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STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION FOR CHILDREN, YOUTH & FAMILIES

Lori A. Shibinette
Commissioner

Joseph E. Ribsam, Jr.
Director

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-4451 1-800-852-3345 Ext. 4451
Fax: 603-271-4729 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

May 24, 2022

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

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division for Children, Youth and Families, to amend an existing contract with Mary Hitchcock Memorial Hospital (VC#177160), Lebanon, NH to extend this contract for an additional two years, to assist DCYF with the medical evaluation of child abuse, by increasing the price limitation by $1,499,410 from $1,499,410 to $2,998,820 and by extending the completion date from June 30, 2022 to June 30, 2024, effective July 1, 2022 or upon Governor and Council approval, whichever is later. 14.01% Federal Funds. 85.99% General Funds.

The original contract was approved by Governor and Council on October 21, 2020, item #10.

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

05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC MEDICAID SERVICES, MEDICAID CARE MANAGEMENT

State Fiscal Year	Class / Account	Class Title	Job Number	Current Budget	Increase/ (Decrease) Amount	Revised Amount
2021	101-500729	Medical Payments to Providers	47004033	$200,000	$0	$200,000
2022	101-500729	Medical Payments to Providers	47004033	$400,000	$0	$400,000
2023	101-500729	Medical Payments to Providers	47004033	$0	$120,000	$120,000
2024	101-500729	Medical Payments to Providers	47004033	$0	$120,000	$120,000
			Subtotal	**$600,000**	**$240,000**	**$840,000**

05-95-95-421010-29580000 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: HUMAN SERVICES, CHILD PROTECTION, CHILD-FAMILY SERVICES

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount	Increase/ (Decrease Amount)	Revised Amount
2021	102-500731	Contracts for Prog Svc	TBD	$209,705	$0	$209,705
2022	102-500731	Contracts for Prog Svc	TBD	$209,705	$0	$209,705
2023	102-500731	Contracts for Prog Svc	42105837	$0	$390,240	$390,240
2024	102-500731	Contracts for Prog Svc	42105837	$0	$389,170	$389,170
			Subtotal	**$419,410**	**$779,410**	**$1,198,820**

05-95-95-421010-29580000 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: HUMAN SERVICES, CHILD PROTECTION, CHILD-FAMILY SERVICES

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount	Increase/ (Decrease Amount)	Revised Amount
2021	103-502507	Contracts for Prog Svc	TBD	$160,000	$0	$160,000
2022	103-502507	Contracts for Prog Svc	TBD	$320,000	$0	$320,000
2023	102-502507	Contracts for Prog Svc	42105837	$0	$240,000	$240,000
2024	102-502507	Contracts for Prog Svc	42105837	$0	$240,000	$240,000
			Subtotal	**$480,000**	**$480,000**	**$960,000**
			Total	**$1,499,410**	**$1,499,410**	**$2,998,820**

EXPLANATION

The purpose of this request is to continue providing on-call access 24 hours a day, 7 days a week to experienced health care professionals who are trained in and can advise on the standardized diagnostic methods, treatment, and disposition of suspected child sexual abuse and physical abuse. Dartmouth Hitchcock's Child Advocacy and Protection Program (CAPP) will continue to conduct physical examinations of children who are suspected victims of multiple types of abuse, and provide the Division for Children, Youth and Families (DCYF) with medical opinions based on these examinations. Dartmouth Hitchcock will also provide case reviews of other specific cases, at the request of DCYF, and consultation to DCYF when necessary. Additionally, the Contractor will continue to provide nurses and child protective service workers performing

screenings and assessments of reported cases of child abuse pre-service training in the standardized medical diagnostic methods, treatment, and disposition, as well as providing training, as requested by DCYF.

The population to be served are children involved with DCYF investigations, who are suspected victims of child abuse or neglect. These services are needed because DCYF, through its investigative process, often requires the expert opinion of appropriately trained medical professionals who specialize in the evaluation and diagnosis of child abuse and neglect. Approximately 1,000 individuals will be served from July 1, 2022, to June 30, 2024.

The Department will monitor services by:

- 90% of all clients will be contacted and offered a family appointment within ten (10) days of CAPP receiving the referral from DCYF.
- 80% of all cases referred to CAPP by the Department will have received a completed evaluation and assessment within two (2) months of the referral from DCYF if family agrees to the CAPP evaluation.
- 100% of medical providers will participate in a minimum of five (5) peer review sessions annually.

As referenced in Exhibit A, Revisions to Standard Contract Provisions, Subsection 1.2 of the original agreement, the parties have the option to extend the agreement for up to four (4) additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties and Governor and Council approval. The Department is exercising its option to renew services for two (2) of the four (4) years available.

Should the Governor and Council not authorize this request DCYF will not have continued access to the expert opinion of appropriately trained medical professionals who specialize in the evaluation and diagnosis of child abuse and neglect.

Area served: Statewide

Source of Federal Funds: Medicaid CFDA# 93.778 FAIN# 2205NH5MAP

Respectfully submitted,

Lori A. Shibinette
Commissioner

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

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

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on October 21, 2020 (Item #10), the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract and in consideration of certain sums specified; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17 and Exhibit A, the contract may be amended upon written agreement of the parties and approval from the Governor and Executive Council; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation to support continued delivery of these services; and

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

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

   June 30, 2024

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

   $2,998,820

3. Modify Exhibit C, Payment Terms, Section 2.4, to read:

   Payment shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this Agreement, and shall be in accordance with the approved line item, as specified in Exhibits C-1, through exhibits C-4 Budget Sheets.

4. Add Exhibit C-3, Budget Sheet, which is attached hereto and incorporated by reference herein.

5. Add Exhibit C-4, Budget Sheet, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be effective July 1, 2022, or upon Governor and Council approval, whichever is later.

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

6/1/2022
Date

DocuSigned by:
Joseph E. Ribsam, Jr.
AAE4DFB3C68E438...
Name: Joseph E. Ribsam, Jr.
Title: Director

Mary Hitchcock Memorial Hospital

5/25/2022
Date

DocuSigned by:
Edward Merrens
8AC426FCA0CC438...
Name: Edward Merrens
Title: Chief Clinical Officer

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

OFFICE OF THE ATTORNEY GENERAL

6/4/2022
Date

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

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

OFFICE OF THE SECRETARY OF STATE

Date

Name:
Title:

New Hampshire Department of Health and Human Services	
Complete one budget form for each budget period.	
Contractor Name:	*Mary Hitchcock Memorial Hospital*
Budget Request for:	*Special Medical Evaluation Services*
Budget Period	*July 1,2022-June 30,2023*
Indirect Cost Rate (if applicable)	0.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	$499,527
2. Fringe Benefits	$66,254
3. Consultants	$0
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$0
5.(a) Supplies - Educational	$0
5.(b) Supplies - Lab	$0
5.(c) Supplies - Pharmacy	$0
5.(d) Supplies - Medical	$10,000
5.(e) Supplies Office	
6. Travel	$2,000
7. Software	$0
8. (a) Other - Marketing/Communications	$0
8. (b) Other - Education and Training	$22,800
8. (c) Other - Other (specify below)	
Call reimbursement for providers	$149,659
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
9. Subrecipient Contracts	$0
Total Direct Costs	$750,240
Total Indirect Costs	$0
TOTAL	**$750,240**

Contractor Initials EM

Date 5/25/22

New Hampshire Department of Health and Human Services	
Complete one budget form for each budget period.	
Contractor Name:	*Mary Hitchcock Memorial Hospital*
Budget Request for:	*Special Medical Evaluation Services*
Budget Period	*July 1,2023-June 30,2024*
Indirect Cost Rate (if applicable)	0.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	$499,527
2. Fringe Benefits	$66,254
3. Consultants	$0
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$0
5.(a) Supplies - Educational	$0
5.(b) Supplies - Lab	$0
5.(c) Supplies - Pharmacy	$0
5.(d) Supplies - Medical	$10,000
5.(e) Supplies Office	
6. Travel	$2,000
7. Software	$0
8. (a) Other - Marketing/Communications	$0
8. (b) Other - Education and Training	$21,730
8. (c) Other - Other (specify below)	
Call reimbursement for providers	$149,659
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
9. Subrecipient Contracts	$0
Total Direct Costs	$749,170
Total Indirect Costs	$0
TOTAL	**$749,170**

Contractor Initials EM

Date 5/25/22

State of New Hampshire

Department of State

CERTIFICATE

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

Business ID: **68517**

Certificate Number: **0005760740**

IN TESTIMONY WHEREOF,

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

David M. Scanlan

Secretary of State

Dartmouth-Hitchcock
Dartmouth-Hitchcock Medical Center
1 Medical Center Drive
Lebanon, NH 03756
Dartmouth-Hitchcock.org

CERTIFICATE OF VOTE/AUTHORITY

I, Roberta L. Hines, MD, of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital, do hereby certify that:

1. I am the duly elected Chair of the Board of Trustees of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital;
2. The following is a true and accurate excerpt from the June 23rd, 2017 Bylaws of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital:
   ARTICLE I – Section A. Fiduciary Duty. Stewardship over Corporate Assets
   "In exercising this [fiduciary] duty, the Board may, consistent with the Corporation's Articles of Agreement and these Bylaws, delegate authority to the Board of Governors, Board Committees and various officers the right to give input with respect to issues and strategies, incur indebtedness, make expenditures, enter into contracts and agreements and take such other binding actions on behalf of the Corporation as may be necessary or desirable in furtherance of its charitable purposes."
3. Article I – Section A, as referenced above, provides authority for the chief officers, including the Chief Executive Officer, the Chief Clinical Officer, and other officers, of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital to sign and deliver, either individually or collectively, on behalf of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital.
4. Edward J. Merrens, MD, is the Chief Clinical Officer of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital and therefore has the authority to enter into contracts and agreements on behalf of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital.
5. The foregoing authority remains in full force and effect as of the date of the agreement executed or action taken in reliance upon this Certificate. This authority shall remain valid for thirty (30) days from the date of this Certificate and the State of New Hampshire shall be entitled to rely upon same, until written notice of the modification, rescission or revocation of same, in whole or in part, has been received by the State of New Hampshire.

IN WITNESS WHEREOF, I have hereunto set my hand as the Chair of the Board of Trustees of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital this 17th day of May, 2022.

Roberta L. Hines, MD, Board Chair

STATE OF NH

COUNTY OF GRAFTON

The foregoing instrument was acknowledged before me this 17 day of May, 2022 by Roberta L Hines, MD.

LAURA K. RONDEAU
STATE OF
-MY-
COMMISSION
EXPIRES
MARCH 9, 2027
NEW HAMPSHIRE
NOTARY PUBLIC

Notary Public
My Commission Expires: March 9, 2027

CERTIFICATE OF INSURANCE

DATE: February 1, 2022

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

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

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

COVERAGES

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

TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	LIMITS	
GENERAL LIABILITY	0002021-A	7/1/2021	7/1/2022	EACH OCCURRENCE	$2,000,000
				DAMAGE TO RENTED PREMISES	$1,000,000
X CLAIMS MADE				MEDICAL EXPENSES	N/A
				PERSONAL & ADV INJURY	$1,000,000
OCCURRENCE				GENERAL AGGREGATE	$2,000,000
OTHER				PRODUCTS-COMP/OP AGG	$1,000,000
PROFESSIONAL LIABILITY	0002021-A	7/1/2021	7/1/2022	EACH CLAIM	$1,000,000
X CLAIMS MADE				ANNUAL AGGREGATE	$3,000,000
OCCURENCE					
OTHER					

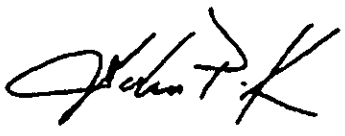
DESCRIPTION OF OPERATIONS/ LOCATIONS/ VEHICLES/ SPECIAL ITEMS (LIMITS MAY BE SUBJECT TO RETENTIONS)
Certificate is issued as evidence of insurance.

CERTIFICATE HOLDER

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

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

AUTHORIZED REPRESENTATIVES



DARTHIT-01 ASTOBERT

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 6/30/2021

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

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

PRODUCER License # 1780862 HUB International New England 275 US Route 1 Cumberland Foreside, ME 04110	CONTACT NAME: Angela Columbus PHONE (A/C, No, Ext): (774) 233-6204 FAX (A/C, No): E-MAIL ADDRESS: Angela.Columbus@hubinternational.com
	INSURER(S) AFFORDING COVERAGE — NAIC #
	INSURER A : Safety National Casualty Corporation — 15105
INSURED Dartmouth-Hitchcock Health 1 Medical Center Dr. Lebanon, NH 03756	INSURER B : INSURER C : INSURER D : INSURER E : INSURER F :

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

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

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
A	WORKER'S COMPENSATION AND EMPLOYER'S LIABILITY			AGC4065185	7/1/2021	7/1/2022	X PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N ☐ N/A						E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

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

Evidence of Workers Compensation coverage for

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

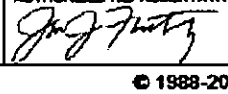
CERTIFICATE HOLDER

NH DHHS
129 Pleasant Street
Concord, NH 03301

CANCELLATION

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

AUTHORIZED REPRESENTATIVE



About Dartmouth Hitchcock Medical Center and Clinics

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

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

Who are Dartmouth Hitchcock Medical Center and Clinics?

Dartmouth Hitchcock Medical Center

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

Dartmouth Hitchcock Clinics

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

Children's Hospital at Dartmouth Hitchcock Medical Center

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

Norris Cotton Cancer Care Pavilion Lebanon

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

Our mission, vision, and values

Our mission

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

Our vision

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

Our values

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

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

Dartmouth-Hitchcock Health and Subsidiaries

Consolidated Financial Statements
June 30, 2021 and 2020

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

Report of Independent Auditors

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

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

Management's Responsibility for the Consolidated Financial Statements

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

Auditors' Responsibility

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

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

Opinion

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

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

pwc

Other Matter

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

PricewaterhouseCoopers LLP

Boston, Massachusetts
November 18, 2021

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Organization and Community Benefit Commitments

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

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

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

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

Community Benefits

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

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

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

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

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

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

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

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

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

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

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

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

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

(in thousands of dollars)

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

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

2. Summary of Significant Accounting Policies

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Level 1 Unadjusted quoted prices in active markets that are accessible at the measurement date for assets or liabilities.

Level 2 Prices other than quoted prices in active markets that are either directly or indirectly observable as of the date of measurement.

Level 3 Prices or valuation techniques that are both significant to the fair value measurement and unobservable.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HHS Reporting Requirements for the CARES Act

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

4. Net Patient Service Revenue and Accounts Receivable

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Implicit Price Concessions

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

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

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

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

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

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

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

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

Accounts Receivable

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

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

5. Investments

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

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

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

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

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

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

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

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

6. Property, Plant, and Equipment

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

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

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

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

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

7. Fair Value Measurements

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

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

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

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

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

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

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

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

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

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

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

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

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

8. Net Assets with Donor Restrictions

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

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

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

9. Board Designated and Endowment Funds

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

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

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

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

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

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

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

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

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

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

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

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

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

10. Long-Term Debt

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

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

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

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

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

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

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

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

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

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

(2) Series 2020A Revenue Bonds

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

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

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

(4) Series 2019A Revenue Bonds

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

(5) Series 2018C Revenue Bonds

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

(6) Series 2012 Revenue Bonds

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

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

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

(8) Series 2016B Revenue Bonds

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

(9) Note payable to financial institution

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

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

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

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

11. Employee Benefits

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

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

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

Defined Benefit Plans

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Postretirement Medical and Life Benefits

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

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

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

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

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

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

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

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

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

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

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

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

12. Professional and General Liability Insurance Coverage

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

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

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

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

13. Commitments and Contingencies

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

Lines of Credit

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

14. Functional Expenses

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

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

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

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

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

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

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

15. Liquidity

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

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

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

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

16. Lease Commitments

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17. Subsequent Events

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

Consolidating Supplemental Information – Unaudited

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

(in thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	Alice Peck Day Memorial	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Assets											
Current assets											
Cash and cash equivalents	$ 1,826	$ 226,779	$ 35,146	$ 41,371	$ 26,814	$ 18,350	$ -	$ 350,286	$ 24,642	$ -	$ 374,928
Patient accounts receivable, net	-	196,350	13,238	6,779	6,699	6,522	-	229,588	2,573	-	232,161
Prepaid expenses and other current assets	23,267	151,336	20,932	2,012	4,771	1,793	(35,942)	168,169	(10,634)	(217)	157,318
Total current assets	25,093	574,465	69,316	50,162	38,284	26,665	(35,942)	748,043	16,581	(217)	764,407
Assets limited as to use	380,020	1,039,327	19,016	15,480	16,725	20,195	(169,849)	1,320,914	57,565	-	1,378,479
Notes receivable, related party	845,157	11,769	-	1,010	-	-	(856,926)	1,010	(1,010)	-	-
Other investments for restricted activities	248	111,209	12,212	1,128	4,266	7,699	-	136,762	31,273	-	168,035
Property, plant, and equipment, net	-	501,640	64,101	22,623	47,232	15,403	-	650,999	29,434	-	680,433
Right of use assets, net	1,233	32,343	2,396	16,104	360	5,819	-	58,255	155	-	58,410
Other assets	2,431	146,226	1,315	14,380	7,282	5,172	-	176,806	292	-	177,098
Total assets	$ 1,254,182	$ 2,416,979	$ 168,356	$ 120,887	$ 114,149	$ 80,953	$ (1,062,717)	$ 3,092,789	$ 134,290	$ (217)	$ 3,226,862
Liabilities and Net Assets											
Current liabilities											
Current portion of long-term debt	$ -	$ 7,575	$ 865	$ 777	$ 91	$ -	$ -	$ 9,308	$ 99	$ -	$ 9,407
Current portion of right of use obligations	354	8,369	656	1,078	197	550	-	11,204	85	-	11,289
Current portion of liability for pension and other postretirement plan benefits	-	3,468	-	-	-	-	-	3,468	-	-	3,468
Accounts payable and accrued expenses	207,566	99,374	11,911	2,455	4,968	5,858	(205,791)	126,341	5,100	(217)	131,224
Accrued compensation and related benefits	-	156,073	8,648	5,706	4,407	5,343	-	180,177	1,893	-	182,070
Estimated third-party settlements	-	160,410	31,226	27,006	26,902	6,230	-	251,774	769	-	252,543
Total current liabilities	207,920	435,269	53,306	37,022	36,565	17,981	(205,791)	582,272	7,946	(217)	590,001
Notes payable, related party	-	811,563	-	-	27,793	17,570	(856,926)	-	-	-	-
Long-term debt, excluding current portion	1,047,659	29,846	22,753	23,558	55	(115)	-	1,123,756	2,601	-	1,126,357
Right of use obligations, excluding current portion	879	24,463	1,876	15,351	172	5,357	-	48,098	69	-	48,167
Insurance deposits and related liabilities	-	78,528	475	325	388	218	-	79,934	40	-	79,974
Liability for pension and other postretirement plan benefits, excluding current portion	-	218,955	5,286	-	-	511	-	224,752	-	-	224,752
Other liabilities	-	179,497	4,224	4,534	4,142	-	-	192,397	22,317	-	214,714
Total liabilities	1,256,458	1,778,121	87,920	80,790	69,115	41,522	(1,062,717)	2,251,209	32,973	(217)	2,283,965
Commitments and contingencies											
Net assets											
Net assets without donor restrictions	(2,524)	526,153	65,224	38,969	39,557	29,838	-	697,217	61,370	40	758,627
Net assets with donor restrictions	248	112,705	15,212	1,128	5,477	9,593	-	144,363	39,947	(40)	184,270
Total net assets	(2,276)	638,858	80,436	40,097	45,034	39,431	-	841,580	101,317	-	942,897
Total liabilities and net assets	$ 1,254,182	$ 2,416,979	$ 168,356	$ 120,887	$ 114,149	$ 80,953	$ (1,062,717)	$ 3,092,789	$ 134,290	$ (217)	$ 3,226,862

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Effective: January 1, 2022

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MHMH/DHC/D-HH Trustee
Adjunct Professor, Australian Catholic University

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MHMH/DHC/D-HH Trustee
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MHMH/DHC/D-HH Trustee
Ex-Officio: Dean, Geisel School of Medicine at Dartmouth

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

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Medical Director, Blood Bank
Department of Pathology and Laboratory Medicine

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MHMH/DHC Trustee
Chief Medical Officer, Southwestern Vermont Medical Center & Medical Director for the D-H Practice, Bennington, Vermont

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

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

Chief Medical Officer, Applied Tissues Technologies, LLC

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

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MHMH/DHC Trustee
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MHMH/DHC Trustee
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MHMH/DHC (Lebanon Physician) Trustee
Division Director of Thoracic Anesthesia and Assistant Professor of Anesthesiology and Medicine at Geisel

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D-HH Trustee & Board Chair
Senior VP, Resident Director for the Hanover, NH Bank of America/Merrill Lynch Office

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(Robert)
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MHMH/DHC/D-HH Trustee
Co-Chief Executive Officer of Audax Group

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

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

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

GEISEL SCHOOL OF MEDICINE CURRICULUM VITAE

Resmiye Oral, MD
Department of Pediatrics
[redacted]

July 31, 2020

I. EDUCATION

Institution	Years	Course of Study and Degree/Title
Ege University Medical School, Izmir, Turkey	1977-83	Medicine, MD #3450 (07/20/83)

II. POSTDOCTORAL TRAINING

Institution	Years	Course of Study and Degree/Title(Date obtained)
Dr. Behcet Uz Teaching Hospital for Children. Izmir, Turkey	1985-89	Residency (Pediatrics) (12/07/89)
Cornell Medical Center, New York, NY	6/92-7/92	Externship, NICU
Ege University Medical School	1994-96	Fellow, Neonatology (03/11/97)
Ohio State University	1998-99	Fellow, Child Abuse & Neglect (06/30/99)
Long Island College Hospital, New York, NY	1999-01	Residency, Pediatrics (06/30/01)

III. PROFESSIONAL DEVELOPMENT ACTIVITIES

Course	Years	Institution	Certificate
Sexual Assault (Nurse) Examiner training Program	9/2000	Long Island College Hospital	Certificate
Mindfulness based stress reduction	2002 and 2014	U of Iowa Psychiatry Dept.	
4 Live-Well Courses (4 sessions each) on Self-Care	6/2017-5/2018	U of Iowa Employee Health	
Coaching, Mentoring, and Team-Building Skills Seminars	10/30-31/2001	U of Iowa OCRME	6 CME credits
Training on Mentoring	8/23/2002	U of Iowa OCRME	1 AMA PRA cat 1 credit
How to enhance productivity and leadership skills	10/29/2002	U of Iowa OCRME	1 AMA PRA cat 1 credit
Women Faculty Career Development Conference	3/5/2010	U of Iowa OCRME	
Period of Purple Crying Training Course	4/9/2010	National Center for Shaken Baby Syndrome	

NICHD Advanced Forensic Interview Course	3/8-11/2011	NICHD	Certificate
Motivational interviewing course	7/30-8/2/15	U of Iowa College of Public Health	
Collaborative Leadership Training	8/18/2015	Iowa Department of Public Health	
Master trainer training program on Adverse Childhood Experiences and Trauma Informed Care	8/31-9/1/15	ACEs Interface	Certificate

IV. ACADEMIC APPOINTMENTS

Title	Institution	Year
Clinical Assistant Professor of Pediatrics	U of Iowa Carver College of Medicine, Dept. of Pediatrics, Division of General Pediatrics & Adolescent Medicine, Iowa City, IA	2001-06
Clinical Associate Professor of Pediatrics	U of Iowa Carver College of Medicine, Dept. of Pediatrics, Division of General Pediatrics & Adolescent Medicine, Iowa City, IA	2006-2010
Clinical Professor of Pediatrics	U of Iowa Carver College of Medicine, Dept. of Pediatrics, Division of General Pediatrics & Adolescent Medicine, Iowa City, IA	2010-2019
Professor of Pediatrics	Geisel School of Medicine, Dept. of Pediatrics, Division of General Pediatrics, Lebanon, NH	2019-present

V. INSTITUTIONAL LEADERSHIP ROLES (Please refer to my personal statement for the impact of these leadership roles)

Director, Child Protection Program	U of Iowa, Stead Family Children's Hospital	2001-2019
Co-chair, Protection of Persons Subcommittee	U of Iowa Hospital Advisory Council	2012-2019
Chair, Child Abuse Panel, Protection of Persons Subcommittee	U of Iowa Hospital Advisory Council	2010-2019
Director, Child Advocacy & Protection Program	Children's Hospital at Dartmouth	2019-date

VI. LICENSURE AND CERTIFICATION

Certification

American Board of Pediatrics, General Pediatrics and Adolescent Medicine (Last renewal: 2018)	10/16/2001	073652
American Board of Pediatrics, Child Abuse Pediatrics	11/15/2011	244

Licensure	Year	Number

Turkish Ministry of Health (Medicine)	7/20/1983	34159
Turkish Ministry of Health (Pediatrics)	12/7/1989	27939-34159
Turkish Ministry of Health (Neonatology)	6/18/1997	42386-34159
Iowa permanent license (Medicine) Last renewal: 2018	2/14/2001	33914
New Hampshire permanent license (Medicine)	4/03/2019	19600
DEA		
Federal DEA, Last renewal: 2018	2001-date	BO7199715
Iowa DEA, Last renewal: 2018	2001-date	1240001

VII. HOSPITAL OR HEALTH SYSTEM APPOINTMENTS

Title	Institution	Year
Director, Family Physician (Responsibilities: supervising 9 rural community health centers)	Burhaniye Mother and Child Health Care Center Burhaniye, Balikesir, Turkey	1983-85
Attending pediatrician (Responsibilities: teaching, research, clinical/inpatient services)	Dr. Behcet Uz State Teaching Hospital for Children, Division of Neonatology, Izmir, Turkey	1989-94
Deputy Division Director (Responsibilities: teaching, research, clinical/inpatient services)	Dr. Behcet Uz Teaching Hospital for Children Division of Emergency/Critical Care, Izmir, Turkey	1996-98
Director, Child Protection Program	U of Iowa Hospitals and Clinics, Iowa City, IA	2001-2019
Child Abuse Specialist	U of I, Child Health Specialty Clinics, Wapello County Clinic, Ottumwa, IA.	2003-2006
Director, Child Advocacy & Protection Program	Children's Hospital at Dartmouth and Dartmouth Hitchcock Medical Center	2019-date

VIII. OTHER PROFESSIONAL POSITIONS

None

IX. TEACHING ACTIVITIES

A. Undergraduate Teaching

152:160 Global Health Seminar - Challenges to Child Health Globally for undergraduates through College of Liberal Arts (3 semester hours)	U of Iowa	2014 spring	devised and co-instructed the course	50 students
1 lecture to undergraduate Trauma & Resiliency certificate program students via webinar	U of Iowa	2019-date	90 minute lecture/semester	30 students

B. Undergraduate Medical Education Classroom Teaching

Classroom teaching on Child Abuse & Neglect topics: M1: 1 hr/year (introductory on physical abuse), M2: 2 hr/year (adverse childhood experiences and trauma informed care); M3: 1 hr/6-12 wks (online

since 2008-abusive head trauma), Mixed Medical students 1-2 hr/month (in a variety of settings as 1 lecture across the institution)

C. Undergraduate Medical Education Clerkship or other Clinical Teaching

2001-03	General Pediatrician at U of Iowa, College of Medicine, Dept. of Pediatrics, Division of General Pediatrics & Adolescent Medicine. I staffed and taught medical students 4-6 half days a week in acute care and diagnostic clinics and mobile clinic sessions that I volunteered for. Mobile Clinic of Iowa City served the underserved population in Johnson County.
2001-2019	Director of Child Protection Program at U of Iowa, Carver College of Medicine, Department of Pediatrics. Office/bedside/clinical teaching on General Pediatrics and Child Abuse & Neglect M1-M2: 4-8 half days/year, M3-M4: 3-6 hr/week
2005-present	I staff and teach M3-4 students during elective Child Protection Rotation: 20-30 weeks/year

D. Graduate Medical Education Teaching

2001-2003	General Pediatrician at U of Iowa, College of Medicine, Dept. of Pediatrics, Division of General Pediatrics & Adolescent Medicine - I staffed and taught residents 4-6 half days a week in acute care, diagnostic, and residency continuity care clinics; from 2003-2010 2 half days/w
2001-2019	Director of Child Protection Program at U of Iowa, Carver College of Medicine, Department of Pediatrics. Office/bedside/clinical teaching on General Pediatrics and Child Abuse & Neglect to pediatric residents and fellows 10-12 hrs/week and; residents from orthopedics, surgery, neurosurgery, and emergency medicine 1-2 hr/week
2005-2010	I staffed and taught pediatric residents/fellows during Child Protection Rotation: 8 hr/month
2010-2011	I staffed and taught pediatric residents during Community Pediatrics Rotation: 1 week/month
2011-date	I staff and teach pediatric residents during Child Protection Rotation: 2-4 weeks/resident, 9-10 residents a year

E. Other clinical education programs

2002-2019	I gave lectures to Physician's Assistant students, APRN students on child abuse and neglect in maternal child health courses (3-4/year)
2018-date	I trained two nurse practitioners to take on my role at the U of Iowa Chidl Protection Program before I left the institution. I am currently training two nurse practitioners at CAPP

F. Graduate teaching

2002-2019	I gave lectures to graduate students from master of social work, master of public health, clinical psychology, pediatric doctoral nurse practitioner program, and law school programs on child abuse and neglect (6-8/year)

G. Other professional/academic programs

None

X. Primary Research Advising

A. Undergraduate students

2010-2011 Kristen Joegerst, Marvina Roebeck, Helen Pope (undergraduate students) on "Impact of in-service training on staff compliance with the new hospital protocol for perinatal illicit drug use" (Presented as an abstract at the Governor's Prevention Conference in Des Moines Iowa in April 2011 and in 11th Helfer Society Annual Meeting, April 5-6, 2011, and published # XXIII.A.9)

B. Graduate students supervised

1-9/2004 Scott Easton, graduate student in social work, working on a research project on "Parental illicit substance use in cases confirmed for child abuse & neglect in Johnson county, Iowa"

3/2005-9/2006 Tara Strang, graduate student in social work, working on a research project on "Intrauterine illicit drug exposure risk factors in mother/infant dyads at the UIHC delivery population" and "Surveillance of neonatal illicit drug screening protocols utilized in hospitals providing delivery services in Iowa" (Published # XXIII.A.6)

2007-2010 Amanda Reedy, Heather Pontasch, and Andrea Austin (graduate social work and medical students), working on a research project on "Impact of in-service training on staff compliance with the new hospital protocol for perinatal illicit drug use" (Presented as a virtual poster at the 10th Helfer Society Annual Meeting, April 18-21, Philadelphia, PA, published # XXIII.A.9)

2008-2009 Jacob Buhrow (MPH student), working on a research project on "Prevalence of illicit drug exposure among children evaluated for child abuse and neglect" (Published # XXIII.A.8)

C. Medical students supervised

4-8/2003 1-8/2004 Jill Goodman (M1), Anna Floryanovich (M1), working on a research project on pediatric falls, published # XXIII.B.17)

1/2004-12/2005 Rebecca Mueller and Waseem Ahmed, medical students (M1), working on a research project on "Intrauterine illicit drug exposure risk factors in mother/infant dyads at the UIHC delivery population" (Oral presentation at 19th San Diego Conference on Child Maltreatment 1/25-28/2005, San Diego, CA)

2008-2009 Abraham Assad (medical student), working on a research project on "Prevalence of illicit drug exposure among children evaluated for child abuse and neglect" (Published # XXIII.A.8)

6-10/2009 Erin Schrunk and Jamie Carlyle (medical students) on "Impact of in-service training on staff compliance with the new hospital protocol for perinatal illicit drug use" (Presented as a virtual poster at the 10th Helfer Society Annual Meeting, April 18-21, Philadelphia, PA, published # XXIII.A.9)

1-12/2015 Stephanie Nakada (M-1), Devin McKissic (M-1), Greta Dahlberg (M-1), supervised on a project of implementing trauma informed care at the Child Assessment Clinic, U of I: The latter won "Award for excellence in pediatric clinical research" on this project

1-5/2015 Stephanie Nakada (M-1), Amy Walz (M-3), Angela Kuntz (M-4) supervised on a review article on Adverse childhood experiences and trauma informed care (Published # XXIII.C.7)

3/2015-6/2016 Marissa Robinson (M-1), supervised on a project of implementing child abuse management systems building in Jamaica

9/2015-6/2018	Clayton Long (M-1 through IV), Angela Lee (M-1 through IV), Devin McKisic (M-1 through IV), Greta Dahlberg (M-1 through IV) on service distinction track on Trauma Informed Care Implementation at the UIHC
9/2016-5/2019	Victoria Rhoeder, M-III during her elective rotation with my program and Sarah Kottenstette, M-I, Kasra Zarei, M-II collecting data on the second line of research to evaluate the family wellbeing assessment model in my clinic (published, # XXIII.A.15)
1/2019-6/2019	Kasra Zarei, MS-II, co-mentoring on a research project on trauma epidemiology in children seen in the ER multiple times a year and mentoring on a case presentation publication "Hypophosphatasia and child abuse differential diagnosis in an infant (Submitted for publication XXIII.B.41)

D. Residents/Fellows supervised

7-12/2005	Riad Rahhal, Huda Elshelshari pediatric residents, "Cervical fracture due to inflicted trauma in a hypotonic child" (Published XXIII.B.15)
6/18-6/2019	Rachel Segal and Meaghan Reaney, Pediatric residents co-mentoring on a research project on trauma epidemiology in children seen in the ER multiple times a year

E. Others (academic international visiting professors)

7/2003	Figen Sahin, Assistant Professor of Pediatrics, Gazi University Medical School, Ankara, Turkey, supervised during visiting professorship at the Child Protection Program, U of I, (Published # XXIII.A.7 and XXIII.A.12 and XXIII.B.21 as a result of this training and subsequent collaboration)
4-12/2006	Munevver Turkmen and Fatih Yagmur (visiting professors from Turkey) working on a research project on "Fatal Abusive Head Trauma cases: Consequence of medical staff missing milder forms of physical abuse" (Published # XXIII.B.18). I supervised Fatih Yagmur, Assistant Professor of Forensic Medicine, Erciyes University Medical School, Kayseri, Turkey for 6 months during mini-fellowship at the Child Protection Program, U of I
2009-2016	Teresa Magalhaes, Professor of Forensic Medicine from Porto University on establishing child advocacy center model and forensic interview techniques in Portugal (Published two review papers # XXIII.C.6 and XXIII.C.8 and two book chapters # XXIII.D.book chapters.4 & 5)
6-9/2010	Serpil Yaylaci, Assistant Professor of Emergency Medicine on "Abusive Head Trauma in Turkey: Are we missing cases?" (Presented in Shaken Baby Syndrome Conference, September 12-14, 2010)
11/2010-5/2011	Feyza Koc, Assistant Professor of Pediatrics, Ege University Medical School, Izmir, Turkey, supervised as a visiting professor at the Child Protection Program, U of I (published two original research # XXIII.A.9 and # XXIII.B.29 and one case presentation # XXIII.B.26)
1-2/2011	Patricia Jardim, Associate of Forensic Medicine, University of Porto, Porto, Portugal, supervised as a visiting professor at the Child Protection Program, U of I (Published one review paper # XXIII.C.6 and two book chapters # XXIII.D.book chapters.4 & 5)

XI. Advising/Mentoring

A. Medical students

2008-2010	Mentoring Andrea Austin and Elizabeth Vanderah (medical students) on "Service with Distinction" project on Shaken Baby Prevention at Pediatrics and Family Practice Clinics, Medical Student Curriculum Program, and Pediatric and Family Practice Residency Programs in Iowa

B. Residents

2018-2019	Advising Rachel Segal, MD, pediatric resident on getting ready for child abuse pediatrics fellowship (Started fellowship at Kansas Children's Medical Center in 2020)
2020-to date	Advising Mica Coulbourn, MD, pediatric resident on getting ready for child abuse pediatrics fellowship

C. Advising/Mentoring international trainees

2010-2013	Naeem Zafar, Pediatrician, Pakistan Child Abuse Prevention Society (PACHAAN), director, on an I-CATCH grant from AAP to train medical staff on recognition and management of child abuse and neglect
1-9/2011	Carlos Pexioto, PhD in Psychology, University of Porto, Porto, Portugal, supervising on forensic interview techniques and its implementation in Portugal
2-3/2014	Ozlem Bag, Pediatrician, Behcet Uz Children's Hospital, Izmir, Turkey, supervised as a visiting professor at the Child Protection Program, U of I
3-4/2014	Betul Ulukol, Professor of Pediatrics, Ankara University Medical School, Ankara, Turkey, supervised as a visiting professor at the Child Protection Program, U of I (Published two review papers # XXIII.C.2 & XXIII.C.5)
2014-persent	Isabella Acuardo, Professor of Psychiatry from National University of Colombia, collaborating and advising on how to establish a national response system to child abuse and neglect in Colombia
7/2015-8/2015	Miguel Eduardo Barrios, Professor of pediatrics, supervised as a visiting professor at the Child Protection Program, U of I
2016-present	Mentoring and advising Assc. Professor of Pediatrics Alexandra Soldatou from the University of Athens Child Protection Program and Afroditi Stathi, the executive director of ELISA a child abuse NGO in Greece to establish a comprehensive multidisciplinary response to child abuse in Greece (visited Greece twice through Fulbright scholarship, published two original articles as a result of these visits: XXIII.B.34 and XXIII.B35)

XII. Engagement, Community Service/Education

1999	Presentations to Rotary club members in Columbus, OH on Child Abuse & Neglect	8 hrs/y
2001-2019	Consultant and expert witness for Department of Human Services and County Attorneys in the State of Iowa for Child abuse & Neglect. **In this role, I trained staff from these government agencies, did record review for them, and testified in court when called for on both cases I had evaluated and as an expert witness. More details are in my personal statement.**	120 hrs/y
2001-2019	Presentations to Rotary Clubs in Iowa City, Cedar Rapids, Oelwein, and Independence on Child abuse & Neglect	4 hrs/y
2002-2005	Board Member, Rape Victims Advocacy Program, Iowa City, IA	20 hrs/y
2002-2019	Attending Radio – TV Programs to talk on Child Abuse & Neglect, interviews with journalists for printed media, Iowa City, IA	20 hrs/y
2003-05	Founding Board member of Prevent Child Abuse – Johnson County in Iowa City, IA. **In this role, I helped the board establish family support projects in the county.**	40 hrs/y
2003-date	Presentations to Rotary Clubs in Izmir, Turkey on Child Abuse & Neglect	2 hrs/y

2003-2015	Member of Johnson County Multidisciplinary Child Protection Team in Iowa City, IA **In this role, I worked with multiple county public servants to improve medical care for abused and neglected children.**	20 hrs/y
2003-2015	Member of Drug Endangered Children Task Force of Wapello County in Ottumwa, IA **In this role, I worked with the local providers and developed a protocol on how to provide medical care to drug endangered children.**	20 hrs/y
2003-2019	Presentations to non-governmental community organizations to raise public awareness on Child Abuse & Neglect in Iowa	20 hrs/y
2004-2009	Board member, Johnson County Sexual Assault Response Team in Iowa City, IA	20 hrs/y
2004-2015	Member of Iowa Alliance of Drug Endangered Children	20 hrs/y
2004-2015	Member of Medical Committee, Iowa Alliance of Drug Endangered Children	10 hrs/y
2005-2009	Presentations on Shaken Baby Syndrome to High School Students to prevent Shaken Baby Syndrome (City High and West High Schools, Family, Science & Community Leaders of America) in Iowa City, IA	4 hrs/y
2005-2018	Iowa statewide collaboration on perinatal illicit drug screening and intervention policy development: **I worked with Iowa Department of Public Health Perinatal Care Program as described in my personal statement and revised the illicit drug screening policy and protocol and helped disseminate it to many birthing hospitals including the UIHC**	20 hrs/y
2006-2019	Member of Johnson County Juvenile Law Community in Iowa City, IA	8 hrs/y
2006-2009	Board Member of Prevent Child Abuse Iowa. **In this role, I worked with other board members to guide the staff of the program and did fund-raising to support it.**	10 hrs/y
2012-2013	Board member of Council on the Status of Women at U of Iowa	10 hrs/y
2014-2018	Iowa Adverse Childhood Experiences Steering Committee member. **In this role, I worked with the committee members and did ACEs screening in the Iowa adult population twice, which revealed ig rates of ACEs in 15% of the population.**	40 hrs/y
2015-2019	Founding member of Johnson County Trauma Informed Care Task Force. **In this role, I collaborated with other members of the community to establish this task force and engaged many governmental and nongovernmental agency representatives to implement trauma informed care and work-force development across the county.**	20 hrs/y
2007-2019	Prevent Child Abuse Johnson County Board member, Iowa City, IA. **In this role, I worked as a bridge between the PCA-Iowa and its Johnson County chapter and helped implement multiple mini-prevention programs.**	10 hrs/y
2018-2019	Invited member, Iowa Trauma Informed Leadership Team. **In this role, we worked on how to expand our trauma informed care efforts to all systems of care.**	20 hrs/y
2018-2019	Johnson County Trauma Informed Care Master Trainers group. **In this role, I became a TIC master trainer and provided numerous lectures to multiple community initiatives all around Iowa**	50 hrs/y

2019	Panel organization and speaker: Who is Tommy production publicity efforts (a live play on a child who was abused and neglected becoming successful in life)	5	hrs

XIII. Research Activities (reverse chronological order)

A. Sponsored Activity (grants and contracts)

Dates	Sponsoring Agency/Project title	My role/ Percent effort	Funding amount
2/5-12/31/2018	Sigma Theta Tau, The Fraternal Order of Eagles. Trauma-Informed Care Survey of staff at UIHC (submitted for publication # XXIII.B.40)	Co-PI/None Anne Nielsen, PI	$2,500 $2,500
5/12-12/31/2017	Iowa Child Protection Council. Conference organization grant	(C)/None	$11,000
4/1-12/31/2017	University of Iowa Office of Outreach and Engagement: Conference organization grant	(C)/None	$10,000
6/1/-12/31/2016	Iowa Department of Public Health contract. Shaken Baby Syndrome Prevention training in Eastern Iowa Emergency Rooms	(C)/None	$4,000
10/15/2014	United Way contract. Prevention of Sexual Abuse	(C)/None	$29,500
5/7/2013-5/7/2014	University of Iowa Provost's Office. Global Forum Award: To organize multi-media training activities to engage international, national, and regional professionals and public on child abuse and neglect and adverse childhood experiences: **As a result of this activity, efforts on Trauma Informed Care increased exponentially on U of Iowa campus, I engaged in long term training and research activities with my colleagues in Colombia, reconnected with colleagues in Turkey and Greece, which led to improving multidisciplinary response to child abuse in these countries.**	(C)/None	$20,000
7/1/2010-6/30-2011	Children's Miracle Network. Perinatal illicit drug screening practices in mother-newborn dyads at a university hospital serving rural/semi-urban communities: Translation of research to quality improvement (Published # XXIII.A.6)	PI/None	$11,665
5/1-12/31/2008	The Fraternal Order of Eagles. Illicit Drug Exposure in patients evaluated for alleged child abuse and neglect (Published # XXIII.A.8)	PI/None	$5,000
12/8/2006-5/1/2014	Children's Miracle Network and The Fraternal Order of Eagles. Impact of In-service training on perinatal illicit drug screening practices at the UIHC and dissemination of the training curriculum to Iowa hospitals for perinatal illicit drug screening (Published # XXIII.A.9)	PI/None	$15,970 $2,000 $2500
1/10/2006-7/21/2013	Children's Miracle Network, University of Iowa Foundation, Noon Pilot Club of Johnson County. Period of Purple Crying Shaken Baby Syndrome Prevention Program Implementation at Mother Baby Units in 7 hospitals.	PI&(C)/None	$12,400 $6,000 $4,300 $2,000

			$6,500
			$2,580
			$5,500
1/1-12/31/2005	Children's Miracle Network. The impact of utilization of a structured screening protocol for perinatal illicit drug exposure. (Published XXIII.A.9)	PI/None	$4,500

XIV. Program Development

A. Clinical/Advocacy

- 2001-2003: Establishment of UIHC Child Protection Program with the following functions:
  - Outpatient Child Assessment Clinic as a referral center to evaluate allegedly abused and neglected children: I devised the structure and guidelines, and trained the hired staff for the clinic. Assessed 80-100 patients/families a year with attendance by 6-8 students and 6-8 residents/year.
  - Inpatient consultation services: I trained hospital social workers and established an in-patient consultation team. Assessed 50-70 patients/families a year with attendance by 6-8 students and 6-8 residents/year
  - Record review for Department of Human Services and County Attorneys: Completed 50-60 record reviews/year
  - Testimony as an expert witness, mostly invited by prosecution. Testified on 10-15 cases/year. **Impact: Many cases of child abuse and neglect were successfully prosecuted and victims and their non-offending family members were protected as described in my personal statement.**
- 2005-2008: I spearheaded a collaboration at the University of Iowa Hospitals and Clinics and revised the hospital perinatal illicit drug screening and intervention protocol: Departments of Pediatrics, Obstetrics, Chemical Dependency, Social Work, Nursing were involved in this project. **Impact: Diagnosis of drug endangered newborns quadrupled.**
- 2005-2010: I led Iowa Department of Public Health and National Center on Shaken Baby Syndrome to expand Shaken Baby Syndrome Prevention Program to all birthing hospitals in Iowa. **Impact: Iowa became designated as one 19 "PURPLE" states by the National Center on Shaken Baby Syndrome which refers to this program being disseminated throughout the state.**
- 2006-2007: Co-led the statewide collaboration involving governmental and non-governmental agencies and developed a statewide policy for perinatal screening and intervention for illicit drugs, which became part of State Perinatal Care Clinical Guidelines statewide stakeholders; Iowa Department of Public Health, Iowa Department of Human Services, Iowa Perinatal Care Program were partners in this program. **Impact: Number of birthing hospitals that had a structured perinatal illicit drug screening program doubled as a result of this work.**
- 2008-2019: I established and led a statewide specialized medical consultancy program to assess child abuse cases from rural Iowa for DHS in real time with a follow-up multidisciplinary management component. **Impact: This helped DHS, law enforcement, and county attorneys better protect abused and neglected children.**
- 2010-2012: Established a network of trained medical providers across Iowa to serve as medical resources for local DHS workers: Spearheaded a team of medical directors of the child protection centers in Iowa and Child Health Specialty Clinics in training these clinicians. **Impact: This helped DHS find local medical services eliminating the need to travel 2-3 hours for families of children with low profile abuse/neglect.**
- 2013-2019: Established and led UIHC Trauma Informed Care Initiative to implement trauma informed practices at the UIHC. In this context, I developed an educational module to use to train staff from multiple department. **Impact: Cumulative efforts of this initiative led to practice**

changes in multiple departments/units, created a model for other hospitals in Iowa and with the associated publications on the model XXIII.A.15, XXIII.C.7), possibly at the national level.

- 2015: I participated in the adoption of umbilical cord testing to replace meconium testing for neonatal toxicology screening. **Impact: This improved the diagnostic accuracy for newborns exposed to illicit substances in utero.**
- 2015-2017: Established Family-Well-being Assessment Clinic run by an independent licensed social worker in Child Abuse Assessment Clinic. **Impact: Increased diagnostic accuracy in two generational trauma and mental/behavioral health problems leading to increased rates of referral to multiple services of involved patients and families.** A study was published as a result of this (XXIII.A.15), another has been submitted (XXIII.B.39).
- 2015-2017: Established Family-Well-being Therapy Clinic run by an independent licensed social worker. **Impact: Numerous families evaluated at the Family-Well-being Assessment Clinic received therapy services with improved compliance to services.**
- 2018: Helped implement trauma informed care at the UIHC Burn Unit and trained their staff on trauma informed assessment model. **Impact: Increased diagnostic accuracy in two generational trauma and mental/behavioral health problems leading to increased rates of referral to multiple services of involved patients and families.** A study was published as a result of this (XXIII.A.14).
- 2018: Helped implement trauma informed care at the UIHC ED Pediatric population. **Impact: Identification that 40% of families with a child seen in ED had four or more adverse childhood experiences revealing need for mental/behavioral health services.**
- 2018-2019: I co-edited as invited editor The United Nations Manual Revision Committee: Effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment (Istanbul protocol, or IP) to set out minimum standards for legal and medical investigations of cases of alleged torture and ill-treatment. **Impact: This protocol is instrumental in reducing multiple forms of torture including electric torture in prisons and jails of countries with human rights violations history.**

B. Educational/Advocacy

INTERNATIONAL

- 2002-to date: **Led training activities in Turkey and created a large network of trainers and had a significant impact on :**
  - Establishment of 15 academic hospital based Multidisciplinary Child Protection Teams,
  - Worked as a consultant with national and regional policy makers and child protection agencies in Turkey and helped a congress bill be passed to implement regional interdisciplinary child abuse task forces and child advocacy centers
  - Became an invited consultant for the Turkish Ministries of Justice and Health in creating a network of >40 Child Advocacy Centers in Turkey Multiple studies were published as a result of this work.
  - Numerous publications from various universities of Turkey.

- 2010-date: I am also a **recognized expert in Portugal, Pakistan, Colombia, Baltic states, and Greece**, in developing a national response to child abuse & neglect and specifically to child sexual abuse and abusive head trauma interdisciplinary/inter-sectorial management, which led to:
  - University of Porto Department of Forensic Medicine implementing regional interdisciplinary child abuse task forces in Portugal and developing guidelines for the Ministry of Justice on the management of child sexual abuse (I was a co-author on some of the publications)
  - I worked with "Protection And Help of Children Against Abuse and Neglect (PAHCHAAN)" non-governmental agency in Pakistan and helped them develop

a training curriculum for medical professionals on the hospital management of abused children

- 2003-2005: I led Turkish National Child Abuse Task Force to join the ISPCAN International Working group on determining the epidemiology of Child Abuse & Neglect in developing countries
- 2005-2008: Contributed to the development of an international medical curriculum on Child Abuse & Neglect for medical practitioners in developing countries by participating in the Ad Hoc Education Committee in International Society for the Prevention of Child Abuse and Neglect (ISPCAN)

NATIONAL:

- 2006-2010: Several hospitals across USA connected with me in revising their policies on perinatal screening and intervention for illicit drugs. **Impact: I am now recognized as one of the experts on drug endangered children in the USA.**

REGIONAL

- 2006-2013: Established Period of Purple Crying Shaken Baby Prevention Program at the NICU, Mother Baby Unit, Pediatrics Clinic, and Family Practice Clinic, after using three years of CMN grant funding, in 2013, it was adopted by the hospital as part of the capital budget, providing the program permanency. **Impact: I disseminated this program to 7 referral affiliated hospitals in my region and worked with Iowa Department of Public Health to disseminate it across the state.**
- 2007-2008: I developed a training curriculum on how to use the new perinatal illicit drug screening protocol for the UIHC staff and created a model curriculum to be used at the birthing hospitals in Iowa. **Impact: Explained above**
- 2014: Co-founded the Iowa Chapter of American Professional Society on the Abuse of Children collaborating with a team of child abuse professionals in Iowa
- 2013-2014: Organized the Provost's Global Forum for Academic Year 2013-2014 (March 25-28/2014) with a theme of Adverse Childhood Experiences and Multidisciplinary Response to Child Abuse" **Impact: Explained above**
- 2015-2017: I was a scientific consultant for the European Union Grant PROMISE project. **Impact: It led to the development of multiple practice tools to implement Child Protection Center model in 20 European countries to address child sexual abuse.**
- 2016: Developed a training module on Trauma Informed Care in Collaboration with School of Social Work to implement Trauma Informed Care at the UIHC. **Impact: This model was established in my child abuse clinic and partially implemented in other units of the UIHC that led to several publications.**
- 2016-2018: Developed two training modules to be used to "train the trainer" programs on educating providers on child physical abuse and child sexual abuse assessment and management for ISPCAN (16 and 18 lectures in each module). **Impact: I trained hundreds of trainees in Greece using these modules in 2016 and 2018 that led to a publication and several are in submission phase. Additionally, these modules were adopted as training tools by ISPCAN, which allowed child abuse professionals from all over the world access quality educational resources to train their national audiences.**
- 2018: Created a package of child safety brochures including abuse and non-abuse related physical, sexual, and emotional injury prevention flyers both for parents and children
- 2018: Organized 6 grand rounds for departments of Pediatrics, Family Practice, Emergency medicine, Nursing, Internal Medicine, Surgery, Anesthesiology, and Hospital Advisory Council on "Implementation of Trauma Informed Care and Behavioral Health Services in Primary Care" to be held on 11/6-9/2018 by two speakers from Montefiore Hospital in New York City. **Impact: This activity led to UIHC community becoming even more engaged toward implementing**

trauma informed care in the institution.

C. Research:

- 2003-2005: I led Turkish National Child Abuse Task Force to join the ISPCAN International Working group on determining the epidemiology of Child Abuse & Neglect in developing countries.
- 2002-date: I established a multicenter research team in Turkey to conduct multiple studies on child abuse and neglect systems building and shaken baby syndrome (Published # XXIII.A.1-5,7,11,12; # XXIII.B.12-14,16,19-21,23-25,27,28,32,37,38; # XXIII.C.2,3,5,9)
- 2010-2015: I established a multicenter research team in Portugal to conduct multiple studies on multidisciplinary response to child abuse and neglect, multiple guidelines were published (# XXIII.C.6 and # XXIII.D.book chapters.4,5)
- 2015-2019: Co-established a Council on Trauma Informed Care ("Promoting Resiliency Initiative") on campus collaborating with the colleges of Education, Public Health, Social Work, Nursing, Medicine, and Law with the goals of research, service, and education (two publications from this team have been submitted for publication)
- 2016-date: I established a multicenter research team in Greece to conduct multiple studies on child abuse and neglect systems building and two studies were published (# XXIII.B.34, # XXIII.B.35), some are in manuscript writing phase.

XV. Entrepreneurial Activities:

None

XVI. Major Committee Assignments

A. National/International:

1999-date	Chair/Co-chair: Conference Organization Committees: I co-organize a national and multiple regional or local conferences, training courses, symposia, and workshops (4-6/year) on Child Abuse & Neglect in Turkey.	Turkey
2005-2008	Member: Ad Hoc Education Committee in International Society for the Prevention of Child Abuse and Neglect (ISPCAN) to develop educational modules for developing countries; I shared multiple educational tools with ISPCAN	Colorado, USA
2010-2015	Member: Training Organization Committees, Training Courses on Child Abuse & Neglect in Portugal (1-2 conferences a year)	Portugal
2010-2012	Co-chair Scientific Committee and member of organization committee: ISPCAN world child abuse conference	Istanbul Turkey
2014-date	Member: Training Organization Committee, National Conference on Child Abuse & Neglect in Colombia (1 conference a year)	Colombia
2015-date	Member, World Perspectives biennial publication of the International Societies for Prevention of Child Abuse and Neglect and World Health Organization	Colorado, USA
2016-date	Co-chair: Training Organization Committees, Training Courses on Child Abuse & Neglect in Greece (4-6 training activities every two years)	Greece
2016-date	Member: ISPCAN education committee –developed two education modules on physical abuse and sexual abuse for developing country professionals.	Colorado, USA
2019-2020	Scientific committee member: 2020 International Conference on	Izmir, Turkey

	Child Abuse & Neglect in Turkey	
2020-2021	Scientific committee member: 2021 International Conference on Adolescent Pediatrics in Turkey	Izmir, Turkey

B. Regional:

2001-2017	Member & Medical consultant; State Child Protection Council	Iowa
2001-2017	Member & Medical consultant; State Citizen's Review Panel	Iowa
2002-2005	Board member – Rape Victims Advocacy Program	Iowa City, IA
2003-2005	Founding Member, Board Member; Prevent Child Abuse Johnson County	Iowa City, IA
2003-2006	Member, Medical Consultant; Wapello County Drug Endangered Children Task Force and its Education Committee	Ottumwa, IA
2004-2007	Board Member, Johnson County Sexual Assault Response Team	Iowa City, IA
2004-2019	Member & Medical consultant; Iowa State Alliance for Drug Endangered Children	Iowa
2006-2008	Co-chair: Perinatal Illicit Drug Screening Practice Guideline Development Committee: Department of Public Health Perinatal Care Group	Iowa
2006-2009 2018-2019	Board Member & Medical consultant; Prevent Child Abuse Iowa	Iowa
2010-2019	Founding member, Johnson County Child Death Review Team	Iowa City, IA
2010-2019	Founding member, Johnson County Child Abuse Multidisciplinary Team	Iowa City, IA
2019-date	Invited member, Attorney General's Child Abuse Task Force	Concord, NH
2019-date	Invited member, NH Child Abuse Needs Assessment (CANA) Committee	New Hampshire
2019-date	Chair of Organization Committee; Shield Children from Harm annual conference at CHaD	Lebanon, NH

C. Institutional:

2001-2019	Member, Protection of Persons Committee, UIHC	Iowa City, IA
2001-2019	Member, Child Abuse Panel, UIHC	Iowa City, IA
2006-2019	Chair, Child Abuse Panel, UIHC	Iowa City, IA
2006-2008	Chair: Training curriculum development committee on Perinatal Illicit Drug Screening Practices at the UIHC	Iowa City, IA
2007	UIHC Emergency Department Review Ad Hoc Committee	Iowa City, IA
2009-2019	Member, Pediatric Trauma Multidisciplinary Team, UIHC	Iowa City, IA
2011-2016	Member, U of I Department of Pediatrics Promotions Advisory Committee	Iowa City, IA
2013-2019	Founding member & chair; UIHC Trauma Informed Care Initiative	Iowa City, IA
2014-2019	Vice-chair, Protection of Persons Subcommittee, UIHC	Iowa City, IA
2014-2019	Member, U of Iowa International Programs Funding Opportunities Committee: This group reviews proposals for the Provost's Global Forum, IP Major Projects Awards, and IP Summer Research Fellowships	Iowa City, IA
2016	Member, UIHC Radiology Department Review Ad Hoc Committee	Iowa City, IA

2016-2019	Elected Member, University of Iowa Faculty Senate	Iowa City, IA
2016-2019	Elected Member, University of Iowa Faculty Council	Iowa City, IA
2016-2019	At large Elected Member, University of Iowa Hospitals & Clinics Hospital Advisory Board	Iowa City, IA Iowa City, IA
2017-date	Member, Professional Practice and Well-being Subcommittee	Iowa City, IA
2017-date	Member, Pediatric Inpatient Services Committee	Iowa City, IA
2018-date	Editing member, United Nations Manual Revision Committee: Effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment (Istanbul protocol, or IP) to set out minimum standards for legal and medical investigations of cases of alleged torture and ill-treatment.	International
2018-2019	Member, Children's Miracle Network Research grant evaluation committee	Iowa City, IA
2018-2019	Member, UI Department of Pediatrics Wellness Committee	Iowa City, IA
2019	Member, Selection committee for Michael J. Brody Award for Faculty Excellence in Service at U of Iowa	Iowa City, IA
2020-date	Pediatric Sexual Assault Team Establishment ad hoc Committee	Lebanon, NH

XVII. Memberships, Office and Committee Assignments in Professional Societies

Turkish Society for Prevention of Child Abuse & Neglect
1994-date Member

American Academy of Pediatrics
1999-2001 Resident member

International Society for Prevention of Child Abuse & Neglect
1999-date Member, Faculty on Education Board, serving on the International Curriculum Development Committee since 2006 and World Perspectives publication committee since 2015

American Academy of Pediatrics
2001-date Fellow

Iowa Chapter of American Academy of Pediatrics
2001-2019 Member

Iowa Medical Society
2001-2019 Member

Midwest Society for Pediatric Research
2001-2010 Member

American Academy of Pediatrics, section on Child Abuse & Neglect
2002-date Member

American Professional Society on the Abuse of Children
2002-date Member
2011-2019 Iowa Chapter, Founding Board Member

Ambulatory Pediatrics Association
2004-date Member

Iowa Chapter of American Academy of Pediatrics, section on Child Abuse & Neglect
2004-2019 Chair

American Academy of Pediatrics, section on International Child Health
2006-date Member, serving on the Committee to review I-CATCH grants

American Academy of Pediatrics, section on International Child Health

2008-date Member, serving on the Nominations Committee
The Ray Helfer Society (Society for pediatric child abuse & neglect experts)
2007-date Invited member
2010-date Nominations Committee member
Turkish Society of Nervous System Surgery
2009-date Invited member
National Children's Alliance (supervisory organization for child advocacy centers)
2010-date Invited member
Portugese Society for Prevention of Child Abuse & Neglect
2010-date Invited member
Midwest Alliance on Shaken Baby Syndrome
2011-2012 Invited founding board member
Council on the Status of Women
2012-2016 Board member (Faculty representative)
Iowa Chapter of American Professional Society on the Abuse of Children
2012-2019 Founding Board member
Ray Helfer Society
2014-date International Subcommittee member of the Helfer Fatal and Nonfatal Severe Abuse Committee
2018-2019 Founding member, Ad Hoc Advocacy Committee

XVIII. Institutional Center or Program Affiliations:

None with protected time

XIX. Editorial Boards

1994-98 *Journal of Neonatology*, Assisting Editor, published in Turkey with an international Editorial Board in English
2010-2013 *Journal of Injury and Violence Research*, Assisting Editor, internationally published
2014-2016 *Journal of Pediatrics & Child Care*, internationally published, open access journal

XX. Journal Referee Activity

2000-date *International Journal of Child Abuse & Neglect*, Journal of International Society to Prevent Child Abuse & Neglect (1-2 review a year)
2002-2015 *Journal of Forensic Sciences*, nationally published journal from Ankara University Medical School, Ankara, Turkey (1 review a year)
2003-2010 *Journal of Forensic Psychiatry*, nationally published journal from Ankara University Medical School, Ankara, Turkey (1 review a year)
2003-2008 *Turkish Journal of Toxicology*, nationally published journal from Ankara University Medical School, Ankara, Turkey (1 review a year)
http://www.medicine.ankara.edu.tr/internal_medical/forensic_medicine/tokdergi.html
2003-2015 *The Turkish Journal of Emergency Medicine*, nationally published journal from Ankara University Medical School, Ankara, Turkey (1-2 review a year)
http://www.medicine.ankara.edu.tr/internal_medical/forensic_medicine/atddergi.html
2006-date *Pediatrics*, Journal of American Academy of Pediatrics (1-2 review a year)
2009-date *Archives of Pediatrics & Adolescent Medicine* (1-2 review a year)
2010-date *Journal of Justice Academy of Turkey*, internationally published journal from Ankara University Medical School, Ankara, Turkey
2010-date *Journal of Injury and Violence Research* (1 review every few years)

2010-date	*Journal of Children and Youth Services Review* (1 review a year)
2010-date	*Behcet Uz Children's Hospital Journal,* nationally published journal, Izmir, Turkey (1 review a year)
2012-date	*Academic Pediatrics* (1 review a year)
2017-date	*British Medical Journal* (1 review every few years)

XXI. Honors, awards, recognitions, outstanding achievements

1997	$15,000 scholarship from Rotary International Foundation for 9-month training on Child Abuse & Neglect
1998	$20,000 scholarship from Turkish Ministry of Health for 6-month training on Child Abuse & Neglect
1998	$15,000 scholarship from Humphrey Mid-Career Fellowship Program for 10-month Training on Child Abuse & Neglect (I had to decline due to inconvenience of institution).
2008	Poster titled "The efficacy of hair and urine confirmatory testing in suspicious pediatric burn injuries" won best overall and best in category at the 40th American Burn Association Convention.
2009, 2016	Nominated and selected as one of the "Best Doctors in America":
2010	Invited to be the senior consultant and instructor for the Ministry of Health on the "Child Protection Center" pilot project in Ankara, Turkey
2013	$18,000, Provost's Global Forum Award to organize training activities on local, regional, national, and global nature of adverse childhood experiences and child abuse and neglect
2015	Article co-authored by me titled "Epidemiology of adverse childhood experiences in three provinces of Turkey" won the best article of the year in Turkey at the National Pediatric Association Annual Conference.
2015	Through a competitive process, I was selected as a master trainer to train trainers in Iowa on childhood adversity and trauma informed care by "ACEs Interface Initiative" national program
2015-2019	Fulbright scholar award to collaborate with international education/research institutions to implement multidisciplinary systems building in developing countries (I spent 3 and 2 weeks in Greece over two visits in 2016 and 2018)

XXII. Invited Presentations

LOCAL: Institutional conferences, grand rounds, journal clubs (All *)

3/12/02	Child Protection Program at the U of Iowa: Clinical guidelines for mandatory reporters, U of I, Department of Social Work	Iowa City, IA
4/29/02	^ Clinical guidelines for the Child Protection Program at the UIHC, Grand Rounds at Center for Disabilities and Development, U of I	Iowa City, IA
6/16/02	Child Protection Program at Children's Hospital of Iowa, Referring Physicians' Advisory Council annual meeting	Iowa City, IA
8/2/02	^ Child Protection Program at the U of Iowa: Clinical guidelines for mandatory reporters, Grand Rounds, Department of Pediatrics, U of Iowa	Iowa City, IA
11/20/02	Management of cases with acute sexual assault, In-service training, Division of General Pediatrics and Adolescent Medicine, Department of Pediatrics, U of Iowa	Iowa City, IA
4/16/03	Domestic Violence: American Medical Women's Association, Noon lecture to medical students (MSI, MS2), U of Iowa	Iowa City, IA

6/18/03	Utilization of sexual assault kit in pediatrics. In-service training, Division of General Pediatrics and Adolescent Medicine, Department of Pediatrics, U of Iowa	Iowa City, IA
9/26/03	Management of drug endangered children: How to improve neonatal drug screening at the UIHC, Neonatology Faculty Noon Conference	Iowa City, IA
10/8/03	How to improve neonatal drug screening at the UIHC, Neonatology nursing staff continuing education U of Iowa	Iowa City, IA
3/31/04	Inflicted fractures, U of Iowa students serving at Mobile Clinics of UIHC U of Iowa	Iowa City, IA
4/21/04	Health system in Turkey and its problems to Global Medicine Society medical student members, U of Iowa	Iowa City, IA
10/6/04	Drug endangered children Part 1, In-service training at the Division of General Pediatrics & Adolescent Medicine, U of Iowa	Iowa City, IA
11/3/04	Drug endangered children Part 2, In-service training at the Division of General Pediatrics & Adolescent Medicine, U of Iowa	Iowa City, IA
12/3/04	^ Drug endangered children and community response-I, Grand Rounds, Department of Pediatrics, U of Iowa	Iowa City, IA
4/29/05	Neonatal Screening Protocol at the UIHC, Neonatology Meeting, U of I	Iowa City, IA
10/26/05	Drug endangered children and medical management at the UIHC, Family Care Center Monthly Area Clinic Directors Meeting, U of Iowa	Iowa City, IA
11/4/05	^ Hair and sweat screening for illicit drugs to Chemical Dependency Treatment Unit staff, U of Iowa	Iowa City, IA
12/16/05	Changes needed to the UIHC neonatal drug screening protocol, Neonatology Monthly Division meeting, U of Iowa	Iowa City, IA
4/13/06 4/27/06	UIHC Child Protection Coverage Clinical Guidelines for the Blue Team and Pediatric Social Work staff-Part I and Part II, U of Iowa	Iowa City, IA
11/28/06	^ UIHC needs to lead birthing hospitals in Iowa to address perinatal illicit drug use, Grand Rounds to Department of Obstetrics and Gynecology	Iowa City, IA
1/31/07	International training on Child Abuse & Neglect, Pediatric Interest Group (M2), U of Iowa	Iowa City, IA
2/2/07	Urine and hair screening methods to test children for illegal drugs, Burn Unit Nursing Staff lecture, U of Iowa	Iowa City, IA
9/28/07	^ UIHC needs to lead birthing hospitals in Iowa to address perinatal illicit drug use, Grand Rounds to Department of Pediatrics, U of Iowa	Iowa City, IA
10/5/07	^ UIHC needs to lead birthing hospitals in Iowa to address perinatal illicit drug use, Grand Rounds to Department of Family Practice, U of Iowa	Iowa City, IA
11/29/07	^ UIHC Child Protection Clinical Guidelines, Grand Rounds to Department of Dermatology, U of Iowa	Iowa City, IA
1/24/08	Management of pediatric acute sexual assault, ED core curriculum, U of Iowa	Iowa City, IA
2/21/08	^ Fetal Alcohol Syndrome and adult outcome, Grand Rounds to Department of Internal Medicine, U of Iowa	Iowa City, IA
12/16/08	^ Fetal Alcohol Syndrome and adult outcome, Grand Rounds to Department of Obstetrics and Gynecology, U of Iowa	Iowa City, IA
5/14/09	^ Abusive Head Trauma, Grand Rounds to Department of Ophthalmology, U of Iowa	Iowa City, IA
6/1/09	^ Abusive Head Trauma, Center for Disabilities and Development staff	Iowa City, IA

6/8/09	^ Abusive Head Trauma, Child Health Specialty Clinics staff via video conference	Iowa City, IA
6/09/09	^ Schwartz Rounds, University of Iowa Children's Hospital, U of Iowa	Iowa City, IA
7/6/09	^ Perinatal Illicit Drug Screening Protocol, Center for Disabilities and Development staff monthly meeting	Iowa City, IA
7/13/09	^ Perinatal Illicit Drug Screening Protocol, Child Health Specialty Clinics staff via video conference	Iowa City, IA
4/1/11	^ Grand Rounds on Recognition of child abuse in disabled children, Center for Disabilities and Development staff	Iowa City, IA
7/11/11	Core curriculum lecture to Urology residents	Iowa City, IA
8/20/12	Shaken Baby Syndrome, Family Practice Core Curriculum lecture	Iowa City, IA
1/27/14	^ Adverse Childhood Experiences: Grand Rounds at Department of Family Practice at the U of Iowa	Iowa City, IA
3/27/14	^ Adverse Childhood Experiences: Grand Rounds at Department of Internal Medicine at the U of Iowa	Iowa City, IA
3/28/14	^ Adverse Childhood Experiences: Grand Rounds at Department of Pediatrics at the U of Iowa	Iowa City, IA
7/15/14	^ Adverse Childhood Experiences: Grand Rounds at Department of Obstetrics and Gynecology at the U of owal	Iowa City, IA
11/21/14	^ Corporal Punishment: Grand Rounds, Department of Pediatrics	Iowa City, IA
12/30/14	How to provide opinion on burn cases to law enforcement and DHS: Burn unit division meeting	Iowa City, IA
1/26/15	Pediatric Neurology: Shaken baby syndrome	Iowa City, IA
12/3/15	^ Grand Rounds on adverse childhood experiences and trauma informed care, Emergency and Trauma Center	Iowa City, IA
12/4/15	^ How to avoid missed child abuse cases: Grand rounds for Dept. of Pediatrics	Iowa City, IA
10/10/16	^ Adverse Childhood Experiences: Grand Rounds at Department of Surgery	Iowa City, IA
12/3/16	^ Adverse Childhood Experiences: Grand Rounds at Department of Psychiatry	Iowa City, IA
1/10/17	Inpatient Services' needs for social work and psychology: Monthly Inpatient Team meeting	Iowa City, IA
2/3/17	The future of the Child Protection Program: Stead Family Children's Hospital Administrators lunch meeting	Iowa City, IA
3/6/17	Outcome of Family Well-being Assessment in Child Assessment Clinic: Weekly Faculty Meeting, Dept. of Pediatrics	Iowa City, IA
5/2/17	^ Trauma Informed Care and Patient Safety: Patient Safety Group quarterly Forum	Iowa City, IA
6/9/17	^ Emotional abuse, child neglect and childhood trauma: Pediatric Grand Rounds	Iowa City, IA
9/5/19	CAPP core curriculum: Pediatric residency Retreat	Lebanon, NH
1/11/20	CAPP and child rights: Annual Physicians for Human Rights Conference	Hanover, NH
10/27/20	CAPP protocol: Pediatric nurses core curriculum	Lebanon, NH
11/17/20	CAPP protocols on referral to CAPP: GAP monthly, staffing meeting	Lebanon, NH
3/2/21	CAPP guidelines for Family Practice physicians	Lebanon, NH
3/18/21	CAPP guidelines for Ob/Gyn residents	Lebanon, NH
9/28/21	Hospital based MDT function: NH Child Abuse Task Force	Concord, NH
1/26/22	How can CAPP best support Rockingham County Attorneys?	Zoom, NH

LOCAL Institutional recurrent lectures/teaching * (Some are CME ^ as listed above)

Child abuse lecture to CDD staff and graduate students, U of Iowa (once every 1-3 years)	2001-2019	Iowa City, IA
Child Abuse lecture to Medical Students (M3), U of Iowa (Every 6-12 weeks)	2001-2002	Iowa City, IA
Core curriculum lectures to Pediatric residents, U of Iowa (on 8 topics cycling every 12-18 months)	2001-2019	Iowa City, IA
Introduction to Child Abuse & Neglect, lecture to Medical Students, (M2) Foundations of Clinical Practice, U of Iowa (Once a year)	2002-2019	Iowa City, IA
Various topics on child abuse and neglect to Global Health Club, (Mixed medical students), (once every 2-3 years)	2002-2019	Iowa City, IA
Abusive Head Trauma lecture to Medical Students (M3), U of Iowa (Every six weeks)	2003-2008	Iowa City, IA
Case by case : Management of Child Abuse & Neglect, U of Iowa (1-2/year)	2003-2008	Iowa City, IA
Osteogenesis Imperfecta, lecture to Medical Students (M1), U of Iowa (Every 2-3 years)	2004-2008	Iowa City, IA
Drug endangered children, Undergraduate Child Abuse Course for School of Social Work students, U of Iowa (Twice a year)	2005-2010	Iowa City, IA
How to interview abused children, Undergraduate Child Abuse Course for School of Social Work students, U of Iowa (Twice a year)	2005-2010	Iowa City, IA
Drug endangered children, Postgraduate (MPH) students for College of Public Health, U of Iowa (Twice a year)	2005-09	Iowa City, IA
Physical Maltreatment lecture to Law School Students, U of Iowa (Every two years)	2005-2019	Iowa City, IA
Pediatric physical and sexual abuse in ETC, Annual PALS course and resident core curriculum, U of Iowa (Twice a year)	2006-2019	Iowa City, IA
Child Abuse lecture to Pediatric Nurse Practitioner Students, U of Iowa (Twice a year)	2007-2018	Iowa City, IA
Child abuse lecture, Family Practice Residency Core Curriculum, U of Iowa(Annually)	2007-2019	Iowa City, IA
Train the trainers lecture series on UIHC Perinatal Illicit Drug Screening and Intervention Protocol (3 lectures)	Jan/2008	Iowa City, IA
Management of sexually abused children and childhood trauma: Child Psychiatry Residency core curriculum, U of Iowa (two lectures annually)	2008-2019	Iowa City, IA
Child abuse lecture, Orthopedics Residency Core Curriculum, U of Iowa (Annually)	2013-2019	Iowa City, IA
Adverse Childhood Experiences Training Series offered to units at the University of Iowa and agencies across the state of Iowa (6-8 lectures/year)	2013-2019	Iowa City, IA
Child Abuse lecture, Postgraduate (MPH) students for College of Public Health, U of Iowa (Annually)	2014-2019	Iowa City, IA
Child Abuse lecture, Dentistry residents for College of Dentistry, U of Iowa (Annually)	2015-2019	Iowa City, IA
Adverse Childhood Experiences lecture to M-1 students (annual lecture)	2014-2019	Iowa City, IA
Adverse Childhood Experiences and Trauma Informed Care lectures to M-2 students (annually, two lectures)	2014-2019	Iowa City, IA
Trauma Informed Care and sexual abuse prevention: Human Rights Medical Student Group (Annually)	2015-2019	Iowa City, IA

Abusive Head Trauma lecture to Medical Students (M3), U of Iowa (Every six weeks)	2015-2019	Iowa City, IA
Adverse childhood experiences and trauma informed care, Undergraduate Child Abuse Course for School of Social Work students, U of Iowa (four lectures a year)	2015-2016	Iowa City, IA
Adverse childhood experiences and trauma informed care, Medicine and Society II course for M-1 students, U of Iowa (one lecture a year)	2015-2019	Iowa City, IA
Patient Safety Forum lectures on trauma sensitive approaches (two quarterly lectures spring and summer)	2017	Iowa City, IA
Annual CAPP clinical guidelines training for pediatric residents	2020-date	Lebanon, NH
Introduction to Physical Abuse Diagnostics: Recurrent Medical student Clerkship lecture (every 6 weeks)	2020-date	Lebanon, NH
Adverse Childhood Experiences, Child sexual and physical abuse recognition: On-Doctoring M-2 Psychiatry course	2020-date	Lebanon, NH
Annual CAPP collaboration with inpatient pediatric nurses	2020-date	Lebanon, NH
Annual clinical guidelines training for Psychiatry residents and child psychiatry fellows (repeated every year)	2020-date	Lebanon, NH
Genital examination in sexually abused children (Obstetrics residents)	2021-date	Lebanon, NH
Adverse Childhood Experiences, Pediatrics Interest Group medical students	2021-date	Lebanon, NH

Invited Local and Regional CME/CEU lectures (All are * and ^)

10/02/98	The problems in establishing a hospital based Child Protection Team in a developing country, Regional Ambulatory Pediatrics Conference	Columbus, OH
12/28/00	Shaken Baby Syndrome, Woodhall Medical Center	Brooklyn, NY
1/03/01	Munchausen Syndrome By Proxy, Beth Israel Medical Center	New York, NY
5/25/01	Sexual abuse. Columbia-Presbyterian Hospital Family Medicine Grand Rounds	New York, NY
2001-03	Lectures in the Training Course for the Child Protection Training Academy program for DHS case workers (One-day course, annually)	Iowa City, IA
1/14/02	Introduction to Diagnosis of Child Abuse & Neglect, Grand Rounds for Department of Surgery, U of Iowa	Iowa City, IA
1/31/02	Child Protection Program at the U of I: Clinical guidelines for mandatory reporters, U of Iowa, Department of Pediatrics	Iowa City, IA
5/22/02	Domestic violence and its impact on children, Child Protection Training Academy Training Program for DHS case workers via ICN	Iowa City, IA
9/26/02	Two 1-hour lectures in the Annual Meeting Des Moines County Task Force on Child Abuse & Neglect	Burlington, IA
2002-07	SPE Conferences (one lecture every two years)	Iowa City, IA
10/18/02	Update on Medical Approach to Child Abuse & Neglect, Blackhawk County Task Force Annual Meeting on Child Abuse & Neglect	Waterloo, IA
10/19/02	Mandatory Reporting for Daycare Providers, Indicators of Child Abuse & Neglect, 4-C's bi-annual conference	Iowa City, IA
10/24/02	Physician's Assistants Association Annual Conference, Medical Approach to Child Abuse & Neglect	Cedar Rapids, IA

1/28/03	How to interview families in alleged Child Abuse & Neglect cases, CEU training to social workers, Dep. Of Social Services, U of Iowa	Iowa City, IA
2/6/03	How to interview children in alleged Child Abuse & Neglect cases, CEU training to social workers, Dep. Of Social Services, U of Iowa	Iowa City, IA
3/20/03	Diagnostic Approach to Child Abuse & Neglect, Regional Perinatal Conference	Mason City, IA
4/29/03	Diagnostic Approach to Child Abuse & Neglect, Prevent Child Abuse Iowa Annual Conference	Des Moines, IA
9/18/03 - 12/16/04	Thirteen 1-hr monthly seminars for the Wapello County Child Protection Task Force	Ottumwa, IA
2/28/04	Diagnostic approach to Child Abuse & Neglect, Annual Conference for Emergency Medical Technicians	Iowa City, IA
2003-date	Medical Approach to Child Abuse & Neglect. Child Protection Training Academy Training Program (Two-day course, twice/year)	Des Moines, IA
4/15/04	Drug Endangered children, Annual Southeastern Iowa Conference on Drug Endangered Children	Ottumwa, IA
2004-date (Once/year)	Child Maltreatment, Advanced Pediatric Life Support Course, Department of Emergency Medicine, U of Iowa	Iowa City, IA
7/29/04	Failure to thrive, Visiting Professor lecture, Broadlawns Medical Center	Des Moines, IA
10/8/04	Children and Domestic Violence, Children's Alliance in Wapello County Fall Conference	Ottumwa, IA
11/5/04	Drug Endangered children, Drug Endangered Children Task Force	Burlington, IA
11/12/04	Drug endangered children and community response, Appanoose County Drug Endangered Children Task Force In-service training	Centerville, IA
11/19/04	How does parental methamphetamine use affect children? Court Improvement Project for Judicial Branch Conference	Des Moines, IA
1/20/05 - 7/20/06	Fifteen 1-hr monthly seminars for the Ottumwa Regional Medical Center medical staff	Ottumwa, IA
3/4/05	Effects of illicit drugs on fetus and children, Southeastern Iowa Spring Conference on Drug Endangered Children	Ottumwa, IA
7/19/05	Child Maltreatment, Advanced Pediatric Life Support Course to Pediatricians & Family Practice Physicians, U of Iowa	Iowa City, IA
9/23/05	Neonatal Screening Protocol at the U of Iowa, AAP Iowa Chapter Postgraduate Fall Course on "Child and Adolescent at Risk"	Iowa City, IA
9/24/05	Medical Evaluation of Sexually Abused Child, AAP Iowa Chapter Postgraduate Fall Course on "Child and Adolescent at Risk"	Iowa City, IA
10/13/05	Physician's Assistants Association Annual Conference, Child Abuse & Neglect Mandatory Reporter Training course	Cedar Rapids, IA
12/2/05	Child Abuse & Neglect Grand rounds to Multidisciplinary Trauma Group, U of Iowa	Iowa City, IA
12/13/05	Neonatal drug screening practices in Iowa and how can it be improved, State Child Protection Council bi-monthly meeting	Des Moines, IA
12/29/05	Munchausen Syndrome by Proxy to Emergency and Trauma Center staff, U of Iowa	Iowa City, IA
1/10/06	Drug Endangered Children, Law Enforcement Annual Child Abuse and Neglect Certification Course, Johnson County Law Enforcement Agencies	Iowa City, IA

1/17/06	Drug Endangered Children, Law Enforcement Annual Child Abuse and Neglect Certification Course, Johnson County Law Enforcement Agencies	Iowa City, IA
1/24/06	Drug Endangered Children, Law Enforcement Annual Child Abuse and Neglect Certification Course, Johnson County Law Enforcement Agencies	Iowa City, IA
1/31/06	Drug Endangered Children, Law Enforcement Annual Child Abuse and Neglect Certification Course, Johnson County Law Enforcement Agencies	Iowa City, IA
2006-date	Visiting Professor lecture and hands-on training on selected cases, (1-3 invitations per year to family practice residencies around the state)	Iowa
4/07/06	Poverty and child abuse, Annual Diversity Conference	Ottumwa, IA
4/14/06	Drug Endangered Children, Johnson County Systems Unlimited Staffing Meeting	Iowa City, IA
6/23/06	Drug Endangered Children, Johnson County Public Defender's Office Annual Conference	Iowa City, IA
6/23/06	Shaken Baby Syndrome, Johnson County Public Defender's Office Annual Conference	Iowa City, IA
9/19/06	Pediatric burns and child abuse, Annual Midwest Burn Conference	Iowa City, IA
9/27/06	Perinatal Illicit Drug Screening Policy efforts in Iowa, Carol County Conference on Drug endangered Children.	Carol, IA
2006-2010	Advanced Training on Medical Approach to Child Abuse & Neglect Child Protection Training Academy Training Program (One-day course, annually)	Des Moines, IA
10/26/06	Munchausen Syndrome by Proxy, Grand Rounds for St. Luke's Hospital Family Practice residency program	Cedar Rapids, IA
8/2/07	Perinatal illicit drug screening and intervention practices in Iowa, Public Health Barn Raising Conference VI	Des Moines, IA
9/6/07	Perinatal illicit drug screening and intervention practices in Iowa, Prevention Symposium	Des Moines, IA
9/26/07	Perinatal Illicit Drug Screening Policy efforts in Iowa, Union County Conference on Drug endangered Children	Creston, IA
10/4/07	Child Abuse & Neglect re-certification Course for Mandatory Reporters, Iowa Physician Assistant Society Fall Conference	Cedar Rapids, IA
3/26/08	Inflicted Head Trauma in Children & Childhood Physical Abuse, Iowa Women's Police Association Conference	Des Moines, IA
4/9-10/08	Statewide Policy on Perinatal Illicit Drug Screening and Intervention, Perinatal Care Conference	Des Moines, IA
4/18/08	How to recognize child abuse? Pediatric Nursing Conference	Iowa City, IA
4/21/08	Prevention of Pediatric Inflicted Head Trauma, Annual Prevent Child Abuse Iowa Conference	Des Moines, IA
3/31/09	Shaken Baby Syndrome Prevention, Family, Career, Communication Leaders of America Annual Conference	Des Moines, IA
4/7/09	Dissemination of the Statewide Perinatal Illicit Drug Screening and Intervention Protocol: Preliminary outcome, Drug Endangered Children Alliance of Iowa Annual Meeting	Des Moines, IA

6/9/09	How do pediatricians deal with emotions and personal biases when managing child abuse cases and interacting with their families: Schwartz Rounds	Iowa City, IA
7/1/09	Shaken Baby Syndrome Prevention, Family Consumer Sciences Teachers Annual Conference	Des Moines, IA
3/20/10	Recognition of child physical abuse, Rural Health Conference, Indian Hills College	Ottumwa, IA
4/13/10	Shaken Baby Syndrome Prevention Efforts in Iowa, Governor's Prevention Conference	Ames, IA
2010-date	Advanced Training on Abusive Head Trauma, Child Protection Training Academy Training Program (One-day course, once a year)	Des Moines, IA
4/11/12	Non-organic failure to thrive and perinatal illicit drug exposure: Visiting Professorship lecture	Waterloo, IA
4/12/12	Nebulous and gray areas in child abuse: Midwestern Family Physicians Conference	Iowa City, IA
10/23/12	Impact of staff training on perinatal illicit drug screening and intervention (Drug Endangered Children Conference)	Des Moines, IA
9/9/13	Sick From Bullying: Reaction Panel at Youth and Violence Conference	Iowa City, IA
9/12/13	Local Perspectives on Adverse Childhood Experiences at The Corridor's ACEs Summit	Cedar Rapids, IA
9/20/13	Abusive Head Trauma at Trauma Conference	Davenport, IA
10/3/13	Maternal and neonatal illicit drug screening (Neonatal Update Conference)	Iowa City, IA
10/4/13	Indicators of child abuse and neglect (Iowa Nursing Conference)	Iowa City, IA
12/3/13	Adverse Childhood Experiences at 4-C's Annual Conference	Iowa City, IA
1/15/14	Adverse Childhood Experiences: Carol County Community Task Force (full day training course)	Creston, IA
4/1/14	Adverse Childhood Experiences: Trainer the trainers seminar for Johnson County Supervisors Group	Iowa City, IA
2/4/14	Inflicted Trauma: Trauma Group Seminar	Iowa City, IA
3/20/14	Skin findings and child abuse: Visiting Professor lecture at Broadlawns Hospital Family Practice Program:	Des Moines, IA
3/26/14	Systems building in Turkey: Provost's Global Forum at the U of Iowa	Iowa City, IA
5/1/14	Adverse Childhood Experiences: Iowa Nurse Practitioners Association Annual Conference	Iowa City, IA
6/24/14	Adverse Childhood Experiences: Trauma Informed Care Course to Fort Dodge Community Task Force	Fort Dodge, IA
8/25/14	Adverse Childhood Experiences: Blackhawk County Community Task Force	Waterloo, IA
10/7/14	Adverse Childhood Experiences: Mason City Medical Society monthly meeting	Mason City, IA
10/9/14	Adverse Childhood Experiences: School Nurses Annual Conference	Des Moines, IA
4/23/15	Munchausen Syndrome by Proxy: Siouxland Medical Center family Practice Residency Program grand Rounds	Sioux City, IA
8/26/15	Domestic Violence and how it effects families: Broadlawns Medical Center Family Practice Program grand rounds	Des Moines, IA
2/5/16	Transforming the U of Iowa to a trauma informed campus: Invited presentation to the UI president, provost, vice president for student affairs	Iowa City, IA
3/18/16	Poverty and child abuse: Ottumwa Annual Regional Diversity Conference	Ottumwa, IA
4/22/16	Childhood Trauma Work at Global Scale: Language Makes a Difference,	Cedar Rapids,

	Coe College French Department Grand Rounds	IA
4/27/16	Trauma Informed Care: Resiliency Triumphs Over Trauma Workshop	Iowa City, IA
5/18/16	Trauma Informed Care on Campus and Beyond: Resiliency Triumphs Over Trauma Workshop	Iowa City, IA
5/18/16	Resiliency Triumphs over Trauma: Just Living Theme Semester workshop	Iowa City, IA
5/19/16	Bullying real life and internet for parents: Visiting Professor lecture at St. Luke's Hospital	Cedar Rapids, IA
8/18/16	Abusive Head Trauma recognition and prevention in the ER: Webinar to all Iowa Hospitals with an ER service	Iowa
10/28/16	How to provide Trauma informed Care to children in foster care: Iowa Foster Care Association annual conference	Cedar Rapids, IA
2/4/17	Nurses' Role in Trauma Informed Practices: UI Nursing Grand rounds	Iowa City, IA
3/4/17	Trauma informed care and trauma sensitive responses: Peri-anesthesiology Nurses Annual Conference	Iowa City, IA
3/8/17	Trauma informed care in primary care: First Five Webinar training	Iowa City, IA
4/18/17	Adverse Childhood Experiences and How they impact all aspects of life: Shelby County Trauma Task Force meeting	Shelby County, IA
4/20/17	How child abuse affects mental health: Mental Health Nurses Annual Conference	Iowa City, IA
5/30/17	Domestic Violence: First Five Webinar training	Iowa City, IA
5/31/17	Recognition of child abuse and neglect in primary care: First Five Webinar training	Iowa City, IA
6/1/17	Trauma Informed Care: The future of Health Care	Cedar Falls, IA
6/2/17	Domestic Violence: First Five Webinar training	Tipton, IA
10/26/17	Trauma Informed Care: Medicine-Psychiatry Nurses Conference	Iowa City, IA
12/14/17	How to implement Trauma Informed Assessment in Systems of Care: Ottumwa Mental Health Task Force	Ottumwa, IA
2/21/18	Adverse Childhood Experiences and Sexual Abuse: First-Five training for primary care providers	Cedar Rapids, IA
3/21/18	Trauma sensitive responses to families in which child abuse occurs: Children's Hospital's Nursing Grand Rounds	Iowa City, IA
4/12/18	How to conduct Trauma Informed Assessment in systems of care: Ottumwa Train-the-Trainer Course (half day)	Ottumwa, IA
4/24/18	How do Adverse Childhood Experiences affect health, education, income, productivity, and mortality: First-Five training for primary care providers	Cedar Rapids, IA
5/8/16	How to respond to sex abuse lecture: UIHC Ob/Gyn residents	Iowa City, IA
5/9/18	How to conduct Trauma Informed Assessment in systems of care: Ames Train-the-Trainer Course (full day)	Ames, IA
5/21/18	Trauma Informed Care: UI Family Practice Grand Rounds	Iowa City, IA
10/31/18	Path to diagnostic accuracy and value based care is Trauma Informed Care	Manchester, IA
11/15/18	Domestic Violence and child abuse: Broadlawns Hospital Grand Rounds	Des Moines, IA
1/22/19	Adverse Childhood Experiences and Their Impact on Health: U of Iowa Trauma and Resiliency Certificate Lecture	Iowa City, IA
3/14/19	How to conduct Trauma Informed Assessment in systems of care: Ottumwa Train-the-Trainer Course (full day)	Ottumwa, IA
10/30/2019	CAPP and its future to lead NH in child abuse response: Dept. of Pediatrics Grand rounds	Lebanon, NH
11/7/2019	Medical Child Abuse: Concord Hospital Pediatric in-service training	Concord, NH

2/19/2020	Medical Child Abuse and how to interview families when abuse is suspected: Concord Family Practice in-service training (2 lectures)	Concord, NH
3/1/2020	How can CAPP collaborate with primary care providers? Annual CHaD Pediatric Conference	Mt. Washington, NH
1/12/2021	Medical Child Abuse: New England Virtual Pediatric Education Course	Lebanon, NH
2/4/2021	Eye findings in Child Abuse for Ophthalmology Grand Rounds	Lebanon, NH
3/24/2021	DCYF referral process to CAPP services	Lebanon, NH
4/6/2021	COVID pandemic and prevention of and response to child abuse and neglect in NH, Panel moderation and discussion at Shield Our Children from Harm Conference	Lebanon, NH
4/7/2021	Psychological maltreatment, Panel discussion at Shield Our Children from Harm Conference	Lebanon, NH
4/8/2021	DCYF patient referral process to CAPP clinics: Annual DCYF conference	Concord, NH
4/9/2021	Hospital based MDT meetings: Annual DCYF conference	Concord, NH
5/12/21	International collaboration on systems building for child abuse and neglect national response in Turkey: Grand rounds for Dept. of Pediatrics	Lebanon, NH
6/18-8/20/2021	Nine biweekly lecture series on medical fundamentals of child abuse and neglect: Comprehensive course for DCYF legal staff	Zoom, NH
June-December 2021	Fifteen biweekly lecture series on medical fundamentals of child abuse and neglect: Comprehensive course for DCYF field staff, district supervisors, and nurses	Zoom, NH
October 12-November 2 2021	Six weekly lectures on Know & Tell Medical Fundamentals of Child Abuse & Neglect: Southern New Hampshire Medical Center and Elliott Hospital staff	Zoom, NH
January 10-February 14 2022	Six weekly lectures on Know & Tell Medical Fundamentals of Child Abuse & Neglect: Valley Regional Center staff	Zoom, NH
January 14-February 18 2022	Six weekly lectures on Know & Tell Medical Fundamentals of Child Abuse & Neglect: Wenworth Douglas Hospital and Dover Pediatrics staff	Zoom, NH
March 15-April 19 2022	Six weekly lectures on Know & Tell Medical Fundamentals of Child Abuse & Neglect: North Country Hospitals staff	Zoom, NH

Invited National CME Lectures (All are * and ^)

3/23/99	Sexual Abuse in Children, Department of Pediatrics Noon Conference at Cornell Medical Center	New York, NY
3/3/00	Munchausen Syndrome By Proxy, Driscoll Children's Hospital	Corpus Christi, TX
1/27/05	Establishment of Interdisciplinary Child Protection Teams in a traditional society: The hurdles and how they are overcome, 19th Annual Conference on Child and Family Maltreatment	San Diego, CA
4/30/06	Neonatal illicit drug screening: How can we prevent sending infants to drug using homes? Pediatric Ambulatory Society Annual Conference, Child Abuse & Neglect Special Interest Group session	San Francisco, CA
10/7/06	Outcome of structured training program on child abuse & neglect in Turkey, AAP International Child Health Section Annual Membership meeting	Atlanta, GA

1/12/07	Perinatal illicit drug use/exposure: Still a dilemma nationwide? Children's Hospital at Dartmouth Grand Rounds	Lebanon, NH
3/5/07	Neonatal illicit drug screening: How can we prevent sending infants to drug using homes? University of Connecticut, Department of Pediatrics Grand Rounds	Hartford, CT
3/7/07	Neonatal illicit drug screening: How can we prevent sending infants to drug using homes? Annual Howard Sloan Day, Long Island College Hospital	New York, NY
4/11/07	Child advocacy center model and medical assessment of sexually abused children, New Hampshire Child Protection Task Force	Manchester, NH
4/12/07	Child advocacy center model and medical assessment of sexually abused children, Children's Hospital at Dartmouth Child Advocacy Center staff in-service training	Hanover, NH
10/21/07	Perinatal Illicit Drug Screening Policy Development Efforts in Iowa, Helfer Society Annual Conference	Stevenson, WA
1/31/08	Perinatal Illicit Drug Screening Policy Development Efforts in Iowa, 22nd San Diego Annual Conference on Child Maltreatment	San Diego, CA
9/23/08	Illicit drug exposure in children evaluated for abuse and neglect, Helfer Society Annual Meeting	Tuscan, AZ
4/6/11	Improvement in perinatal illicit drug screening and intervention practices at the UIHC, Helfer Society Annual Meeting	Amelia Island, FL
3/20/12	Leading the way to Child Advocacy Center model in Turkey, National Children's Alliance Annual Meeting	Huntsville, AL
8/10/12	Assessment of child homicides: Child fatalities symposium, Midwest Alliance on Shaken Baby Syndrome	Minneapolis, MN
10/20/12	Systems Building in Turkey on child abuse management and prevention (AAP annual conference)	New Orleans, LA
4/5/13	Munchausen Syndrome by Proxy (full day course to forensic investigators)	Minneapolis, MN
11/14/14	Drug Endangerment of Children (full day course to forensic investigators)	Minneapolis, MN
4/19-22/15	Trauma informed care by child abuse pediatricians: Helfer Society Annual Conference	Savannah, GA
5/5/15	Trauma informed care at Child Advocacy Centers: National Children's Alliance Annual Conference	Norfolk, VA
1/27/16	Trauma Informed Care at the UICH: Helfer Society Prevention Committee Quarterly Meeting	Houston, TX
3/4/16	Adverse Childhood Experiences and how childhood trauma affects health: AIAFS Training Course for Forensic Scientists	Minneapolis, MN
7/11/18	Path to diagnostic accuracy and value based care is Trauma Informed Care: Mount Sinai Children's Hospital Grand Rounds	New York City, NY
9/25/18	Path to diagnostic accuracy and value based care is Trauma Informed Care: UC at Irvine Child Protection Program Grand Rounds	Irvine, CA
10/28/18	Path to diagnostic accuracy and value based care is Trauma Informed Care: University of New York Grand rounds	Syracuse, NY
11/19/18	Path to diagnostic accuracy and value based care is Trauma Informed Care: Hackensack University Medical Center Child Protection Program Grand Rounds	Hackensack, NJ
1/11/19	Trauma Informed Care and Trauma Sensitive Responses in Health	Minneapolis, MN

	care: AIAFS day-long Training Course for Forensic Scientists	
2/25/2020	Drug Endangered Children and Assessment: Grand Rounds at Baystate University Medical Center	Springfield, MA
5/8/2020	Trauma Informed Care and Trauma Sensitive Responses in Health care: AIAFS day-long Training Course for Forensic Scientists	Minneapolis, MN

Invited International CME/CEU lectures (All are * and ^)

3/19/02	Collaboration of Medical, Legal and Social work fields in Child Neglect prevention in Turkey, Ege University Medical School (One-day in-service training course)	Izmir, Turkey
3/20/02	Collaboration of Medical, Legal and Social Work fields in Child Abuse & Neglect prevention in Turkey, Ankara and Gazi University Medical Schools (Three 1-hr lectures)	Ankara, Turkey
3/21/02	Collaboration of Medical, Legal and Social Work fields in Child Abuse & Neglect prevention in Turkey, Ankara and Gazi University Medical Schools (Half day in-service training course)	Ankara, Turkey
3/22/02	Medical diagnostic approach to Child Abuse & Neglect, Duzce University Medical School (One-day in-service training course)	Duzce, Turkey
3/25/02	Problems of a newly established hospital-based Child Abuse & Neglect follow-up team, 3-hour workshop, Dokuz Eylul University	Izmir, Turkey
3/27/02	Problems of a newly established hospital-based Child Abuse & Neglect follow-up team, 3-hour workshop, Ege University	Izmir, Turkey
5/3/03	Training Course for physicians on Child Abuse & Neglect, Istanbul Chapter of Turkish Medical Association (One-day in-service training course)	Istanbul, Turkey
5/5/03	Training Course for multidisciplinary professionals on Child Abuse & Neglect Akdeniz University Medical School (One-day in-service training course for hospital staff)	Antalya, Turkey
5/6/03	Training Course for interdisciplinary professionals on Child Abuse & Neglect Akdeniz University Medical School (One-day in-service regional training course)	Antalya, Turkey
5/9/03	Training course to hospital based multidisciplinary team members, Ege University Medical School (One-day in-service training course)	Izmir, Turkey
5/12/03	Training Course for general practitioners on Child Abuse & Neglect, Ege University Medical School (One-day in-service training course)	Izmir, Turkey
5/13/03	Role of schools in the management of Child Abuse & Neglect, Ege University Medical School (Half-day symposium, four 1-hr lectures)	Izmir, Turkey
5/20/04	Introductory training to Aydin Regional Child Protection Task Force, Aydin Municipality Human Resources Center (One-day in-service training course)	Aydin, Turkey
5/21/04	Establishing and running a child advocacy center in Turkey to Aydin Child and Youth Center staff, Aydin Child and Youth Center (4 hours)	Aydin, Turkey
5/24-26/04	5th National Conference of Sexuality & Sexual Disorders (Two 1-hour lectures)	Istanbul, Turkey
5/27-28/04	Training course to hospital based multidisciplinary team members, Hacettepe University Medical School (Two-day in-service training course)	Ankara, Turkey
6/2-3/05	Training course to hospital based multidisciplinary team members on Child Abuse & Neglect, Baskent University Medical School (Two-day in-service training course)	Ankara, Turkey

6/3/05	How to improve legal response to Child Abuse & Neglect, Ankara Bar Association	Ankara, Turkey
6/4/05	How to interview sexually abused children, Vth Social Psychiatry Conference, Osmangazi University Medical School (Half day Workshop)	Eskisehir, Turkey
6/7-8/05	How to organize regional interdisciplinary response to Child Abuse & Neglect, Erciyes University Medical School (Two-day in-service training course)	Kayseri, Turkey
5/15/06	Two 3-hour workshops for Multidisciplinary Child Protection Teams in Ankara, Gazi University Medical School	Ankara, Turkey
5/16-17/06	Biennial conference on response to Child Abuse and Neglect, Turkish Society for the Prevention of Child Abuse and Neglect (3-hour workshop)	Ankara, Turkey
5/18-19/06	Training course on response to Child Abuse and Neglect, Ondokuz Mayis University Medical School (Two-day in-service training course)	Samsun, Turkey
6/8/06	Grand Rounds on Inflicted Head Trauma in Children, National Forensic Medicine Institute	Istanbul, Turkey
6/9/06	Cerrahpasa Medical School Child Protection Symposium (Two 1-hour lectures)	Istanbul, Turkey
6/9/06	Capa Medical School Child Protection Symposium (Three 1-hour lectures)	Istanbul, Turkey
5/21-22/07	Conference on response to Child Abuse and Neglect, Uludag University Medical School, (Two-day in-service training course)	Bursa, Turkey
5/24-28/07	Forensic Medicine Association Annual Symposium (Three 4-hour workshops)	G-antep Turkey
6/4/07	Medical management of inflicted head trauma	Aydin, Turkey
5/5/08	Regional Conference on Child abuse & Neglect, Ege University Medical School (2-hour lecture)	Izmir, Turkey
5/8-10/08	National Conference on response to Child Abuse and Neglect, Turkish Society for the Prevention of Child Abuse and Neglect (2-hour workshop)	Ankara, Turkey
5/9/08	Task Force meeting on National Child Protection System Development: Collaboration among State Departments of Social Services, Health, Justice, Education, Internal Affairs, and Education (2-hour workshop)	Ankara, Turkey
5/26/08	Izmir Interdisciplinary Child Abuse & Neglect Task Force meeting (2-hour workshop)	Izmir, Turkey
11/3/08	Izmir Department of Public Health Annual Conference (2-hour workshop)	Izmir, Turkey
11/4/08	Izmir Child Abuse Task Force monthly meeting (2-hour workshop)	Izmir, Turkey
11/5/08	Izmir Forensic Medicine Institute Grand Rounds Inflicted head trauma and case management on a multidisciplinary basis	Izmir, Turkey
4/12-14/09	19th National Child and Adolescent Psychiatry conference One day course on Interdisciplinary Management of Child Sexual Abuse	Antakya, Turkey
4/16-17/09	Izmir Child Abuse Task Force and Behcet Uz Children's Hospital Grand Rounds (1-hour lecture)	Izmir, Turkey
9/27-30/09	National Conference on Child Maltreatment, Ankara Child Protection Task Force (One day in-service training course, 4-hour workshop, key note lecture)	Ankara, Turkey
10/1-4/09	5th Neurosurgery Conference (2-hour workshop on program development on Shaken Baby Syndrome)	Urgup, Turkey

10/14-17/09	4th Mediterranean Academy of Forensic Sciences Meeting (4-hour workshop and 90 minute round table)	Antalya, Turkey
5/19-20/10	Child Abuse in-service training course, University of Porto (2-day course on program development on Shaken Baby Syndrome and Child Sexual Abuse)	Porto, Portugal
5/22-24/10	Unicef/Marmara University Collaborative Meeting (3-day in-service training course on establishment of child advocacy centers at 9 universities in Turkey)	Istanbul, Turkey
5/26-28/10	1st National Shaken Baby Syndrome Conference (Half day inservice training course, four 1-hour lectures)	Ankara, Turkey
5/30/10	Celal Bayar University Conference of Social aspects of medical care for elderly and children (One two-hour lecture on management of abusive head trauma)	Manisa, Turkey
6/16-17/10	Cumhuriyet University and Sivas Child Abuse Task Force meeting (2 day in-service course to support interagency team establishment, 6 one-hour lectures)	Sivas, Turkey
7/26-30/10	Ministry of Health in-service training on Child Protection Pilot Project Team building (5 day in-service course, 9 one hr lectures, 2 workshops)	Ankara, Turkey
11/8-9/10	Zeynep Kamil Children's Hospital in-service training on child abuse & neglect (3 one-hr lectures)	Istanbul, Turkey
11/8-10/10	Ministry of Health in-service training on updates on Child Protection Center Pilot Project Team building (2 day in-service course, 3 one-hr lectures)	Ankara, Turkey
11/11/10	Samsun Child Abuse Task Force Meeting (4 one-hour lectures)	Samsun, Turkey
11/12/10	Izmir Child Abuse Task Force meeting (1-day course on Child Protection Center model)	Izmir, Turkey
12/5-7/10	10th National Conference on Child Abuse and Neglect (half-day workshop on hospital based child protection team building)	Lahore, Pakistan
5/2-7/11	University of Porto Annual Child Abuse Conference (two day forensic interview course, one-day child advocacy center course and two lectures	Porto, Portugal
5/18/11	Izmir Child Abuse Task Force symposium (lectures on child advocacy center model and abusive head trauma management)	Izmir, Turkey
6/1-2/11	Trabzon Child Abuse Task Force symposium (lectures on child advocacy center model and interdisciplinary response to child abuse & neglect)	Trabzon, Turkey
9/12-17/11	International Association of Forensic Sciences 19th Triennial Conference (three workshops on sexually transmitted infections, assessment of acute sexual assault, and child advocacy center model)	Madeira, Portugal
9/18-21/11	Establishment of Child Advocacy Centers in Turkey and Portugal (Symposium at the 12th European Child Abuse Conference)	Tampere, Finland
9/18/11	Child Protection Program Development in Turkey (International Working Group on Epidemiology of child abuse & neglect meeting)	Tampere, Finland
11/25/11	Updates on Child Abuse & Neglect (University of Crete Symposium)	Crete, Greece
12/1-3/11	Child Advocacy Center in reducing secondary traumatization within the system of sexually abused children (Excellence in Child Mental Health 2011 Conference)	Istanbul, Turkey
6/14-16/12	Child Abuse management systems building in Turkey (Sustaining Families: Global and local perspectives-U of I College of Law International Conference)	Iowa City, IA
7/16/12	Child Advocacy Center Model to respond to child abuse & neglect, University of Guatemala	Guatemala City

9/6-7/12	Evaluation of the First Child Advocacy Center in Turkey: First Annual Conference	Ankara, Turkey
9/9-12/12	Evaluation of severe physical abuse (19th International Congress on Child Abuse & Neglect –ISPCAN)	Istanbul, Turkey
1/18/13	Corporal Punishment of Children & Child Advocacy Center Model (3rd SPECAN International Child Abuse Conference)	Porto, Portugal
1/18/13	Child Advocacy Center Model for Portugal (3rd SPECAN International Child Abuse Conference)	Porto, Portugal
1/15-16/13	Prevalence of Child Abuse & Neglect in Turkey (BECAN National Conference)	Izmir, Turkey
3/18/13	What Clergy needs to recognize and prevent child abuse and neglect: Izmir Child Abuse Task Force meeting	Izmir, Turkey
3/20/13	How to establish a hospital based child protection team: Grand rounds at Dokuz Eylul University Medical School	Izmir, Turkey
3/20/13	Case conference: How to improve child abuse case management in Izmir	Izmir, Turkey
3/21/13	Child Advocacy Center: Behcet Uz Children's Hospital Grand rounds	Izmir, Turkey
7/30-31/13	Acute Sexual Assault Response Systems Building at Mugla Task Force's Workshop Days	Mugla, Turkey
8/6/13	Acute Sexual Assault and Forensic Medical Examination, Grand Rounds, Turkish National Institute of Forensic Medicine, Istanbul Headquarters	Istanbul, Turkey
8/7/13	Acute Sexual Assault and Forensic Medical Examination, Grand Rounds, Turkish National Institute of Forensic Medicine, Izmir Chapter	Izmir, Turkey
11/9/13	How to keep your children safe in digital age at National Conference on Child Safety and Internet	Ankara, Turkey
11/15/13	Child Advocacy Center Model in Turkey at Child Abuse Task Force Meeting	Aydin, Turkey
11/18/13	Child Advocacy Center Model in Turkey at Child Abuse Task Force Meeting	Antalya, Turkey
11/22-23/13	Multidisciplinary team response to child abuse and neglect at National Conference on Child Maltreatment	Nicosia, Cyprus
5/4-6/14	How to establish multidisciplinary/interagency response to abusive head trauma at International Abusive Head Trauma Conference	Paris, France
7/31/14	How to establish multidisciplinary/interagency response to child abuse at children's hospitals; Bogota University Medical School, Department of Psychiatry Grand Rounds	Bogota, Colombia
8/4-6/14	How to establish multidisciplinary/interagency response to child abuse at children's hospitals (Plenary at International Conference on Child Maltreatment	Bogota, Colombia
8/4-6/14	Adverse Childhood Experiences (Keynote Speech at International Conference on Child Maltreatment	Bogota, Colombia
10/23-25/14	Child Death Review Teams at International Conference on Child Maltreatment	Istanbul, Turkey
6/30/15	Bullying and Pediatrics: Behcet Uz Children's Hospital Grand Rounds	Izmir, Turkey
9/27-30/2015	Adverse Childhood Experiences and Trauma informed care	Bucharest, Romania
11/16-18/15	Train the trainers on fundamentals of child abuse and neglect diagnosis and management: ELIZA child abuse grant educational activities	Athens, Greece
2/18/16	Challenges in diagnosing child physical abuse: National Pediatric Conference	Muscat,

		Oman
6/1-5/16	Train the trainers on how to establish hospital based child protection team in Greece (3 day course, during which I gave 11 lectures and prepared 16 lectures for others to deliver)	Athens, Greece
6/8/16	Integrating Trauma informed care into health: Solidarity Clinic grand rounds	Rethymnon Greece
6/10-13/16	Integrating Trauma informed care into health and human services in Greece: National Conference on how to improve social sciences in Greece	Rethymnon Greece
6/22-23/16	Revisiting forensic interview principles: Grand rounds at Behcet Uz Children's Hospital Child Protection Center and hands on peer-review	Izmir, Turkey
5/14-26/17	In-service training course on how to implement interdisciplinary child protection programs in Colombia: University of Bogota and AFECTO child abuse task force (5 day course, I prepared and gave 12 lectures)	Bogota, Colombia
6/14/17	Interdisciplinary response to child abuse and neglect across the community: PROMISE European Project conference	Brussels, Belgium
10/11-13/17	Videogames and child abuse and neglect: Internet and Child Safety Conference – Digital games	Ankara, Turkey
11/13-14/17	Course on physical abuse and its hospital based multidisciplinary and regional interdisciplinary management in Lahore: The Children's Hospital and The Institute of Health symposium on child abuse	Lahore, Pakistan
11/15-17/17	Physical abuse management at children's hospitals: 1st South Asia Regional Conference on Child Rights & 12th National Child Rights Conference	Lahore, Pakistan
1/25-27/18	Adverse Childhood Experiences and Trauma Informed Care: Adolescent Health Conference	Lisbon, Portugal
3/13-15/18	Multidisciplinary response to Child Abuse and neglect in Pakistan via Child Protection teams and centers	Islamabad, Pakistan
5/28-31/18	Course on Forensic Interviews: Izmir Child Protection Center annual course	Izmir, Turkey
7/21-25/18	Trauma informed Care and Sexual Abuse management: National Colombian Child Maltreatment Annual Conference (two lectures)	Bogota, Colombia
10/18/18	Medical evaluation of child victims of sexual abuse: Webinar for PROMISE European Union Project	Webinar
12/3/18	Interdisciplinary Response to Child Abuse & Neglect at Hospital Setting: Kyriakou Children's Hospital Child Protection Team	Athens, Greece
12/4/18	Inter-hospital collaborative Child Protection Program Establishment: Combined Grand Rounds for Kyriakou Children's Hospital and Agia Sophia Children's Hospital	Athens, Greece
12/6/18	Diagnostic Comprehensive Evaluation of Child Sexual Abuse: Kyriakou Children's Hospital Grand Rounds	Athens, Greece
12/10/18	Training Course on Interagency Response to Child Sexual Abuse: Annual Training Course for Northern Greece Prosecutors, Law enforcement and Judges (half day course)	Athens, Greece
12/11/18	Training Course on Interagency Response to Child Sexual Abuse: Annual Training Course for Southern Greece Prosecutors, Law enforcement and Judges (half day course)	Athens, Greece
12/12/18	International Success Story on Implementing Interagency collaborative Response to Child Sexual Abuse: ELIZA Board of Directors Quarterly Meeting	Athens, Greece
12/13/18	How to assess inpatient child physical abuse cases: Kyriakou Children's Hospital Pediatric resident weekly seminar	Athens, Greece
1/17/19	How to integrate child and family advocacy services into Child Advocacy	Izmir,

	Center model in Turkey: Webinar for national leaders on child abuse	Turkey
4/8-12/19	Best practices to respond to four major categories of child abuse and neglect (2 day course) National Conference on Child Maltreatment	Istanbul, Turkey
11/27-30/19	Adverse Childhood Experiences and Trauma Informed Care: 2nd International 7th National Pediatric Nursing Congress	Izmir, Turkey
10/14/2020	How to prevent child maltreatment via Truama Informed Care, International Child Maltreament Conference	Izmir, Turkey
1/6/2021	Sexually Transmitted Infecitons in sexually abused children: Marmara University Dept of Forensic Medicine Grand rounds	Istanbul, Turkey
6/2-9/2021	Sexual abuse course (4 lectures over 6 hours to Regional Multidisciplinary/Interagency Child Abuse Task Force)	Athens/ Greece
11/9/2021	Adverse Childhood Experiences and Trauma Informed Care	Porto, Portugal
2/8/2022	Physical findings in children who have been tortured by police forces: ISPCAN international course	San Diego, USA
3/21-22/22	Sexual Abuse course to Athens Hospital Based Child Protecton Programs	Athens, Greece
3/24/2022	Adverse Childhood experiences and mental health: Turkish Annual Child and Adolescent Psychiatry Conference	Izmir, Turkey
3/25/2022	Adverse Childhood experiences in primary care: Ankara City Hospital grand rounds	Ankara, Turkey

Invited Lectures at other Meetings *

9/23/03	Drug Endangered Children, Annual Public Forum of Prevent Child Abuse-Johnson County Council	Iowa City, IA
5/6/05	Shaken Baby Syndrome, City High School Health Class students	Iowa City, IA
5/17/05	Shaken Baby Syndrome, West High School Health Class students	Iowa City, IA
2/10/06	Perinatal Illicit Drug Screening Protocols in Iowa, Iowa Alliance on Drug Endangered Children bimonthly meeting	Des Moines, IA
2/28/06	Community collaboration is needed: Drug Endangered Children Community Task Force, Monthly luncheon meeting, Johnson County Juvenile Law Community	Iowa City, IA
8/8/06	Sexual Assault Nurse Examiner's responsibilities in assessing pediatric acute sexual assault cases, SART monthly meeting	Iowa City, IA
8/22/06	How to improve perinatal illicit drug screening in Iowa, Iowa Department of Public Health staffing meeting	Des Moines, IA
10/7/06	International training activities make a difference in the management of child abuse and neglect, American Academy of Pediatrics International child Health Section Executive Board Meeting	Atlanta, GA
3/8/07	How to improve perinatal illicit drug screening in Iowa, Department of Public Health, Maternal and Child Health Advisory Council Meeting	Des Moines, IA
1/10/08	Statewide Policy on Perinatal Illicit Drug Screening and Intervention in Iowa, Department of Public Health, Maternal and Child Health Advisory Council Meeting.	Des Moines, IA
1/10/08	Statewide perinatal illicit drug screening and intervention policy in Iowa, Department of Public Health, Maternal and Child Health Advisory Council Meeting	Des Moines, IA
9/10/08	Shaken Baby Syndrome Prevention Panel, Family Career & Community Leaders Annual In-service Training	Ankeny, IA

9/10/08	Shaken Baby Syndrome Prevention Panel, Family Consumer Science Teachers Luncheon Meeting	Ankeny, IA
2008-2010	Profile of abusive families, Coe College Sociology Department (annual lecture to Sociology of the Family class	Cedar Rapids, IA
11/9/09	International Mondays: Child Abuse & Neglect prevention in Turkey	Iowa City, IA
2010-2018	Historical background of the political environment in Turkey (annual lecture to Psychology and Society Class)	Cedar Rapids, IA
2/17/11	How to prevent missed abuse, Iowa Child Death Review Team	Des Moines, IA
3/19/15	How to address the needs of drug exposed children in foster care, Cedar Rapids Foster Families	Cedar Rapids, IA
4/13/15	Adverse Childhood Experiences and Trauma Informed Care: Kirkwood Community College Nursing students	Cedar Rapids, IA
9/10/15	Neonatal Abstinence Syndrome: Medicaid Enterprise of Iowa monthly meeting	Des Moines, IA
10/14/15	Career path of a pediatrician from general practice to neonatology to child abuse pediatrics: ImmUNITY campaign student group	Iowa City, IA
12/1/15	International systems building on child protection-From the University of Iowa to Turkey and beyond: Iowa City Foreign Relations Council	Iowa City, IA
1/5/16	Adverse Childhood Experiences: Johnson County Morning Rotary Club	Iowa City, IA
2/7/16	Implementing Trauma Informed Care on campus at the U of Iowa: Presentation to the President, Provost, Vice President of Students	Iowa City, IA
4/27/16	Resiliency Triumphs over Trauma: Just Living Theme Semester workshop	Iowa City, IA
8/4/16	Nurses' role in Trauma Informed Care: Nurse Managers Council monthly meeting	Iowa City, IA
11/4/16	Child Trauma Prevention: From UI to Greece – UI Fulbright Annual Presentation Series	Iowa City, IA
10/22/2018	Path to diagnostic accuracy and value based care is Trauma Informed Care: Dartmouth University Child Protection Program Seminar	Lebanon, NH
1/15/2019	Importance of specialized medical evaluation of all alleged victims of child abuse and neglect: Forum discussion with New Hampshire Legislature	Concord, NH
2/4/19	Panel presentation for the City Circle Theater in Relation to "Who is the Tommy" musical	Coralville, IA
8/27/19	Quechee Lakes Landowners Association CHaD Classic Gala Night	Queeche, VT
9/5/2019	How to utilize CAPP Services and how to interview families: Pediatric Residency Retreat	Lebanon, NH
11/7/2019	CAPP and NH stakeholders collaboration: County Attorneys Monthly Meeting	Concord, NH
12/8/2019	New Hampshire Specialized Medical Services for Child Protection System: Attorney General's Child Abuse Task Force Quarterly meeting	Concord, NH
12/18/2019	New Hampshire Specialized Medical Services for Child Protection System: Presentation to CANA-statewide stakeholders	Bedford, NH
1/16/2020	How to implement trauma informed care in primary care: Mt. Ascutney Hospital Board Meeting	Windsor, VT
10/28/2020	CAPP collaboration with inpatient pediatric nurses	Lebanon, NH
11/17/2020	CAPP protocol in collaboration with GAP staff at CHaD	Lebanon, NH
3/2/2021	CAPP protocol in collaboration with Family Practice staff at CHaD	Lebanon, NH
3/18/2021	Annual clinical guidelines training for Ob/Gyn residents	Lebanon, NH
8/19/2021	Professionalism while assessing families for child abuse and neglect	Lebanon, NH

XXIII. Bibliography

A. Most significant peer-reviewed publications in print or other media (Underlined are undergraduate or graduate students I supervised, **$$ indicates THE MOST impactful five studies I published**)

1. **Oral R,** Yavuz S, Battered Child Syndrome. *Anatol J Pediatr* 1994, 3:32-35. (First published shaken baby syndrome case in Turkey that led to pediatricians and neurosurgeons diagnosing SBS in increasing rates in Turkey, My role: Concept & design, analysis & interpretation of data, writing the manuscript)(In Turkish).
2. **Oral R,** Can D, Yavuz S. Beware of epiphysiolysis: Child Abuse. *J Contin Med Edu*, 1997 6(10):332-334. (First published inflicted fracture case in Turkey, which changed pediatricians and orthopedists' approach to fractures in infants. My role: Concept & design, analysis & interpretation of data, writing the manuscript) (In Turkish).
3. Betin N, **Oral, R.** Battered Child Syndrome. *Cukurova Med Sch J* 1998, 23:106-110. (First report of skeletal survey establishing diagnosis of inflicted pediatric trauma in Turkey, which institutionalized this diagnostic tool in child abuse pediatrics in the country. My role: Analysis & interpretation of data, writing the manuscript) (In Turkish).
4. **Oral R**, Can D, Hanci H, Miral S, Ersahin Y, Tepeli N, Bulguc AG, Tiras B. A multicenter child maltreatment study: Twenty-eight cases followed-up on a multidisciplinary basis. *Turk J Pediatr* 1998; 40(4)515-523. (First case series of child abuse in Turkey assessed and managed by the first multidisciplinary team of the country that led to recognition of the need to establish hospital based multidisciplinary teams. My role: Concept & design, analysis & interpretation of data, writing the manuscript).
5. **Oral R**, Can D, Miral S, Hanci H, Kaplan S, Ates N, Polat S, Ersahin Y, Tepeli N, Uran N, Tiras B. The First Child Abuse Case Series Followed-up on a Multidisciplinary Basis in Turkey, *Child Abuse Negl* 25 (2001) 279-290. (This publication introduced pioneering child abuse work to international arena and led to academics in Turkey starting to research this field. My role: Concept & design, analysis & interpretation of data, writing the manuscript).
6. **$$ Oral R,** Strang T. Neonatal Illicit Drug Screening Practices in Iowa: The impact of utilization of a structured screening protocol. J Perinatol 2006; 26(11):660-6. (This study verified the importance of a structured protocol on this topic in neonatal case finding of perinatally drug endangered infants, which led to my work on statewide new protocol development in Iowa. My role: Concept & design, analysis & interpretation of data, critical review of manuscript).
7. **$$** Agirtan CA, Akar T, Akbas S, ... **Oral R,** ... et al. (with 79 authors from multiple centers in alphabetical order). Establishment of Interdisciplinary Child Protection Teams in Turkey 2002-2006: Identifying the strongest link can make a difference! Child Abuse & Neglect 2009; 33(4):247-55. (With my leadership in building a sustained education campaign on child abuse in Turkey, a large collaboration was established leading to this study among others, which was followed with the establishment of 40 child advocacy centers in the country as well as 15 hospital based child protection centers. My role: Concept & design, train the trainers for the project, provide consultation and guidance for MDT establishment, analysis & interpretation of data, writing the manuscript).
8. **$$ Oral R**, Bayman L, Assad A, Wibbenmeyer L, Buhrow J, Strang T, Austin A, Bayman EO. Illicit Drug Exposure in patients evaluated for alleged child abuse and neglect. Pediatric Emergency Care, 2011;27(6):490-5 (This study led to the practice of screening victims of child abuse via hair and urine toxicology testing, which led to numerous hospitals in the country implementing the same practice. My role: Concept & design, analysis & interpretation of data, writing the manuscript).
9. **$$ Oral R**, Koc, F, Bayman EO, Assad A, Strang T, Austin A. Perinatal illicit drug screening practices in mother-newborn dyads at a university hospital serving rural/semi-urban communities:

Translation of research to quality improvement. J Mat-Fet & Neonat Med, 2012, 25(11):2441. (This study verified the importance of staff training on case finding of perinatally drug endangered children. My role: Concept & design, analysis & interpretation of data, writing the manuscript).

10. Longmuir SQ, McConnell L, **Oral R**, Dumitrescu A, Kamath S, Erkonen G. S. Retinal hemorrhages in intubated pediatric intensive care patients. J AAPOS. 2014 Apr;18(2):129-33. (This study added to the limited body of literature that illnesses that require critical care or critical care itself do not cause retinal hemorrhages in infants, which had been a controversial topic in high profile abusive head trauma cases. My role: Contributing to the concept & design, provision of the patient list, critical review of the manuscript)
11. Sofuoglu Z, **Oral R,** Aydin F, Cankardes S, Kandemirci B, Koc F, Halicioglu O, Aksit S. Epidemiological study on negative childhood experiences in three provinces of Turkey. Turk Pediatr Arch 2014; 49: 47-56 (This study led to Turkish medical community recognize the importance of adverse childhood experiences and multiple studies followed this study. My role: Contributing to the concept & design, analysis & interpretation of data, critical review of the manuscript)
12. Yaylaci S, Dallar Y, ... **Oral R**, ... Karagoz F (32 authors). Abusive Head Trauma in Turkey and Impact of Multidisciplinary Team Establishment Efforts on Case Finding and Management: Preliminary Findings. Eur J Emer Med 2016; 15:24-29 (This study established the practice of using a structured abusive head trauma response guidelines in hospitals in Turkey. My role: Concept & design, analyzing data, critical review of the manuscript)
13. Soldatou, A, Paouri, B, Stathi, A, Nega, C, Tsolia, M, **Oral, R**, Leventhal, J. Missed Opportunities for the Detection of Physical Abuse and Neglect among Patients Hospitalized with Burns at a Tertiary Children's Hospital in Greece (2017). Eur J Pediatr 176 (11), 1547-1548 (This study is one of multiple studies published and submitted for publication after I trained the trainers in Greece during my Fulbright scholarship. (My role: Concept & design, creating and delivering the intervention tool/training module, critical review of the manuscript)
14. Fassel M, Grieve B, Hosseini S, **Oral R**, Galet C, Ryan C, Kazis L, Pengsheng N, Wibbenmeyer L. The Impact of Adverse Childhood Experiences (ACEs) on Burn Outcomes in Adult Burn Patients. J Burn Care Research 2019; 26;40(3):294-30. (My role: critical review of methodology and the manuscript)
15. **$$** Kottenstette S, Segal R, Roeder V, Rochford H, Schnieders E, Bayman L, McKissic DA, Dahlberg GJ, Krewer R, Chambliss J, Theurer JL, **Oral R**. Two-generational trauma-informed assessment improves documentation and service referral frequency in a child protection program. Child Abuse Negl. 2019. 16;101:104327.

B. Original peer reviewed articles (Underlined are undergraduate or graduate students I supervised)

1. **Oral R**, Can D, Ibrahimhakkioglu M, Sumer S. Neonatal Multifocal Salmonella Typhimurium Osteomyelitis. *J Neonatol* 1995; 2(1):29-36. (My role: Concept & design, analysis & interpretation of data, writing the manuscript).
2. **Oral R**, Kultursay N, Ozturk C, Tansug N. Dual Energy X-Ray Absorptiometry in Determining Bone Mineral Content of Prematurely Born Infants, *Ann Med Sci* 1996; 5:13-17. (My role: Concept & design, analysis & interpretation of data, writing the manuscript).
3. Kültürsay N, Gelal F, Mutluer S, Senreçper S, Oziz E, **Oral R**. Antenatally diagnosed neonatal craniopharyngioma. *J Perinatol.* 1995; 15(5):426-428 (My role: Writing the manuscript).
4. Ozkinay F, Akisü M, **Oral R,** Tansuğ N, Ozyürek R, Kültürsay N. Spondylocostal dysplasia and cardiac anomalies in one dizygotic twin. *Turk J Pediatr* 1996;38(3):381-4. (My role: analysis & interpretation of data, writing the manuscript).

5. Ozkinay FF, Akisü M, Kültürsay N, **Oral R**, Tansug N, Sapmaz G. Agenesis of the corpus callosum in Schinzel-Giedion syndrome associated with 47,XXY karyotype. *Clin Genet.* 1996; 50(3):145-148. (My role: analysis & interpretation of data, writing the manuscript).
6. Akisu M, Kultursay N, Coker I, **Oral R**, Huseyinov A. Myocardial Free Carnitine Depletion in Asphyxiated Young Mice-Do Hypoxic Ischemic Newborn Infants Need Carnitine Supplement? *Turk J Med Sci* 1997; 27:349-353. (My role: analysis & interpretation of data, writing the manuscript).
7. **Oral R**, Akisu M, Kultursay N, Vardar F, Tansug N. Neonatal Klebsiella Pneumonia sepsis and imipenem/cilastatin. *Indian J Pediatr* 1998; 65(1):121-129. (My role: Concept & design, analysis & interpretation of data, writing the manuscript).
8. Can D, Inan G, Yendur G, **Oral R**, Gunay I. Salbutamol or Mist in Acute Bronchiolitis. *Acta Pediatr Jpn* 1998; 40(3):252-255. (My role: Writing the manuscript).
9. Akisu M, Darcan S, **Oral R**, Kultursay N. Serum Lipid and Lipoprotein composition in Infants of Diabetic Mothers. *Indian J Pediatr* 1999; 66(3):381-386. (My role: analysis & interpretation of data, writing the manuscript).
10. Johnson CF, **Oral R,** Gullberg L. Diaper Burn: Accident, Abuse or Neglect. *Pediatr Emerg Care*, 2000; 16:173-175 reviewed in Child Abuse Quarterly Medical Update VIII (1):14. (My role: Writing the manuscript and interpretation of findings).
11. **Oral R,** Johnson CF, Blum K. Fractures in young children and child abuse. *Pediatr Emerg Care* 2003; 19 (3):148-153. (My role: Concept & design, analysis & interpretation of data, writing the manuscript).
12. Ozkara E, Karatosun V, Izge Gunal, **Oral, R**. Trans-metatarsal amputation as a complication of child sexual abuse. *J Clin Forensic Med.* 2004; 11(3):129-132 (My role: analysis & interpretation of data, writing the manuscript.
13. Acik Y, Deveci E, **Oral R**. Level of knowledge and attitude of primary care physicians in Eastern Anatolian cities in relation to child abuse and neglect. *Prev Med. 2004;;39(4):791-7.* (My role: Concept & design, analysis & interpretation of data, writing the manuscript).
14. Acik Y, Deveci SE, Polat A, **Oral R.** Adolescents in Apprentice: Abuse experiences and attitudes toward violence. *J Public Health* 2004; 14(1):95-102. (My role: Concept & design, analysis & interpretation of data, critical review of manuscript) (In Turkish).
15. **Oral R**, Rahhal R, Elshelshari H, Menezes AH. Intentional Avulsion Fracture of the 2nd Cervical Vertebra in a Hypotonic Child. Pediatr Emerg Care 2006, 22(5):352-4. (My role: Concept & design, analysis & interpretation of data, critical review of manuscript).
16. Yucel-Beyaztas F, Dokgoz H, **Oral R,** Demirel Y. Child physical abuse: a five-case report. Middle East Journal of Family Medicine, 2006; 4(2):21-26. (My role: Analysis & interpretation of data, writing the manuscript)
17. **Oral R,** Florvanovich A, Goodman J. Household falls in children less than 2 years of age. Turkish J Pediatr 2007, 49(4): 379-384. (My role: Concept & design, analysis & interpretation of data, critical review of manuscript).
18. **Oral R,** Yagmur F, Nashelsky M, Turkmen M, Kirby P. Fatal Abusive Head Trauma cases: Consequence of medical staff missing milder forms of physical abuse. J Pediatr Emerg Care 2008; 24(12):816-21. (My role: Concept & design, analysis & interpretation of data, critical review of manuscript).
19. Atılmış ÜÜ, Gündüz T, Karbeyaz K, Balcı Y, **Oral R.** Diagnostic dilemma in a case with incest suspicion. J Clin Turk Foren Med 2008;5(3):124-32. (My role: Concept & design, writing the manuscript).
20. Yucel-Beyaztas F, **Oral R,** Butun C, Beyaztas A, Buyukkayhan D. Four cases of physical abuse in children. Turkish J Pediatr 2009, 52(2):75-80. (My role: critical review of manuscript).
21. Sahin F, Kuruoğlu AC, Demirel B, Akar T, Camurdan AD, Işeri E, Demiroğulları B, Paslı F, Beyazova U, **Oral R.** Six year- experience of a hospital based child protection team in Turkey. Turkish J Pediatr 2009;51(4):336-43. (My role: Concept & design, critical review of manuscript).

22. Hayek SN, Wibbenmeyer LA, Kealey LH, Williams IM, **Oral R,** Onwuameze O, Light TD, Latenser BA, Lewis II RW, Kealey G P. The efficacy of hair and urine toxicology screening on the detection of child abuse by burning. J Burn Care and Research, 2009;30(4):587-92. (My role: Review of concept & design, analysis & interpretation of data, critical review of manuscript).
23. Tiras U, Dallar Y, Dilli D, **Oral R**. Evaluation and follow up of cases diagnosed as child abuse and neglect at a tertiary hospital in Turkey. Turk J Med Sci, 2009; 3(96):969-977. (My role: Concept & design, writing the manuscript).
24. Kucuker H, Demir T, Koken R, **Oral R**. Pediatric Condition Falsification (Munchausen Syndrome by Proxy) as a Continuum of Maternal Factitious Disorder (Munchausen Syndrome). Pediatric Diabetes, 2010; 11(8):572-8. (My role: Analysis & interpretation of data, writing the manuscript).
25. Butun C, Beyaztas FY, **Oral R,** Guney C, Buyukkayhan D, Sato Y. Twins physically abused by the father. Turkish Archives of Pediatrics, 2011; 46: 346-50 (My role: Concept & design, analysis & interpretation of data, editing the manuscript).
26. **Oral R,** Koc F, Smith J, Sato Y. Abusive Suffocation Presenting as New Onset Seizure. Pediatric Emergency Care, 2011; 27(11):1072-4 (My role: Concept & design, analysis & interpretation of data, editing the manuscript).
27. Kondolot M, Yağmur F, Yıkılmaz A, Turan C, Oztop D, **Oral R.** A life-threatening presentation of child physical abuse: jejunal perforation. Pediatric Emergency Care, 2011; 27(11):1075-7 (My role: Concept & design, analysis & interpretation of data, editing the manuscript).
28. Demirli Çaylan N, Yılmaz G, **Oral R**, Karacan CD, Zorlu P. Abusive head trauma: report of 3 cases. Ulus Travma Acil Cerrahi Derg. 2013, 19(3):261-6 (My role: Concept & design, critical review of the manuscript).
29. Koc F, **Oral R**, Butteris R. Missed cases of multiple forms of child abuse and neglect. Int J Psychiatry Med. 2014;47(2):131-9. (My role: Concept & design, patient care, critical review of the manuscript).
30. Wibbenmeyer L, Liao J, Heard J, Kealey L, Kealey G, **Oral R**. Factors Related to Child Maltreatment in Children Presenting With Burn Injuries. J Burn Care Res. 2014 Sep-Oct;35(5):374-81 (My role: Concept & design, critical review of the manuscript).
31. Longmuir S, **Oral R**, Walz AE, Kemp PS, Ryba J, Zimmerman BM, Abramoff MD. Quantitative Measurement of Retinal Hemorrhage in Children Suspected of Abuse. J of AAPOS, 2014; 18(6):529-33. (My role: Contributing to the concept & design, provision of the patient list, critical review of the manuscript)
32. **Oral R**, Sofuoglu Z. Case-Based Surveillance Study in Judicial Districts in Turkey: Child Sexual Abuse Sample from four Provinces. J Child & Fam Social Work, 2017. DOI:10.1111/cfs.12427 (My role: Concept & design, critical review of the manuscript)
33. Evans EM, Jennissen CA, **Oral R**, Denning GM. Child welfare professionals' determination of when children's access or potential access to loaded firearms constitutes child neglect. Trauma Acute Care Surg. 2017 Nov;83(5S Suppl 2):S210-S216 (My role: Critical review of the manuscript)
34. Soldatou, A, Paouri, B, Hountala, A, Koutrouveli, E, Plevriti, E, Kyriakidou, T, Stathi, A, Tsolia, M, Oral, R, Leventhal, J. Age and Outcome of Inpatients Evaluated for Possible Physical Abuse at a Tertiary Children's Hospital in Greece. Eur J Pediatr 2017; 176 (11), 1547 (My role: Concept & design, creating the intervention tool/training module, critical review of the manuscript).
35. Jennissen C, Evans E, **Oral R**, Denning G. Child Abuse and Neglect Experts' Determination of When a Child Being Left Home Alone Constitutes Child Neglect. Inj Epidemiol. 2018; 10;5 (Suppl 1):16 (My role: finalizing concept & design, creating partnerships for the study, critical review of the manuscript)
36. Sofuoglu Z, Cankardas-Nalbantcilar S, **Oral R,** Ince B. Case-based surveillance study in judicial districts in Turkey: Child sexual abuse sample from four provinces. Child & Fam Social Work 2018; 23(4):566-573. (My role: finalizing concept & design, critical review of the manuscript)

37. Altan H, Sahin F, **Oral R.** Measuring Awareness about Child Abuse and Neglect: Validity and Reliability of a Newly Developed Tool- Child Abuse and Neglect Awareness Scale. Turkish J Peds, 2018; 60:392-399. (My role: Concept & design, critical review of the manuscript)
38. Soldatou A, Stathi A, Paouri B, Nega C, Apergi FS, Tsolia M, Leventhal J, **Oral, R.** A national educational campaign to raise awareness of child physical abuse among health care professionals. Europ J Ped, 2020, 179(9):1395-1403. (My role: Concept & design, creating the intervention tool/training module, critical review of the manuscript)
39. Conrad A, Butcher B, **Oral R**, Ronnenberg M, Peek-Asa, C. Trends in Shaken Baby Syndrome Diagnosis Codes Among Young Children Hospitalized for Abuse. Injury Epidemiology, 202. 8:46. (My role: Concept & design, critical review of the manuscript)
40. Ong JE, Fassel M, Scieszinski L, Hosseini S, Galet C, **Oral R**, Wibbenmeyer L. The burden of adverse childhood experiences in children and those of their parents in a burn population. Journal of Burn Care & Research, 2021 Jan 23;irab009. doi: 10.1093/jbcr/irab009. Online ahead of print (My role: Concept & design, creating the intervention tool/training module, critical review of the manuscript)
41. Wojciak AS, Butcher B, Conrad A, Coohey C, **Oral R,** Peek-Asa C. National Trends in Child Abuse and Neglect Hospitalization Rates and Costs in the United States of America. MDPI IJERPH, 2021. 18(14)7585. (My role: Concept & design, critical review of the manuscript)
42. O'Hara M, Valvano TJ, Kashyap M, Daly JC, Bachim AN, ... Oral R. Understanding Bilateral Skull Fractures in Infancy: A Retrospective Multi-Center Case Review. Ped Emerg Care 2022 (Accepted for publication; My role: Concept & design, critical review of the manuscript)

C. Review papers:

1. **Oral R**. Perinatal Illicit Drug Use and Fetal Exposure: Consequences and Management with a Public Health Approach. J Drug Testing & Analysis, Published Online: Mar 10 2009 7:07AM DOI: 10.1002/dta.21 (Invited by editor, reviewed by editor).
2. B, **Oral R.** Child poverty and neglect in Turkey. In: Dubowitz H (ed). World Perspectives on Child Abuse. Tenth edition, 2012. International Society for Prevention of Child Abuse and Neglect, Turkey. pp 36-39. (Invited by editor, reviewed by editor. My role: Critical review of the manuscript).
3. Kaynak H, **Oral R.** Protection of children from neglect in the Turkish laws. In: Dubowitz H (ed). World Perspectives on Child Abuse: Tenth edition, 2012. International Society for Prevention of Child Abuse and Neglect, Turkey. pp 40-43. (Invited by editor, reviewed by editor. My role: Critical review of the manuscript).
4. den Otter J, Smit Y, Dela Cruz LB, Ozkalipci O, **Oral R.** Documentation of torture and cruel, inhuman or degrading treatment of children: a review of existing guidelines and tools. Forensic Science International, 2013, 10;224(1-3):27-32. (Invited by editor, reviewed by editor. My role: Analysis & interpretation of data, critical review of the manuscript).
5. Akco S, Dagli T, Inanici MA, Kaynak H, **Oral R**, Sahin F, Sofuoglu Z, Ulukol B (alphabetically listed by last name). Child abuse and neglect in Turkey: professional, governmental and non-governmental achievements in improving the national child protection system. Paed Intrntl Child Health. 2013, 33(4):301-9 (Invited by editor, reviewed by peers. My role: Concept & design, critical review of the manuscript).
6. Silveira Ribeiro, C., Oral, R., Carmo, R., Jardim, P., Magalhaes, T. (2013). Management of child abuse and neglect in Portugal. A comprehensive and critical review. In Magalhães, T & Vieira, DN (Ed.), Abuse & Neglect Series I – To improve the Management of Child Abuse

and Neglect (11-30). Maia: SPECAN. ISBN: 978-989-97275-0-2 (Invited by editor, reviewed by editor. My role: Critical review of the manuscript).

7. **Oral R.** Ramirez M, Peek-Asa C, Nakada S, Walz A, Kuntz A, Coohey C. Childhood Adversity and Trauma Informed Care. Pediatric Research 2016;79(1-2):227-33. (Invited by editor, reviewed by peers. My role: Concept & design, writing one section, critical review of the manuscript)
8. **Oral R**, Ilyas F, Leventhal JM, Magalhaes T, Oliveira M, Soldatou A, Stathi A, Zafar N. Building systems to address child abuse and neglect: Successful collaborations with international partners, World Perspectives 2018 (ed: Howard Dubowitz) (Invited by editor, reviewed by editor. My role: Concept & design, critical review of the manuscript).
9. Bag O, **Oral R.** Child Protection Systems in the USA and Europe, J of Turkish Clinics 2020 (Invited by editor, reviewed by peers. My role: Concept & design, writing two sections, critical review of the manuscript)
10. Statement on conversion therapy. Independent Forensic Expert Group. J Forensic Leg Med. 2020 May;72:101930. PMID: 32452446
11. Oral R, Coohey C, Zarei K, Conrad A, Nielsen A, Wibbenmeyer L, Segal R, Wojciak A, Charles Jennissens, Corinne Peek-Asa. Nationwide efforts for trauma informed care implementation and workforce development in healthcare and related fields: a systematic review. J of Turkish Clinics 2020; 62: 906-920 (My role: Concept & design, writing two sections, critical review of the manuscript)
12. Alempijevic D, Beriashvili R, Beynon J, Alempijevic Petersen D, Birmanns B, Brasholt M, Cohen J, Alempijevic Petersen D, Duque M, Duterte P, Van Es A, Fernando R, Korur Fincanci S, Holger Hansen S, Hamzeh S, Hardi L, Heisler M, Iacopino V, Mygind Leth P, Lin J, Louahlia S, Luytkis H, Louahlia S, Morcillo-Mendez MD, Moreno A, Moscoso V, **Oral R**, Ozkalipci O, Payne-James J, Quiroga J, Ozkalipci O, Reyes H, Rogde S, Sajantilla A, Ozkalipci O, Schick M, Terzidis A, Lange Thomsen J, Tidball-Binz M, Treue F, Vanezis P, Viera DN. Statement of the Independent Forensic Expert Group on Conversion Therapy. Torture. 2020;30(1):66-78. (My role: Critical review of the manuscript)
13. Bag, O, **Oral R.** Child Protection Systems in the United States of America and in the World Türkiye Klinikleri; 2021. p.93-7. (My role: Concept & design, writing one section, critical review of the manuscript)

D. Books, Book chapters, Other monographs

Books:

1. *Report by Izmir Non-governmental Organizations on Children's Rights*. Ed: **Resmiye Oral**, National Medical Association Press, Izmir, 1996. (My role: Concept & design, writing child abuse section, critical review and comprehensive editing of the book).
2. *Primary Care Physicians and Child Abuse & Neglect*. Ed: **Resmiye Oral**. Ministry of Health Print shop, Ankara, 1998. (My role: Concept & design, writing and comprehensive editing of the book).
3. *Physical Abuse: Training Kit for Physicians*. Charles F. Johnson, **Resmiye Oral** (eds), Ohio State University Publications, 1999, Columbus. (My role: Concept & design, writing the first draft and co-editing).

Book chapters:

1. **Oral, R.** Hepatitis B and Hemophilus Influenza Vaccination Practices. In: *Antibiotic Use in Pediatrics and Goals in Immunization Practices*. Turkish National Pediatric Association Press, Izmir, 1994:65-78. (My role: Concept & design, writing and editing the chapter).
2. **Oral, R.** Child Abuse. In: *Report by Izmir Non-governmental Organizations on Children's Rights*.

(ed. Resmiye Oral). National Medical Association Press, Izmir, 1996. (My role: Concept & design, writing and editing the chapter).

3. **Oral, R.** Child Abuse. In: *Forensic Psychiatry* (ed: Hamit I. Hanci), Intertip, Izmir, 1997. (My role: Concept & design, writing and editing the chapter).
4. **Oral, R,** Jardim P, Magalhaes T. Sexually transmitted infections in child sexual abuse/assault: diagnosis, forensic significance, and treatment. In: Abuse & Neglect Series, n° 1 – "To improve the management of Child Abuse & Neglect" (ed: Teresa Magalhaes), SPECAN publications, 2011. (My role: Critical review and editing the chapter).
5. Ribeiro CS, **Oral, R,** Do Carmo R, Jardim P, Magalhaes T. Management of child abuse and neglect in Portugal: A comprehensive and critical review. In: Abuse & Neglect Series, n° 1 – "To improve the management of Child Abuse & Neglect" (ed: Teresa Magalhaes), SPECAN publications, 2011. (My role: Critical review and editing the chapter).
6. **Oral R**. Multidisciplinary Management of Child Sexual Abuse. In: From TRAUMA to Post Traumatic Stress Disorder (ed: Fani Triantafullou and Oresis Giotakos) (in print for 2019). (My role: Writing and editing the chapter).

Guidelines

1. UIHC Child Protection Program Clinical Practice Guidelines: Developed in 2001, updated in 2003, 2004, 2005, 2006, 2008, 2009, 2010, 2019 (My role, concept-design, writing the original version and editing each following version)
2. Ambulatory Pediatric Association (APA)'s Educational guidelines Revision Project (2002-2004), grant award to the APA by Josiah Macy, Jr., Foundation (Project Director, Diane Kittredge). (My role, concept-design, writing the section on child abuse)
3. Identifying the Child Victim of Abuse or Neglect: *Protocols for Assessment. Care for Kids: Early Periodic Screening,* Diagnosis & Treatment, 2003; 10(3):1-6. (My role, concept-design, writing the manuscript)
4. Iowa Statewide Protocol on Perinatal Illicit Substance Screening and Intervention. *Care for Kids: Early Periodic Screening, Diagnosis & Treatment* (2008). (My role, concept-design, writing the manuscript)
5. CHaD/DHMC Child Advocacy & Protection Program Clinical Practice Guidelines: Developed in 2019 (My role, concept-design, writing the original draft in consultation with CAPP medical providers, ED, SANE, Pediatrics Department leadership)

E. Other publications

Newsletter publications (My role, concept-design, writing the manuscripts listed below; if with a co-author, editing the final draft)

1. **Oral, R**. Role of Rib Fractures. The Clinician's Corner, *News from the AAP Iowa Chapter*, Spring 2004 pp 7-8.
2. **Oral, R**. Denial of Critical Care/Child Neglect. *Care for Kids: Early Periodic Screening, Diagnosis & Treatment,* 2004; 11(1):3-6.
3. **Oral, R,** Figen Sahin. Establishing multidisciplinary Child Abuse Teams in Turkey. *AAP Section on International Child Health quarterly newsletter,* Fall 2006.
6. **Oral, R.** When to consider abuse and neglect in children. *Pediatric Trauma Update,* 2008, 1(2):1-2.
7. **Oral, R**. Care for children exposed to illicit drugs. *Care for Kids: Early Periodic Screening, Diagnosis & Treatment* Winter, 2009.
8. **Oral, R**. Perinatal Illicit Substance Exposure and the Dilemma Related to Prescription Abuse. *Care for Kids: Early Periodic Screening, Diagnosis & Treatment* Fall, 2013.

9. **Oral, R,** Corbin M. Adverse Childhood Experiences and Pediatrician's responsibility: The foundations of a lifelong health are built in early childhood. *Care for Kids: Early Periodic Screening, Diagnosis & Treatment* Spring, 2015.

Electronic publications (My role, concept-design, created the written material listed below; if with a co-author, editing the final draft)

2001-2019 Web page describing the Child Protection Program at the U of I
http://www.uihealthcare.com/depts/childrenshospitalofiowa/childprotection/index.html
http://www.vh.org/navigation/vch/bibliography/archive/index.html

2002-2019 Teaching material for medical students and residents online via Virtual Hospital on Introduction to Medical Approach to Child Abuse, Inflicted Head Trauma, Denial of Critical Care Part I: Medical/Dental Neglect, Denial of Critical Care Part II: Non-organic failure to thrive
http://www.vh.org/navigation/vh/textbooks/pediatrics.html

2003-2019 Educational and descriptive brochures on Child Abuse & Neglect online for families, children and professionals on Sexual abuse, Shaken Baby, Child Discipline, Prevention of Child Abuse
http://www.uihealthcare.com/depts/childrenshospitalofiowa/childprotection/brochures.html

2005-2019 Child Protection Clinical Guidelines (accessible via IPR)
http://forms.uihc.uiowa.edu/pdf/abuseforms/index.htm

2005-2015 Medical Management of Drug Endangered Children for the website of Iowa Alliance for Drug Endangered Children http://www.iowadec.org/wst_page6.html

2005-2012 Mandatory reporter training course on Child Abuse & Neglect via Iowa Communications Online (ICON) and The Point http://forms.uihc.uiowa.edu/pdf/abuseforms/index.htm

2006 Video production for online training of General Pediatricians on how to interview families of children allegedly sexually abused or suffered from inflicted head trauma, U of I
http://forms.uihc.uiowa.edu/pdf/abuseforms/index.htm

9/18/06 D'Alessandro DM, Oral R. What Should I Do When I'm Called To See A Drug-Exposed Child? www.pediatriceducation.org/2006/09/18

2007-date Mandatory reporter training course on Child Abuse & Neglect for pediatricians in Iowa:
http://www.iowapeds.org/

2007-date Perinatal Illicit drug Screening and Intervention Policy in Iowa: http://www.iowapeds.org/

12/03/07 D'Alessandro DM, Oral R, Kao SC. How Old Are Those Subdural Hematomas.
http://www.pediatriceducation.org/2007/12/03

2008 Video production for online training of staff involved in the care of pregnant or delivering women and newborns on perinatal illicit substance screening/testing practices, U of I
http://forms.uihc.uiowa.edu/pdf/abuseforms/index.htm

12/2014 Adverse childhood experiences: Helping Services for Northeast Iowa-Domestic Violence Awareness Online Training https://helpingservices.skypepapp.com (access via rmatt@helpingservices.org)

3/2015 Domestic Violence and Women: TASSA March 2015 Newsletter

3/2021 COVID-19 Crisis and Preventing Child Abuse and Neglect through Interagency Collaboration and Innovation. Cote A, Alvarez de Toledo B, Brennan C, Tappan C, Simmonds C, Berrien F, Ribsam J, Barrett J, Schollette L, Linebaugh M, Sink M, O'Neill M, **Oral R,** Chapman S. International Society for the Prevention of Child Abuse and Neglect: World Perspectives 2020 (eds) John Fluke and Heather Hein. Pp 29-34.
(https://www.dropbox.com/s/f8d59srztuq2ii2/ISPCAN_0001-20_World%20Perspectives%20Report_2.7.pdf?dl=0.

F. Reviews of publications/programs

1. Johnson CF, **Oral R**, Gullberg L. Diaper Burn: Accident, Abuse or Neglect. *Emerg Pediatr Care*, 2000; 16:173-175 reviewed in *Child Abuse Quarterly Medical Update* 2001; VIII(1):14.
2. **Oral R,** Strang T. Neonatal Illicit drug screening practices in Iowa: The impact of utilization of a structured screening protocol. *J Perinatol* 2006; 1:1-7 reviewed in *Child Abuse Quarterly Medical Update* 2007; XIV(3):32-33.
3. My role in the field of child abuse & neglect as a child abuse pediatrician was reviewed in: The Child Abuse Doctors. David Chadwick (ed). GW Medical Publishers/STM Learning, Inc. (in press)
4. My role in systems building on child abuse management in Turkey was reviewed in: Turkish American Scientists & Scholars Association newsletter 2013; 2(1) accessible at http://www.tassausa.org/Newsroom/item/1407/Building-a-bridge-from-Iowa-to-Turkiye-for-Children?utm_source=2013+January+Newsletter&utm_campaign=September+2012+Newsletter&utm_medium=email (1.30.2013)
5. Article co-authored by me titled "Epidemiology of adverse childhood experiences in three provinces of Turkey" won the best article of the year in Turkey.

G. Abstracts (Oral and poster presentations):
INTERNATIONAL

4/22-24/93	# Knowledge, behavior and attitude of Turkish physicians on Child Abuse & Neglect, 1st Balkan, Caucasian, and Middle East Conference on Child Abuse & Neglect	Ankara, Turkey
10/24-27/93	# Neonatal Salmonella Typhimurium infections in 21st International Congress of Union of Middle Eastern and Mediterranean Pediatric Societies (Published, #12 in original peer reviewed articles list)	Izmir, Turkey
4/3-5/96	# Epidemiology of Caustic Esophagitis, 1st World Conference on the Prevention and Treatment of Caustic Esophageal Burns in Children	Izmir, Turkey
9/8-9/97	# Twenty-eight cases of child abuse reported from five teaching hospitals in Izmir, International Seminar on Child Abuse & Neglect, (Published, #4 in most significant peer reviewed publications list)	Antalya, Turkey
1/27-30/98	# How was the first multidisciplinary Child Abuse follow-up team established in Turkey, San Diego Conference on Responding to Child Maltreatment	San Diego, CA
10/13-16/99	# Child Maltreatment Study: 83 cases followed up on multidisciplinary basis, Annual Congress of European Society for Social Pediatrics	Istanbul, Turkey
8/24-26/01	# Turkish Physicians' knowledge on Child Abuse & Neglect. European Conference on Child Abuse & Neglect, (Published, #13 in original peer reviewed articles list)	Istanbul, Turkey
5/21-27/05	# Diffusion-weighted imaging of brain injury in shaken baby syndrome. American Society of Neuroradiology meeting	Toronto, Canada
9/11-15/05	# Establishment of Interdisciplinary child protection teams in a traditional society: The hurdles and how they are being overcome, Vth European Conference on Child Abuse & Neglect, (Published, #7 in most significant peer reviewed publications list)	Berlin, Germany

9/3-6/06	# Missed inflicted trauma with subsequent fatal inflicted head trauma in infants, XVIth International Conference on Child Abuse & Neglect, (Published, #18 in original peer reviewed articles list)	York, England
9/3-6/06	# Establishment of Interdisciplinary child protection teams in a traditional society: The hurdles and how they are being overcome, XVIth International Conference on Child Abuse & Neglect, (Published, #7 in most significant peer reviewed publications list)	York, England
10/5-7/08	# Fatal inflicted head trauma in cases with missed diagnosis of milder forms of abuse. Seventh North American Conference on Shaken Baby Syndrome, (Published, #18 in original peer reviewed articles list)	Vancouver, BC-Canada
10/14-18/09	# Prevalence of illegal drug exposure in children evaluated for abuse and neglect, 4th Mediterranean Academy of Forensic Sciences Meeting, (#8 in most significant peer reviewed publications list)	Antalya, Turkey
9/18-21/11	# Child Advocacy Center Model: Implementation efforts in Turkey as a national model, 12th European Child Abuse Conference	Tampere, Finland
5/23-25/12	# European Conference on Child Abuse & Neglect: A new project; A structured child protection service in Turkey	Amsterdam, The Netherlands
5/23-25/12	# European Conference on Child Abuse & Neglect: The first year experience of Ankara CIM (Child Follow up Center)	Amsterdam, The Netherlands
5/23-25/12	# European Conference on Child Abuse & Neglect: Illicit drug exposure in cases with alleged maltreatment	Amsterdam, The Netherlands
9/9-12/2-12	# Prevalence and Etiology of Retinal Hemorrhages in Pediatric Intensive Care Unit in Intubated Patients: 19th ISPCAN meeting	Istanbul, Turkey
9/9-12/2-12	# Impact of staff training on perinatal illicit drug screening and intervention: 19th ISPCAN meeting	Istanbul, Turkey
9/9-12/2-12	# International implementation of the CAC model to respond to child abuse and neglect : 19th ISPCAN meeting	Istanbul, Turkey
7/7-10/15	# Family Related Variables As A Risk Factor For Negative Childhood Experiences in Three Provinces of Turkey. 14th European Psychology Congress	Milano, Italy
11/17-19/16	# Case Based Surveillance Child Sexual Abuse Study in Four Provinces in Turkey; II. International Congress of Clinical and Health Psychology on Children and Adolescents (Published #32 in original peer reviewed articles list)	Barcelona, Spain
6/22-25/17	# Evaluation of an educational campaign to raise awareness of child physical abuse among health care professionals in Greece	Rome, Italy
9/2-5/18	# Missed opportunities for the detection of physical abuse among patients hospitalized with fractures at a tertiary children's hospital in Greece. Biennial World ISPCAN conference	Prague, Czech Republic
9/2-5/18	# Secondary prevention of Adverse Childhood Experiences (ACEs) via implementation of trauma informed practices and care at an academic hospital	Prague, Czech Republic
3/17-21/19	# Secondary Prevention Opportunity for Adverse Childhood Experiences via implementation of family wellbeing assessment at an academic hospital	Panama City, Panama

NATIONAL

10/08-12/89	Lipoprotein Metabolism in Insulin Dependent Diabetic Children 23rd National Conference of Pediatrics	Bursa, Turkey
6/2-7/91	Hepatitis B Prevalence in Children with Malignancy, 9th National Cancer and 6th Pediatric Tumors Conference	Izmir, Turkey
5/6-10/91	Ampicillin/sulbactam treatment in neonatal sepsis, 6th National Chemotherapeutics and Antibiotics Conference	Antalya, Turkey
5/28-30/92	# Hypoxic Ischemic Encephalopathy in Neonates 1st National Pediatric Neurology and 4th Mediterranean Countries Pediatric Neurology Conference	Ankara, Turkey
7/14-18/93	Congenital Rubella, 2nd National Neonatology and 30th Conference of Pediatrics	Istanbul, Turkey
4/14-17/94	Prevalence of Child Abuse & Neglect in an outpatient population followed up at Child Psychiatry Clinic at Behcet Uz Children's Hospital, in 4th Child and Adolescent Psychiatry Conference	Bursa, Turkey
9/18-21/94	Brain stem auditory potentials in neonates, 38th National Congress of Pediatrics	Trabzon, Turkey
3/1-2/95	Renal failure in asphyxiated newborns, Neonatal Nephrology Days	Istanbul, Turkey
6/4-8/95	Renal vein thrombosis in two newborns, 39th National Congress of Pediatrics	Ankara, Turkey
6/10-14/95	Multifocal Salmonella Osteomyelitis in newborns, 10th National Antibiotics and Chemotherapeutics Conference, (Published, #1 in original peer reviewed articles list)	Nevsehir, Turkey
9/6-8/95	Spontaneous gastric perforation in a neonate, 1st National Pediatric Gastroenterology and Nutrition Conference	Izmir, Turkey
10/4-6/95	Brainstem visual evoked responses in neonates, 3rd Çapa Neonatology Days	Istanbul, Turkey
10/23-27/95	Knowledge, attitudes and behaviors of physicians in child abuse and neglect cases, 31st Turkish Pediatric Conference	Istanbul, Turkey
4/24-26/96	Report of non-governmental organizations on improving children's rights, 2nd National Conference on Child Abuse & Neglect (Published, #2 in book chapters list)	Ankara, Turkey
10/14-17/96	Izmir Child Abuse & Neglect Task Force multidisciplinary experience, 40th National Pediatric Conference	Gaziantep, Turkey
5/26-29/97	Bone densitometry of newborns, 8th National Neonatology Conference, (Published, #2 in original peer reviewed articles list)	Izmir, Turkey
6/27-30/97	Eight cases of Child Abuse & Neglect followed up on a multidisciplinary basis, 41st National Pediatric Conference	Van, Turkey
10/29-31/97	Calcium and phosphorus metabolism of premature infants, 4th National Metabolic Diseases and Nutrition Symposium	Izmir, Turkey
4/15-18/98	Thirty-two cases of CAN followed up on a multidisciplinary basis, 6th National Public Health Conference	Adana, Turkey
1/22-24/01	Fractures in young children: Inflicted or Un-inflicted ? Conference on Responding to Child Maltreatment, (Published, #11 in original peer reviewed articles list)	San Diego, CA
9/12-15/02	# Avulsion fracture of odontoid in a hypotonic child due to physical abuse. 4th Shaken Baby Syndrome Conference, (Published, #15 in original peer reviewed articles list)	Salt Lake City, UT

1/25-28/04	# Preliminary Results on Consequences of falls in children under two years of age: Parental survey, 18th Annual Conference on Child and Family Maltreatment, (Published, #17 in original peer reviewed articles list)	San Diego, CA
11/12/04	# Diffusion-weighted imaging of brain injury in shaken baby syndrome. Scientific exhibit at the Radiological Society of North America 90th Annual Meeting	Chicago, IL
1/22-25/05	# Intrauterine illicit Drug Exposure risk factors in mother/infant dyads at the UIHC delivery population, 19th Annual Conference on Child and Family Maltreatment, (#6 in most significant peer reviewed publications list)	San Diego, CA
1/22-25/05	# Consequences of falls in children under two years of age: Parental survey, 19th Annual Conference on Child and Family Maltreatment (Published, #17 in original peer reviewed articles list)	San Diego, CA
7/11-13/07	# Perinatal Illicit Drug screening Practices in Iowa: Statewide Policy Development Efforts, APSAC Annual Colloquium	Boston, MA
4/29-5/2/08	# The efficacy of hair and urine confirmatory testing in suspicious pediatric burn injuries. American Burn Association 40th Annual Meeting, (Published, #22 in original peer reviewed articles list)	Chicago, IL
4/21-24/10	# Staff training makes a difference: Improvements in neonatal illicit drug screening and intervention, Annual Helfer Society Conference	Philadelphia, PA
9/12-14/10	# Multicenter efforts to prevent shaken baby syndrome in Turkey, 11th International Conference on Shaken Baby Syndrome	Atlanta, GA
9/12-14/10	# Multicenter efforts to prevent shaken baby syndrome in Iowa, 11th International Conference on Shaken Baby Syndrome	Atlanta, GA
9/26-29/10	# Establishing shaken baby syndrome management and prevention teams in Turkey, XVIIIth ISPCAN International Conference on Child Abuse & Neglect	Honolulu, HI
10/22-25/11	# Prevalence and Etiology of Retinal Hemorrhages in Pediatric Intensive Care Unit in Intubated Patients: 115th American Academy of Ophthalmology Annual Meeting (Published #10 in most significant peer reviewed articles list)	Orlando, FL
4/28-5/1/12	# Prevalence and Etiology of Retinal Hemorrhages in Pediatric Intensive Care Unit in Intubated Patients: PAS Annual Meeting	Boston, MA
10/21-25/2016	# Child Welfare Professionals' Determination of When Certain Unsafe Activities and Lack of Child Protection Constitutes Child Neglect: AAP National Conference in the Section on Child Abuse and Neglect	San Francisco, CA
12/2-4/2016	# Child Welfare Professionals' Determination of When Certain Unsafe Activities and Lack of Child Protection Constitutes Child Neglect: Forging New Frontiers: Looking into the Future of Childhood Injury Prevention. 21st Annual Injury Free Coalition for Kids® Conference.	Fort Lauderdale, FL
4/22-27/17	# Revisited Imaging Findings and Pathophysiology of Abusive Head Trauma with Emphasis on Diffusion-Weighted Imaging: ASNR 55th Annual Meeting	Long Beach, CA
5/6-9/17	# Trauma-informed assessment (TIA) at an academic child protection clinic Annual PAS Meeting	San Francisco, CA
6/22-25/17	# Updates on Pathophysiology and Imaging of Abusive Head Trauma: RSNA Annual conference	Chicago, Il
12/1-3/17	# Child Abuse and Neglect Experts' Determination of When a Child	Fort Lauderdale, FL

11/4/18	Being Left Home Alone Constitutes Child Neglect: Forging New Frontiers: Moving Forward with Childhood Injury Prevention. 22nd Annual Injury Free Coalition for Kids® Conference. (Published #36 in original peer reviewed articles list) # Referral for Follow-up Assessment of High Risk Families from the ED: A Comparison of Two Methods. Council on Child Abuse and Neglect. American Academy of Pediatrics National Conference & Exhibition	Orlando, FL

REGIONAL:

10/2/98	The first hospital based Child Protection Team in Turkey Regional Ambulatory Pediatrics Conference	Columbus, OH
10/16/98	The establishment of the first Turkish Child Abuse & Neglect Follow-up Team, Regional Meeting of Ohio Chapter of American Academy of Pediatrics, Section of Child Abuse & Neglect	Columbus, OH
4/5/11	Does in-service training make a difference in staff's compliance with the Iowa statewide perinatal illicit drug screening and intervention protocol at the UIHC, Governor's Conference on Public Health	Ames, IA

XXIV. Personal Statement

I am a double board certified general pediatrician (2001-date) and a child abuse pediatrician (2011-date). I came to the USA in 1998 to do a child abuse pediatrics fellowship and pursued academic career in this field starting in 2001. Child abuse pediatrics became a board certified specialty in 2009 about 50 years after child abuse became a diagnostic entity in pediatrics. Board certified child abuse pediatricians are very few (only ~ 300, nationwide), but their expertise is extremely important to diagnose victims of child abuse accurately, to assess their families holistically, and connect them with needed mental/behavioral health and social services followed with advocating for them at the community level, within the legal system as well as by implementing prevention programs to reduce mortality and morbidity of this psychosocial illness. Furthermore, board certified child abuse pediatricians are instrumental in establishing systems approach to child maltreatment institutionally and regionally.

A good child protection program that every academic center should establish engages multiple disciplines collaborating toward the same goal, which should be the best interest of the child and ultimate prevention of child abuse. Assessments are completed with a team approach; post-diagnostic service referrals and child and family advocacy efforts are taken seriously with structured family navigation; team members reach out to collaborate with child protection services, primary care providers and non-governmental organizations to deliver preventive care, and the court system to ensure that children are removed from abusive families or reunited with rehabilitated parents in a timely manner. Lastly, a child abuse pediatrician can and should work at the legislative and state level to advocate for policies, laws and regulations to prevent, address and treat child abuse and its consequences.

My academic life has been extremely gratifying and rewarding since I was able to integrate all domains of academic career and my passions via teaching, service, program development/advocacy and research into my activities with significant impact at the institutional, regional/national, and international arenas. Before moving on, I would like to explain how I moved project after project forward during my academic career: In every institution I worked at, after establishing a functional child protection program with available resources, I identified the gaps in the system and conducted necessary clinical studies to gather data. I used the data and my teaching abilities to close the gaps in the system: i.e. I identified that many newborns exposed to illicit substances in-utero were missed at the time of delivery. I did staff training on perinatal exposure to illicit substances, collected data and proved my hypothesis, published multiple studies, reached out to both hospital-based and statewide stakeholders to resolve this problem. I joined Iowa Department of Public Health Perinatal Care group and collaboratively we revised the Iowa Perinatal Illicit Drug Exposure Policy and developed a risk assessment

tool for pregnant women and newborn infants. Then, I worked with University of Iowa Perinatal Care group and revised the hospital protocol on the same, developed a train-the-trainer module and trained all relevant staff to follow the new protocol. This work quadrupled the number of newborns identified as being exposed to illicit drugs in-utero with subsequent services for both children and their families. I then published the positive outcome of this practice, which led to multiple hospitals in the national arena reaching out to me to implement a version of the protocol in their institution. With this approach, the major themes of my academic career have been:

* **Institutional/Regional program development with evidence based models**:

I established institutional multidisciplinary child protection programs at Behcet Uz Children's Hospital, Izmir, Turkey (1996, the first in the country that established the clinical practice of child protection) and University of Iowa Hospitals and Clinics, Iowa City, Iowa (2001). With both programs, I developed extensive evidence based clinical guidelines, a comprehensive service array consisting of inpatient consultation, acute sexual assault response, outpatient clinical assessment, record review and educated all hospital staff and enhanced their competencies in recognizing and responding to child abuse; at the end of my tenure at the latter institution, annual child abuse reports had tripled with no similar increase at the state level. Working collaboratively with state agencies, I brought $200-250,000/year revenue to my program every year.

I spearheaded many projects both institutionally and statewide that improved institutional and regional capacity to better diagnose and protect drug endangered children, psychologically abused children, and children and families suffering from psychological intergenerational trauma, and prevent shaken baby syndrome. I contributed to the literature and clinical practice modifications with all my projects. Thus, with my leadership and utilization of all my academic skills, I moved the state of Iowa and University of Iowa Hospitals and Clinics forward in multiple areas of child abuse recognition, assessment, management, and prevention. With these major projects, I became recognized as a regional/national leader and was invited to join Ray Helfer Honorary Society.

* **International work force development**:

I conducted a collaborative intensive workforce development campaign in Turkey, my country of origin between 2001-2014. I organized and actively participated in numerous national conferences, regional conferences, courses, and workshops in Turkey and created a large network of interdisciplinary providers, some of whom I trained in Iowa in the mini-fellowship I developed specifically for international medical leaders. As a result, ~ 20 hospital based child protection programs and > 40 child advocacy centers were established in Turkey, which serve as the backbone of the national child protection response system. As my CV reveals, I was instrumental in creating the science around child maltreatment in Turkey.

Through my work in Turkey I became a recognized expert internationally and have done training, research and work force development in multiple countries including Portugal, Colombia, Pakistan, and Greece. In each of these countries, my scientific consultation helped them improve professional awareness, develop guidelines, and establish coordinated efforts toward a more structured child protection system in the country. In the last five years, I have also been invited to larger international projects as a scientific consultant (BECAN, PROMISE) and to International Society for the Prevention of Child Abuse and Neglect Education Committee, the details of which are in my CV.

My first year at Geisel School of Medicine and DHMC

Since August 2019, when my tenure started at DHMC, I have recognized that CAPP and DHMC units and departments it is in collaboration with had multiple strengths as well as some systems gaps, preventing CAPP from becoming a center of excellence. I recognized CAPP had not developed structured clinical guidelines and protocols for all hospital staff to follow. As a result, I started working with the Emergency Department, Sexual Assault Nurse Examiner Program, Nursing Department, Care Management Office, Risk Management Office, and sections of the Department of Pediatrics to collaboratively develop guidelines and protocols, which are very close to fruition. Those protocols that were needed solely for the CAPP's internal workings have already been developed and being followed by all CAPP providers.

I also recognized that CAPP along with statewide culture and practice was functioning more under the guidance of police and prosecution (prosecutorial model) rather than balancing investigative work with medical

diagnostics and rehabilitative efforts. Additionally, I discovered that there was lack of connection among the four branches of CAPP, which I believe needs to be eliminated to create a true team spirit involving all team members. Lastly, both at the institutional level other than core members of CAPP, and at the state level, there is a dire need for professional education to enhance DCYF, police, medical provider, social worker, nursing competencies in recognizing, reporting, diagnosing, documenting, treating child abuse and neglect and protecting its victims.

Arriving at a consensus vision for CAPP with my department administration, I participated in the conversations with the legislature and Child Abuse Needs Assessment State Task Force and helped them secure state funding of ~$1,400,000 for child abuse specialized medical services for two years, which is at contract signing phase as of July 2020. Presenting my vision and sharing the identified staffing needs for CAPP, I secured $500,000/year for five years with the major external donor for CAPP (an increase from $250,000 for one year).

With retiring staff, I moderated hiring activities for a 0.8 FTE nurse and a 1.0 FTE nurse practitioner and we are in the process of hiring, a 1.0 FTE secretary, a 1.0 FTE program coordinator, and 2.0 FTE social worker to make sure both Manchester and Lebanon CAPP teams have full time social worker support. I have established multiple layers of teams to both run CAPP activities swiftly and effectively while working on team building efforts as well as keeping all team members connected with one another.

I have already worked with Elliott Hospital CAPP leadership and we arrived at consensus to combine our clinical and call functions in 2021, which will be the first step toward bringing all CAPP activities in NH under one coordination. I have trained two CAPP APRNs to join the CAPP call system as well as recruiting our part time Family Practice physician, to take some calls. I am in the process of recruiting and training additional medical providers to join our call-taking team to respond to DCYF calls in real time 24/7 (already recruited one APRN and one pediatrician). With the new DCYF contract, I will start training DCYF nurses and supervisors followed with all DCYF field workers on child abuse medical fundamentals. Working with Granite State Children's Alliance I contributed to the development of the Know&Tell medical module, which I will use as a DHMC CME program to expand professional education to include front line workers from multiple fields including but not limited to medicine, social services, child advocacy centers, law enforcement, prosecutors and judges, among other staff.

I have also identified that the absence of 24/7 Pediatric Sexual Assault Program in the DHMC ED was a big gap that is inconsistent with other academic children's hospitals' practice. I am working with Pediatric Department Administration and other DHMC stakeholders to close this GAP first by utilizing the DCYF grant and SANE certification of CAPP APRNs for two years to be followed with hospital-wide investment into this task.

My goal at CHaD is to establish a systems approach to all child abuse functions via comprehensive clinical guidelines to be complied to by all DHMC staff, to train my team members to a higher level of competency, and gradually replace the prosecutorial approach to child abuse with a medical/rehabilitative approach without sacrificing the forensic aspect of our work. I also would like to expand this vision to New Hampshire at large so that community agencies and our affiliated medical facilities also follow similar protocols and guidelines and New Hampshire's overall prosecutorial approach to child abuse is modified to a more rehabilitative and truly multidisciplinary model.

ANNA MARSH, CPNP-PC

[redacted] Work: 603-653-3658

WORK EXPERIENCE

SEPTEMBER 2019 – CURRENT

CERTIFIED PEDIATRIC NURSE PRACTITIONER – CHILD ADVOCACY AND PROTECTION PROGRAM, DARTMOUTH HITCHCOCK MEDICAL CENTER – LEBANON, NH

FACULTY APPOINTMENT AS INSTRUCTOR OF PEDIATRIC SPECIALITIES, THE GEISEL SCHOOL OF MEDICINE AT DARTMOUTH

Conduct inpatient and outpatient, urgent and routine, multidisciplinary evaluations of children who are suspected victims of physical abuse, sexual abuse, and/or neglect. We conduct these evaluations at the request of medical professionals within and outside of Children's Hospital at Dartmouth and at the request of child protective services (CPS) social workers or police investigators. Other activities include state and regional coordination of services for abused children, child abuse prevention activities, medical-legal case reviews at the request of CPS social workers, police investigators, and attorneys with expert testimony when required, ongoing training regarding child maltreatment to teachers, health care professionals, attorneys, police investigators, and CPS social workers, partake in child abuse research, and provide direct support to the Child Advocacy Centers in New Hampshire and Vermont.

AUGUST 2013 – SEPTEMBER 2019

PEDIATRIC INTENSIVE CARE UNIT PROFESSIONAL STAFF NURSE RN BSN, UPMC CHILDREN'S HOSPITAL OF PITTSBURGH, PA

Highly skilled and detail oriented professional with experience working in a Level 1 trauma 36-bed PICU providing exceptional care for critically ill infants, children, and adolescents. Experience with ECMO, CRRT, Level 1 traumas, transplants, chronic illness, acute illness, mechanical ventilation, etc. Cooperated and communicated effectively with physicians to ensure client satisfaction and compliance with set standards. Continually improved knowledge, skills and performance based on feedback and self-identified professional developmental needs.

MAY 2018 – SEPTEMBER 2018

PEDIATRIC INTENSIVE CARE UNIT TRAVEL RN, AMERICAN MOBILE, CA

Seattle Children's Hospital – Seattle, WA
Pediatric Intensive Care Unit with floating to Cardiac Intensive Care Unit and Neonatal Intensive Care Unit.

JANUARY 2018 – APRIL 2018

PEDIATRIC INTENSIVE CARE UNIT TRAVEL RN, AYA HEALTHCARE, CA

Primary Children's Hospital – Salt Lake City, UT
Level 1 Pediatric Intensive Care Unit with floating to Cardiac Intensive Care Unit.

AUGUST 2012 – AUGUST 2013

PICU PATIENT CARE TECHNICIAN, UPMC CHILDREN'S HOSPITAL OF PITTSBURGH, PA

Interacted effectively with patients, families, staff and other hospital department staff to deliver a high level of customer service and teamwork. Assisted patients with activities of daily living under guidance of the registered nurse.

MAY 2012 – AUGUST 2012

PICU STUDENT NURSE INTERN, UPMC CHILDREN'S HOSPITAL OF PITTSBURGH, PA

Expanded nursing skills in pediatric intensive care. Skills include mechanical ventilator care, tracheostomy care, ECMO, ICP monitoring, central line insertion assistance, NG tubes, TPN, blood product transfusions, hemodynamic monitoring. Managed patient care, including checking vital signs.

NOVEMBER 2010 – MAY 2012

PATIENT SUPPORT ASSISTANT, UPMC CHILDREN'S HOSPITAL OF PITTSBURGH, PA

Supports others in improving the health and wellbeing of all children through excellence in patient care, teaching, and research. Provides basic personal hygiene and assistance in activities of daily living.

EDUCATION

JUNE 2019

MASTERS OF SCIENCE IN PEDIATRIC PRIMARY CARE NURSE PRACTITIONER, DREXEL UNIVERSITY – PHILADELPHIA, PA

MAY 2013

BACHELOR OF SCIENCE IN NURSING, DUQUESNE UNIVERSITY – PITTSBURGH, PA

JUNE 2008

HIGH SCHOOL DIPLOMA, SOMERSET AREA HIGH SCHOOL – SOMERSET, PA

STUDENT PNP CLINICAL EXPERIENCES

JANUARY 2019 – JUNE 2019

PEDIATRIC ALLIANCE, ARCADIA DIVISION

WEXFORD, PA

APRIL 2019

ADOLESCENT MEDICINE AT UPMC CHILDREN'S HOSPITAL OF PITTSBURGH

PITTSBURGH, PA

JANUARY 2019

OTOLARYNGOLOGY (ENT) AT UPMC CHILDREN'S HOSPITAL OF PITTSBURGH

PITTSBURGH, PA

SEPTEMBER 2018 – DECEMBER 2018

UPMC CHILDREN'S COMMUNITY PEDIATRICS, PITTSBURGH PEDIATRICS

PITTSBURGH, PA

SEPTEMBER 2017 – DECEMBER 2017

PEDIATRIC ASSOCIATES OF WESTMORELAND

GREENSBURGH AND IRWIN, PA

JUNE 2017 – AUGUST 2017

CHAN SOON-SHIONG MEDICAL CENTER, PEDIATRIC SPECIALIST DR. BOROUMAND

WINDBER, PA

CERTIFICATIONS

- APRN-NP License: State of New Hampshire – License # 081088-23
- Pediatric Nursing Certification Board: Certified Pediatric Nurse Practitioner, Primary Care – License # 201914026
- RN License: State of New Hampshire – License # 081088-21
- CCRN (Pediatric): AACN, January 2017
- Pediatric Advanced Life Support: American Heart Association, renewed September 2020
- CPR/BLS: American Heart Association, renewed September 2020

AFFILIATIONS

- National Association of Pediatric Nurse Associates and Practitioners – member: current
- American Association of Critical Care Nurses – member: 2017-2019
- UPMC Children's Hospital of Pittsburgh PICU nursing preceptor
- UPMC Children's Hospital of Pittsburgh Beads of Courage Ambassador: Spring 2016
- PICU Patient-Family Centered Care board at UPMC Children's Hospital of Pittsburgh: 2014-2019
- National Student Nurses' Association – member: Fall 2009-Spring 2013
- Student Nurses' Association of Pennsylvania – House of Delegates: Fall 2010 and Fall 2011
- Duquesne University Student Nurses' Association – Publicity Chair: May 2011-May 2013
- Alpha Tau Delta Professional Nursing Fraternity – Vice President: January 2011-May 2013

TRAININGS

- 01/2021: 36th Annual San Diego International Conference on Child and Family Maltreatment – The Chadwick Center for Children and Families, Rady Children's Hospital-San Diego, the University of California, San Diego School of Medicine

o Featured over 200 experts from around the globe providing the latest research, practical experience and skill building workshops on evidence based practices. The conference is directed to multidisciplinary audiences from fields of medicine, mental health, legal, investigations, education, domestic violence, child welfare, infant and early childhood, administration, public policy, and research. Conference also focused on preventions, diagnosis, and the treatment of child abuse, family, and community violence.

- 2020: Weekly Child Abuse Pediatrics (CAP) Fellowship ECHO – Children's Healthcare of Atlanta
- 10/14/2020: Youth With Problematic Sexualized Behavior Training Series – Granite State Children's Alliance
- 10/2020-11/2020: International Conference on Forensic Nursing Science and Practice - International Association of Forensic Nurses
- 06/03/2020 – 08/19/2020: Trauma and Resilience Level 2 ECHO
- 03/25/2020-04/29/2020: Trauma and Resilience Level 1 ECHO
    - 6 continuing education credits
- 06/16/2020: Missing and Exploited Children Training Program from the Office of Juvenile Justice and Delinquency Prevention: National Criminal Justice Training Center of Fox Valley Technical College – From Suspicion to Disclosure
- 06/09/2020: Granite State Children's Alliance: New Hampshire's Network of Child Advocacy Centers - Youth with Problematic Sexualized Behavior Training Series
- 2019-2020: Monthly CAPP Medical Peer Review – Children's Hospital at Dartmouth, Child Advocacy and Protection Program
    - 1.25 continuing education credits/meeting
- 04/08/2020-04/29/2020: American Academy of Pediatrics Trauma and Resilience ECHO
    - 6 continuing education credits
- 03/12/2020: Comprehensive Sexual Assault Nurse Examiner Training Program (Pediatric/Adolescent/Adult) – NH Coalition Against Domestic and Sexual Violence
    - 65 contact hours
- 03/07/2020: Pelvic exam simulation training – NH Coalition Against Domestic and Sexual Violence
    - 8 contact hours
- 01/25/2020-01/31/2020: 35th Annual San Diego International Conference on Child and Family Maltreatment – The Chadwick Center for Children and Families, Rady Children's Hospital-San Diego, the University of California, San Diego School of Medicine
    - Featured over 200 experts from around the globe providing the latest research, practical experience and skill building workshops on evidence based practices. The conference is directed to multidisciplinary audiences from fields of medicine, mental health, legal, investigations, education, domestic violence, child welfare, infant and early childhood, administration, public policy, and research. Conference also focused on preventions, diagnosis, and the treatment of child abuse, family, and community violence.
    - 40 continuing education credits/contact hours
- 10/15/2019: Pediatric Sexual Assault: An Online Training Program for Sexual Assault Nurse Examiners and Other Medical Professionals Serving Children – Postgraduate Institute for Medicine
    - 10 contact hours
- 10/09/2019: Center for Rural Emergency Services and Trauma 2019 – Who's in your waiting room? How Health Care Can Respond to Human Trafficking)
    - 1.0 credit

ADDITIONAL CONTACT HOURS – CHILDREN'S HOSPITAL AT DARTMOUTH, GRAND ROUNDS

- 11/11/2020: Parenting and Substance Use Disorders: A Bi-generational Approach - Elizabeth Peacock-Chambers, MD, MSc – 1.00 credit
- 10/29/2020: Part 2 - Changing the Culture Surrounding Mental Illness: It's Way Past Time – 1.00 credit
- 10/28/2020: The Intersection of Human Trafficking and Domestic Violence – Janet Carroll, RN, SANE – 1.00 credit
- 10/28/2020: The Here and Now Care of Acute Appendicitis - Jill Rockwell, APRN, MSN – 1.00 credit
- 10/21/2020: Pediatric Cardiology 1990-2020: What has changed and what has not. - Norm Berman, MD – 1.00 credit
- 10/07/2020: Too Much, Too Little, or Just Right: Seeking the Goldilocks Approach to Enteral Nutrition in the PICU Patient - Ann-Marie Brown, PhD – 1.00 credit
- 09/23/2020: Life Support: Equity as a Social Determinant of Health - Xusana Davis, Esq. – 1.00 credit
- 09/16/2020: Taking the Fight to Facebook: "Those Nerdy Girls" versus the COVID Infodemic - Lindsey Leininger, PhD – 1.00 credit
- 09/09/2020: A Vexatious, Versatile Virus - SARS-CoV-2 - Paul Palumbo, MD – 1.00 credit
- 04/22/2020: Understanding Maternal Addiction: A Neuroscience-Informed Approach – Helena Rutherford, PhD – 1.00 credit
- 04/15/2020: Concussion Management: Guidance for School and Home – Jonathan Lichenstein, PhD – 1.00 credit
- 03/25/2020: Better Together, A Quality Improvement Initiative to increase Nursing Presence on Rounds – Jessica Truelove, MD – 1.00 credit
- 03/11/2020: Should We Let Our Children Play Contact Sports? – Robert Murray, MD – 1.0 credit
- 02/26/2020: Early Childhood Brain Development/Adolescent Parenting – Lee Savio Beers, MD – 1.0 credit
- 02/19/2020: Nutrition as Medicine in Premature Neonates – Keira Kilmartin, MD – 1.0 credit
- 02/12/2020: #BODYACCEPTANCE as a Health Promotion Tool for Adolescents – Olutosin Ojugbele, MD – 1.0 credit
- 01/22/2020: Immunotherapy: The Good, The Bad, The Ugly – Bonnie Lau, PhD – 1.0 credit
- 01/15/2020: Collaborative Care in Pediatrics – Julie Balaban, MD and Katherine Shea, MD – 1.0 credit
- 01/08/2020: Dravet Syndrome: Is There a Cure On the Horizon? – Richard Morse, MD – 1.0 credit
- 12/18/2019: It's Perfectly Normal: Teens, Disability, and Sex – Catherine Shubkin, MD – 1.0 credit
- 12/04/2019: Management of Familial Hypercholesterolemia in 2019 – Mary McGowan, MD – 1.0 credit
- 11/20/2019: The Alphabet Soup of Psychotherapies: CBT, PMT, MBSR, and What? A Review for Pediatric Practices – Susan Pullen, LICSW – 1.0 credit
- 11/13/2019: Understanding Asthma in the Age of Biologic Therapeutics – Joshua Boyce, MD – 1.0 credit
- 10/30/2019: NH Specialized Medical Services for Children in Need of Protection: How will DHMC Lead the State in 2020 and Beyond – Resmiye Oral, MD, FAAP – 1.0 credit
- Health Care Without Walls: Opportunities and Challenges for Pediatrics – Susan Dentzer, MD – 1.0 credit

- 10/09/2019: The Burden of Neonatal Disease: Caring for the World's Most Vulnerable Patients – Shaun O'Dell, MD – 1.0 credit
- 10/02/2019: Emerging Eating Pathologies: What and Why – Olivio Bermudez, MD – 1.0 credit

JR

Jill Rockwell, APRN

SUMMARY STATEMENT

Compassionate pediatric nurse practitioner with high energy and integrity

Passionate to assure quality care and reduce disparities related to race, ethnicity and income

Proven ability to manage proficient clinics, Prioritizing the needs of patients, while simultaneously valuing and encouraging teamwork

Strong comfort level in care of the orthopaedic, trauma and surgical pediatric patient.

PROFESSIONAL EXPERIENCE

DATES

December 2021 Present

Dartmouth Health, Lebanon, NH

Pediatric Nurse Practitioner for CAPP

- Serves as an expert in pediatrics, an educator, collaborator, case coordinator, and resource to all those involved in child protective services.
- Have a comprehensive knowledge of the child and family in various settings to enhance management of the child's care. Creating better working partnerships between social workers and providers which serves to benefit the child protective serve, social workers, and the families involved.
- Promote public awareness about risks to children and develop trust between members of the public and professionals.
- Documenting the nature and extent of injuries due to possible abuse or neglect.

- Knowledge about the special developmental and emotional needs of child and adolescent abuse victims, and able to recognize behavioral indicators and clinical signs of abuse.
- Being Familiar with local Child Protective Services and other services available to abused children/adolescents and their families is essential. In addition, the physician must understand the roles of other professionals, be willing to provide consultation to them, objectively document findings, and be willing to provide testimony in court proceedings.

DATES

June 2017 – December 2021

Dartmouth Health, Lebanon, NH
Pediatric Nurse Practitioner for Pediatric General Surgery

- Provided anticipatory guidance to pediatric patients and their families concerning growth and developmental milestones, nutrition and hygiene, and safety.
- Evaluated patients with possible surgical interventions needed and made appropriate referrals.
- Identified disease/syndrome entities not limited to but including pilonidal cysts, abscesses, GI irregularities, bowel diseases and the needs for ostomies and cares. Also identified the teaching needs for gastrostomy, NG and cecostomy tubes.
- Managed the care of the inpatient trauma patient, and assuring readiness for discharge, coordinating and assuring follow-ups.
- Managed the non-accidental trauma patient as an inpatient and assured readiness for discharge, assuring appropriate safety plans in place and facilitating discharge.

January 2013 – June 2017

Dartmouth Health, Lebanon, NH
Staff RN on Pediatric Inpatient Floor

- Served as a patient advocate, assessing patient status and notifieng physician of any changes
- Performed as charge nurse, supervising staff and assuring safety of all patients.
- Evaluated staffing requirements, floor assignments and and managing unit activities for all patients

- Acted as a strong resource for residents and nursing staff on the management of their patients.,
- Maintained accurate, detailed reports and records.
- Precepted many new RNs with varied experience.

Colby-Sawyer College, New London, NH

September 2001 - May 2011

Adjunct Professor of Pediatric Nursing

- Facilitated class instruction -Evaluated student performance
- Responded promptly to grade
- determination
- Organized, prepared and revised (as needed) course materials.
- Corrected and graded writing assignments
- Assured content met the needs of students to enable them to pass their NCLEX exams for pediatrics
- When need necessitated, I also taught the clinical portion of Pediatrics
- Assuring students met the skill level needed to care for the ill pediatric

Dartmouth Health, Lebanon, NH

August 2010 – January 2013

Transfer Center Nurse

- Triaging all levels of patients from all areas served by DHMC. This included but was not limited to
- clinics, outlying hospitals, and patients "out in the field". Patients were triaged for placement to the appropriate level of care and appropriate floor.
- Excellent communication skills and knowledge of most medical diagnoses was necessary.
- An ability to work efficiently, quickly and accurately was required.

Dartmouth Health, Lebanon, NH

August 2001 – July 2009

Pediatric Orthopaedic Nurse Practitioner

- Evaluated, diagnosed and managed injuries and maladies of the pediatric patient. Including but not limited to scoliosis, cerebral palsy, developmental dysplasia of the hips, clubfeet, spina bifida.
- Initiated treatments including orthotics, casting, initiation of pavlic harness, ordering tests and procedures.
- Managed independent clinics and assumed surgeons scheduled emergently

EDUCATION

Northeastern University, Boston MA
Master of Science.
Graduated 2001 Graduating with high honors

Santa Ana Junior College, Santa Ana, CA
Associate of Science
Graduated with high honors

CORNELIA HANDY GONSALVES
Pediatric Nurse Practitioner
[redacted]

EDUCATION

1981 - 1983 ***Yale University School of Nursing***

New Haven, Connecticut
Pediatric Nurse Practitioner Program
Master of Science in Nursing, May, 1983

1975 - 1979 ***Boston College School of Nursing***

Chestnut Hill, Massachusetts
Baccalaureate of Science in Nursing
Summa cum Laude, May, 1979

QUALIFICATIONS

P.N.P. Certification Pediatric Nursing Certification Board
October, 1984: Certificate Maintenance Program. Expiration: February 28, 2022

R.N. /A.R.N.P. Licensure New Hampshire: # APRN 074682-23, Expiration 8/10/2022
RN 074682-21, Expiration 8/10/2022

CPR Healthcare Provider Certification American Heart Association, Expiration: May 2023

PALS Provider Certification American Heart Association, Expiration: July 2021

NURSE PRACTITIONER EXPERIENCE

January 2017-present ***Dartmouth Hitchcock Medical Center***, 1 Medical Center Drive, Lebanon, NH
Responsibilities:

- Collaborating, triaging and coordinating care with CAPP staff, law enforcement, child advocacy centers, Department of Child and Family Services, mental health professionals, pediatric medical specialists and other residential or advocacy agencies, including on-call services
- Providing medical evaluation with CAPP team for children referred for child maltreatment/neglect concern(s) in southern/central New Hampshire, and southern Maine
- Working with a multidisciplinary team for child advocacy and state directives towards advocacy, prevention of child abuse and improving care for affected children and their families.

- Coordinating program and clinical process improvement for the Child Advocacy and Protection Program for southern New Hampshire.

NURSE PRACTITIONER EXPERIENCE (Cont'd)

March 4, 2013-
December 23, 2016

Florida Epilepsy Center/Florida Hospital for Children, Neurology, 615 E. 615 E. Princeton St., Suite #540, Orlando, FL.
Responsibilities:

- Participating on an interdisciplinary, epilepsy team caring for children and adolescents with new onset, psychogenic or intractable epilepsy through inpatient and outpatient care through Florida Hospital for Children
- Coordinating and providing medical management, triage of acute seizure episodes, family education from the initial clinic evaluation or hospitalization through ongoing clinic and hospital admissions
- Ordering tests/procedures, following results and coordinating care for children and adolescents under care
- Mentoring pediatric medical residents at Florida Hospital as well as supporting/advising nursing staff inpatient and outpatient
- Collaborating on clinical research, program protocol development and publication efforts

November 2008-
February 22, 2013

Cincinnati Children's Hospital Medical Center, Neurology 3333 Burnet Ave Avenue, Cincinnati, OH.
Responsibilities:

- Participating on an interdisciplinary, epilepsy surgery team caring for children and their families through in-patient, operative and post-operative admission and out-patient clinic visits
- Coordinating and providing medical management, triage of acute seizure episodes from the initial clinic evaluation visit through postoperative care
- Developing a vagal nerve stimulator pre and post-operative program for children with intractable epilepsy
- Assisting families and collaborating with psychological, social work and child life colleagues in dealing with behavioral and co-morbid conditions as well as safety for children with epilepsy while at CCHMC
- Ordering tests/procedures, following results and coordinating care for patients
- Working with an interdisciplinary team to develop an excellent epilepsy surgery program by:
  - creating educational materials to assist families through the complex epilepsy surgery process
  - acting as a change agent with neurology and neurosurgery teams, advocating for issues important to children and families in the EMU, PICU, inpatient floors, and clinic.

- coordinating and participating in quality improvement projects for epilepsy surgery and the Comprehensive Epilepsy Program

September, 2007-
October, 2008

Cincinnati Children's Hospital Medical Center, Rehabilitation- 3333 *Burnet* Avenue, Cincinnati, OH.

Responsibilities:

- Offering acute and chronic health care to children in outpatient rehabilitation clinic
- Providing inpatient consultations for children with brain injury, brain tumors and cerebral palsy
- Participating in inpatient rehabilitation and trauma rounds
- Coordinating the Flu Collaborative Initiative for Physical Medication and Rehab 2008

February, 1994 -
August, 2007

Geneva Family Practice- 302 Randall Road, Suite #202 Geneva, IL.

Responsibilities:

- Providing well-child and acute care to children, aged two weeks to young adulthood in a dynamic group practice.
- Admitting, rounding on and discharging newborn and pediatric patients of Geneva Family Practice, through Delnor Community Hospital privileges obtained Spring, 1994
- Lecturing on infant and adolescent issues for Delnor Community Hospital, community education program

June, 1993 -
1st January, 1994

Loyola University Medical Center, Bone Marrow Transplant Unit- 2160 South Avenue, Maywood, IL.

Responsibilities:

- Managing adolescent and adult cancer patients admitted for allogeneic or autologous bone marrow transplants.
- Surgically assisting with bone marrow harvesting and transplant procedures in the operating room
- Working with an interdisciplinary team to meet the individual and family needs of patients on the bone marrow transplant unit

June, 1992-
February, 1993

Yale-New Haven Hospital/Pediatric HIV Care Program, Yale-New Haven Hospital, 20 York Street, New Haven, CT.

Responsibilities:

- Providing specialized, primary health care to children, aged birth to 13 years with HIV exposure and disease
- Acting as a study coordinator for the National Institute of Health HIV clinical research studies
- Lecturing and precepting graduate nursing students on the care of patients/families with HIV disease

- coordinating and participating in quality improvement projects for epilepsy surgery and the Comprehensive Epilepsy Program

September, 2007-
October, 2008

Cincinnati Children's Hospital Medical Center, Rehabilitation- 3333 *Burnet* Avenue, Cincinnati, OH.

Responsibilities:

- Offering acute and chronic health care to children in outpatient rehabilitation clinic
- Providing inpatient consultations for children with brain injury, brain tumors and cerebral palsy
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February, 1993

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- Providing specialized, primary health care to children, aged birth to 13 years with HIV exposure and disease
- Acting as a study coordinator for the National Institute of Health HIV clinical research studies
- Lecturing and precepting graduate nursing students on the care of patients/families with HIV disease

January, 1988 - June, 1992

Hartford Hospital, Pediatric Primary Care Center **-80 Seymour Street** Hartford, CT.

Responsibilities:

- Offering well-child and acute care to inner city children, aged two weeks to 16 years, in the newborn nurseries and outpatient clinic
- Precepting graduate nursing students from Yale University and Boston College
- Acting as nurse consultant for Hartford Hospital Infant, Toddler and Preschool Programs

June, 1987 - November, 1987

Visiting Nurse Association, Naugatuck Valley - Shelton and New Haven, CT.

Responsibilities:

- Providing well-child care at clinics for children aged two months to 5 years

January, 1984 - June, 1988

Dr. Martin Sklaire- P.O. Box 589, Madison, CT.

Responsibilities:

- Providing primary health care to preteen and adolescents in a private pediatric practice, four hours per week
- Collaborating on mutual interests in school health and sports medicine

August, 1984 - June, 1985

Hamden High School – 2040 Dixwell Avenue, Hamden, CT.

Responsibilities:

- Expanding the 1983/1984, part-time nurse practitioner/trainer role to a full-time position in sports medicine
- Collaborating with school nurses, administrators and teachers on issues of adolescent health

August, 1983 - July, 1984

Hamden High School – 2040 Dixwell Avenue, Hamden, CT.

Responsibilities:

- Developing a 22.5 hour per week nurse practitioner/trainer position for athletic candidates and athletes at the secondary school level
- Formulating procedures and policies toward a comprehensive sports medicine program
- Implementing a sports medicine program including presport medical preparation, treatment of injuries, basic rehabilitation and referral to specialists

July, 1983 - June, 1986

Toddler Coop - New Haven, CT.

Responsibilities:

- Voluntary consulting for a local daycare center housing children aged one to three years

RESEARCH EXPERIENCE

November 2008-
February 2013

Epilepsy Surgery Program, Neurology Division, Cincinnati Children's Hospital, Cincinnati, OH.
Responsibilities:

- Participating in data collection for pediatric epilepsy patients with sleep disorders
- Collecting data from the epilepsy surgery data base for use in academic presentations and studies

November, 1990 -
June, 1991

Department of Rehabilitation Medicine at New England Medical Center and Tufts University School of Medicine -Boston, MA.
Responsibilities:

- Collecting normative data for standardization of the Pediatric Evaluation of Disability Inventory; a grant supported in part by the U.S. Department of Education, grant # (H133B80009)
- Initiating and coordinating participation in this multicenter/multistate research project by Hartford Hospital pediatric nurse practitioners

July, 1984 -
July, 1985 and
February, 1993

Hamden Board of Education & Hamden School Health Service - Hamden, CT.
Responsibilities:

- Co-investigator for the Connecticut State Department of Education grant, "*Health Assessments for Handicapped Students*", grant # (062-926-08- 121)
- Developing health assessment tools and training school nurses in their use
- Analyzing study results and summarizing findings for the states report

May, 1983 -
May, 1984

Yale University School of Medicine - New Haven, CT.
Responsibilities:

- Interviewing young adults with cystic fibrosis for a study investigating their developmental and psychological needs
- Reviewing interview recordings, interpreting data and consulting with the two chief investigators in preparing the study's results

TEACHING EXPERIENCE

1989-2007 Clinical preceptorship of matriculating pediatric nurse practitioner students involved in Yale University and University of Illinois-DeKalb master's degree programs

August, 1985 - May, 1988 ***Yale University School of Nursing*** – 100 Church Street South, New Haven, CT. 06519

Responsibilities:

- Program instructor for pediatric nurse practitioner graduate students
- Lecturing, providing clinical supervision and offering thesis consultation in the areas of primary health care, perinatal management, physical assessment, school health, adolescent health
- Maintaining a faculty practice of pediatric patients in the Primary Care Center (PCC) at Yale-New Haven Hospital
- Teaching parenting classes to pregnant adolescents in an inner city secondary school (1985 - 1987)

March - May - 1983, 1985, 1987 ***Yale University School of Nursing/Program for Non-Nurse College Graduates-*** New Haven, CT.

Responsibilities:

- Lecturing on pediatric physical assessment, gastrointestinal, respiratory and urinary problems
- Supervising nursing students on pediatric rotations at Yale-New Haven Hospital

October, 1986 - January, 1987 ***University of Connecticut: Continuing Education Division*** - Stamford, CT.

Responsibilities:

- Co-teaching an eight session, four hour per week, course on pediatric health assessment for pediatric and school nurses

October, 1984 - February, 1985 ***Albertus Magnus College*** - New Haven, CT.

Responsibilities:

- Guest lecturing undergraduate classes about general health/fitness maintenance and common sport injuries

September, 1983 - May, 1984 ***Southern Connecticut State University*** – 501 Crescent Street, New Haven, CT.

Responsibilities:

- Acting as adjunct faculty member in working with junior year, undergraduate nursing students

STAFF NURSE EXPERIENCE

- 7/1980 – 9/1981 (F.T.) ***Yale-New Haven Hospital*** - New Haven, CT
- 9/1981 – 5/1983 (P.T.)
- 5/1983- 8/1983 (F.T.) Responsibilities:
  - Providing care as a staff and charge nurse on a pediatric research and special care floor for children one month to 18 years of age

July, 1979 - July, 1980 ***Duke University Medical Center*** - Durham, NC.
Responsibilities:
- Acting as a staff nurse, team leader and charge nurse on a pediatric surgical floor with children one month to 20 years of age
- Working on the hospital's preceptorship program and peer review committee

January, 1979 - May, 1979 ***Staff Builders, Inc., Temporary Nursing Agency*** - **Boston, MA.**
Responsibilities:
- Working as a nurse's aide in various children's rehabilitative, community, arthritic and large urban hospitals in the greater Boston area

May, 1978 - August, 1978 ***Veteran's Administration Hospital*** - Fort Lyons, CO.
Responsibilities:
- Participating in a nationwide program for students in various healthcare disciplines while offering nursing care and counseling to 25 geripsychiatric patients on a locked ward

HONORS/AWARDS

November 15, 2019 Hands for Hope, Hillsborough North Child Advocacy Center awardee, Meredith, NH

April 4, 2019 Champion for Kids, Rockingham Child Advocacy Center, Portsmouth, NH

September, 2004: Diocese of Rockford, IL. - Bishop O'Neill Award in Catechetics

October, 1989-February, 1993: Clinical Instructor Appointment, Yale University School of Nursing,

May, 1979: The Reverend E.J. Gorman, S.J. Student Organizational Award
Boston College School of Nursing

May, 1979: The Reverend Finnigan, S.J. Award, School of Nursing nominee, Boston College

April, 1978: Sigma Theta Tau, National Honorary Society of Nursing,
Alpha Chi Chapter, Boston College School of Nursing

PROFESSIONAL MEMBERSHIP

2017 to present	American Professional Society on the Abuse of Children
2017 to present	National Association of Pediatric Nurse Practitioners: SIG on Child Abuse and Neglect
2009-2018	American Epilepsy Association
2007-2013	Ohio Association of Advanced Practice Nurses
1985 - 1989	American School Health Association
1985 - 1987	Transcultural Nursing Society
1984 - 1991	Connecticut Association of School Health
1984 - 1987	Council on Intercultural Nursing, American Nurses' Association
1982 - present	National Association of Pediatric Nurse Practitioners
1980 - 1989	Connecticut Nurses' Association
1979 - 1989	American Nurses' Association
1978 - 1993	Sigma Theta Tau, Delta Mu Chapter/Alpha Chi Chapter

PUBLICATIONS

Gonsalves, CH (2016). Nursing role on the epilepsy monitoring unit: a historical perspective. *Journal of Pediatric Epilepsy*, 5(4), accepted for publication May 10, 2016.

Arya, R., Greiner, H.M., Lewis, A., Horn, P.S., Mangano, F.T., Gonsalves C., Holland, K.D. 2014. Predictors of response to vagus nerve stimulation in childhood-onset medically refractory epilepsy. *Journal of Child Neurology*, 29(12): 1652-1659.

Trout, A.T., Larson, D.B., Mangano, F.T., Gonsalves, C.H. 2013. Twiddler syndrome with a twist: a cause of vagal nerve stimulator lead fracture. *Pediatric Radiology*, 43 (12): 1647-1651.

RESEARCH

May 1983 — Pediatric Nurse Practitioners and Ethnicity of Clientele: A Study of Attitude, Unpublished master's thesis, Yale University School of Nursing - New Haven, CT., Principal Investigator, self- funded

RECENT PRESENTATIONS

April 8, 2021 — Address ACEs: Early Detection and Intervention for Child Abuse, Northern New New England Nurse Practitioner Conference, Co-presenter with Deborah Pullin APRN, 1.5 hrs, Conference via Whova platform

March 23, 2021 — Child Maltreatment for the Provider, Lamprey Health Care, APRN Meeting via Zoom

March 16, 2021 — The Process of CAPP, Co-Presenter with Dr. Amy Roy, North Hillsborough Child Advocacy Center, MDT Meeting in Zoom

March 1, 2021 — Child Maltreatment Cases, Pediatric Medical Provider Meeting, D-H Manchester

Feb. 10, 2021 — Sexualized Behaviors in children: Normal or Not?, Rockingham Child Advocacy Center, MDT Meeting Presentation in Zoom

Jan. 20, 2021 — Bruises and 4-TEN in Suspected Child Maltreatment, Merrimack Child Advocacy Center, MDT Meeting Presentation via Zoom.

Dec. 20, 2020 — CAPP (Child Advocacy and Protection Program) and Reporting Maltreatment or Neglect for Children in NH, Pediatric Department Staff, D-H Manchester, NH

Oct. 29, 2019 — What a Primary Care Provider Needs to Know In Considering Maltreatment. Lamprey Elliot Health Systems, Newmarket, NH

July 15, 2019 — Demystifying the Medical Exam (CAPP), Strafford County Child Advocacy Center, Dover, NH

May 20, 2019 — Medical issues for Child Advocacy and Protection: Sexual Abuse, Elliot Hospital, Doctor's Park providers and staff, Manchester, NH

April 17, 2019 — Demystifying the Medical Exam (CAPP), Merrimack County Child Advocacy Center, Bow, NH

March 2019 — Child Maltreatment: Physical Abuse, Elliot Hospital Doctor's Park providers and Staff, Manchester, NH

Feb. 20, 2019 — Pediatric Pearls: Child Maltreatment: Outpatient Considerations, Elliot Hospital Providers, Manchester, NH

Jan. 16, 2019 — Sexually Transmitted Infections, Merrimack County Child Advocacy Center, Bow, NH

RECENT PRESENTATIONS (Cont'd)

Dec., 2014 American Epilepsy Society Annual Conference. Poster presentation: Use of nicotine patch for drug- resistant ADNFLE in children: a case study, Seattle, WA.

May, 2014 - January, 2016 Bi-annual Epilepsy Course. Pediatric neuro-assessment, Phase I & Phase II epilepsy surgery evaluation and Vagal nerve stimulator therapy. Florida Hospital for Children, Orlando, FL.

PROFESSIONAL/EDUCATIONAL ACTIVITIES: Child Advocacy and Protection

Dec. 11, 2020 Child Neglect/Failure to Thrive, Child Abuse Pediatrics (CAP) Fellowship ECHO, 1 hr.

Nov. 13, 2020 Review of Health Care (CAP) Literature/Research, child Abuse Pediatrics (CAP) Fellowship ECHO, 1 hr.

Nov. 6, 2020
Oct. 30, 2020 Child Abuse Pediatrics (CAP) Fellowship ECHO, 1 hr.

August 2020 Participant in UNH Research Study : Improving CAC/MDT response in Youth with Problematic Sexualized Behaviors in NH, Professor Wendy Walsh.

June 24, 2020 NH Coalition Against Domestic and Sexual Violence, Case Review, Zoom, concord, NH 1.5 hr.

June 16, 2020 Missing & Exploited Children Child Abuse: From Suspicion to Disclosure, OJJDP/NCJTC, 6 hrs.

Oct. –Dec. 2019 2019 Child Abuse Medical Provider Program (CHAMP) Webcast Series, University of Buffalo, 1 hr.

Sept. 24, 2019. Trauma and Brain Science: Why Can't I Think My Way Out of this?, Office of Juvenile Justice and Delinquency Prevention, 1 hr.

April 24, 2019 Bridges: Building a Supportive Community, Sexual Harassment, Abuse and Violence, Dartmouth College, Hanover, NH, 1 hr.

April 8, 2019 Combating Human Trafficking in New Hampshire, Nashua, NH , 1.5 hrs.

April 11, 2019 Shield Our Children Conference, Dartmouth Hitchcock Medical Center, Lebanon, NH, 7 hrs.

January 26-31 2019 Rady Children's 34th Annual International Conference on Child & Family Maltreatment, San Diego, California, 24 hrs.

PROFESSIONAL/EDUCATIONAL ACTIVITIES (Cont'd)

Sept. 12, 2018	Five B's of Child Physical Abuse: Bruises, Burns, Bones, Bellies and Brains, 1.5 hrs Webinar, NCJTC of Fox Valley Technical College
Sept. 10, 2018	Team STEPS: Team Strategies and Tools to Enhance Performance and Patient Safety, Elliot Hospital, Manchester, NH. 2.25 hrs.
June 12-16, 2018	4-Day Colloquium, American Professional Society on the Abuse of Children (APSAC), New Orleans, Louisiana, 18.25 hrs.
May 31, 2017	NH Coalition Against Domestic and Sexual Violence, Forensic case Review and Serving Transgendered Populations, D-H Manchester, 6.5 hrs.
May 23, 2018	Adverse Childhood Experiences, Southern New Hampshire Area Health Education Center, Bedford, NH, 2 hrs.
April 2018	Shield Our Children Conference, Dartmouth Hitchcock Medical Center, Lebanon, NH, 8 hrs.
Sept. 7, 2017	Emerging Issues and MDT Response in Child Abuse Training, Gunderson National Child Training Center, Bedford, NH, 8 hrs.
May 31, 2017	Forensic Case Review and Serving Transgender Populations, NH Coalition Against Domestic and Sexual Violence, Manchester NH, 8 hrs.
April 29, 2017	NH Coalition Against Domestic and Sexual violence, Pelvic Exam Stimulation Training, DHMC, Lebanon, NH, 8 hrs.
April 17-20,2017	Medical Clinical Preceptorship, Midwest Regional Children's Advocacy Center, Pittsburg Children's Hospital, Pittsburg, PA.
April 2017	Shield Our Children Conference, Dartmouth Hitchcock Medical Center, Lebanon, NH, 7 hrs.
March 2017-Dec.2019	Child Fatality Review: Concord, NH, bimonthly meeting
March-April, 2017	SANE (sexual abuse nurse examiner) training: Adult and Pediatric, Contocook NH., 40 hrs.
March 2, 2017	Medical Training Academy, Midwest Regional Child Advocacy Center, online course in physical and sexual maltreatment of children as well as neglect, 20 hr.

PROFESSIONAL/EDUCATIONAL ACTIVITIES (Cont'd)

March 22, 2017	SUNY Upstate Medical Center, CHAMP Educational Case Review: the Adverse Childhood Experiences Study: Effects of Maltreatment now and later, online Webinar, 1.5 hr.
February 2017	3- Day Clinical Observation with Dr. Karyn Patno to see children with suspected sexual maltreatment in Plattsburgh, NY and Mohawk Native American Reservation, NY State

PROFESSIONAL ACTIVITIES: Other

May 2013, May 2014	Medical Mission Trip to Haiti, St. Louis de Nord, to help children and adults with epilepsy and other special needs/neurology concerns, one week each
February 2012, May 2012	Medical Mission Trip to Haiti, several villages: Port au Prince, Port de Paie, St Louis de Nord, Mole de St Nicholas, three weeks each
February 2011	Medical Mission Trip to Port au Prince and several villages in Haiti, 10 days
July 2010-June 2011 Medical Center	APN Coordinating Council, Chair- Elect, Cincinnati Children's Hospital
February, 2008- June 2010 Center	APN Coordinating Council member, Cincinnati Children's Hospital Medical
July 2009- June 2010 Medical Center	APN Professional Practice Council, Chair, Cincinnati Children's Hospital
July 2008- June 2009 Hospital Medical Center	APN Professional Practice Council, Chair- Elect, Cincinnati Children's
October, 2007- present Medical Center	APN Professional Practice Council member, Cincinnati Children's Hospital
July 2010- 2012	APN Web Team member, Cincinnati Children's Hospital Medical Center
February 2004, 2005, June 2006, February 2007	Medical Mission Trip to Montanuela, Honduras to assist with medical care provision to children in region

PROFESSIONAL ACTIVITIES: ROLES

1997, 1999	Breastfeeding Advisory Committee, Delnor Community Hospital, Geneva IL.
1996	Diabetes Pathway Committee, Delnor Community Hospital, Geneva IL.
1990 – 1992	Nursing Research Committee, Hartford Hospital, Hartford, CT.
1990 - 1992	Differentiation of Nursing Practice Task Force, Hartford Hospital, Hartford, CT.
1987 - 1991	Corresponding Secretary, Delta Mu Chapter, Sigma Theta Tau, Yale University
1985 - 1988	Recruitment Committee, Yale University School of Nursing
1985 - 1987	Treasurer, Connecticut Association of School Health
1986 - 1987	Chairperson, Nominating Committee, CT. Nurses' Association
1985 - 1987	Committee Member, Nominating Committee, CT. Nurses' Association

COMMUNITY INVOLVEMENT

November 2017-2018	Xaris Founders, helping lives of children in foster care, Manchester, NH
April 2013, April 2014 March 2016	Epilepsy Foundation, Annual Walk, Orlando, FL.
April 2013, April 2014 April 2015, March 2016	Participant in 5K for Organ Donation, Longwood FL.
April 2013	Participant in St. Margaret Mary Church Hunger Project, Winter Park FL.
Fall 2010, Fall 2012	Leader and participant in epilepsy surgery reunion for children/families, Cincinnati Children's Hospital Medical Center, Cincinnati, OH
October 2009, 2010	Participant in "Cincinnati Walks for Kids", Cincinnati, OH
Winter 2008	Team Leader, American Heart Association, Mercy Mini Marathon, Cincinnati, OH.
Summer 2005, 2006	Leukemia Society, Illinois Chapter, Team in Training Cyclist/Fundraiser Participant in the 2005 and 2006 Apple Cider Century (100 mile) Cycling Criterion
1994 - 2007	Catechist, Children's Liturgy Presenter, Lector and Eucharistic Minister, Holy Cross Parish, Batavia, IL.

1994-present	Monthly sponsor for children in Mercy Home for Boys and Girls, Chicago, IL.
1991 – 1993	Engaged Encounter, Diocesan Coordinator, Family Life Office, Hartford Diocese, Hartford, CT.
1987-1993	Engaged Encounter volunteer team member in creating and managing weekends in diocese, Hartford Diocese, Hartford, CT.
1986 - 1989	Community Soup Kitchen and Columbus House Shelter - New Haven, CT. Volunteer worker - meal preparation and service
1979 - present	World Vision International, monthly financial sponsor for four children
1979 - 1986	Boston College Alumni Admissions Council, Interviewer for area applicants

REFERENCES

Available upon request.

CATHERINE COLLIER

REGISTERED NURSE

CONTACT

[redacted]

[redacted]

PROFILE

I am a Registered Nurse with 27 years of experience, primarily in the outpatient pediatric setting. I have displayed 23 years of commitment to the mission of Dartmouth Hitchcock, and have proven excellent skill in nursing leadership, telephone triage, and pediatric nursing assessment, with a more recent focus on child maltreatment. I am a loyal, collaborative team player, with a passion for providing quality care for the most vulnerable patients within our community.

PROFESSIONAL SKILLS

- NURSING ASSESSMENT
- NURSING LEADERSHIP
- SANE TRAINED
- EPIC/E-DH SYSTEM
- PHOTO DOCUMENTATION
- TELEPHONE TRIAGE
- PATIENT EDUCATION

EDUCATION

University of Vermont

Associates of Science in Nursing

1995

LICENSURE/TRAINING

Registered Nurse, NH license # 045156-21

CPR Certified

Yellow Belt trained

SANE trained

EXPERIENCE

Clinical Nurse-CAPP *Apr 2016-present*

Dartmouth Hitchcock- Manchester Pediatrics

- Support the work of the Manchester, Nashua, and Elliot CAPP Providers in the clinic setting with both administrative and clinical task including:
  - Schedule coordination and referral processing.
  - Facilitate telephone triage and follow-up with patient as needed.
  - Perform patient care, exam assistance and photo documentation
  - Communication with multidisciplinary team (CAC,DCYF, Law Enforcement)

Pediatric Sexual Assault Nurse Examiner *Jan 2021-present*

Dartmouth Hitchcock- Lebanon ED

- On-call for the DH Lebanon Pediatric SANE team, one night per week and one weekend per month
  - Respond and perform exam, evidence collection, and photo documentation for children under 12 years of age who present to the Emergency Department after disclosure of a sexual assault

Clinical Nurse Supervisor *Aug 2016-Aug 2019*

Dartmouth Hitchcock –Manchester Pediatrics

- Supervision and coordination of 12-14 direct reports and management of their performance including: evaluations, coaching, disciplinary action as appropriate, and orientation and training for new employees
- Conflict resolution as needed. Maintained smooth operations of the department, and performed service recovery to promote patient and employee retention.
- Service as a liaison with other persons/departments/clinics/outside agencies

Attended: San Diego International Conference on Child and Family Maltreatment, Jan 2019

- Coordination and implementation of special quality improvement pilots and projects including:
  - NH Healthy Homes and Lead Poisoning Prevention Program POCT lead screening
  - Ages and Stages Screening
  - IDN funded Integrated Behavioral Health Initiative
  - Participated on Symptom Governance Committee to develop e-tool for call center

Clinical Nurse *May 1999-Aug 2016*

Dartmouth Hitchcock- Manchester Pediatrics

- Telephone triage and provider support for a large Pediatric department in the ambulatory setting.

Charge Nurse *May 1995-Aug 1997*

Marion Memorial Hospital, Medical/Surgical Unit

Curriculum Vitae

Patricia T. Glowa, MD
[redacted]

Community Health Center
1 Medical Center Drive
Lebanon, NH 03766
(603) 650-4000

Date of Birth: June 24, 1950
Place of Birth: Middlebury, Vermont
SSN: 545-80-6642
Email: Patricia.T.Glowa@Hitchcock.org

Education:

1973-1977	Harvard Medical School, Boston, MA, M.D.
1971-1973	City College of the City University of New York, NY, B.A.
1967-1970	McGill University, Montreal, P.Q., Canada, English major

Post Doctoral Training:

1997-1998	National Institute for Program Director Development, Association of Family Practice Residency Directors
1993-1994	Faculty Development Fellowship, Department of Family Medicine, University of North Carolina - Chapel Hill
1979-1980	Co-Chief Resident, Family Medicine Program, Highland Hospital, Rochester, NY
1977-1980	Internship and Residency in Family Medicine, Highland Hospital, Rochester, NY

Licensure and Certification:

1980, certified	Diplomate, American Board of Family Practice
1986, 1992, 1998, 2004	Recertified, American Board of Family Practice
1980-present	New Hampshire license for medicine and surgery, lic. no. 6250
1978-2011	New York license for medicine and surgery, lic. no. 134698
1983-present	Vermont license for medicine and surgery, lic. no. 6920
1991-1995	North Carolina license for Medicine, lic. no. 33831
1997-present	Approved ALSO (Advanced Life Support in Obstetrics) Instructor

Academic Appointments:

2003-present	Assistant Professor, Department of Pediatrics, Dartmouth Medical School
1995-present	Assistant Professor, Department of Community & Family Medicine, Dartmouth Medical School

1992-1995	Clinical Assistant Professor, Department of Community & Family Medicine, University of North Carolina, residency faculty
1991-1992	Clinical Instructor of Family Medicine, University of North Carolina, 1991-1995
1980-1991	Adjunct Assistant Professor of Clinical Community and Family Medicine, Dartmouth Medical School

Major Professional Positions:

1995-2000	Residency Program Director, NH Dartmouth Family Practice Residency Program, Lebanon, NH
1995-1998	Medical Director, Community Health Center, Hanover, NH
1992-1995	University of North Carolina - Chapel Hill, Department of Family Medicine, Clinical Assistant Professor; Team Leader - Family Practice Center
1991-1992	Haywood - Moncure Health Center, Moncure, NC, practice of Family Medicine
1980-1991	Monroe Clinic, Monroe, NH, partnership private practice of Family Medicine with Donald Kollisch, M.D.

Other Professional Positions:

1995-present	Attending Staff, Dartmouth-Hitchcock Medical Center
1993-1995	Associate Director, Family Practice Center, Department of Family Medicine, University of North Carolina - Chapel Hill
1991-1995	Attending Staff, University of North Carolina Memorial Hospitals
1980-1991	Active Staff, Cottage Hospital, Woodsville, NH
1983	President, Medical Staff, Cottage Hospital, Woodsville, NH
1998-present	Sexual Abuse Evaluation Clinic (Child Advocacy and Protection Program), Co-Founder and Attending Physician, Dartmouth Hitchcock Medical Center, Lebanon, NH
1995-present	Sexual Abuse Examiner, Dartmouth-Hitchcock Medical Center, Lebanon, NH
1991-1995	Attending Physician of the University of North Carolina Child Medical Evaluation Program (a referral and training clinic on child abuse for the State of North Carolina)
1987-1988	Sexual Abuse Team, Division Children & Youth Services, Department of Welfare, Littleton, NH
1984-1991	Sexual Abuse Examiner, Division Children & Youth Services, Department of Welfare, Littleton, NH

Committees:

2001-2004	Steering Committee, Child Advocacy Center, Grafton and Sullivan Counties, New Hampshire
2000-2004	Advisory Board, Child Advocacy Center at the Family Place,

	Norwich, Vermont
1999-2010	CARE Network, New Hampshire statewide group of child sexual abuse examiners, meetings for education and case review
1999-present	Child Advocacy and Protection Program, Dartmouth Hitchcock Medical Center, Lebanon, NH
1998-1999	Children At Risk Team, Dartmouth Hitchcock Medical Center, Lebanon, NH

Memberships:

1980-present	American Academy of Family Practice
1991-present	Society of Teachers of Family Medicine
1992-2000	American Medical Women's Association
1993-present	American Professional Society on the Abuse of Children
1995-2000	Association of Family Practice Residency Directors

Teaching Experience and Responsibilities:

3/2004	Pelvic exam training for prospective SANE nurses
2003-2007	Training in child sexual abuse evaluation to DCYF (Division of Children, Youth and Families) workers, State of NH
1999-2003	Invited presentations on child sexual abuse to community hospitals in northern New Hampshire (five)
1992-2008	Conference presentations and skills training workshops on evaluation of child sexual abuse, domestic violence, ALSO (Advanced Life Support in Obstetrics) and other women's health topics to family medicine residents and faculty, medical students, medical and nursing staff of community hospitals, and residents in other departments (internal medicine, obstetrics & gynecology), four to ten presentations per year
1992-1995	Child Medical Evaluation Program: UNC referral sexual abuse clinic, teaching residents and students in a referral clinic

Additional Training:

2018-present	Monthly CAPP case review - education and quality assurance
4/11/19	Dartmouth-Hitchcock Medical Center Conf - Shield Our Children From Harm, 5.25 CME hours
4/11/17	Dartmouth-Hitchcock Medical Center Conf - Shield Our Children From Harm, 5.25 CME hours

4/19/16	Dartmouth-Hitchcock Medical Center Conf - Shield Our Children From Harm, 5.25 CME hours
4/9/15	Dartmouth-Hitchcock Medical Center Conf - Shield Our Children From Harm, 5.25 CME hours
4/18/14	Dartmouth-Hitchcock Medical Center Conf - Shield Our Children From Harm, 5.25 CME hours
4/11/13	Dartmouth-Hitchcock Medical Center Conf - Shield Our Children From Harm, 5.25 CME hours
1/28-31/13	San Diego Int'l Conf on Child and Family Maltreatment, San Diego CA, 22.5 CME hours
9/20-21/12	Harvard Medical School Conf. on Pediatric and Adolescent Gynecology, 9 CME hours
1/23-26/12	San Diego Int'l Conf on Child and Family Maltreatment, San Diego CA, 28.5 CME hours
1/22-23/12	APSAC Pre-conference, Advanced Medical Training for Child Sexual Abuse Evaluation, San Diego CA, 10.5 CME hours
9/22-23/11	Harvard Medical School Conf. on Pediatric and Adolescent Gynecology, 16 CME hours
4/26/11	Dartmouth-Hitchcock Med. Ctr. Conf. - Shield Our Children From Harm, 5 CME hours
9/23-24/10	Harvard Medical School Conf. on Pediatric and Adolescent Gynecology, 15.25 CME hours
4/15/10	Dartmouth-Hitchcock Med. Ctr. Conf. - Shield Our Children From Harm, 5 CME hours
4/6/09	Dartmouth-Hitchcock Med. Ctr. Conf. - Shield Our Children From Harm, 5 CME hours
10/4-5/07	Harvard Medical School Conf. on Pediatric and Adolescent Gynecology, 18.25 CME hours
4/3/07	Dartmouth-Hitchcock Med. Ctr. Annual Conf. on Child Abuse and Neglect, 6.25 CME hours
4/3/06	Dartmouth-Hitchcock Med. Ctr. Annual Conf. on Child Abuse and Neglect, 4.25 CME hours
1/23/06	San Diego International Conf. on Child/Family Maltreatment, 28.50 CME hours
3/31/04	MacNamee Memorial Conf. - Impact of Domestic Violence on Children, Dr. Robert Kinscherff, DHMC, 5.0 CME hours
4/15/04	Community Focus on Child Abuse 2004, DHMC, 4 CME hours
10/21-25/02	Advanced Training on Child Sexual Abuse Examinations, Calif. Chapter 4 American Academy of Pediatrics, 35 CME hours,

	Orange, Calif.
3/13-16/01	17th Annual Symposium on Child Sexual Abuse, National Children's Advocacy Center, 13.50 CME hours, Huntsville, Ala.
11/13-15/00	Third Annual Northeast Child Maltreatment Conference, Tufts Univ. School of Medicine, 14.5 CME hours, Providence, RI
1999-present	CARE Network meetings, quarterly case review and education
3/27-28/95	Expert Medical Evaluation in Child Physical and Sexual Abuse, Wake AHEC, 11 CME hours, Raleigh, NC

rev. 8/22/20

CONTRACTOR NAME

Key Personnel

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Resmiye Oral	CAPP Medical Director		90%	$329,662
Anna Marsh	CAPP APRN		25%	$32,918
Jill Rockwell	CAPP APRN		25%	$36,895
Cornelia Gonsalves	CAPP APRN		25%	$36,895
Cathy Collier	CAPP RN		1%	$1,065
Pat Glowa	CAPP MD		5%	$14,010

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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION FOR CHILDREN, YOUTH & FAMILIES

Lori A. Shibinette
Commissioner

Joseph E. Ribsam, Jr.
Director

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-4451 1-800-852-3345 Ext. 4451
Fax: 603-271-4729 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

September 21, 2020

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

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division for Children, Youth and Families, to enter into a **Sole Source** contract with Mary Hitchcock Memorial Hospital (VC#177160), Lebanon, NH, in the amount of $1,499,410, for 24/7 on-call access to and training services from health care professionals specializing in standard diagnostic methods and treatment of children who have been abused or neglect, with the option to renew for up to four (4) additional years, effective upon Governor and Council approval through June 30, 2022. 20% Federal Funds. 80% General Funds.

Funds are available in the following account for State Fiscal Year 2021, and are anticipated to be available in State Fiscal Year 2022, upon the availability and continued appropriation of funds in the future operating budget, with the authority to adjust budget line items within the price limitation and encumbrances between state fiscal years through the Budget Office, if needed and justified.

05-95-47-470010-7948 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT, HHS: OFC MEDICAID SERVICES, MEDICAID CARE MANAGEMENT

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2021	101-500729	Medical Payments to Providers	47004033	$200,000
2022	101-500729	Medical Payments to Providers	47004033	$400,000
			Subtotal	**$600,000**

05-95-95-421010-29580000 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: HUMAN SERVICES, CHILD PROTECTION, CHILD-FAMILY SERVICES

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2021	102-500731	Contracts for Prog Svc	TBD	$209,705
2022	102-500731	Contracts for Prog Svc	TBD	$209,705

05-95-95-421010-29580000 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: HUMAN SERVICES, CHILD PROTECTION, CHILD-FAMILY SERVICES

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2021	103-502507	Contracts for Prog Svc	TBD	$160,000
2022	103-502507	Contracts for Prog Svc	TBD	$320,000
			Subtotal	**$480,000**
			Total	**$1,499,410**

EXPLANATION

This request is **Sole Source** because the Contractor is uniquely positioned as an accredited educational facility with the only certified child abuse and neglect pediatrician in NH. The Contractor also possess a statewide network of health care facilities and access to trainers that would satisfy the any future anticipated business or legislative requirements. Additionally, the Contractor has numerous public and private partnerships that would allow for the successful administration of this program.

The purpose of this request is to provide on-call access 24 hours a day, 7 days a week to experienced health care professionals who are trained in and can advise on the standardized diagnostic methods, treatment, and disposition of suspected child sexual abuse and physical abuse. Dartmouth Hitchcock's Child Advocacy and Protection Program (CAPP) will conduct physical examinations of children who are suspected victims of multiple types of abuse, and provide the Division for Children, Youth and Families (DCYF) with medical opinions based on these examinations. Dartmouth Hitchcock will also provide case reviews of other specific cases, at the request of DCYF, and consultation to DCYF when necessary. The Contractor will also provide training, as requested by DCYF.

The Contractor will provide nurses and child protective service workers performing screenings and assessments of reported cases of child abuse pre-service training in the standardized medical diagnostic methods, treatment, and disposition. Further, the Contractor will periodically have health care providers, experienced in child abuse and neglect, provide in-service training. Health care professionals who participate in the training or are members of a multidisciplinary team, working with the Department of Health and Human Services or law enforcement, will participate in periodic peer or expert review of their evaluations and undertake continuing education in the medical evaluation of child abuse and neglect according to professional standards.

The population to be served are children involved with DCYF investigations, who are suspected victims of child abuse or neglect. These services are needed because DCYF, through its investigative process, often requires the expert opinion of appropriately trained medical professionals who specialize in the evaluation and diagnosis of child abuse and neglect. Approximately 1,000 individuals will be served from October 7, 2020, to June 30, 2022.

The Department will monitor contracted services by ensuring:

- 90% of all clients will be contacted and offered a family appointment within ten (10) days of CAPP receiving the referral from DCYF.

- 80% of all cases referred to CAPP by the Department will have received a completed evaluation and assessment within two (2) months of the referral from DCYF if the family agrees to the CAPP evaluation.
- 10% increase in medical providers recruited to be CAPP consultants annually.
- 100% of medical providers participate in a minimum of five (5) peer review sessions annually.

As referenced in Exhibit A, Revisions to Standard Contract Provisions, Section 1.2, of the attached contract, the parties have the option to extend the agreement for up four (4) additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties and Governor and Council approval.

Should the Governor and Council not authorize this request children who are alleged victims of physical and sexual abuse will not have access to these specialized evaluations to ensure they receive appropriate treatment and services.

Area served: Statewide

Source of Funds: Medicaid CFDA#93.778

The Department will request General Funds in the event that Federal Funds are no longer available and services are still needed.

Respectfully submitted,

Lori Shibinette

Lori A. Shibinette
Commissioner

Subject: Special Medical Evaluation Services (SS-2020-DCYF-13-SPECI-01)

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

AGREEMENT

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

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name New Hampshire Department of Health and Human Services		1.2 State Agency Address 129 Pleasant Street Concord, NH 03301-3857	
1.3 Contractor Name Mary Hitchcock Memorial Hospital		1.4 Contractor Address One Medical Center Drive Lebanon, NH, 03756	
1.5 Contractor Phone Number (603) 646-1110	1.6 Account Number 05-095-42-4210-2958 05-095-47-4700-7948	1.7 Completion Date June 30, 2022	1.8 Price Limitation $1,499,410
1.9 Contracting Officer for State Agency Nathan D. White, Director		1.10 State Agency Telephone Number (603) 271-9631	
1.11 Contractor Signature Susan Reeves Date: 9/17/2020		1.12 Name and Title of Contractor Signatory Susan A. Reeves, EdD, RN Executive Vice President	
1.13 State Agency Signature Date: 9/22/20		1.14 Name and Title of State Agency Signatory Joseph E. Ribsam, Jr., Director, DCYF	
1.15 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)* By:		Director, On:	
1.16 Approval by the Attorney General (Form, Substance and Execution) *(if applicable)* By: Catherine Pinos		On: 09/22/20	
1.17 Approval by the Governor and Executive Council *(if applicable)* G&C Item number:		G&C Meeting Date:	

Contractor Initials SAR
Date 9-17-2020

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

3. EFFECTIVE DATE/COMPLETION OF SERVICES.

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

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

4. CONDITIONAL NATURE OF AGREEMENT.

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

5. CONTRACT PRICE/PRICE LIMITATION/ PAYMENT.

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

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

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

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

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

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

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

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

7. PERSONNEL.

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

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

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

Contractor Initials SAR

Date 9-17-2020

8. EVENT OF DEFAULT/REMEDIES.

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

8.1.1 failure to perform the Services satisfactorily or on schedule;

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

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

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

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

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

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

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

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

9. TERMINATION.

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

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

10. DATA/ACCESS/CONFIDENTIALITY/ PRESERVATION.

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

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

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

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

12. ASSIGNMENT/DELEGATION/SUBCONTRACTS.

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

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

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

Contractor Initials SAH

Date 9-17-2020

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

14. INSURANCE.

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

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

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

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

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

15. WORKERS' COMPENSATION.

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

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

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

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

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

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

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

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

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

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

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

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Date 9-17-2020

REVISIONS TO STANDARD CONTRACT PROVISIONS

1. Revisions to Form P-37, General Provisions

1.1. Paragraph 3, Subparagraph 3.2, Effective Date/Completion of Services, is deleted in its entirety and replaced as follows:

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

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

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

1.3. Paragraph 7, Subparagraph 7.1, Personnel, is deleted in its entirety and replaced as follows:

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

1.4. Paragraph 9, Subparagraph 9.1, Termination, is amended to include the following language:

9.1 Contractor may terminate the Agreement by providing the State with thirty (30) days advance written notice if the State fails to pay the undisputed amount of any expense report submitted by Contractor pursuant to Exhibit C within thirty (30) days after the date of the report; however, upon receipt of such notification the State has an additional twenty (20) days to make payment of undisputed amounts to avoid termination.

1.5. Paragraph 9, Subparagraph 9.2, Termination, is deleted in its entirety and is replaced as follows:

9.2 In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall, at the State's discretion, deliver to the Contracting Officer, not later than fifteen (15)

days after the date of termination, a report ("Termination Report") describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination Report shall be identical to those of any Final Report described in the attached EXHIBIT B.

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

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

1.7. Paragraph 13, Indemnification, is deleted in its entirety and replaced as follows:

13. CONTRACTOR LIABILITY. The Contractor is responsible and liable for any personal injury or property damages caused by its, its employees, agents, contractors and subcontractors' action or omission.

1.8. Paragraph 14, Subparagraph 14.1.2, Insurance, is deleted in its entirety and replaced as follows:

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

1.9. Paragraph 14, Subparagraph 14.2, is deleted in its entirety and is replaced as follows:

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

Scope of Services

1. Statement of Work

1.1. The Contractor shall provide services in this agreement to the Department to service children who are suspected victims of abuse or neglect.

1.2. The Contractor shall ensure services are available in multiple locations throughout the state.

1.3. For the purposes of this agreement, all references to days shall mean calendar days.

1.4. For the purposes of this agreement, all references to business hours shall mean Monday through Sunday, twenty four (24) hours per day.

1.5. Special Medical Evaluation Services

1.5.1. The Contractor shall provide on-call access 24 hours a day, seven (7) days a week to the Department and other health care providers including, but not limited to:

1.5.1.1. Pediatricians.

1.5.1.2. Emergency Room staff.

1.5.1.3. Family Care Doctors.

1.5.1.4. Medical providers who are treating a child with a suspicion of abuse or neglect.

1.5.2. The Contractor shall evaluate children who are suspected victims of abuse or neglect, ensuring:

1.5.2.1. Evaluations are conducted on both an inpatient and outpatient basis, as appropriate.

1.5.2.2. Professional guidance as to the severity or possible origin of injuries is provided to the referral source.

1.5.3. The Contractor shall ensure on-call staff are experienced health care professionals who are trained in, and can advise on, standardized diagnostic methods, treatment, and disposition of suspected child sexual abuse; physical abuse; or neglect.

1.5.4. The Contractor shall determine the level of the client's injuries and coordinate client transfer or care to the Children's Hospital at Dartmouth (CHAD) or other medical facilities, as appropriate.

1.5.5. The Contractor shall complete an intake and referral form during the initial contact with the provider, which includes, but is not limited to:

1.5.5.1. Name of agency.

1.5.5.2. Patient name.

1.5.5.3. Patient date of birth.

1.5.5.4. Patient address.

1.5.5.5. Nature of child maltreatment, which may include, but is not limited to:

1.5.5.5.1. Physical abuse.

1.5.5.5.2. Sexual abuse.

1.5.5.5.3. Neglect.

1.5.5.5.4. Psychological/Emotional Abuse.

1.5.5.6. Brief history of concern.

1.5.5.7. Parent or guardian contact information.

1.5.5.8. Referral from the Division for Children, Youth and Families (DCYF), or law enforcement.

1.5.6. The Contractor shall provide information to non-DCYF callers relative to filing a report with the Department, if appropriate, and document the random intake number for the filed report.

1.5.7. The Contractor shall provide all assessment notes and documents, relative to each encounter with the family, including phone triage and clinically follow-up information, within 24 hours of each encounter to the Department to enable the Department to develop:

1.5.7.1. An appropriate safety plan for each client; and

1.5.7.2. Further strategic planning in any occurrence in which a child requires ongoing consultation or follow-up due to hospitalization or extended need.

1.5.8. The Contractor shall ensure an experienced health care professional is available to the Department 24 hours per day, seven (7) days per week by telephone to clarify any diagnostic issues.

1.5.9. The Contractor shall receive or initiate requests for hospital-based multi-disciplinary team meetings with the Department and subspecialists.

1.5.10. The Contractor shall ensure multi-disciplinary team members include, but are not limited to:

1.5.10.1. Department staff.

1.5.10.2. Law enforcement.

1.5.10.3. County attorney.

1.5.11. The Contractor shall ensure CAPP members provide medical testimonials in court per Department request.

1.6. Medical Provider Peer Review Consultation

1.6.1. The Contractor shall facilitate a peer review meeting to the Child Advocacy and Protection Program (CAPP) medical provider network, statewide, in order to present and receive guidance on active cases.

1.6.2. The Contractor shall ensure peer review entities include, but are not limited to:

1.6.2.1. New Hampshire Medical Providers Peer Review.

1.6.2.2. New England Provider Medical Peer Review.

1.6.3. The Contractor shall ensure all medical providers attend a minimum of five (5) peer review sessions annually.

1.7. Training

1.7.1. The Contractor shall provide pre-service and in-service trainings to the Department, as requested, on topics that include, but are not limited to:

1.7.1.1. Child abuse and neglect.

1.7.1.2. Psychological and emotional abuse.

1.7.1.3. Physical abuse training that includes, but is not limited to:

1.7.1.3.1. Abusive skin injuries and fractures.

1.7.1.3.2. Types of abusive head trauma.

1.7.1.3.3. Abusive internal organ and burn injuries.

1.7.1.3.4. History and categories of child abuse and neglect.

1.7.1.3.5. CAPP Services.

1.7.1.3.6. How CAPP services can provide guidance to Department and medical providers.

1.7.1.3.7. Diagnostic approach and diagnostic work up protocols to child abuse and neglect.

1.7.1.3.8. Signs and indicators of neglect, sexual, physical and psychological abuse.

1.7.1.3.9. Photo documentation.

1.7.2. The Contractor shall ensure nurse and child protective service worker professionals receive pre-service and in-service training on topics that include, but are not limited to:

1.7.2.1. Standardized diagnostic methods.

1.7.2.2. Follow up treatment needs.

1.7.2.3. Medical disposition of child abuse and neglect diagnosis.

2. Exhibits Incorporated

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

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

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

3. Reporting Requirements

3.1. The Contractor shall provide quarterly reports to the Department within fifteen (15) days following the end of the quarter, ensuring reports include, but are not limited to:

3.1.1. Number of calls to CAPP.

3.1.2. Number of cases referred to CAPP by the Department and evaluated for special medical services.

3.1.3. Number of record reviews conducted for the Department by CAPP.

3.1.4. Number of court appearances by CAPP members.

3.1.5. Number of multi-disciplinary team meetings attended by CAPP members, including but not limited to:

3.1.5.1. County based multi-disciplinary case reviews.

3.1.5.2. Hospital-based multi-disciplinary interagency case review.

3.1.6. Number of trainings provided to the Department.

3.1.7. Annual number and duration of trainings provided to the Department staff by CAPP.

3.1.8. Annual number of over-the-phone consultations provided to the Department:

4. Performance Measures

4.1. The Department will monitor Contractor performance based on the outcomes that include, but are not limited to:

4.1.1. 90% of all clients will be contacted and offered a family appointment within ten (10) days of CAPP receiving the referral from DCYF.

4.1.2. 80% of all cases referred to CAPP by the Department will have received a completed evaluation and assessment within two (2) months of the referral from DCYF if family agrees to the CAPP evaluation.

4.1.3. 10% increase in medical providers recruited to be CAPP consultants annually.

4.1.4. 100% of medical providers participate in a minimum of five (5) peer review sessions annually.

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

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

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

5. Additional Terms

5.1. Impacts Resulting from Court Orders or Legislative Changes

5.1.1. The Contractor agrees that, to the extent future state or federal legislation or court orders may have an impact on the Services described herein, the State has the right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance therewith.

5.2. Culturally and Linguistically Appropriate Services (CLAS)

5.2.1. The Contractor shall submit and comply with a detailed description of the language assistance services they will provide to persons with limited English proficiency and/or hearing impairment to ensure meaningful access to their programs and/or services within ten (10) days of the contract effective date.

5.3. Credits and Copyright Ownership

5.3.1. All documents, notices, press releases, research reports and other materials prepared during or resulting from the performance of the services of the Contract shall include the following statement, "The preparation of this (report, document etc.) was financed under a Contract with the State of New Hampshire, Department of Health and Human Services, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services."

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

6. Force Majeure

6.1.1. Any delays in performance by a party under the contract shall not be considered a breach of the contract if and to the extent caused by occurrences beyond the reasonable control of the party affected: acts of God, embargoes, governmental restrictions, strikes, pandemics, fire, earthquake, flood, explosion, riots, wars, civil disorder, rebellion, or sabotage. The party suffering such occurrence shall immediately notify the other party of the occurrence of the Force Majeure event (in reasonable detail) and the expected duration of the event's effect on the party. A disruption in a party's performance due to Force Majeure extending beyond a stated period may be the cause for termination of the Contract at the sole discretion of the State. The State reserves the right to extend any time for performance by the actual time of the delay caused by the occurrence, provided that the party affected by the event uses reasonable efforts to overcome such delay. Notwithstanding anything in this provision, Force Majeure shall not include the novel coronavirus COVID-19 pandemic, which is ongoing as of the date of the execution of this Contract. In the event that the Contractor's performance under the contract may be delayed due to a supply chain disruption or shortage and/or other similar occurrences completely outside of Contractor's control, the Contractor must notify the State of such delay and the State, at its sole discretion, may modify the delivery of services due to the circumstances. Said discretion on the part of the State to modify the delivery of services will not be unreasonably withheld, delayed, or conditioned.

7. Records

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

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

7.1.2. All records must be maintained in accordance with accounting procedures and practices, which sufficiently and properly reflect all such costs and expenses, and which are acceptable to the Department, and to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.

7.1.3. Statistical, enrollment, attendance or visit records for each recipient of services, which records shall include all records of application and eligibility (including all forms required to determine eligibility for each such recipient), records regarding the provision of services and all invoices submitted to the Department to obtain payment for such services.

7.1.4. Medical records on each patient/recipient of services.

7.2. During the term of this Contract and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives shall have access to all reports and records maintained pursuant to the Contract for purposes of audit, examination, excerpts and transcripts. Upon the purchase by the Department of the maximum number of units provided for in the Contract and upon payment of the price limitation hereunder, the Contract and all the obligations of the parties hereunder (except such obligations as, by the terms of the Contract are to be performed after the end of the term of this Contract and/or survive the termination of the Contract) shall terminate, provided however, that if, upon review of the Final Expenditure Report the Department shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

	A	B	C
1	Procedure Code	Description	Current Rate
2	99205	Office/outpatient visit new	$83.14
3	99211	Established patient office or other outpatient visit, typically 5 minutes	$15.91
4	99212	Established patient office or other outpatient visit, typically 10 minutes	$32.06
5	99213	Established patient office or other outpatient visit, typically 15 minutes	$44.04
6	99214	Established patient office or other outpatient, visit typically 25 minutes	$67.83
7	99215	Established patient office or other outpatient, visit typically 40 minutes	$77.37
8	99245	Patient office consultation, typically 80 minutes	$117.78
9	99285	Emergency department visit, problem with significant threat to life or function	$97.00
10	99223	Initial hospital inpatient care, typically 70 minutes per day	$115.47
11	99255	Inpatient hospital consultation, typically 110 minutes	$117.78
12	99170	Examination of genital and anal region of child using an endoscope, suspected trauma	$84.26
13	99354	Prolonged office or other outpatient service first hour	$62.35
14	99356	PROLONGED SERVICE IN THE INPATIENT OR OBSERVATION SETTING, REQUIRING UNIT/FLOOR TIME BEYOND THE USUAL SERVICE; FIRST HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR INPATIENT EVALUATION AND MANAGEMENT SERVICE)	$57.74
15	99357	PROLONGED SERVICE IN THE INPATIENT OR OBSERVATION SETTING, REQUIRING UNIT/FLOOR TIME BEYOND THE USUAL SERVICE; EACH ADDITIONAL 30 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PROLONGED SERVICE)	$57.74
16	99359	PROLONGED EVALUATION AND MANAGEMENT SERVICE BEFORE AND/OR AFTER DIRECT PATIENT CARE; EACH ADDITIONAL 30 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PROLONGED SERVICE)	$27.72

Contractor Initials SAL

Date 4-17-2020

New Hampshire Department of Health and Human Services
Special Medical Evaluation Services

EXHIBIT C

Payment Terms

1. This Agreement is funded by:
   1.1. 20%, This contract is funded with funds from the Foster Care Program, Title IV-E, Catalog of Federal Domestic Assistance (CFDA) #93.658, Federal Award Identification Number (FAIN) #2001NHFOST and Medicaid.
   1.2. 80% General funds.
2. For the purposes of this Agreement:
   2.1. The Department has identified the Contractor as a Contractor, in accordance with 2 CFR 200.0. et seq.
   2.2. The de minimis Indirect Cost Rate of 10% applies in accordance with 2 CFR §200.414.
   2.3. The Department has identified this Contract as NON-R&D, in accordance with 2 CFR §200.87.
   2.4. Payment shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this Agreement, and shall be in accordance with the approved line item, as specified in Exhibits C-1, and C-2 Budget Sheets.
3. The Contractor shall submit an invoice in a form satisfactory to the State by the fifteenth (15th) working day of the following the end of the quarter, which identifies and requests reimbursement for authorized expenses incurred in the prior month. The Contractor shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
4. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to DCYFInvoices@dhhs.nh.gov, or invoices may be mailed to:

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

   4.1. The Contractor shall bill the appropriate funding sources in accordance with standard billing procedures in both NH Medicaid and DCYF. The Contractor shall submit NH Medicaid expenses via the Website below:

   https://www.nhmmis.nh.gov

   4.2. Non-clinical DCYF services

   4.2.1. The Contractor shall submit non-clinical expenses via the Website below:

   https://business.nh.gov/beb/pages/index.aspx

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

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

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

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

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

10. Notwithstanding Paragraph 18 of the General Provisions Form P-37, changes limited to adjusting amounts within the price limitation and adjusting encumbrances between State Fiscal Years and budget class lines through the Budget Office may be made by written agreement of both parties, without obtaining approval of the Governor and Executive Council, if needed and justified.

11. Audits

11.1. The Contractor is required to submit an annual audit to the Department if any of the following conditions exist:

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

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

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

11.2. If Condition A exists, the Contractor shall submit an annual single audit performed by an independent Certified Public Accountant (CPA) to the Department within 120 days after the close of the Contractor's fiscal

year, conducted in accordance with the requirements of 2 CFR Part 200, Subpart F of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal awards.

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

11.4. In addition to, and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions and shall return to the Department all payments made under the Contract to which exception has been taken, or which have been disallowed because of such an exception.

Exhibit C-1, Budget Sheet

New Hampshire Department of Health and Human Services

Contractor Name: Mary Hitchcock Memorial Hospital

Budget Request for: Special Medical Evaluation Services

Budget Period: July 1, 2020 - June 30, 2021 SFY 2021

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Annual Medical Consultation	$ 144,080.00	$ -	$ 144,080.00	$ -	$ -	$ -	$ 144,080.00	$ -	$ 144,080.00
2. Annual Network Support	$ 38,400.00	$ -	$ 38,400.00	$ -	$ -	$ -	$ 38,400.00	$ -	$ 38,400.00
3. Training	$ 34,450.00	$ -	$ 34,450.00	$ -	$ -	$ -	$ 34,450.00	$ -	$ 34,450.00
4. Web Billing	$ 360,000.00	$ -	$ 360,000.00	$ -	$ -	$ -	$ 360,000.00	$ -	$ 360,000.00
TOTAL	$ 576,930.00	$ -	$ 576,930.00	$ -	$ -	$ -	$ 576,930.00	$ -	$ 576,930.00
Indirect As A Percent of Direct		0.0%							

Mary Hitchcock Memorial Hospital
SS-2020-DCYF-13-MPECH-01
Exhibit C-1, Budget Sheet
Page 1 of 1

Contractor Initials SAH
Date 9-17-2020

Exhibit C-2, Budget Sheet

New Hampshire Department of Health and Human Services

Contractor Name: Mary Hitchcock Memorial Hospital

Budget Request for: Juvenile Medical Evaluation Services

Budget Period: July 1, 2021 - June 30, 2022 SFY 2022

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Annual Worksite Evaluation	$ 141,672.00	$ -	$ 141,672.00	$ -	$ -	$ -	$ 141,672.00	$ -	$ 141,672.00
2. Annual Network Support	$ 35,450.00	$ -	$ 35,450.00	$ -	$ -	$ -	$ 35,450.00	$ -	$ 35,450.00
3. Training	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Work Hours	$ 770,000.00	$ -	$ 770,000.00	$ -	$ -	$ -	$ 770,000.00	$ -	$ 770,000.00
TOTAL	$ 967,466.00	$ -	$ 967,466.00	$ -	$ -	$ -	$ 967,466.00	$ -	$ 967,466.00

Indirect As A Percent of Direct: 0.0%

Mary Hitchcock Memorial Hospital
SS-2022-DCYF-13-SPEC-01
Exhibit C-2, Budget Sheet
Page 1 of 1

Contractor Initials: SAL
Date: 9-17-2020

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The Vendor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

This certification is required by the regulations implementing Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.). The January 31, 1989 regulations were amended and published as Part II of the May 25, 1990 Federal Register (pages 21681-21691), and require certification by grantees (and by inference, sub-grantees and sub-contractors), prior to award, that they will maintain a drug-free workplace. Section 3017.630(c) of the regulation provides that a grantee (and by inference, sub-grantees and sub-contractors) that is a State may elect to make one certification to the Department in each federal fiscal year in lieu of certificates for each grant during the federal fiscal year covered by the certification. The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment. Contractors using this form should send it to:

Commissioner
NH Department of Health and Human Services
129 Pleasant Street,
Concord, NH 03301-6505

1. The grantee certifies that it will or will continue to provide a drug-free workplace by:
   - 1.1. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
   - 1.2. Establishing an ongoing drug-free awareness program to inform employees about
     - 1.2.1. The dangers of drug abuse in the workplace;
     - 1.2.2. The grantee's policy of maintaining a drug-free workplace;
     - 1.2.3. Any available drug counseling, rehabilitation, and employee assistance programs; and
     - 1.2.4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
   - 1.3. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);
   - 1.4. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will
     - 1.4.1. Abide by the terms of the statement; and
     - 1.4.2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
   - 1.5. Notifying the agency in writing, within ten calendar days after receiving notice under subparagraph 1.4.2 from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer on whose grant activity the convicted employee was working, unless the Federal agency

has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

1.6. Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph 1.4.2, with respect to any employee who is so convicted
  1.6.1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
  1.6.2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

1.7. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs 1.1, 1.2, 1.3, 1.4, 1.5, and 1.6.

2. The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant.

Place of Performance (street address, city, county, state, zip code) (list each location)

Check ☐ if there are workplaces on file that are not identified here.

Vendor Name:

9-17-2020
Date

Name: Susan A. Reeves, EdD, RN
Title: Executive Vice President

CERTIFICATION REGARDING LOBBYING

The Vendor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Section 319 of Public Law 101-121, Government wide Guidance for New Restrictions on Lobbying, and 31 U.S.C. 1352, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

Programs (indicate applicable program covered):
*Temporary Assistance to Needy Families under Title IV-A
*Child Support Enforcement Program under Title IV-D
*Social Services Block Grant Program under Title XX
*Medicaid Program under Title XIX
*Community Services Block Grant under Title VI
*Child Care Development Block Grant under Title IV

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor).

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor), the undersigned shall complete and submit Standard Form LLL, (Disclosure Form to Report Lobbying, in accordance with its instructions, attached and identified as Standard Exhibit E-I.)

3. The undersigned shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Vendor Name:

9-17-2020
Date

Susan A Reeves
Name: Susan A. Reeves, EdD, RN
Title: Executive Vice President

CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

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

INSTRUCTIONS FOR CERTIFICATION

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

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

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

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

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

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

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

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

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

Vendor Initials SBK
Date 9-17-2020

information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

10. Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal government, DHHS may terminate this transaction for cause or default.

PRIMARY COVERED TRANSACTIONS

11. The prospective primary participant certifies to the best of its knowledge and belief, that it and its principals:
    11.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;
    11.2. have not within a three-year period preceding this proposal (contract) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or a contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
    11.3. are not presently indicted for otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (l)(b) of this certification; and
    11.4. have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

12. Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal (contract).

LOWER TIER COVERED TRANSACTIONS

13. By signing and submitting this lower tier proposal (contract), the prospective lower tier participant, as defined in 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:
    13.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
    13.2. where the prospective lower tier participant is unable to certify to any of the above, such prospective participant shall attach an explanation to this proposal (contract).

14. The prospective lower tier participant further agrees by submitting this proposal (contract) that it will include this clause entitled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion - Lower Tier Covered Transactions," without modification in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

Vendor Name:

9-17-2020
Date

Name: Susan A. Reeves, EdD, RN
Title: Executive Vice President

CERTIFICATION OF COMPLIANCE WITH REQUIREMENTS PERTAINING TO FEDERAL NONDISCRIMINATION, EQUAL TREATMENT OF FAITH-BASED ORGANIZATIONS AND WHISTLEBLOWER PROTECTIONS

The Vendor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

Vendor will comply, and will require any subgrantees or subcontractors to comply, with any applicable federal nondiscrimination requirements, which may include:

- the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. Section 3789d) which prohibits recipients of federal funding under this statute from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act requires certain recipients to produce an Equal Employment Opportunity Plan;

- the Juvenile Justice Delinquency Prevention Act of 2002 (42 U.S.C. Section 5672(b)) which adopts by reference, the civil rights obligations of the Safe Streets Act. Recipients of federal funding under this statute are prohibited from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act includes Equal Employment Opportunity Plan requirements;

- the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, which prohibits recipients of federal financial assistance from discriminating on the basis of race, color, or national origin in any program or activity);

- the Rehabilitation Act of 1973 (29 U.S.C. Section 794), which prohibits recipients of Federal financial assistance from discriminating on the basis of disability, in regard to employment and the delivery of services or benefits, in any program or activity;

- the Americans with Disabilities Act of 1990 (42 U.S.C. Sections 12131-34), which prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation;

- the Education Amendments of 1972 (20 U.S.C. Sections 1681, 1683, 1685-86), which prohibits discrimination on the basis of sex in federally assisted education programs;

- the Age Discrimination Act of 1975 (42 U.S.C. Sections 6106-07), which prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance. It does not include employment discrimination;

- 28 C.F.R. pt. 31 (U.S. Department of Justice Regulations – OJJDP Grant Programs); 28 C.F.R. pt. 42 (U.S. Department of Justice Regulations – Nondiscrimination; Equal Employment Opportunity; Policies and Procedures); Executive Order No. 13279 (equal protection of the laws for faith-based and community organizations); Executive Order No. 13559, which provide fundamental principles and policy-making criteria for partnerships with faith-based and neighborhood organizations;

- 28 C.F.R. pt. 38 (U.S. Department of Justice Regulations – Equal Treatment for Faith-Based Organizations); and Whistleblower protections 41 U.S.C. §4712 and The National Defense Authorization Act (NDAA) for Fiscal Year 2013 (Pub. L. 112-239, enacted January 2, 2013) the Pilot Program for Enhancement of Contract Employee Whistleblower Protections, which protects employees against reprisal for certain whistle blowing activities in connection with federal grants and contracts.

The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment.

In the event a Federal or State court or Federal or State administrative agency makes a finding of discrimination after a due process hearing on the grounds of race, color, religion, national origin, or sex against a recipient of funds, the recipient will forward a copy of the finding to the Office for Civil Rights, to the applicable contracting agency or division within the Department of Health and Human Services, and to the Department of Health and Human Services Office of the Ombudsman.

The Vendor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this proposal (contract) the Vendor agrees to comply with the provisions indicated above.

Vendor Name:

9-17-2020
Date

Name: Susan A. Reeves, EdD, RN
Title: Executive Vice President

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, Part C - Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 per day and/or the imposition of an administrative compliance order on the responsible entity.

The Vendor identified in Section 1.3 of the General Provisions agrees, by signature of the Contractor's representative as identified in Section 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this contract, the Vendor agrees to make reasonable efforts to comply with all applicable provisions of Public Law 103-227, Part C, known as the Pro-Children Act of 1994.

Vendor Name:

9-17-2020
Date

Name: Susan A. Reeves, EdD, RN
Title: Executive Vice President

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT BUSINESS ASSOCIATE AGREEMENT

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

(1) Definitions.

a. "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

b. "Business Associate" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

c. "Covered Entity" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

d. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR Section 164.501.

e. "Data Aggregation" shall have the same meaning as the term "data aggregation" in 45 CFR Section 164.501.

f. "Health Care Operations" shall have the same meaning as the term "health care operations" in 45 CFR Section 164.501.

g. "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act, TitleXIII, Subtitle D, Part 1 & 2 of the American Recovery and Reinvestment Act of 2009.

h. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160, 162 and 164 and amendments thereto.

i. "Individual" shall have the same meaning as the term "individual" in 45 CFR Section 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.501(g).

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

k. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR Section 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

l. "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR Section 164.103.

m. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

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

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

p. Other Definitions - All terms not otherwise defined herein shall have the meaning established under 45 C.F.R. Parts 160, 162 and 164, as amended from time to time, and the HITECH
Act.

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

a. Business Associate shall not use, disclose, maintain or transmit Protected Health Information (PHI) except as reasonably necessary to provide the services outlined under Exhibit A of the Agreement. Further, Business Associate, including but not limited to all its directors, officers, employees and agents, shall not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

b. Business Associate may use or disclose PHI:
   I. For the proper management and administration of the Business Associate;
   II. As required by law, pursuant to the terms set forth in paragraph d. below; or
   III. For data aggregation purposes for the health care operations of Covered Entity.

c. To the extent Business Associate is permitted under the Agreement to disclose PHI to a third party, Business Associate must obtain, prior to making any such disclosure, (i) reasonable assurances from the third party that such PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (ii) an agreement from such third party to notify Business Associate, in accordance with the HIPAA Privacy, Security, and Breach Notification Rules of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.

d. The Business Associate shall not, unless such disclosure is reasonably necessary to provide services under Exhibit A of the Agreement, disclose any PHI in response to a request for disclosure on the basis that it is required by law, without first notifying Covered Entity so that Covered Entity has an opportunity to object to the disclosure and to seek appropriate relief. If Covered Entity objects to such disclosure, the Business

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

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

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

a. The Business Associate shall notify the Covered Entity's Privacy Officer immediately after the Business Associate becomes aware of any use or disclosure of protected health information not provided for by the Agreement including breaches of unsecured protected health information and/or any security incident that may have an impact on the protected health information of the Covered Entity.

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

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

The Business Associate shall complete the risk assessment within five (5) business days of the breach and immediately report the findings of the risk assessment in writing to the Covered Entity.

c. The Business Associate shall comply with all sections of the Privacy, Security, and Breach Notification Rule.

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

e. Business Associate shall require all of its business associates that receive, use or have access to PHI under the Agreement, to agree in writing to adhere to the same restrictions and conditions on the use and disclosure of PHI contained herein, including the duty to return or destroy the PHI as provided under Section 3 (l). The Covered Entity shall be considered a direct third party beneficiary of the Contractor's business associate agreements with Contractor's intended business associates, who will be receiving PHI

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

f. Within five (5) business days of receipt of a written request from Covered Entity, Business Associate shall make available during normal business hours at its offices all records, books, agreements, policies and procedures relating to the use and disclosure of PHI to the Covered Entity, for purposes of enabling Covered Entity to determine Business Associate's compliance with the terms of the Agreement.

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

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

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

j. Within ten (10) business days of receiving a written request from Covered Entity for a request for an accounting of disclosures of PHI, Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill its obligations to provide an accounting of disclosures with respect to PHI in accordance with 45 CFR Section 164.528.

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

l. Within ten (10) business days of termination of the Agreement, for any reason, the Business Associate shall return or destroy, as specified by Covered Entity, all PHI received from, or created or received by the Business Associate in connection with the Agreement, and shall not retain any copies or back-up tapes of such PHI. If return or destruction is not feasible, or the disposition of the PHI has been otherwise agreed to in the Agreement, Business Associate shall continue to extend the protections of the Agreement, to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business

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

(4) Obligations of Covered Entity

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

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

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

(5) Termination for Cause

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

(6) Miscellaneous

a. Definitions and Regulatory References. All terms used, but not otherwise defined herein, shall have the same meaning as those terms in the Privacy and Security Rule, amended from time to time. A reference in the Agreement, as amended to include this Exhibit I, to a Section in the Privacy and Security Rule means the Section as in effect or as amended.

b. Amendment. Covered Entity and Business Associate agree to take such action as is necessary to amend the Agreement, from time to time as is necessary for Covered Entity to comply with the changes in the requirements of HIPAA, the Privacy and Security Rule, and applicable federal and state law.

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

d. Interpretation. The parties agree that any ambiguity in the Agreement shall be resolved to permit Covered Entity to comply with HIPAA, the Privacy and Security Rule.

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

f. Survival. Provisions in this Exhibit I regarding the use and disclosure of PHI, return or destruction of PHI, extensions of the protections of the Agreement in section (3) I, the defense and indemnification provisions of section (3) e and Paragraph 13 of the standard terms and conditions (P-37), shall survive the termination of the Agreement.

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

Department of Health and Human Services	Mary Hitchcock Memorial Hospital
The State	Name of the Contractor
Signature of Authorized Representative	Signature of Authorized Representative
Joseph E. Ribsam, Jr.	Susan A. Reeves, EdD, RN
Name of Authorized Representative	Name of Authorized Representative
Director, DCYF	Executive Vice President
Title of Authorized Representative	Title of Authorized Representative
9/22/20	9-17-2020
Date	Date

CERTIFICATION REGARDING THE FEDERAL FUNDING ACCOUNTABILITY AND TRANSPARENCY ACT (FFATA) COMPLIANCE

The Federal Funding Accountability and Transparency Act (FFATA) requires prime awardees of individual Federal grants equal to or greater than $25,000 and awarded on or after October 1, 2010, to report on data related to executive compensation and associated first-tier sub-grants of $25,000 or more. If the initial award is below $25,000 but subsequent grant modifications result in a total award equal to or over $25,000, the award is subject to the FFATA reporting requirements, as of the date of the award.
In accordance with 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), the Department of Health and Human Services (DHHS) must report the following information for any subaward or contract award subject to the FFATA reporting requirements:

1. Name of entity
2. Amount of award
3. Funding agency
4. NAICS code for contracts / CFDA program number for grants
5. Program source
6. Award title descriptive of the purpose of the funding action
7. Location of the entity
8. Principle place of performance
9. Unique identifier of the entity (DUNS #)
10. Total compensation and names of the top five executives if:
    - 10.1. More than 80% of annual gross revenues are from the Federal government, and those revenues are greater than $25M annually and
    - 10.2. Compensation information is not already available through reporting to the SEC.

Prime grant recipients must submit FFATA required data by the end of the month, plus 30 days, in which the award or award amendment is made.
The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of The Federal Funding Accountability and Transparency Act, Public Law 109-282 and Public Law 110-252, and 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:
The below named Contractor agrees to provide needed information as outlined above to the NH Department of Health and Human Services and to comply with all applicable provisions of the Federal Financial Accountability and Transparency Act.

Contractor Name:

9-17-2020
Date

Name: Susan A. Reeves, EdD, RN
Title: Executive Vice President

FORM A

As the Contractor identified in Section 1.3 of the General Provisions, I certify that the responses to the below listed questions are true and accurate.

1. The DUNS number for your entity is: 069910297

2. In your business or organization's preceding completed fiscal year, did your business or organization receive (1) 80 percent or more of your annual gross revenue in U.S. federal contracts, subcontracts, loans, grants, sub-grants, and/or cooperative agreements; and (2) $25,000,000 or more in annual gross revenues from U.S. federal contracts, subcontracts, loans, grants, subgrants, and/or cooperative agreements?

   X NO _____ YES

   If the answer to #2 above is NO, stop here

   If the answer to #2 above is YES, please answer the following:

3. Does the public have access to information about the compensation of the executives in your business or organization through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C.78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986?

   _____ NO _____ YES

   If the answer to #3 above is YES, stop here

   If the answer to #3 above is NO, please answer the following:

4. The names and compensation of the five most highly compensated officers in your business or organization are as follows:

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

New Hampshire Department of Health and Human Services

DHHS Security Requirements

Exhibit K

A. Definitions

The following terms may be reflected and have the described meaning in this document:

1. "Breach" means the loss of control, compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, or any similar term referring to situations where persons other than authorized users and for an other than authorized purpose have access or potential access to personally identifiable information, whether physical or electronic. With regard to Protected Health Information, "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

2. "Computer Security Incident" shall have the same meaning "Computer Security Incident" in section two (2) of NIST Publication 800-61, Computer Security Incident Handling Guide, National Institute of Standards and Technology, U.S. Department of Commerce.

3. "Confidential Information," "Confidential Data," or "Data" (as defined in Exhibit K), means all confidential information disclosed by one party to the other such as all medical, health, financial, public assistance benefits and personal information including without limitation, Substance Abuse Treatment Records, Case Records, Protected Health Information and Personally Identifiable Information.

   Confidential Information also includes any and all information owned or managed by the State of NH - created, received from or on behalf of the Department of Health and Human Services (DHHS) or accessed in the course of performing contracted services - of which collection, disclosure, protection, and disposition is governed by state or federal law or regulation. This information includes, but is not limited to Protected Health Information (PHI), Personal Information (PI), Personal Financial Information (PFI), Federal Tax Information (FTI), Social Security Numbers (SSN), Payment Card Industry (PCI), and or other sensitive and confidential information.

4. "End User" means any person or entity (e.g., contractor's employee, business associate, subcontractor, other downstream user, etc.) that receives DHHS data or derivative data in accordance with the terms of this Contract.

5. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.

6. "Incident" means an act that potentially violates a security policy, which includes successful attempts) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or

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

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

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

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

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

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

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

I. RESPONSIBILITIES OF DHHS AND THE CONTRACTOR

A. Business Use and Disclosure of Confidential Information.

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

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

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

II. METHODS OF SECURE TRANSMISSION OF DATA

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

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

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

III. RETENTION AND DISPOSITION OF IDENTIFIABLE RECORDS

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

A. Retention

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

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

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

B. Disposition

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

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

IV. PROCEDURES FOR SECURITY

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

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

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

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

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

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

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

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

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

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

health information and as applicable under State law.

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

11. Contractor agrees to maintain a documented breach notification and incident response process. The Contractor must notify the DHHS Security Office and the Program Contact via the email addresses provided in Section VI of this Exhibit, immediately upon the Contractor determining that a breach or security incident has occurred and that DHHS confidential Information/data may have been exposed or compromised. This includes a confidential information breach, computer security incident, or suspected breach which affects or includes any State of New Hampshire systems that connect to the State of New Hampshire network.

12. Contractor must restrict access to the Confidential Data obtained under this Contract to only those authorized End Users who need such DHHS Data to perform their official duties in connection with purposes identified in this Contract.

13. The Contractor is responsible for End User oversight and compliance with the terms and conditions of the contract and Exhibit K.

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

V. LOSS REPORTING

The Contractor must immediately notify the State's Privacy Officer, Information Security Office and Program Manager of any Security Incidents and Breaches as specified in Section IV, paragraph 11 above.

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

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

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

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

VI. PERSONS TO CONTACT

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

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

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

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

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