. Consultants	$ 3,000.00	$ -	$ 3,000.00	0
4. Equipment:	$ -	$ -	$ -	0
Rental	$ -	$ -	$ -	0
Repair and Maintenance	$ -	$ -	$ -	0
Purchase/Depreciation	$ -	$ -	$ -	0
5. Supplies:	$ -	$ -	$ -	0
Educational	$ -	$ -	$ -	0
Lab	$ -	$ -	$ -	0
Pharmacy	$ -	$ -	$ -	0
Medical	$ -	$ -	$ -	0
Office	$ -	$ -	$ -	0
6. Travel	$ -	$ 50.00	$ 50.00	Prog Coor..travel to Concord, NH - administering / MCH Grant -Approx 137 Mi @$.365/Mi
7. Occupancy	$ -	$ -	$ -	0
8. Current Expenses	$ -	$ -	$ -	0
Telephone	$ -	$ -	$ -	0
Postage	$ -	$ -	$ -	0
Subscriptions	$ -	$ -	$ -	0
Audit and Legal	$ -	$ -	$ -	0
Insurance	$ -	$ -	$ -	0
Board Expenses	$ -	$ -	$ -	0
9. Software	$ -	$ -	$ -	0
10. Marketing/Communications	$ -	$ -	$ -	0
11. Staff Education and Training	$ -	$ -	$ -	0
12. Subcontracts/Agreements	$ 50,600.00	$ -	$ 50,600.00	0
13. Other (specific details mandatory):	$ 5,725.00	$ -	$ 5,725.00	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
0	$ -	$ -	$ -	0
TOTAL	**$ 223,595.00**	**$ 50.00**	**$ 223,645.00**	0

Indirect As A Percent of Direct 0.0%

Contractor Initials: Pmc

Date: 3-14-14

State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that WHITE MOUNTAIN COMMUNITY HEALTH CENTER is a New Hampshire nonprofit corporation formed June 1, 1981. I further certify that it is in good standing as far as this office is concerned, having filed the return(s) and paid the fees required by law.

In TESTIMONY WHEREOF, I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 3rd day of March A.D. 2014

William M. Gardner
Secretary of State

CERTIFICATE OF VOTE

I, Angela Zakon of White Mountain Community Health Center, do hereby certify that:

1. I am the duly elected Treasurer of White Mountain Community Health Center;

2. The following are true copies of two resolutions duly adopted at a meeting of the Board of Directors of the corporation, duly held on January 23, 2014;

   RESOLVED: That this corporation enters into contracts with the State of New Hampshire, acting through its Department of Health and Human Services, Division of Public Health Services.

   RESOLVED: That the Executive Director is hereby authorized on behalf of this corporation to enter into said contracts with the State and to execute any and all documents, agreements, and other instruments; and any amendments, revisions, or modifications thereto, as she may deem necessary, desirable, or appropriate. Patricia McMurry is the duly elected Executive Director of the corporation.

3. The foregoing resolutions have not been amended or revoked and remain in full force and effect as of March 14, 2014.

IN WITNESS WHEREOF, I have hereunto set my hand as the Treasurer of the corporation this 14th day of March, 2014.

[signature]
Treasurer of White Mountain Community Health Center

STATE OF NEW HAMPSHIRE

COUNTY OF CARROLL

The foregoing instrument was acknowledged before me this 14th day of March, 2014 Angela Zakon.

Diane Brothers
Notary Public/Justice of the Peace
My Commission Expires:

DIANE BROTHERS
Notary Public - New Hampshire
My Commission Expires August 19, 2014

WHITE-4 OP ID: JS

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 02/27/2014

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 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
Noyes Hall & Allen Insurance
www.noyeshallallen.com
170 Ocean Street, PO Box 2403
South Portland, ME 04116-2403
Chalmers Insurance Group

CONTACT NAME: Thomas P. Noyes, CPCU
PHONE (A/C, No, Ext): 207-799-5541 FAX (A/C, No): 207-767-7590
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Medical Mutual Insurance Co.	
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
White Mountain Community Health Center
298 White Mountain Highway
North Conway, NH 03818

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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY / PRO-JECT / LOC			NH HCP 004254	01/01/2014	01/01/2015	EACH OCCURRENCE	$ 1,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 100,000
							MED EXP (Any one person)	$ 5,000
							PERSONAL & ADV INJURY	$ 1,000,000
							GENERAL AGGREGATE	$ 3,000,000
							PRODUCTS - COMP/OP AGG	$ 1,000,000
								$
	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS / SCHEDULED AUTOS HIRED AUTOS / NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident)	$
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (PER ACCIDENT)	$
								$
A	X UMBRELLA LIAB / OCCUR EXCESS LIAB / X CLAIMS-MADE DED X RETENTION $ 10000			NH UMB 004256	01/01/2014	01/01/2015	EACH OCCURRENCE	$ 1,000,000
							AGGREGATE	$ 1,000,000
								$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A					WC STATU-TORY LIMITS / OTH-ER	
							E.L. EACH ACCIDENT	$
							E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Med Prof Liab Claims Made			NH HCP 004254	01/01/2014	01/01/2015	Each Loss	1,000,000
							Aggregate	3,000,000

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

RE: State Grants

CERTIFICATE HOLDER

DHHS123

DHHS
Contracts and Procurement
Unity
129 Pleasant Street
Concord, NH 03301

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 3/21/2014

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 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
Chalmers Insurance Group - North Conway
PO Box 2480
3277 White Mountain Highway
North Conway NH 03860

CONTACT NAME: Andrea Nicklin
PHONE (A/C, No, Ext): (603) 356-6926 FAX (A/C, No): (603) 356-6934
E-MAIL ADDRESS: anicklin@chalmersinsurancegroup.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: Technology Insurance Co.	
INSURER B:	
INSURER C:	
INSURER D:	
INSURER E:	
INSURER F:	

INSURED
White Mountain Community Health Center
PO Box 2800
Conway NH 03818

COVERAGES CERTIFICATE NUMBER: 14/15 WC 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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	GENERAL LIABILITY						EACH OCCURRENCE	$
	COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
	CLAIMS-MADE / OCCUR						MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
							GENERAL AGGREGATE	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$
	POLICY / PRO-JECT / LOC							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS / NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB / OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB / CLAIMS-MADE						AGGREGATE	$
	DED / RETENTION $							$
A	**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY** Y/N						WC STATU-TORY LIMITS / OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? **(Mandatory in NH)**	N/A		TWC3396073	1/1/2014	1/1/2015	E.L. EACH ACCIDENT	$ 100,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 100,000
							E.L. DISEASE - POLICY LIMIT	$ 500,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
Evidence of Insurance

CERTIFICATE HOLDER

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
Andrea Nicklin/ANDREA

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WHITE MOUNTAIN COMMUNITY HEALTH CENTER

AUDITED FINANCIAL STATEMENTS

JUNE 30, 2013 AND 2012

BRAD BORBIDGE, P.A.
CERTIFIED PUBLIC ACCOUNTANTS
197 LOUDON ROAD, SUITE 350
CONCORD, NEW HAMPSHIRE 03301

TELEPHONE 603/224-0849
TELEFAX 603/224-2397

Independent Auditor's Report

Board of Directors
White Mountain Community Health Center
Conway, New Hampshire

We have audited the accompanying balance sheets of White Mountain Community Health Center, as of June 30, 2013 and 2012, and the related statements of operations, changes in net assets and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these 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 financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the 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 entity'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 financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of White Mountain Community Health Center as of June 30, 2013 and 2012, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Concord, New Hampshire
October 2, 2013

WHITE MOUNTAIN COMMUNITY HEALTH CENTER

BALANCE SHEETS

JUNE 30, 2013 AND 2012

ASSETS

	2013	2012
Current Assets		
Cash and cash equivalents	$ 456,578	$ 493,037
Investments	6,441	5,559
Patient accounts receivable, net of allowances for uncollectible accounts of $35,000 and $33,638 at June 30, 2013 and 2012, respectively	95,634	52,261
Other receivables	53,887	61,707
Prepaid expenses	22,111	20,897
Total Current Assets	634,651	633,461
Assets Limited As To Use	19,677	103,474
Property And Equipment, Net	82,898	61,004
TOTAL ASSETS	$ 737,226	$ 797,939

LIABILITIES AND NET ASSETS

	2013	2012
Current Liabilities		
Accounts payable and accrued expenses	$ 33,418	$ 72,506
Accrued payroll and related expenses	78,289	88,173
Deferred revenue	57,430	50,690
Total Current Liabilities	169,137	211,369
Net Assets		
Unrestricted	548,412	548,545
Temporarily restricted net assets	19,677	38,025
Total Net Assets	568,089	586,570
TOTAL LIABILITIES AND NET ASSETS	$ 737,226	$ 797,939

(See accompanying notes to these financial statements)

WHITE MOUNTAIN COMMUNITY HEALTH CENTER

STATEMENTS OF OPERATIONS

FOR THE YEARS ENDED JUNE 30, 2013 AND 2012

	2013	2012
Operating Revenue		
Patient service revenue	$ 760,053	$ 773,691
Provision for bad debt	(24,660)	(24,550)
Net Patient Service Revenue	735,393	749,141
Government and private grants	478,346	509,071
In-kind contributions	80,508	98,672
Other operating revenue	17,876	9,226
Net assets released from restrictions	18,443	14,769
Total Operating Revenue	1,330,566	1,380,879
Operating Expenses		
Salaries and benefits	931,278	933,069
Professional fees and contract services	164,883	148,170
Other operating expenses	163,719	164,890
Program supplies	84,365	82,751
Depreciation	13,325	17,654
Interest expense	352	124
In-kind contributed expenses	80,508	98,672
Total Operating Expenses	1,438,430	1,445,330
OPERATING LOSS	(107,864)	(64,451)
Other Revenue and Gains		
Contributions	77,096	65,049
Investment income	942	1,999
Total Other Revenue and Gains	78,038	67,048
(DEFICIT) EXCESS OF REVENUE OVER EXPENSES	(29,826)	2,597
Change in unrealized gain on investments	882	305
Net assets released from restriction for capital acquisition	28,811	32,000
(DECREASE) INCREASE IN UNRESTRICTED NET ASSETS	$ (133)	$ 34,902

(See accompanying notes to these financial statements)

WHITE MOUNTAIN COMMUNITY HEALTH CENTER

STATEMENTS OF CHANGES IN NET ASSETS

FOR THE YEARS ENDED JUNE 30, 2013 AND 2012

	Unrestricted	Temporarily Restricted	Total
Balance, June 30, 2011	$ 515,029	$ 41,646	$ 556,675
Excess of revenue over expense	1,211	-	1,211
Change in unrealized gain on investments	305	-	305
Contributions	-	43,082	43,082
Temp restricted investment income	-	66	66
Net assets released for capital acquisition	32,000	(32,000)	-
Net assets released for operations	-	(14,769)	(14,769)
Change in Net Assets	33,516	(3,621)	29,895
Balance, June 30, 2012	548,545	38,025	586,570
Deficit of revenue over expense	(29,826)	-	(29,826)
Change in unrealized gain on investments	882	-	882
Contributions	-	41,562	41,562
Temp restricted interest income	-	22	22
Net assets released to The Memorial Hospital	-	(12,678)	(12,678)
Net assets released for capital acquisition	28,811	(28,811)	-
Net assets released for operations	-	(18,443)	(18,443)
Change in Net Assets	(133)	(18,348)	(18,481)
Balance, June 30, 2013	$ 548,412	$ 19,677	$ 568,089

(See accompanying notes to these financial statements)

WHITE MOUNTAIN COMMUNITY HEALTH CENTER

STATEMENTS OF CASH FLOWS

FOR THE YEARS ENDED JUNE 30, 2013 AND 2012

	2013	2012
Cash Flows From Operating Activities		
Change in net assets	$ (18,481)	$ 29,895
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation	13,325	17,654
Bad debt expense	24,660	25,936
Restricted contributions	(41,562)	(43,082)
Transfer to The Memorial Hospital	12,678	-
Change in unrealized gain on investments	(882)	(305)
(Increase) decrease in the following assets:		
Patient accounts receivable	(68,033)	(28,195)
Other receivables	7,820	46,467
Prepaid expenses	(1,214)	3,015
Increase (decrease) in the following liabilities:		
Accounts payable and accrued expenses	(39,088)	39,356
Accrued payroll and related expenses	(9,884)	510
Deferred revenue	6,740	14,112
Net Cash (Used) Provided by Operating Activities	(113,921)	105,363
Cash Flows From Investing Activities		
Decrease in assets limited as to use	83,797	3,503
Capital expenditures	(35,219)	(41,193)
Net Cash Provided (Used) by Investing Activities	48,578	(37,690)
Cash Flows From Financing Activities		
Transfer to The Memorial Hospital	(12,678)	-
Restricted contributions	41,562	43,082
Net Cash Provided by Financing Activities	28,884	43,082
Net (Decrease) Increase in Cash and Cash Equivalents	(36,459)	110,755
Cash and Cash Equivalents, Beginning of Year	493,037	382,282
CASH AND CASH EQUIVALENTS, END OF YEAR	$ 456,578	$ 493,037
Supplemental Disclosures of Cash Flow Information:		
Cash paid for interest	$ 352	$ 124

(See accompanying notes to these financial statements)

Mission Statement:

"White Mountain Community Health Center provides comprehensive, high-quality primary care services and health education on a sustainable basis to women, men and children in the Mount Washington Valley community regardless of ability to pay."

P.O. Box 2800 • 298 White Mountain Highway • Conway, NH 03818 • (603) 447-8900
• Fax (603) 447-4846 • www.whitemountainhealth.org

Board of Directors

Trish Murray, D.O.
President
Brenda Leavitt
Vice President
Angela Zakon
Treasurer
Eric Hirschfeld, DDS
Secretary
Carol Hastings

Susan Logan

Scott McKinnon

Chris Meier

Michelle O'Donnell

Ben Wilcox

Updated February 2014

P.O. Box 2800 • 298 White Mountain Highway • Conway, NH 03818 • (603) 447-8900
Fax (603) 447-4846 • www.whitemountainhealth.org

KEY ADMINISTRATIVE PERSONNEL

NH Department of Health and Human Services

Contractor Name: White Mountain Community Health Center

Name of Bureau/Section: MCH Primary Care

BUDGET PERIOD: SFY 14

Program Area: MCH Primary Care

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
McMurry, Patricia	Executive Director	$84,338	0.00%	$0.00
		$0	0.00%	$0.00
		$0	0.00%	$0.00
		$0	0.00%	$0.00
		$0	0.00%	$0.00
		$0	0.00%	$0.00
		$0	0.00%	$0.00
		$0	0.00%	$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$0.00**

KEY ADMINISTRATIVE PERSONNEL

NH Department of Health and Human Services

Contractor Name: White Mountain Community Health Center

Name of Bureau/Section: MCH Primary Care & BCCP

BUDGET PERIOD: SFY 15

Program Area: MCH Primary Care Services

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Hill, Julie Ann	Director of Clinical Services	$41,075	14.06%	$5,776.00
McMurry, Patricia	Executive Director	$84,338	0.00%	$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$5,776.00**

Program Area: Breast and Cervical Cancer Program Services

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Hill, Julie Ann	Director of Clinical Services	$41,075	9.37%	$3,850.00
McMurry, Patricia	Executive Director	$84,338	0.00%	$0.00
				$0.00
				$0.00
				$0.00
				$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$3,850.00**

Program Area: Rural Health and Primary Care Services

NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
McMurry, Patricia	Executive Director	$84,338	0.00%	$0.00
				$0.00
				$0.00
				$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$0.00**

Patricia M. McMurry

QUALIFICATIONS

- Extensive experience in business administration, project management and finance
- Skilled in human relations, group facilitation, public speaking, leadership and team building
- Strong marketing, advertising and public relations skills
- Seasoned professional with a breadth of abilities and experience and a proven track record for achieving increasing responsibilities and accomplishing significant business goals

EXPERIENCE

Executive Director **White Mountain Community Health Center** **2002-Present**

Responsible for all aspects of operations of a non-profit community health center. This Center serves the uninsured and underinsured of Northern Carroll County in New Hampshire. Prenatal, children, adults and teens are seen by health care providers including physician, mid-wives, nurse practitioners, RN's, aides, social workers, hygienist, dentist and nutritionist. Substantially increased and sustained the financial viability of the health center. New and expanded services and patient volume doubled in five years.

Business Consultant **Kleen Oil Kompany** **1999-2002**

Responsible for all aspects of business operations

- Increased collections
- Developed marketing plans and strategy
- Developed policies, procedures and job descriptions
- Developed incentive plans

Director of Operations **HealthSouth Corporation*** **1995-1998**

Responsible for oversight of both a 50-bed and a 100-bed acute rehabilitation hospital, and eight contracted rehabilitation units in four states

- Promoted in one year from Assistant Vice President to Director of Operations
- Managed the physical relocation of the 100-bed acute rehabilitation hospital
- Initiated negotiations for joint venture between a large non-profit hospital and a publicly traded rehabilitation company

Chief Executive Officer **National Medical Enterprises** **1988-1995**

Responsible for oversight of both a 40-bed and an 88-bed rehabilitation hospital

- Promoted in two years from CEO of a 40-bed hospital to CEO of an 88-bed rehabilitation hospital and was made Company Assistant Vice President
- Managed all aspects of the 88-bed hospital, resulting in three prestigious awards for the highest quality and business goals performance from N.M.E.
- Developed and opened three outpatient rehab clinics
- Maintained the financial turnaround of a 40-bed hospital and sustained "above plan" financial performance during my tenure as CEO
- Managed a 40-bed hospital, resulting in three Special Achievement Awards and a Florida Certificate of Need to increase the capacity to 70 beds

* HealthSouth acquired National Medical Enterprises Rehabilitation Hospitals in 1995

V.P. of Operations **Charter Medical Corporation** **1987-1988**

Responsible for marketing, planning, business development, and program management for a newly-opened psychiatric hospital

- Supervised all Clinical Program Directors and the Intake Coordinator
- Became the physician-liaison to the CEO
- Was consultant to an affiliated psychiatric hospital, training staff to use human relations techniques with disruptive teens
- Implemented the utilization review, risk management, and quality assurance activities to achieve J.C.A.H.O accreditation

Director, Community Relations and Resource Development **1985-1987**
Eastern State Hospital

Responsible for community relations as well as identification and alignment of resources required for hospital and community use of a large state psychiatric hospital

- Designed and implemented a community relations plan to ensure the success of appropriate admissions and discharges
- Established a strategic partnership with the Virginia Supreme Court, Community Mental Health Directors, and area psychiatric facilities
- Organized and promoted the first judicial conference at the hospital
- Negotiated crisis intervention inpatient stays for children in their home communities with private sector hospitals

EDUCATION

M.S.W. – Norfolk State University
B.A. – College of William and Mary

TRAINING

UVA Forensic Institute
L.C.S.W. and A.C.S.W. (Virginia))

HONORS

President's Circle – HealthSouth
Special Achievement Awards – National Medical Enterprises

Julie Everett Hill, RN

PROFILE

I am a Registered Nurse with a current NH License, currently serving as the Director of Clinical Services at a rural community health center. I enjoy the dynamic nature of working in primary care and the challenge of thinking creatively to solve problems. My interests include mental health and asthma education, with an emphasis on viewing the family as a whole when providing care.

EXPERIENCE

Director of Clinical Services, White Mountain Community Health Center, Conway NH November 2011-Present

Direct supervisor to thirteen clinical staff; responsible for management and oversight of clinical quality measures, protocols, budgets, MCH grantee compliance, medication bridge program and staffing. Case Manager for Breast and Cervical Screening Program. Recently responsible for implementation of e-prescribing and in-house electronic patient registries.

Registered Nurse, White Mountain Community Health Center, Conway NH 2009- November 2011

Primary care and family planning focus, with patient population newborn through geriatric. Strong focus on patient education, including asthma education and diabetic teaching. Other roles include triage and prioritization of care and coordination of patient care with resources both within and outside of the clinic.

Registered Nurse, The Memorial Hospital; N. Conway, NH June 2007- June 2010

Medical Surgical nursing care of a broad range of patients from pediatric to geriatric. Roles include assessment and care of acutely ill patients with medical, surgical and or orthopedic diagnoses. Patient education, care planning, complete patient assessment and accurate documentation in EMR are an integral part of this position.

Licensed Practical Nurse, The Memorial Hospital; N. Conway, NH May 2006- June 2007

Medical Surgical, post-partum and newborn nursing care under the supervision of an RN.

LNA/Unit Secretary, The Memorial Hospital; N. Conway, NH February 2001- May 2006

Unit secretary LNA in fast-paced medical surgical unit. Duties included transcribing doctor's orders, managing patient carts, answering and directing phone calls, assisting nurses with order entry and facilitating communication between departments.

EDUCATION

St. Anselm College, Manchester NH- Advanced Nursing Leadership Certificate Program – September 2012- present, as part of pursuing RN to BSN.

NHCTC-Berlin Associates Degree in Science, Nursing; May 17, 2007

Phi Theta Kappa Honor Society

Southern Maine Technical College, Portland ME - Nursing Assistant Certificate 1994

University of Southern Maine 1992-1993; English Major

Certifications and relevant continuing education include:

Blending Mission and Margin: Business Skills for the Nurse Leader; St. Anselm College September 2012

Current ACLS and BLS

Asthma Educators Institute 2010

Diabetes Nurse Champion, September 2008

WIC Breastfeeding Peer Counselor Certificate, November 2000.

Nicholas A. Toumpas
Commissioner

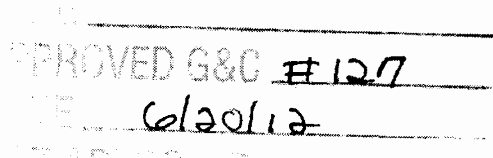
José Thier Montero
Director

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

29 HAZEN DRIVE, CONCORD, NH 03301-6527
603-271-4517 1-800-852-3345 Ext. 4517
Fax: 603-271-4519 TDD Access: 1-800-735-2964

May 17, 2012



His Excellency, Governor John H. Lynch
and the Honorable Executive Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Public Health Services, Bureau of Population Health and Community Services, Maternal and Child Health Section, to enter into an agreement with White Mountain Community Health Center (Vendor #174170-R001), 298 White Mountain Highway, PO Box 2800, Conway, New Hampshire 03818, in an amount not to exceed $315,568.00, to provide primary care services and breast and cervical cancer screening, to be effective July 1, 2012 or date of Governor and Executive Council approval, whichever is later, through June 30, 2014. Funds are available in the following accounts for SFY 2013, and are anticipated to be available in SFY 2014 upon the availability and continued appropriation of funds in the future operating budgets.

05-95-90-902010-5190 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES, MATERNAL AND CHILD HEALTH

Fiscal Year	Class/Object	Class Title	Job Number	Total Amount
SFY 2013	102-500731	Contracts for Program Services	90080000	$134,913
SFY 2014	102-500731	Contracts for Program Services	90080000	$134,913
			Sub-Total	$269,826

05-95-90-901010-5149 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF PUBLIC HEALTH SYSTEMS, POLICY AND PERFORMANCE, RURAL HEALTH AND PRIMARY CARE

Fiscal Year	Class/Object	Class Title	Job Number	Total Amount
SFY 2013	102-500731	Contracts for Program Services	90073001	$10,000
SFY 2014	102-500731	Contracts for Program Services	90073001	$10,000
			Sub-Total	$20,000

05-95-90-902010-5659 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES, COMPREHENSIVE CANCER

Fiscal Year	Class/Object	Class Title	Job Number	Total Amount
SFY 2013	102-500731	Contracts for Program Services	90080081	$12,871
SFY 2014	102-500731	Contracts for Program Services	90080081	$12,871
			Sub-Total	$25,742
			Total	$315,568

EXPLANATION

Funds in this agreement will be used to provide breast and cervical cancer screening and office-based primary care services for low-income and uninsured families. This agreement provides funds for services as a last resort; contractor is required to make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid.

Primary health care services include preventive and episodic health care for acute and chronic health conditions for people of all ages, including pregnant women, children, adolescents, adults, and the elderly. Community health agencies that receive support through the Division of Public Health Services deliver primary and preventive health care services to underserved people who face barriers to accessing health care, due to issues such as a lack of insurance, inability to pay, language barriers, and geographic isolation. In addition to medical care, community health centers are unique among primary care providers for the array of patient-centered services they offer, including care coordination, translation, transportation, outreach, eligibility assistance, and health education. These services help individuals overcome barriers to getting the care they need and achieving their optimal health. One area of particular success has been in ensuring that eligible families maintain consistent enrollment in Medicaid for their children. Community health centers provide support for families in filling out applications and ensuring that children have continuity of care.

Community health agencies throughout New Hampshire have demonstrated success in meeting the health care needs of the uninsured and under-insured citizens of the state. Division of Public Health Services funded primary care providers participate in rigorous quality improvement efforts utilizing standard performance measures that focus attention on improving health outcomes for patients. For example, in State Fiscal Year 2011:

- 88% of eligible children served were enrolled in Medicaid/Healthy Kids Gold.
- 86% of children 24-35 months, served received the appropriate schedule of immunizations.
- 82% of infants born to women served received prenatal care beginning in the first trimester of pregnancy.

In addition, breast and cervical cancers continue to be ongoing public health issues for New Hampshire. The Division of Public Health Services, Breast and Cervical Cancer Screening Program provides support for breast and cervical cancer screening services that include clinical examinations, pap smears and referral for mammography. Through this program, women found to have abnormal screening results, following their testing,

receive additional coverage for diagnostic work-up and, if necessary, have their care coordinated through the initiation of treatment.

Should Governor and Executive Council not authorize this Request, a minimum of 7,330 low-income individuals from the Northern Carroll County area may not have access to primary care services, and eligible women may not receive recommended breast and cervical cancer screenings. A strong primary care infrastructure reduces costs for uncompensated care, improves health outcomes, and reduces health disparities. Additionally women that receive recommended breast and cervical cancer screenings are at lower risk of late diagnosis of breast and cervical cancers.

White Mountain Community Health Center was selected for this project through a competitive bid process. A Request for Proposals was posted on the Department of Health and Human Services' web site from January 10, 2012 through February 16, 2012. In addition, a bidder's conference, conference call, and web conference were held on January 19, 2012 to alert agencies to this bid.

Thirteen proposals were received in response to the posting. Each proposal was scored by three professionals, who work internal and external to the Department of Health and Human Services. All reviewers have between three to twenty years experience either in clinical settings, providing community-based family support services, and managing agreements with vendors for various public health programs. Areas of specific expertise include maternal and child health; quality assurance and performance improvement; chronic and communicable diseases and public health infrastructure. The reviewers used a standardized form to score agencies' relevant experience and capacity to carry out the activities outlined in the proposal. Reviewers look for realistic targets when scoring performance measures in addition to detailed workplans including evaluation components. Budgets were reviewed to be reasonable, justified and consistent with the intent of the program goals and outcomes. There were no competing applications within each of the separate service areas. Scores were averaged and all proposals were recommended for funding. In those instances where scores were less than ideal, agency specific remedial actions were recommended and completed. Some primary care agencies are being funded at levels higher than they requested. Agencies were instructed to develop budgets based on previous allocations. While some proposed budgets higher than what was available for funding, others proposed budgets lower than what was available. There was an increase in breast and cervical cancer screening funds that bidders were unaware of when they drafted budgets. Adjustments were made accordingly for those agencies that proposed budgets at levels lower than available funds. This is a contract where that situation occurred. The Bid Summary is attached.

As referenced in the Request for Proposals, Renewals Section, this competitively procured Agreement has the option to renew for two additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties and approval of the Governor and Executive Council. These services were contracted previously with this agency in SFY 2011 and SFY 2012 in the amount of $512,174. This represents a decrease of $196,606. The decrease is due to budget reductions.

The performance measures used to measure the effectiveness of the agreement are attached.

Area served: Northern Carroll County.

Source of Funds: 25.22% Federal Funds from US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau and 74.78% General Funds.

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

Respectfully submitted,

José Thier Montero, MD
Director

Approved by:
Nicholas A. Toumpas
Commissioner

JTM/PMT/sc

Primary Care Performance Measures

State Fiscal Year 2013

Primary Care Prenatal (PN) Performance Measure #1

Measure: Percent of infants born to women receiving prenatal care beginning in the first trimester of pregnancy.

Primary Care Prenatal (PN) Performance Measure #2

Measure: Percent of pregnant women identified as cigarette smokers that are referred to QuitWorks-New Hampshire.

Primary Care Prenatal (PN) Performance Measure #3

Measure: Percent of pregnant women who were screened, using a formal valid screening tool, for alcohol and other drug use during every trimester the patient was enrolled.

Primary Care Child Health Direct (CH – D) Performance Measure #1

Measure: Percent of eligible children enrolled in Medicaid

Primary Care Child Health Direct (CH – D) Performance Measure #2

Measure: Percent of at-risk children who were screened for blood lead between 18 and 30 months of age

Primary Care Child Health Direct (CH – D) Performance Measure #3

Measure: Percent of children age two to nineteen years receiving primary care preventive health services with a Body Mass Index (BMI) percentile greater than or equal to the 85th percentile with documented discussion of encouraging 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks.

Primary Care Child Health Direct (CH – D) Performance Measure #4

Measure: Percent of eligible infants and children with client record documentation of enrollment in Women Infant Children Program.

Primary Care Child Health Direct (CH – D) Performance Measure #5

Measure: Percent of infants who were exclusively breastfed for the first three months, at their four month well baby visit.

Primary Care Financial (PC) Performance Measure #1

Measure: Patient Payor Mix

Primary Care Financial (PC) Performance Measure #2

Measure: Accounts Receivables (AR) Days

Primary Care Financial (PC) Performance Measure #3

Measure: Current Ratio

Primary Care Performance Measures

State Fiscal Year 2013

Primary Care Clinical Adolescent (PC-C) Performance Measure #1

Measure: Percent of adolescents aged 10-21 years who received annual health maintenance visits in the past 12 months.

Primary Care Clinical Prenatal (PC-C) Performance Measure #2

Measure: Percent of women and adolescent girls aged 15-44 who take a multi-vitamin with folic acid.

Subject: Primary Care Services

AGREEMENT

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

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name		1.2 State Agency Address	
NH Department of Health and Human Services Division of Public Health Services		29 Hazen Drive Concord, NH 03301-6504	
1.3 Contractor Name White Mountain Community Health Center		1.4 Contractor Address 298 White Mountain Highway PO Box 2800 Conway, New Hampshire 03818	
1.5 Contractor Phone Number 603-447-8900	1.6 Account Number 010-090-5190-102-500731 010-090-5149-102-500731 010-090-5659-102-500731	1.7 Completion Date June 30, 2014	1.8 Price Limitation $315,568
1.9 Contracting Officer for State Agency Joan H. Ascheim, Bureau Chief		1.10 State Agency Telephone Number 603-271-4501	
1.11 Contractor Signature Patricia McMurry		1.12 Name and Title of Contractor Signatory Patricia McMurry, Executive Director	

1.13 Acknowledgement: State of NH, County of Carroll

On 4/4/12, before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.

1.13.1 Signature of Notary Public or Justice of the Peace

Diane Brothers

DIANE BROTHERS
Notary Public - New Hampshire
My Commission Expires August 19, 2014

[Seal]

1.13.2 Name and Title of Notary or Justice of the Peace

Diane Brothers Notary Public

1.14 State Agency Signature	1.15 Name and Title of State Agency Signatory
[signature]	Joan H. Ascheim, Bureau Chief

1.16 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)*

By: Director, On:

1.17 Approval by the Attorney General (Form, Substance and Execution)

By: Jeanne P. Herrick, Attorney On: 4 June 2012

1.18 Approval by the Governor and Executive Council

By: On:

NH Department of Health and Human Services

Exhibit A

Scope of Services

Primary Care Services

CONTRACT PERIOD: July 1, 2012 or date of G&C approval, whichever is later, through June 30, 2014

CONTRACTOR NAME: White Mountain Community Health Center

ADDRESS: 298 White Mountain Highway, PO Box 2800
Conway, New Hampshire 03818
Executive Director: Patricia McMurry
TELEPHONE: 603-447-8900

The Contractor shall:

I. General Provisions

A) Eligibility and Income Determination

1. Office-based primary care services will be provided to low-income individuals and families (defined as ≤ 185% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), in the State of New Hampshire.

2. Breast and Cervical Cancer screening services will be provided to low-income (defined as ≤ 250% of the U.S. Department of Health and Human Services (USDHHS), Poverty Guidelines, updated annually and effective as of July 1 of each year), New Hampshire women age 18 – 64, *uninsured or underinsured*.

3. The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing if, at any time, the practice is closed to new patients, or maintains a wait list for new patients, or any other mechanism is used that limits access for new patients for more than a one month period.

4. The Contractor shall document annually, for each client enrolled in the program, family income and family size, and calculate percentage of the federal poverty level. If calculations indicate that the client may be eligible for enrollment in Medicaid, the Contractor shall complete with the client the most recent version of the 800P form.

5. The Contractor shall implement, and post in a public and conspicuous location, a sliding fee payment schedule, approved in advance by the Division of Public Health Services (DPHS), for low-income patients. Signage must state that no client will be denied services for inability to pay.

   a. As an alternative, the contractor may post, in a public and conspicuous location, a notice to clients that a sliding fee scale is available and that no client will be denied services for inability to pay. The sliding fee scale must be updated annually based on USDHHS Poverty guidelines as published in the Federal Register, submitted to and approved by DPHS *prior to implementation.*

6. The primary care contract entered into here shall be the payer of last resort. The contractor shall make every effort to bill all other payers including but not limited to: private and commercial insurances, Medicare, and Medicaid, for all reimbursable services rendered.

B) Numbers Served

1. The contract funds shall be expended to provide the above services to a minimum of 3665 users annually with 6785 medical encounters, as defined in the Data and Reporting Requirements. Breast and Cervical Cancer Screening for eligible women, as defined by the Breast and Cervical Cancer Program (BCCP), shall be provided to 75 women annually and billed directly to the BCCP. Clinical service reimbursements shall not exceed the Medicare rate.

C) **Culturally and Linguistically Appropriate Standards of Care**

The Department of Health and Human Services (DHHS) recognizes that culture and language have considerable impact on how consumers access and respond to public health services. Culturally and linguistically diverse populations experience barriers in efforts to access health services. To ensure equal access to quality health services, the Division of Public Health Services (DPHS) expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.

2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.

3. *Provide* clients of limited English proficiency (LEP) with interpretation services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.

4. Offer consumers a forum through which clients have the opportunity to provide feedback to providers and organizations regarding cultural and linguistic issues that may deserve response.

5. The contractor shall maintain a program policy that sets forth compliance with Title VI, Language Efficiency and Proficiency Citation 45 CFR 80.3(b) (2). The policy shall describe the way in which the items listed above were addressed and shall indicate the circumstances in which interpretation services are provided and the method of providing service (e.g. trained interpreter, staff person who speaks the language of the client, language line).

D) **State and Federal Laws**

The Contractor is responsible for compliance with all relevant state and federal laws. Special attention is called to the following statutory responsibilities:

1. The Contractor shall report all cases of communicable diseases according to New Hampshire RSA 141-C and He-P 301, adopted 6/3/08.

2. Persons employed by the contractor shall comply with the reporting requirements of New Hampshire RSA 169:C, Child Protection Act; RSA 161:F46, Protective Services to Adults, RSA 631:6, Assault and Related Offences and RSA 130:A, Lead Paint Poisoning and Control.

3. Immunizations shall be conducted in accordance with RSA 141-C and the Immunization Rules promulgated hereunder.

E) **Relevant Policies and Guidelines**

1. The Contractor shall design and provide the services described above to meet the unique and identified health needs of the populations within the contracted service area.

Contractor Initials: PMc
Date: 4-4-12

2. Primary Care funds shall be targeted to populations in need. Populations in need are defined as follows:

   a) uninsured;

   b) under-insured;

   c) families and individuals with significant psychosocial and economic risk, including low income status;

   d) all life cycles including perinatal, child, adolescent, adult, and elderly who meet one or more of the above criteria.

3. The Contractor shall design and implement systems of governance, administration, financial management, information management, and clinical services which are adequate to assure the provision of contracted services, and to meet the data and reporting requirements. These systems shall meet the most current minimum standards described in at least one of the following: Health Resources and Services Administration (HRSA) Office of Performance Review protocols, Joint Commission on Accreditation of Health Care Organizations *(JCAHO)*, Accreditation Association for Ambulatory Healthcare (AAAHC), Community Health Accreditation Program (CHAP), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey.

4. *The Contractor shall have an agency emergency preparedness and response plan in accordance with HRSA Health Center Emergency Management Program Expectations, Document #2007-15 or most recent version. Such plan shall also include a Continuity of Operations plan.*

5. The Contractor shall carry out the work as described in the performance Workplan submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

6. No Workplan is required by the Breast and Cervical Cancer Program (BCCP). The contractor shall be required to respond to the Quality Improvement Feedback Report twice a year.

7. The Contractor shall carry out the work as described in the Supplemental Funding Form submitted with the proposal and approved by the Rural Health and Primary Care Section (RHPCS), and the Maternal and Child Health Section (MCHS).

F) Publications Funded Under Contract

1. The DHHS and/or its funders will retain COPYRIGHT ownership for any and all original materials produced with DHHS contract funding, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports.

2. All documents (written, video, audio, *electronic*) produced, reproduced, or purchased under the contract shall have prior approval from DPHS before printing, production, distribution, or use.

3. The Contractor shall credit DHHS on all materials produced under this contract following the instructions outlined in Exhibit C (14).

G) Subcontractors

1. If any services required by this Exhibit are provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section must be notified in writing *and approve the subcontractual agreement,* prior to initiation of the subcontract.

2. In addition, the original DPHS contractor will remain liable for all requirements included in this Exhibit and carried out by subcontractors.

II. Minimal Standards of Core Services

A) Service Requirements

1. *Medical Home*

The Contractor shall provide a Medical Home that:

a) *Facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family.*

b) ***Provides care facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.***

2. Primary Care Services

The Contractor shall provide office-based primary care services to populations in need who reside in the contractor's service area. Primary care services shall include:

a) Health care provided by a New Hampshire licensed MD, DO, APRN, or PA, including diagnosis and treatment of acute and chronic illnesses within the scope of family practice; preventive services, screenings, and health education according to established, documented state or national guidelines; assessment of need for social and nutrition services, and appropriate referrals to health, *oral health*, and behavioral health specialty providers.

b) ***Referral to the WIC Nutrition Program for all eligible pregnant women, infants and children.***

c) In-hospital care for conditions within the scope of family practice must be provided at a hospital, within the agency service area, through a staff clinician with full hospital privileges, or in the alternative, through a formal referral and admissions procedure available to clients on a 24 hour/7 day a week basis.

d) Access to a healthcare provider, directly or by referral or subcontract, by telephone twenty-four hours per day, seven days per week.

e) Assessment of psychosocial risk for all clients at least annually and for children at scheduled preventive care visits, including, at a minimum, age appropriate assessment of safety in the home, domestic violence, adequacy of food and housing, care and welfare of children, transportation needs, and provision of necessary social services to address the priority needs and safety issues of clients and families.

f) Falls prevention screening for patients 65 years and older using the algorithm and guidelines of the American Geriatrics Society.

g) Behavioral health care directly or by referral to an agency or provider with a sliding fee scale.

h) *Nutrition assessment for all clients as part of the health maintenance visit.* Therapeutic nutrition services shall be provided *as indicated* directly or by referral to an agency or provider with a sliding fee scale. These services shall be recorded in the medical record.

i) Formal arrangements with a local hospital for emergency care must be in place and reviewed annually.

Contractor Initials: PMc
Date 4-4-12

j) Home health care directly or by referral to an agency or provider with a sliding fee scale.

k) Assisted living and skilled nursing facility care by referral.

l) *Oral screening annually for all clients 19 years and older to note obvious dental decay and soft tissue abnormalities with a reminder to the patient that poor oral health impacts total health.*

m) *Diagnosis and management of pediatric and adult patients with asthma provided according to National Heart Lung Blood Institute, National Asthma Education and Prevention Program, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, 2007.*

2. Breast and Cervical Cancer Screening

   a) Women age 18 to 64 who are eligible for Breast and Cervical Cancer Program (BCCP) services according to income (equal to or under 250% of poverty, underinsured/uninsured) *and insurance status* criteria shall be provided the following services:

      i. cervical cancer screening including a pelvic examination and Pap smear;
      ii. annual breast cancer screening including a clinical breast exam, mammogram and,
      iii. referrals for diagnostic and treatment services based on screening results,
      iv. case management services.

   b) All referrals under this provision shall be to approved certified laboratory, pathology, radiology, and surgical services. Mammography units shall be accredited by the American College of Radiology, and must be FDA certified under MQSA. Laboratories shall be CLIA certified.

   c) All services shall be provided in accordance with the Breast and Cervical Cancer Program (BCCP) Policy and Procedure Manual.

   d) Follow-up and tracking of all tests done, and referrals made shall be provided in accordance with the minimum standards outlined in the Breast and Cervical Cancer Program Policy and Procedure Manual.

   e) All services for women enrolled in the Breast and Cervical Cancer Program (BCCP) shall be billed directly to the BCCP in accordance with protocols established by the Breast and Cervical Cancer Program.

3. Reproductive Health Services

   The Contractor shall provide prenatal, interconceptional and preconception medical care, social services, nutrition services, education, and nursing care to all women of childbearing age. Preconceptional care includes the preconception, interconceptional, and postpartum periods in women's health. It is recommended that preconceptional and interconceptional care visits focus on maintaining or achieving the optimal health of the mother, lowering the risk of future adverse pregnancy outcomes, the family's future plans, and how additional children fit into that plan. Preconceptional counseling may be done during an office, group or home visit.

   a) In the event prenatal care is not provided directly by the Contractor a formal Memorandum/a of Agreement for coordinated referral to an appropriately qualified provider must be maintained.

   b) Prenatal care shall, at minimum, be provided in accordance with the Guidelines for Perinatal Care, sixth or most current edition, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and /or the Centers for Disease Control.

Contractor Initials: PM
Date: 4-4-12

c) Age appropriate reproductive health care shall, at a minimum, be provided in accordance with the American College of Obstetricians and Gynecologists, or the USDHHS Centers for Disease Control (CDC) current guidelines.

d) *Pregnant women enrolled in the WIC Nutrition Program shall be referred to WIC for breastfeeding education and referral to the WIC Nutrition Program peer counselors.*

e. Family planning counseling for prevention of subsequent pregnancy following an infant's birth shall be discussed with the infant's mother *at the first postpartum visit and at the infant's 2-month visit and other visits as appropriate.* Rationale for birth intervals of 18-24 months shall be presented.

f) A referral to a Title X Family Planning Clinic or other reproductive health care provider shall be made as appropriate.

4. Services for Children and Adolescents

The Contractor shall provide as a minimum, comprehensive and age-appropriate health care, screenings, and health education according to the American Academy of Pediatrics' most recent periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent. Children and adolescent visits shall include:

a) Blood lead testing shall be performed in accordance with "New Hampshire Childhood Lead Poisoning Screening and Management Guidelines", issued by the New Hampshire Department of Health and Human Services, 2009 or subsequent revisions.

b) All children enrolled in either Healthy Kids-Gold or the Women, Infant, and Children (WIC) Program and/or who are ≤ 185% poverty, regardless of town of residence, are required to have a blood lead test at ages one and two years. All children ages three to six years who have not been previously tested shall have a capillary or venous blood lead test performed.

c) All children shall be screened for iron deficiency anemia as outlined in the Centers for Disease Control and Prevention document "Recommendations to Prevent and Control Iron Deficiency in the United States (4/2/98)".

d) Age-appropriate anticipatory guidance, dietary guidance, and *feeding practice counseling* for optimal oral health shall be provided at each well child visit according to the American Academy of Pediatrics' periodicity schedule "Recommendations for Preventive Pediatric Health Care" and "Bright Futures - Guidelines for Health Supervision of Infants, Children, and Adolescents", Third Edition or most recent edition. Starting at age 6 months, it is recommended that all children receive an oral health assessment at every well child visit.

e) Supplemental fluoride shall be prescribed as needed based upon the fluoride levels in the child's *drinking* water supply. The fluoride dosage regimen accepted by the American Academy of Pediatrics shall be followed. No fluoride shall be prescribed without obtaining water from private wells or noting the presence or absence of fluoride in the public water supply. *Supplemental fluoride may include bottled water containing fluoride and topical applications such as varnishes.*

f) *For infants enrolled in the WIC Nutrition Program, parents shall be referred to WIC for breastfeeding support and referral to the WIC Nutrition Program peer counselors.*

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5. Sexually Transmitted Infections

Primary Care Services shall provide age appropriate screening and treatment of sexually transmitted infections.

a) Treatment for sexually transmitted infections shall be provided according to the United States Centers for Disease Control Sexually Transmitted Diseases Treatment Guidelines, 2010 or subsequent revisions.

b) All clients, including women, shall be offered HIV testing following the most current recommendations of the United States Centers for Disease Control.

c) The contractor shall be responsible for ensuring referral to appropriate treatment services for any woman found to screen positive.

d) Appropriate risk reduction counseling shall be provided based on client needs.

6. Substance Use Services

a) A substance use screening history using a formal, validated screening tool shall be obtained for all clients as soon after entry into care as possible. Substance use counseling *or other substance abuse intervention, treatment, or recovery services* by an appropriately credentialed provider shall be provided on-site, or by referral, to clients with identified needs for these services. *For these identified clients, ongoing primary care services should include follow up monitoring relative to substance abuse.*

b) All clients, including pregnant women, identified as smokers shall receive counseling *using the 5A's (ask, advise, assess, assist, and arrange) treatment available through the NH Tobacco Helpline* as cited in the US Public Health Services report "Tobacco Use and Dependence", 2008, or "Smoking Cessation During Pregnancy: *A Clinician's Guide to Helping Pregnant Women Quit Smoking*", American College of Obstetricians and Gynecologists, 2011. *With prior approval, agencies may also opt to participate in the DPHS best practice initiative of the 2A's and R (ask, advise and refer).*

7. Immunizations

a) The Contractor shall adhere to the most current version of the "Recommended Adult Immunization Schedule United States", approved by the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

b) The Contractor shall administer vaccines according to the most current version of the *"Recommended Immunization Schedule for Persons Aged 0 Through 6 Years - United States", and "Recommended Immunization Schedule for Persons Aged 7 Through 18 Years – United States"* approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians, based upon availability of vaccine from the New Hampshire Immunization Program.

8. Prenatal Genetic Screening

a) A genetic screening history shall be obtained on all prenatal clients as soon after entry into care as possible.

b) All pregnant women should be offered voluntary genetic screening for fetal chromosomal abnormalities at the appropriate time following recommendations found in the American College of Obstetricians and Gynecologists' "Screening for Fetal Chromosomal

Abnormalities (2007)" or more recent guidelines. The Contractor shall be responsible for ensuring referral to appropriate genetic testing and counseling for any woman found to have a positive screening test.

9. Additional Requirements

a) The Contractor's Medical Director shall participate in the development and approval of specific guidelines for medical care that supplement minimal clinical standards. Supplemental guidelines should be reviewed, signed, and dated annually, and updated as indicated.

b) Contractors considering clinical or sociological research using clients as subjects must adhere to the legal requirements governing human subjects research. Contractors must inform the DPHS, MCHS prior to initiating any research related to this contract.

c) *The Contractor shall provide information to all employees annually about the Medical Reserve Corps Unit within their Public Health Region to enhance recruitment.*

d) *The Contractor shall provide information to all employees annually regarding the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) managed by the NH Department of Health and Human Services' Emergency Services Unit, to enhance recruitment.*

B) Staffing Provisions

The Contractor shall have, at minimum, the following staff positions:

a) executive director

b) fiscal director

c) registered nurse

d) clinical coordinator

e) medical service director

f) nutritionist *(on site or by referral)*

g) social worker

Staff positions required to provide direct services on-site include:

a) registered nurse

b) clinical coordinator

c) social worker

1. Qualifications

All health and allied health professionals shall have the appropriate New Hampshire licenses whether directly employed, contracted, or subcontracted.

In addition the following minimum qualifications shall be met for:

a) Registered Nurse

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a. A registered nurse licensed in the state of New Hampshire. Bachelor's degree preferred. Minimum of one-year experience in a community health setting.

b) Nutritionists:

a. A Bachelor's degree in nutritional sciences or dietetics, or a Master's degree in nutritional sciences, nutrition education, or public health nutrition or current Registered Dietitian status in accordance with the Commission on dietetic Registration of the American Dietetic Association.

b. Individuals who perform functions similar to a nutritionist but do not meet the above qualifications shall not use the title of nutritionist.

c) Social Workers shall have:

a. A Bachelor's or Master's degree in social work or Bachelor's or Master's degree in a related social science or human behavior field. A minimum of one year of experience in a community health or social services setting is preferred.

b. Individuals who perform functions similar to a social worker but do not meet the above qualifications shall not use the title of social worker.

d) Clinical Coordinators shall be:

a. A registered nurse (RN), physician, physician assistant, or nurse practitioner with a license to practice in New Hampshire.

b. The coordinator is a clinical position that oversees and takes responsibility for the clinical and administrative functions of each program.

c. The coordinator may be responsible for more than one MCH funded program.

2. New Hires

The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing within one month of hire when a new administrator, clinical coordinator, or any staff person essential to carrying out contracted services is hired to work in the program. A resume of the employee shall accompany the aforesaid notification.

3. Vacancies

a) The Contractor must notify the MCHS in writing if any critical position is vacant for more than one month, or if at any time funded under this contract does not have adequate staffing to perform all required services for more than one month. This may be done through a budget revision.

b) Before an agency hires new program personnel that do not meet the required staff qualifications, the agency shall notify the MCHS in writing requesting a waiver of the applicable staffing requirements. The Section may grant waivers based on the need of the program, individuals' experience, and additional training.

C) Coordination of Services

1. The Contractor shall coordinate, where possible, with other service providers within the contractor's community. At a minimum, such collaboration shall include interagency referrals and coordination of care.

2. The Contractor shall participate in activities *in the Public Health Region in which they provide services* as appropriate. These activities enhance the integration of community-based public health

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prevention and health care initiatives that are being implemented by the contractor and may include community needs assessments, public health performance assessments, and/or the development of regional health improvement plans.

3. The Contractor agrees to *participate* in and coordinate public health activities as requested by the Division of Public Health Services during any *disease outbreak* and/or *emergency*, natural or man made, affecting the public's health.

4. The Contractor is responsible for case management of the client enrolled in the program and for program follow-up activities. Case management services shall promote effective and efficient organization and utilization of resources to assure access to necessary comprehensive medical, nutritional, and social services for clients.

5. The Contractor shall assure that *appropriate, responsive, and timely* referrals and linkages for other needed services are made, carried through, and documented. Such services shall include, but not be limited to: dental services, genetic counseling, high risk prenatal services, mental health, social services, including domestic violence crisis centers, substance abuse services; and family planning services, Early Supports and Services Program, local WIC/CSF Program, Home Visiting New Hampshire Programs and health and social service agencies which serve children and families in need of those services.

D) Meetings and Trainings

The contractor will be responsible for sending staff to meetings and training required by the MCHS program, including but not limited to:

1. MCHS Agency Directors' meetings
2. Prenatal and Child Health Coordinators' meetings
3. MCHS Agency Medical Services Directors' meetings

III. Quality or Performance Improvement (QI/PI)

A) Workplans

1. Performance Workplans are required for this program and are used to monitor achievement of standard measures of performance of the services provided under this contract. The workplans are a key component of the RHPCS and the MCHS performance-based contracting system and of this contract. Outcomes shall be reported by clinical site.

2. Submit Performance Workplans and Workplan Outcome reports according to the schedule and instructions provided by the MCHS. The MCHS shall notify the Contractor at least 30 days in advance of any changes in the submission schedule.

3. The Contractor shall incorporate required and developmental performance measures, defined by the MCHS into the agency's Performance Workplan. Reports on Workplan Progress/Outcomes shall detail the Performance Workplan plans and activities that monitor and evaluate the agency's progress toward performance measure targets.

4. The Contractor shall comply with modifications and/or additions to the workplan and annual report format as requested by RHPCS and MCHS. MCHS will provide the contractor with reasonable notice of such changes.

5. Agencies contracting for Primary Care Services must submit the workplans for Primary Care *Clinical and Financial*, Child Health, and Prenatal Care.

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B) **Additional Reporting requirements**

In addition to Performance Workplans, the Contractor shall submit to MCHS the following data and information listed below which are used to monitor program performance:

1. In years when contracts or amendments are not required, the DPHS Budget Form, Budget Justification, Sources of Revenue and Program Staff list forms must be completed according to the relevant instructions and submitted as requested by DPHS and, at minimum, by April 30 of each year.

2. The Sources of Revenue report must be resubmitted at any point when changes in revenue threaten the ability of the agency to carry out the planned program.

3. Completed Uniform Data Set (UDS) tables reflecting program performance in the previous calendar year, by March 31 of each year.

4. The Perinatal Client Data Form (PCDF) shall be submitted electronically according to the instructions set forth by the MCHS.

5. A copy of the agency's updated Sliding Fee Scale including the amount(s) of any client fees and the schedule of discounts must be submitted by March 31st of each year. The agency's sliding fee scale must be updated annually based on the US DHHS Poverty guidelines as published in the Federal Register.

6. An annual summary of program-specific patient satisfaction results obtained during the prior contract period and the method by which the results were obtained shall be submitted annually as an addendum to the Workplan Outcome/Progress reports.

C) **On-site reviews**

1. The contractor shall allow a team or person authorized by the Division of Public Health Services to periodically review the contractor's systems of governance, administration, data collection and submission, clinical and financial management, and delivery of education services in order to assure systems are adequate to provide the contracted services.
2. Reviews shall include client record reviews to measure compliance with this exhibit.
3. The contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.
4. On-Site reviews may be waived or abbreviated at the discretion of MCHS, upon submission of satisfactory reports of reviews such as Health Services Resources Administration (HRSA): Office of Performance Review (OPR), or reviews from nationally accreditation organizations such as the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), Medicare, the Community Health Accreditation Program (CHAP), Accreditation Association for Ambulatory Healthcare (AAAHC), or the Centers for Medicare and Medicaid Services (CMS) Rural Health Clinic Survey. Abbreviated reviews will focus on any deficiencies found in previous reviews, issues of compliance with this exhibit, and actions to strengthen performance as outlined in the agency Performance Workplan.

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