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

Jeffrey A. Meyers
Commissioner

Katja S. Fox
Director

129 PLEASANT STREET, CONCORD, NH 03301
603-271-9544 1-800-852-3345 Ext. 9544
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September 19, 2019

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

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division for Behavioral Health, to **retroactively** exercise a renewal option and amend an existing agreement with Mary Hitchcock Memorial Hospital, Vendor #177160, One Medical Center Drive, Lebanon, NH 03756, to provide integrated obstetric, primary care, pediatric, and Medication Assisted Treatment (MAT) for pregnant and postpartum women with opioid use disorder by increasing the price limitation by $1,499,970 from $2,755,443 to $4,255,413 and by extending the completion date from June 30, 2019 to September 30, 2020, retroactive to June 30, 2019, effective upon Governor and Executive Council approval. 100% Federal Funds.

This agreement was originally approved by the Governor and Executive Council on January 24, 2018 (Item #8 Vote 5-0).

Funds to support this request are anticipated to be available in the following account(s) for State Fiscal Years 2020 and 2021 upon the availability and continued appropriation of funds in the future operating budget, with authority to adjust amounts within the price limitation and adjust encumbrances between State Fiscal Years through the Budget Office, if needed and justified.

05-95-92-920510-25590000 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION FOR BEHAVIORAL HEALTH, BUREAU OF DRUG AND ALCOHOL, OPIOID STR GRANT

SFY	Class/ Account	Class Title	Job Number	Current Modified Budget	Increase/ (Decrease)	Revised Modified Budget
2018	102-500731	Contracts for Program Services	92052559	$ 862,630	$0	$ 862,630
2019	102-500731	Contracts for Program Services	92052559	$1,892,813	$0	$1,892,813
2020	102-500731	Contracts for Program Services	92052559	$0	$600,000	$600,000
			Subtotal	***$2,755,443***	***$600,000***	***$3,355,443***

05-95-92-920510-70400000 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION FOR BEHAVIORAL HEALTH, BUREAU OF DRUG AND ALCOHOL, STATE OPIOID RESPONSE GRANT

SFY	Class/ Account	Class Title	Job Number	Current Modified Budget	Increase/ (Decrease)	Revised Modified Budget
2020	102-500731	Contracts for Program Services	92057040	$ 0	$603,472	$ 603,472
2021	102-500731	Contracts for Program Services	92057040	$0	$296,498	$296,498
			Subtotal	***$0***	***$899,970***	***$899,970***
			Total	**$2,755,443**	**$1,499,970**	**$4,255,413**

EXPLANATION

This request is **retroactive** because additional time was required to address invoice matters that needed to be resolved prior to executing this amendment. The Department also held discussions with the Contractor during this time to identify necessary changes to the scope of work, described below, that will allow the Contractor to achieve desired positive outcomes for the targeted population and service areas.

This purpose of this request is to allow the Contractor to continue to serve their target population and geographic areas without interruption, while revising the project to accurately reflect changes to the scope of services by reducing the number of service sites from eight (8) to six (6). Through the initial agreement, the Contractor collaborated with the Department to identify and approach agencies in geographic areas of need and was able to reach agreement with six (6) of the eight (8) sites proposed and offer services at the following locations: Dartmouth Hitchcock - Keene, Dartmouth Hitchcock - Manchester, Dartmouth Hitchcock - Nashua, Coos County Family Health, Goodwin Community Health - Dover, and Darthmoth Hitchcock - Lebanon. They were unable to reach agreement with two (2) additional providers who were not interested in expanding their services at this time. Changes reflected in this amendment will allow the Contractor to continue to achieve positive outcomes for the women and children served at the six (6) existing sites.

The Contractor will continue to provide integrated obstetric care, primary care, pediatric care and Medication Assisted Treatment (MAT) for pregnant and postpartum women with opioid use disorder and any co-occurring mental health disorders. MAT services will be integrated with prenatal and postpartum care, and provided with parenting support and education at six (6) sites across New Hampshire, including sites in the high need areas of Belknap and Coos Counties where opioid use disorder treatment services are limited.

Approximately 260 individuals served from July 1, 2019 through September 30, 2020.

The original agreement, included language in Exhibit C-1, Revisions to General Provisions, Section 3, Extension, that allows the Department to renew the contract for up to two (2) years, subject to the continued availability of funding, satisfactory performance of service, parties' written authorization and approval from the Governor and Executive Council. The Department is in agreement with renewing services for one (1) year and three (3) months of the two (2) years at this time.

The Contractor delivers services through both a Perinatal Addiction Treatment Program in Lebanon, NH that is integrated with obstetrics/gynecology and pediatric care on-site and at seven (7) other sites which are obstetrical/gynecological practices that are enhanced with Medication Assisted Treatment services and pediatric care.

The State of New Hampshire was awarded funding authorized through the 21st Century CURES Act by the Substance Abuse and Mental Health Services Administration which is overseeing the process for states to receive federal funding through the State Targeted Response to the Opioid Crisis Grants Program. New Hampshire's application is a joint effort by several state agencies and proposes to use evidence-based methods to expand treatment, recovery and prevention services to targeted populations. These critical funds will strengthen established programs that have had a positive impact on the opioid crisis as well as expanding the capacity for programs that have shown promise in helping individuals battling a substance misuse issue and combatting the epidemic in New Hampshire.

In 2018, the State of New Hampshire experienced four hundred seventy-one (471) deaths from drug overdoses. At present, the State is experiencing an increase in the need for population-specific Substance Use Disorder Treatment and Recovery Support Services for pregnant women due to a rise in Neonatal Abstinence Syndrome in infants born to mothers who have used opioids. Babies with this syndrome experience symptoms of drug withdrawal and require special treatment prior to leaving the hospital. It is critical that providers develop integration of services, approaches to meet individual client needs, and approaches to maximize State and Federal dollars to meet the public's demand for these specific services. The services provided by the Contractor will be comprehensive and focused not only on the mother's recovery, but also on ensuring that the infant is receiving the necessary health and social supports and services to mitigate risk associated with maternal opioid use.

Mary Hitchcock Memorial Hospital's effectiveness in delivering services will be measured through monitoring of the following aggregate performance measures on an annual basis:

- Fifty percent (50%) of women referred to the program, who consent to treatment and qualify based on clinical evaluation, will enter opioid use disorder (OUD) treatment as reported by the Contractor.
- Seventy-five percent (75%) of women identified by American Society of Addiction Medicine (ASAM) criteria as in need of a higher level of care will be referred to treatment services in order to increase referral of pregnant and postpartum women to OUD treatment providers as reported by the Contractor.
- Five percent (5%) decline in neonatal abstinence syndrome (NAS) rates of infants born to mothers served in this program, not attributable to the mother taking MAT medications as prescribed, as reported by the Contractor.
- Five percent (5%) decrease in positive urine drug screens for illicit substances for pregnant women served in this program as reported by the Contractor.
- Five percent (5%) decrease in reports to Division for Children, Youth, and Family (DCYF) of substance-exposed infants born to mothers served in this program, not attributable to the mother taking MAT medications as reported by the Contractor and through the use of collected hospital and DCYF data.

Should the Governor and Executive Council not authorize this request, pregnant and postpartum women in New Hampshire diagnosed with opioid use disorder may not receive the support necessary to overcome their addiction which could negatively impact their health and the health of their newborn child(ren).

Area served: Statewide

Source of Funds: 100% Federal Funds. CFDA#93.788 /FAIN# TI080246 and FAIN # TI081685.

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

Respectfully submitted,

Jeffrey A. Meyers
Commissioner

STATE OF NEW HAMPSHIRE
DEPARTMENT OF INFORMATION TECHNOLOGY
27 Hazen Dr., Concord, NH 03301
Fax: 603-271-1516 TDD Access: 1-800-735-2964
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Denis Goulet
Commissioner

September 23, 2019

Jeffrey A. Meyers, Commissioner
Department of Health and Human Services
State of New Hampshire
129 Pleasant Street
Concord, NH 03301

Dear Commissioner Meyers:

This letter represents formal notification that the Department of Information Technology (DoIT) has approved your agency's request to enter into a retroactive contract amendment with Mary Hitchcock Memorial Hospital, of Lebanon NH as described below and referenced as DoIT No. 2018-047A.

> This is a request to enter into a retroactive contract amendment with Mary Hitchcock Memorial Hospital to provide integrated obstetric, primary care, pediatric, and medication assisted treatment for pregnant and postpartum women with substance use disorder (SUD). This will also include utilizing the State's Prescription Drug Monitoring Program (PDMP) database to mitigate prescription drug diversion or harmful interactions.
>
> The funding amount for this amendment is $1,499,970.00, increasing the current contract from $2,755,443.00 to $4,255.413.00, retroactive to June 30, 2019 and by extending the completion date from June 30, 2019 to September 30, 2020, effective upon Governor and Executive Council approval.

A copy of this letter should accompany the Department of Health and Human Services' submission to the Governor and Executive Council for approval.

Sincerely,

Kenneth Dean FOR

Denis Goulet

DG/kaf/ck
DoIT #2018-047A
cc: Bruce Smith, IT Manager, DoIT

State of New Hampshire
Department of Health and Human Services
Amendment #1 to the Integrated Medication Assisted Treatment for Pregnant and Postpartum Women Contract

This 1st Amendment to the Integrated Medication Assisted Treatment for Pregnant and Postpartum Women contract (hereinafter referred to as "Amendment #1") is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Mary Hitchcock Memorial Hospital, (hereinafter referred to as "the Contractor"), a nonprofit corporation with a place of business at Dartmouth-Hitchcock, One Medical Center Drive, Lebanon, NH 03756.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on January 24, 2018, (Item #8), the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended and in consideration of certain sums specified; and

WHEREAS, the State and the Contractor have agreed to make changes to the scope of work, payment schedules or terms and conditions of the contract; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 18, and Exhibit C-1, Revisions to General Provisions, Paragraph 3, 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, and modify the scope of services to support continued delivery of these services; and

WHEREAS, all terms and conditions of the Contract and prior amendments not inconsistent with this Amendment #1 remain in full force and effect; and

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

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

   September 30, 2020.

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

   $4,255,413.

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

   Nathan D. White, Director.

4. Form P-37, General Provisions, Block 1.10, State Agency Telephone Number, to read:

   603-271-9631.

5. Form P-37, General Provisions, Section 14, Insurance, Subsection 14.2, to read:

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

6. Form P-37, General Provisions, Section 15, Workers' Compensation, Subsection 15.2, to read:

   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 as required in N.H. RSA chapter 281-A. Contractor shall furnish the Contracting Officer identified in block 1.9, or his/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.

7. Delete Exhibit A, Scope of Services in its entirety and replace with Exhibit A - Amendment #1, Scope of Services.
8. Add Exhibit B-3, Amendment #1.
9. Add Exhibit B-4, Amendment #1.
10. Delete Exhibit K, DHHS Information Security Requirements, dated 032917, and replace with Exhibit K, DHHS Information Security Requirements, v4, dated October 2018.

This amendment shall be retroactively effective to June 30, 2019, upon the date of Governor and Executive Council approval.

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

State of New Hampshire
Department of Health and Human Services

9/10/19
Date

Name: Katja S. Fox
Title: Director

Mary Hitchcock Memorial Hospital

9/6/19
Date

Name: Edward J. Merrens
Title: Chief Clinical Officer

Acknowledgement of ~~Contractor's~~ Ed Merrens signature:

State of New Hampshire County of Grafton on September 6, 2019, before the undersigned officer, personally appeared the person identified directly above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.

Signature of Notary Public or Justice of the Peace

LAURA K. RONDEAU
STATE OF
NOTARY PUBLIC
NEW HAMPSHIRE
MY COMMISSION EXPIRES APRIL 19, 2022

Laura Rondeau, Notary Public
Name and Title of Notary or Justice of the Peace

My Commission Expires: April 19, 2022

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

OFFICE OF THE ATTORNEY GENERAL

9/13/19
Date

Name: CATHERINE PINOS
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:

Scope of Services

1. Provisions Applicable to All Services

1.1. The Contractor shall submit a detailed description of the language assistance services they will provide to persons with limited English proficiency to ensure meaningful access to their programs and/or services within ten (10) days of the contract effective date.

1.2. The Contractor agrees that, to the extent future legislative action by the New Hampshire General Court or federal or state court orders may have an impact on the Services described herein, the State Agency has the right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance therewith.

2. Scope of Work

2.1. The Contractor shall provide comprehensive Medication Assisted Treatment (MAT) for pregnant and postpartum women diagnosed with opioid use disorder (OUD) and co-occurring mental health disorders, integrated with prenatal and postpartum care, and provide parenting support and education for parents at six (6) sites across the State of New Hampshire, including one (1) in Coos County.

2.2. The Contractor shall deliver the required services in Lebanon through the Dartmouth Hitchcock (D-H) Moms in Recovery Program a comprehensive addiction treatment service with integrated obstetrical/gynecological (OB/Gyn) services and pediatric care offered on-site.

2.3. The Contractor shall ensure delivery of the required services at the five (5) other sites where services shall be offered by OB/Gyn practices that are enhanced with integrated addiction services and pediatric support.

2.4. The Contractor shall provide project management, program consultation, and clinical consultation through their D-H Center for Addiction Recovery in Pregnancy and Parenting team to each site.

2.5. The Contractor shall provide services at all six (6) sites including, but not limited to:

2.5.1. On-site family support for children.

2.5.2. Peer recovery coaches.

2.5.3. Resource/Employment specialists.

2.5.4. Case management/Care coordination.

2.5.5. Parenting education groups.

2.5.6. Health education.

2.5.7. Social supports including, but not limited to access and/or referrals to food, housing, and transportation services.

2.6. The Contractor shall employ a licensed behavioral health clinician whose responsibilities shall include, but not be limited to:

2.6.1. Providing necessary supervision at each site.

2.6.2. Supporting and mentoring for weekly MAT visits.

2.6.3. Supporting and mentoring of the leadership providing group therapy for participating women.

2.6.4. Collaborating with each site to identify or develop behavioral health resources in the local community.

2.7. The Contractor shall ensure each site:

2.7.1. Identifies a minimum of one (1) waivered provider to prescribe buprenorphine.

2.7.2. Provides consultative phone calls over a twelve (12)-month period in a frequency determined necessary by the providers and the Contractor.

2.8. The Contractor shall provide services through the D-H Moms in Recovery Program which include, but are not limited to:

2.8.1. Collaborating with the Family Resource Centers, whose services include, but are not limited to:

2.8.1.1. Home visiting.

2.8.1.2. Lactation support.

2.8.1.3. Case management.

2.8.2. Providing parent education groups to program participants on a regular basis which integrate the parenting education curriculum with addiction treatment, so that participants have the opportunity to learn about the impact of substance use on family functioning and healthy child development.

2.8.3. Providing educational sessions to all pregnancy groups which include, but are not limited to "The Period of Purple Crying," safe sleep practices, and car seat safety and are integrated with newborn nursery and outpatient pediatric follow up.

2.8.4. Collaborating with Continuum of Care Coordinators as part of Region 1 Integrated Delivery Network (IDN).

2.8.5. Participating in the Boyle Program, which co-sponsors and facilitates the Child Focus Forum, a bi-monthly collaborative of medical, governmental and community agencies serving parents and children.

2.8.6. Offering co-located child "play time," which provides supportive child engagement that allows women to participate fully in group therapy and receive care without distraction.

2.8.7. Sponsoring co-location of resources such as a food pantry, infant books, and diaper bank through active partnerships with community agencies such as The Upper Valley Haven and The Family Place.

2.9. The Contractor shall ensure patient-centered, effective, integrated care and attention to overdose prevention by employing educational materials which include, but are not limited to:

2.9.1. Center for Disease Control (CDC) opioid prescribing guidelines.

2.9.2. Substance Abuse and Mental Health Services Administration's (SAMHSA's) Opioid Overdose Prevention Toolkit.

2.9.3. State-published Guidance Document on Best Practices: Key Components for Delivering Community Based Medication Assisted Treatment Services for Opioid Use Disorders in New Hampshire.

2.9.4. Care guidelines for OB/GYN providers and delivery hospitals developed by the Northern New England Perinatal Quality Improvement Network (NNEPQIN).

2.10. The Contractor shall provide interim OUD treatment services when the needed treatment services are not available to the participant within forty-eight (48) hours of referral.

2.11. The Contractor shall provide OUD treatment services that support the Resiliency and Recovery Oriented Systems of Care (RROSC) by operationalizing the Continuum of Care Model. (More information can be found at http://www.dhhs.nh.gov/dcbcs/bdas/continuum-of-care.htm.)

2.12. The Contractor shall ensure that participants are able to easily transition between levels of care within a group of services which includes, but is not limited to:

2.12.1. Working with the Continuum of Care Facilitator(s) in the development of a resiliency and recovery oriented system of care (RROSC) in the region(s).

2.12.2. Participating in the Regional Continuum of Care Workgroup(s).

2.12.3. Participating in the Integrated Delivery Network(s) (IDNs).

2.12.4. Working with the Doorways system.

2.13. The Contractor shall ensure ongoing communication and care coordination with entities involved in the participants' care including child protective services, treatment providers, home visiting services, and pediatric providers.

2.14. The Contractor shall actively participate in the Regional Continuum of Care and IDN Region 1, and maintain good relationships with relevant community partners.

2.15. The Contractor shall assist enhanced sites with hiring for any vacant position for a Recovery Coach to help participants locate community resources including, but not limited to local recovery centers, peer support meetings, and transitional housing.

2.16. The Contractor shall assist enhanced sites with collaborating with their local/regional Continuum of Care Facilitators and leaders of their regional Integrated Delivery Networks to ensure alignment and coordination across these service networks.

2.17. The Contractor shall collaborate with each enhanced site to modify workflows and electronic records processes to ensure screening and required data collection.

2.18. The Contractor shall modify the obstetrics office electronic health record (EHR) and clinical work flow to ensure required screening activities by OB staff and appropriate required data collection by care coordinators.

2.19. The Contractor shall utilize the State's Prescription Drug Monitoring Program (PDMP) database to mitigate prescription drug diversion or harmful interactions and shall assess each enhanced site's use and support them to develop protocols to monitor the PDMP regularly.

2.20. The Contractor shall ensure that D-H Lebanon Addiction Treatment Program protocol for PDMP monitoring includes, but is not limited to, reviewing the PDMP at a patient's first visit and the day before each subsequent visit.

2.21. The Contractor shall develop and implement outreach activities, which may include marketing designed to engage pregnant women with an OUD in the community. The Contractor and Contractor's sites are not required to market themselves publicly as substance use disorder treatment centers. The Contractor shall:

2.21.1. Ensure that their staff at the Center for Addiction Recovery in Pregnancy and Parenting collaborate with the appropriate D-H department to develop appropriate materials and methods to promote the program throughout their service areas.

2.21.2. Collaborate with each implementing site to ensure marketing materials, if any, and outreach methods used, are consistent with the Contractor's standards and policies in its discretion.

2.21.3. Actively engage with referral networks in the service areas to increase awareness of the program with pregnant women with OUD and to enable the program to be utilized to its greatest capacity.

2.22. The Contractor shall maintain formal and effective partnerships with behavioral health, OUD specialty treatment and Recovery Support Services (RSS), and medical practitioners to meet the needs of the target population and the goals of MAT Expansion.

2.23. The Contractor shall ensure meaningful input of consumers in program assessment, planning, implementation, and improvement which includes, but is not limited to:

2.23.1. Using their Patient Advisory Board, which meets quarterly and is composed of participants in long-term recovery.

2.23.2. Engaging participants in all stages of recovery in the development of key program elements through focus groups and targeted interviews.

2.24. The Contractor shall ensure that treatment is provided in a child-friendly environment with childcare support available to participants which includes, but is not limited to:

2.24.1. Developmentally-appropriate childcare support as well as integration with pediatric and developmental services at all enhanced sites.

2.24.2. Co-located child "Play Time" where children engage in developmentally appropriate play while their mothers participate in group treatment and receive care in both Lebanon and Keene.

2.24.3. On-site well-child care at D-H Lebanon Moms in Recovery Program.

2.25. The Contractor shall ensure participants' transportation needs are met to maintain participant involvement in the program by utilizing a Resource Specialist whose duties related to transportation may include, but not be limited to:

2.25.1. Assisting participants to enroll in Medicaid transportation services.

2.25.2. Developing a network of support to help with transportation needs.

2.25.3. Identifying resources to help participants to obtain a valid driver's license or an affordable car loan.

2.25.4. Finding housing in close proximity to social services.

2.26. The Contractor shall use data to support quality improvement including, but not limited to:

2.26.1. Developing, disseminating, and implementing best practices for pregnant and parenting women with OUD.

2.26.2. Collecting data on participant demographics and more than thirty (30) key perinatal, neonatal, and treatment outcomes for all program participants, using a REDCap database designed for this purpose.

2.26.2.1. REDCap allows de-identified, participant-level data to be entered remotely by sites.

2.26.2.2. Data shall be entered for each participant from the time of entry into the program until three (3) months postpartum. For example, a participant entering care in the late first trimester, data would entered at entry to care, at 24-28 weeks of pregnancy, at delivery, and at three (3) months postpartum.

2.26.2.3. Data shall be utilized for quality improvement purposes and program evaluation, as well as development of targeted services at all sites.

2.26.3. Collecting data on key measures identified by the Department and the Contractor's multidisciplinary stakeholder group and using the data to track performance.

2.26.3.1. The existing REDCap database shall be expanded as needed to include additional measures identified by the Department.

2.26.3.2. Site specific data shall be reviewed quarterly.

2.26.4. Reporting data to sites quarterly and addressing areas flagged for improvement both directly through discussion and process improvement at the individual practice level and through learning collaborative sessions with multiple practices.

2.26.5. Employing a research assistant to support sites with data entry challenges and ensure data quality.

2.26.6. Analyzing the data and promoting quality improvement efforts.

2.27. The Contractor shall maintain the infrastructure necessary to achieve the goals of MAT Expansion for the target population, to meet SAMHSA requirements, and to deliver effective medical care to pregnant and postpartum women with an OUD.

2.28. The Contractor shall participate in the State-funded "Community of Practice for MAT" along with other State-funded projects which include, but are not limited to:

2.28.1. Project-specific trainings.

2.28.2. Quarterly web-based discussions.

2.28.3. On-site Technical Assistance (TA) visits.

2.28.4. Ad hoc communication with expert consultants on MAT clinical care topics such as Hepatitis C Virus (HCV) and Human Immunodeficiency Virus (HIV) prevention, diversion risk mitigation, and other relevant issues.

2.29. The Contractor shall participate in the development of a Safe Plan of Care with birth attendants and the New Hampshire Division of Children, Youth, and Families (DCYF) for each infant affected by illegal substance use, withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder, which includes, but is not limited to:

2.29.1. Employing a social worker to work with clients in this program.

2.29.2. Ensuring that planning and communication regarding the Safe Plan of Care will also involve other community agency supports including, but not limited to home visitation, WIC, housing, and other services central to recovery and parenting.

2.30. The Contractor shall establish formal agreements with hospitals to aid in preparing the hospital system with the clinical policies and procedures necessary to address neonatal abstinence syndrome in the newborn while supporting the mother's recovery.

2.30.1. The Contractor shall engage with the NNEPQIN learning collaborative, the organization that has developed policies and procedures to effectively address neonatal abstinence syndrome while supporting the mother's recovery.

2.31. The Contractor shall have billing capabilities which include, but are not limited to:

2.31.1. Enrolling with Medicaid and other third party payers.

2.31.2. Contracting with managed care organizations and insurance companies for MAT and delivery of prenatal care.

2.31.3. Having a proper understanding of the hierarchy of the billing process.

2.32. The Contractor shall assist the participant with obtaining either on-site or off-site RSS's including, but not limited to:

2.32.1. Transportation.

2.32.2. Childcare.

2.32.3. Peer support groups.

2.32.4. Recovery coach.

2.33. The Contractor shall use the New Hampshire Alcohol and Drug Treatment Locator (http://www.nhtreatment.org) and Doorways to identify specific services that are available by location, population, and payer to enable patient choice.

2.34. The Contractor shall establish agreements with specialty treatment organizations that can provide higher levels of OUD treatment and co-occurring mental health treatment.

2.35. The Contractor shall deliver parenting and personal development education using evidence-based curriculum including, but not limited to:

2.35.1. Marsha Linehan's Dialectical Behavior Therapy approach to treatment and Lisa Najavits' Seeking Safety curriculum to increase emotion regulation skills in participants to address Post-Traumatic Stress Disorder (PTSD) symptoms and decrease emotional vulnerability that could lead to relapse.

2.35.2. SAMHSA materials, 12-Step information, and other materials that the program has developed to increase participants' knowledge of the disease model of addiction and to enhance understanding of biological vulnerability and the progression of addiction.

2.35.3. Cognitive Behavioral Therapy (CBT), SAMSHA materials, 12-Step materials, and mindfulness-based stress reduction approaches to bolster relapse prevention strategies and improve resiliency.

2.35.4. Duluth Model Domestic Abuse Intervention Programs and Dialectical Behavior Therapy (DBT) to promote healthy relationships and decrease risk of interpersonal violence.

2.35.5. Circle of Security and the Nurturing Program for Families in Substance Abuse Treatment and Recovery curricula to increase parent-child attachment and increase parents' knowledge of healthy child development.

2.36. The Contractor shall improve participants' access to a sober network of support and increased resiliency to relapse which includes, but is not limited to.

2.36.1. Utilizing an on-site Recovery Coach who participates in group therapy sessions and engages one-on-one with participants to provide additional support between sessions.

2.36.2. Inviting representatives from 12-Step groups and peer-run recovery groups on a regular basis to speak to participants.

2.37. The Contractor shall refer relapsing participants to residential or intensive outpatient care and provide support for accessing appropriate services including, but not limited to follow-up care after intensive treatment services are completed.

2.38. The Contractor shall provide parenting supports to participants including, but not limited to:

2.38.1. Parenting groups.

2.38.2. Childbirth education.

2.38.3. Safe sleep education.

2.39. The Contractor shall collaborate with other providers that offer services to pregnant women with an OUD including, but not limited to programs funded by the Cures Act resources for similar populations.

2.40. The Contractor shall ensure compliance with confidentiality requirements, which include, but are not limited to:

2.40.1. Applicable federal and state laws.

2.40.2. HIPAA Privacy Rule.

2.40.3. 42 C.F.R Part 2.

2.40.3.1. The D-H Moms in Recovery Program shall be required to follow 42 C.F.R Part 2 rules.

2.40.3.2. The OB/Gyn programs that will be enhanced with integrated addiction services are not required to follow 42 C.F.R. Part 2.

2.41. The Contractor shall participate in all evaluation activities associated with the funding opportunity, including national evaluations.

2.42. The Contractor shall submit an updated work plan to the Department for review and approval, which describes the process for ensuring the completion of all aspects of the Scope of Services (Section 2), Staffing (Section 3), and Training (Section 4) as outlined in this Contract within thirty (30) days of Governor and Executive Council approval of the Contract.

2.43. The Contractor shall maintain policies and procedures and have regular required employee training (at least annually) in the areas of ethical conduct, confidentiality, compliance, cyber security, and conflict of interest.

3. Staffing

3.1. The Contractor shall meet the minimum MAT team staffing requirements to provide the Scope of Services which includes, but is not limited to at least one (1):

3.1.1. Waivered prescriber.

3.1.2. Masters Licensed Alcohol and Drug Counselor (MLADC) or behavioral health provider with addiction training.

3.1.3. Obstetrician or midwife.

3.1.4. Care coordinator.

3.1.5. Non-clinical/administrative staff.

3.2. The Contractor shall ensure that all unlicensed staff providing treatment, education, and/or recovery support services are under the direct supervision of a licensed supervisor.

3.3. The Contractor shall ensure that no licensed supervisor oversees more than eight (8) unlicensed staff, unless the Department has approved an alternative supervision plan.

3.4. The Contractor shall ensure that at least one Certified Recovery Support Worker (CRSW) is available for every fifty (50) participants or portion thereof.

3.5. The Contractor shall ensure that unlicensed staff providing clinical or recovery support services must hold a CRSW within six (6) months of hire or from the effective date of this contract, whichever is later.

4. Training

4.1. The Contractor shall make available initial and on-going training resources to all staff including, but not limited to buprenorphine waiver training for physicians, nurse practitioners, and physician assistants. The Contractor shall develop a plan for Department approval to train and engage appropriate staff.

4.2. The Contractor shall participate in training and technical assistant activities as directed by the Department including, but not limited to the Community of Practice for MAT which may include, but is not limited to:

4.2.1. Project-specific trainings.

4.2.2. Quarterly web-based discussions.

4.2.3. On-site technical assistance visits.

4.2.4. Ad hoc communication with expert consultants regarding MAT clinical care topics including, but not limited to:

4.2.4.1. HCV and HIV prevention.

4.2.4.2. Diversion risk mitigation.

4.2.4.3. Other relevant issues.

4.3. The Contractor shall train staff on relevant topics which may include, but are not limited to:

4.3.1. Integrated care.

4.3.2. Trauma-informed care.

4.3.3. MAT (e.g. prescriber training for buprenorphine).

4.3.4. Care coordination.

4.3.5. Trauma-informed wrap around care/RSS delivery best practices.

4.3.6. Evidence-Based Practices (EBPs) such as Screening, Brief Intervention, and Referral to Treatment (SBIRT).

4.3.7. Buprenorphine waiver trainings, available locally and at websites including, but not limited to:

4.3.7.1. https://www.samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training

4.3.7.2. https://www.asam.org/education/live-online-cme/buprenorphine-course

4.3.7.3. https://aanp.inreachce.com/Details?groupId=714cb0a9-73b2-4daf-8382-27cbdb70ef5a

4.3.8. Cognitive behavioral therapy, dialectical behavior therapy, motivational enhancement therapy, mindfulness, and relapse prevention.

4.4. The Contractor shall provide ongoing supervision for buprenorphine prescribers with access to consultation from experienced providers.

4.5. The Contractor's Center for Addiction Recovery in Pregnancy and Parenting shall offer online training, CME/CNE events, and monthly learning collaboratives to each practice including, but not limited to:

4.5.1.1. Toolkit of training materials.

4.5.1.2. Weekly team meetings on day of clinic facilitated by the behavioral health clinician.

4.5.1.3. Monthly webinar learning collaboratives for all participating practices with rotating topics

4.5.1.4. Quarterly in-person gatherings for all participating practices, focused on relationship building and sharing of experiences, hosted at rotating locations to maximize participation.

4.5.1.5. Annual CME event aimed at all staff involved in this model of care.

4.6. The Contractor shall collaborate with the Doorways to provide assistance to all sites regarding training and logistics for the distribution of naloxone kits to patients and family members.

4.7. The Contractor shall assist practice staff in attending the following externally provided formal trainings:

4.7.1. CRSW training for prospective Recovery Coaches

4.7.2. Buprenorphine training for MDs/PAs/ARNPs

4.7.3. Smoking cessation training for any interested staff

4.7.4. Motivational Interviewing training for any interested staff

4.7.5. Additional trainings on trauma-informed care and other evidence based treatment strategies as indicated

5. Reporting

5.1. The Contractor shall gather, monitor, and submit participant data to the Department monthly. Participant data will be submitted in de-identified, aggregate form to the Department using a Department-approved method. The data being collected includes all data points required in the Treatment Episode Data for Admissions.

5.2. The Contractor shall report on federally-required data points specific to this funding opportunity quarterly and send the results in de-identified, aggregate form to the Department using a Department-approved method. The required data points include, but are not limited to:

5.2.1. Number of participants with OUD's:

5.2.1.1. In total.

5.2.1.2. Receiving integrated MAT with prenatal care.

5.2.1.3. Receiving care coordination/case management.

5.2.1.4. Receiving peer recovery support services.

5.2.1.5. Participating in parenting education programming.

5.2.1.6. Referred to or placed in recovery housing.

5.2.1.7. Referred to higher levels of care.

5.2.2. Number of providers in the program implementing MAT.

5.2.3. Number of OUD prevention and treatment providers trained by the program including, but not limited to Nurse Practitioners, Physician's Assistants, physicians, nurses, counselors, social workers, and case managers.

5.2.4. Numbers and rates of opioid overdose-related deaths within population served.

5.2.5. Number of children receiving childcare services by MAT program.

5.2.6. Number of infants in the program born with NAS not attributable to the mother taking prescribed MAT medications.

5.2.7. Number of referrals made to DCYF for substance-exposed infants not attributable to the mother taking prescribed MAT medications.

5.3. The Contractor shall require that all MAT-providing implementation sites report on the data points specified by the Department, utilizing a standardized protocol.

5.3.1. Each site will have exclusive access to protected health information for its own participants, and REDCap will be used to facilitate reporting of de-identified, aggregated data.

5.3.2. The Contractor shall provide a research assistant to help sites develop and implement appropriate site-specific data collection strategies to ensure compliance with reporting protocols.

5.4. The Contractor shall provide a final report to the Department within thirty (30) days of the termination of the contract which will include the following de-identified information based on the work plan progress, but shall not be limited to:

5.4.1. Policies and practices established.

5.4.2. Outreach activities.

5.4.3. Demographics of participants.

5.4.4. Outcome data (as directed by the Department).

5.4.5. Participant satisfaction.

5.4.6. Description of challenges encountered and action taken.

5.4.7. Other progress to date.

5.4.8. A sustainability plan to continue to provide MAT services to the target population beyond the completion date of the contract, subject to approval by the Department.

5.5. The Contractor shall provide a report to the Department regarding critical incidents and sentinel events which include, but are not limited to:

5.5.1. All critical incidents to the Department in writing as soon as possible and no more than 24 hours following the incident. The Contractor agrees that:

5.5.1.1. "Critical incident" means any actual or alleged event or situation that creates a significant risk of substantial or serious harm to physical or mental health, safety, or well- being, including but not limited to:

5.5.1.1.1. Abuse;

5.5.1.1.2. Neglect;

5.5.1.1.3. Exploitation;

5.5.1.1.4. Rights violation;

5.5.1.1.5. Missing person;

5.5.1.1.6. Medical emergency;

5.5.1.1.7. Restraint; or

5.5.1.1.8. Medical error.

5.5.2. All contact with law enforcement to the Department in writing as soon as possible and no more than 24 hours following the incident.

5.5.3. All media contacts to the Department in writing as soon as possible and no more than 24 hours following the incident.

5.5.4. Sentinel events to the Department as follows:

5.5.4.1. Sentinel events shall be reported when they involve any individual who is receiving services under this contract.

5.5.4.2. Upon discovering the event, the Contractor shall provide immediate verbal notification of the event to the Department, which shall include:

5.5.4.2.1. The reporting individual's name, phone number, and agency/organization.

5.5.4.2.2. Name and date of birth (DOB) of the individual(s) involved in the event.

5.5.4.2.3. Location, date, and time of the event.

5.5.4.2.4. Description of the event, including what, when, where, how the event happened, and other relevant information, as well as the identification of any other individuals involved.

5.5.4.2.5. Whether the police were involved due to a crime or suspected crime.

5.5.4.2.6. The identification of any media that had reported the event.

5.5.4.3. Within 72 hours of the sentinel event, the Contractor shall submit a completed "Sentinel Event Reporting Form" (February 2017), available at https://www.dhhs.nh.gov/dcbcs/documents/reporting-form.pdf to the Department.

5.5.4.4. Additional information on the event that is discovered after filing the form in Section1.9.4.3. above shall be reported to the Department, in writing, as it becomes available or upon request of the Department; and

5.5.4.5. Submit additional information regarding Sections 5.5.4.1 through 5.5.4.4 above if required by the department; and

5.5.4.6. Report the event in Sections 5.5.4.1 through 5.5.4.4 above, as applicable, to other agencies as required by law.

6. Performance Measures

6.1. The following aggregate performance indicators are to be annually achieved and monitored monthly to measure the effectiveness of the agreement:

6.1.1. The Contractor shall ensure that fifty percent (50%) of women referred to the program who consent to treatment and qualify based on clinical evaluation will enter OUD treatment as reported by the Contractor.

6.1.2. The Contractor shall ensure seventy-five percent (75%) of women identified by ASAM criteria as in need of a higher level of care will be referred to treatment services in order to increase referral of pregnant and postpartum women to OUD treatment providers as reported by the Contractor.

6.1.3. The Contractor shall attempt to ensure that NAS rates of infants born to mothers served in this program not attributable to the mother taking MAT medications as prescribed will decline by five percent (5%) from SFY18 to SFY19 as reported by the Contractor.

6.1.4. The Contractor shall attempt to lower positive urine drug screens for illicit substances for pregnant women served in this program by five percent (5%) from SFY18 to SFY19 as reported by the Contractor.

6.1.5. The Contractor shall seek to help lower reports to DCYF of substance-exposed infants born to mothers served in this program, not attributable to the mother taking MAT medications as prescribed by five percent (5%) from SFY18 to SFY19. This performance measure will be reported by the Contractor and through the use of collected hospital and DCYF data.

6.2. Annually, the Contractor shall develop and submit to the Department, a corrective action plan for any performance measure that was not achieved.

New Hampshire Department of Health and Human Services

Contractor name: Mary Hitchcock Memorial Hospital

Budget Request for: Integrated Medication Assisted Treatment for Pregnant and Postpartum Women

Budget Period: SFY20 (7/1/19-6/30/20)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share			
	Direct Incremental	Indirect Fixed	Total	Direct Incremental	Indirect Fixed	Total	Direct Incremental	Indirect Fixed		Total
1. Total Salary/Wages	$ 509,874	$ 140,393	$ 650,267	$ -	$ -	$ -	$ 509,874	$ 140,393	$	650,267
2. Employee Benefits	$ 141,341	$ 41,413	$ 182,753	$ -	$ -	$ -	$ 141,341	$ 41,413	$	182,753
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$	-
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$	-
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$	-
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$	-
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$	-
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$	-
Educational	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$	-
Lab	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$	-
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$	-
Medical	$ 9,360	$ 2,742	$ 12,102	$ -	$ -	$ -	$ 9,360	$ 2,742	$	12,102
Office	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$	-
6. Travel	$ 5,892	$ 1,726	$ 7,618	$ -	$ -	$ -	$ 5,892	$ 1,726	$	7,618
7. Occupancy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$	-
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$	-
Telephone	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$	-
Postage	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$	-
Subscriptions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$	-
Audit and Legal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$	-
Insurance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$	-
Board Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$	-
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$	-
10. Marketing/Communications	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$	-
11. Staff Education and Training	$ 58,500	$ 17,141	$ 75,641	$ -	$ -	$ -	$ 58,500	$ 17,141	$	75,641
12. Subcontracts/Agreements	$ 237,895	$ 21,975	$ 259,870	$ -	$ -	$ -	$ 237,895	$ 21,975	$	259,870
13. Other (specify details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$	-
Patient Education Materials	$ 4,811	$ 1,410	$ 6,220	$ -	$ -	$ -	$ 4,811	$ 1,410	$	6,220
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$	-
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$	-
TOTAL	$ 967,672	$ 234,800	$ 1,203,472	$ -	$ -	$ -	$ 967,672.39	$ 234,799.74	$	1,203,472.13
Indirect As A Percent of Direct		24.4%								

Mary Hitchcock Memorial Hospital
RFP-2018-BOAS-05-INTEG
Exhibit B-3 - Amendment #1
Page 1 of 1

Contractor Initials

Date 9/6/19

New Hampshire Department of Health and Human Services

Contractor name: Mary Hitchcock Memorial Hospital

Budget Request for: Integrated Medication Assisted Treatment for Pregnant and Postpartum Women

Budget Period: SFY21 (7/1/20-6/30/20)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct Incremental	Indirect Fixed	Total	Direct Incremental	Indirect Fixed	Total	Direct Incremental	Indirect Fixed	Total
1. Total Salary/Wages	$ 129,893	$ 36,059	$ 167,952	$ -	$ -	$ -	$ 129,893	$ 36,059	$ 167,952
2. Employee Benefits	$ 34,928	$ 10,234	$ 45,162	$ -	$ -	$ -	$ 34,928	$ 10,234	$ 45,162
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Educational	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Lab	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medical	$ 2,340	$ 686	$ 3,026	$ -	$ -	$ -	$ 2,340	$ 686	$ 3,026
Office	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6. Travel	$ 1,473	$ 432	$ 1,905	$ -	$ -	$ -	$ 1,473	$ 432	$ 1,905
7. Occupancy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Telephone	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Postage	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subscriptions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Audit and Legal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Board Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11. Staff Education and Training	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12. Subcontracts/Agreements	$ 59,474	$ 17,426	$ 76,900	$ -	$ -	$ -	$ 59,474	$ 17,426	$ 76,900
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Patient Education Materials	$ 1,203	$ 352	$ 1,555	$ -	$ -	$ -	$ 1,203	$ 352	$ 1,555
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 229,310	$ 67,189	$ 296,499	$ -	$ -	$ -	$ 229,310.33	$ 67,187.83	$ 296,498.34
Indirect As A Percent of Direct		29.3%							

Contractor Initials: ZM

Date: 9/6/19

DEPARTMENT OF HEALTH & HUMAN SERVICES

Program Support Center
Financial Management Portfolio
Cost Allocation Services

26 Federal Plaza, Room 41-122
New York, NY 10278
PHONE: (212) 264-2069
EMAIL: CAS-NY@psc.hhs.gov

June 23, 2015

Ms. Tina E. Naimie
Vice President-Corporate Finance
Mary Hitchcock Memorial Hospital
One Medical Center Drive
Lebanon, New Hampshire 03756-0001

Dear Ms. Naimie:

A copy of an indirect cost rate agreement is being sent to you for signature. This agreement reflects an understanding reached between your organization and a member of my staff concerning the rate(s) that may be used to support your claim for indirect costs on grants and contracts with the Federal Government.

Please have the agreement signed by an authorized representative of your organization and return within ten business days of receipt. The signed agreement should be emailed to CAS-NY@psc.hhs.gov, while retaining a copy for your files. We will reproduce and distribute the agreement to the appropriate awarding organizations of the Federal Government for their use only when the signed agreement is returned.

An indirect cost proposal, together with the supporting information, is required to substantiate your claim for indirect costs under grants and contracts awarded by the Federal Government. Thus, your next proposal based on actual costs for the fiscal year ending 6/30/2017 is due in our office by 12/31/2017. Please submit your next proposal electronically via email to CAS-NY@psc.hhs.gov.

Sincerely,
Darryl W. Mayes -S

Darryl W. Mayes
Deputy Director
Cost Allocation Services

Enclosure

PLEASE SIGN AND RETURN THE NEGOTIATION AGREEMENT BY EMAIL

HOSPITALS RATE AGREEMENT

EIN: 1020222140A1

ORGANIZATION:
Dartmouth-Hitchcock
Mary Hitchcock Memorial Hospital
One Medical Center Drive
Lebanon, NH 03756-

DATE:06/23/2015

FILING REF.: The preceding agreement was dated 03/27/2014

The rates approved in this agreement are for use on grants, contracts and other agreements with the Federal Government, subject to the conditions in Section III.

SECTION I: INDIRECT COST RATES

RATE TYPES: FIXED FINAL PROV. (PROVISIONAL) PRED. (PREDETERMINED)

EFFECTIVE PERIOD

TYPE	FROM	TO	RATE(%)	LOCATION	APPLICABLE TO
PRED.	07/01/2015	06/30/2018	29.30	On-Site	Other Sponsored Programs
PROV.	07/01/2018	06/30/2020	29.30	On-Site	Other Sponsored Programs

*BASE

Total direct costs excluding capital expenditures (buildings, individual items of equipment; alterations and renovations), that portion of each subaward in excess of $25,000; hospitalization and other fees associated with patient care whether the services are obtained from an owned, related or third party hospital or other medical facility; rental/maintenance of off-site activities; student tuition remission and student support costs (e,g., student aid, stipends, dependency allowances, scholarships, fellowships).

ORGANIZATION: Dartmouth-Hitchcock

AGREEMENT DATE: 6/23/2015

SECTION II: SPECIAL REMARKS

TREATMENT OF FRINGE BENEFITS:

Fringe Benefits applicable to direct salaries and wages are treated as direct costs.

TREATMENT OF PAID ABSENCES

Vacation, holiday, sick leave pay and other paid absences are included in salaries and wages and are claimed on grants, contracts and other agreements as part of the normal cost for salaries and wages. Separate claims are not made for the cost of these paid absences.

Equipment means an article of nonexpendable, tangible person property having a useful life of more than two years, and an acquisition cost of $2,000 or more per unit.

Your next proposal based upon fiscal year ending 6/30/17 is due by 12/31/17.

ORGANIZATION: Dartmouth-Hitchcock

AGREEMENT DATE: 6/23/2015

SECTION III: GENERAL

A. LIMITATIONS:

The rates in this Agreement are subject to any statutory or administrative limitations and apply to a given grant, contract or other agreement only to the extent that funds are available. Acceptance of the rates is subject to the following conditions: (1) Only costs incurred by the organization were included in its indirect cost pool as finally accepted; such costs are legal obligations of the organization and are allowable under the governing cost principles; (2) The same costs that have been treated as indirect costs are not claimed as direct costs; (3) Similar types of costs have been accorded consistent accounting treatment; and (4) The information provided by the organization which was used to establish the rates is not later found to be materially incomplete or inaccurate by the Federal Government. In such situations the rate(s) would be subject to renegotiation at the discretion of the Federal Government.

B. ACCOUNTING CHANGES:

This Agreement is based on the accounting system purported by the organization to be in effect during the Agreement period. Changes to the method of accounting for costs which affect the amount of reimbursement resulting from the use of this Agreement require prior approval of the authorized representative of the cognizant agency. Such changes include, but are not limited to, changes in the charging of a particular type of cost from indirect to direct. Failure to obtain approval may result in cost disallowances.

C. FIXED RATES:

If a fixed rate is in this Agreement, it is based on an estimate of the costs for the period covered by the rate. When the actual costs for this period are determined, an adjustment will be made to a rate of a future year(s) to compensate for the difference between the costs used to establish the fixed rate and actual costs.

D. USE BY OTHER FEDERAL AGENCIES:

The rates in this Agreement were approved in accordance with the cost principles promulgated by the Department of Health and Human Services, and should be applied to the grants, contracts and other agreements covered by these regulations subject to any limitations in A above. The hospital may provide copies of the Agreement to other Federal Agencies to give them early notification of the Agreement.

E. OTHER:

If any Federal contract, grant or other agreement is reimbursing indirect costs by a means other than the approved rate(s) in this Agreement, the organization should (1) credit such costs to the affected programs, and (2) apply the approved rate(s) to the appropriate base to identify the proper amount of indirect costs allocable to these programs.

BY THE INSTITUTION:	ON BEHALF OF THE FEDERAL GOVERNMENT:
Dartmouth-Hitchcock Mary Hitchcock Memorial Hospital	DEPARTMENT OF HEALTH AND HUMAN SERVICES
(INSTITUTION)	(AGENCY) Darryl W. Mayes -S
(SIGNATURE)	(SIGNATURE)
Robin Kilfeather-Mackey	Darryl W. Mayes
(NAME)	(NAME)
Chief Financial Officer	Deputy Director, Cost Allocation Services
(TITLE)	(TITLE)
7/15/15	6/23/2015
(DATE)	(DATE) 1324

HHS REPRESENTATIVE: Louis Martillotti

Telephone: (212) 264-2069

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 Dataand any derivative of the data for the duration of this Contract. After such time, the Contractor will have 30 days to destroy the data and any derivative in whatever form it may exist, unless, otherwise required by law or 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.

Contractor Initials

Date 9/4/19

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 and 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, knowingly or unknowingly, any State of New Hampshire or Department data offshore or outside the boundaries of the United States unless prior express written consent is obtained from the Information Security Office leadership member within the Department.

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 will notify the State's Privacy Officer, and additional email addresses provided in this section, of any security breach within 24-hours of the time that

the Contractor learns of its occurrence. 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 notify the State's Privacy Officer, Information Security Office and Program Manager of any Security Incidents and Breaches within 24- hours of the time that the Contractor learns of their occurrence.

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.

Contractor Initials _____

Date 9/4/19

VI. PERSONS TO CONTACT

A. DHHS contact program and policy:

(Insert Office or Program Name)
(Insert Title)
DHHS-Contracts@dhhs.nh.gov

B. DHHS contact for Data Management or Data Exchange issues:

DHHSInformationSecurityOffice@dhhs.nh.gov

C. DHHS contacts for Privacy issues:

DHHSPrivacyOfficer@dhhs.nh.gov

D. DHHS contact for Information Security issues:

DHHSInformationSecurityOffice@dhhs.nh.gov

E. DHHS contact for Breach notifications:

DHHSInformationSecurityOffice@dhhs.nh.gov

DHHSPrivacy.Officer@dhhs.nh.gov

Contractor Initials

Date 9/6/19

State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that 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: **0004496386**

IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 15th day of April A.D. 2019.

William M. Gardner

Secretary of State

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

CERTIFICATE OF VOTE/AUTHORITY

I, Charles G. Plimpton, of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital, do hereby certify that:

1. I am the duly elected Secretary and Treasurer 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 December 7th, 2012 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."
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.

IN WITNESS WHEREOF, I have hereunto set my hand as the Secretary and Treasurer of the Board of Trustees of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital this 6th day of September 2019

Charles G. Plimpton
Board of Trustees, Secretary/Treasurer

STATE OF NH

COUNTY OF GRAFTON

The foregoing instrument was acknowledged before me this 6th day of September, by Charles Plimpton.

Notary Public
My Commission Expires: 9-21-2021

FAITH E. JOHNSTON
MY COMMISSION EXPIRES SEPT. 21, 2021
NOTARY PUBLIC NEW HAMPSHIRE

CERTIFICATE OF INSURANCE

DATE: 09/17/2019

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 – DH-H
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		0002019-A	07/01/2019	06/30/2020	EACH OCCURRENCE	$1,000,000
					DAMAGE TO RENTED PREMISES	$100,000
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		0002019-A	07/01/2019	06/30/2020	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)

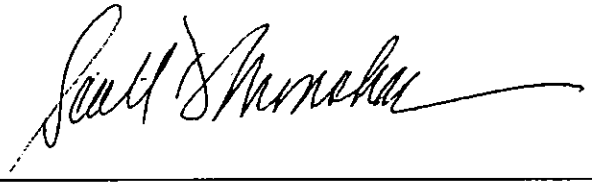
Certificate of Insurance issued as evidence of insurance for the development and operation of a substance use disorder treatment and recovery facility.

CERTIFICATE HOLDER

NH Dept 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 JKELLEY1

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 8/15/2019

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

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

PRODUCER License # 1780862 HUB International New England 100 Central Street, Suite 201 Holliston, MA 01746	CONTACT NAME: Jessica Kelley PHONE (A/C, No, Ext): (774) 233-6212 FAX (A/C, No): E-MAIL ADDRESS: Jessica.Kelley@hubinternational.com
	INSURER(S) AFFORDING COVERAGE — NAIC #
	INSURER A : Safety National Casualty Corporation — 15105
INSURED Dartmouth-Hitchcock Health 1 Medical Center Dr. Lebanon, NH 03756	INSURER B :
	INSURER C :
	INSURER D :
	INSURER E :
	INSURER F :

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

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

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	☐ OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						X PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N [N]	N/A		AG4061049	7/1/2019	7/1/2020	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 Mary Hitchcock Memorial Hospital

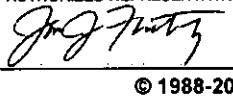
CERTIFICATE HOLDER

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



- Mission Statement: **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.**

Board of Directors https://www.dartmouth-hitchcock.org/about_dh/trustees.html

Dartmouth-Hitchcock Health and Subsidiaries

Report on Federal Awards in Accordance With the Uniform Guidance
June 30, 2018
EIN #02–0222140

Dartmouth-Hitchcock Health and Subsidiaries
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June 30, 2018 and 2017

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Part I
Financial Statements and
Schedule of Expenditures of Federal Awards

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, 2018 and June 30, 2017, and the related consolidated statements of operations, changes in net assets and 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 did not audit the financial statements of Alice Peck Day Hospital, a subsidiary whose sole member is Dartmouth-Hitchcock Health, which statements reflect total assets of 2.8% of consolidated total assets at June 30, 2017 and total revenues of 3.3% of consolidated total revenue for the year then ended. Those statements were audited by other auditors whose report thereon has been furnished to us, and our opinion expressed herein, insofar as it relates to the amounts included for Alice Peck Day Hospital, is based solely on the report of the other auditors. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement. The financial statements of Alice Peck Day Hospital were not audited in accordance with *Government Auditing Standards* in 2017.

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, based on our audits and the report of the other auditors, 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, 2018 and June 30, 2017, and the results of their operations, changes in net assets and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Our audits were 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 audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves and other additional procedures, in accordance with 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.

Other Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying schedule of expenditures of federal awards for the year ended June 30,

2018 is presented for purposes of additional analysis as required by Title 2 U.S. *Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the schedule of expenditures of federal awards is fairly stated, in all material respects, in relation to the consolidated financial statements as a whole.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated November 7, 2018 on our consideration of the Health System's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements and other matters for the year ended June 30, 2018. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing and not to provide an opinion on the effectiveness of internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Health System's internal control over financial reporting and compliance

PricewaterhouseCoopers LLP

Boston, Massachusetts
November 7, 2018

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Balance Sheets
Years Ended June 30, 2018 and 2017

(in thousands of dollars)	2018	2017
Assets		
Current assets		
Cash and cash equivalents	$ 200,169	$ 68,498
Patient accounts receivable, net of estimated uncollectibles of $132,228 and $121,340 at June 30, 2018 and 2017 (Note 3)	219,228	237,260
Prepaid expenses and other current assets	97,502	89,203
Total current assets	516,899	394,961
Assets limited as to use (Notes 4 and 6)	706,124	662,323
Other investments for restricted activities (Notes 4 and 6)	130,896	124,529
Property, plant, and equipment, net (Note 5)	607,321	609,975
Other assets	108,785	97,120
Total assets	$ 2,070,025	$ 1,888,908
Liabilities and Net Assets		
Current liabilities		
Current portion of long-term debt (Note 9)	$ 3,464	$ 18,357
Current portion of liability for pension and other postretirement plan benefits (Note 10)	3,311	3,220
Accounts payable and accrued expenses (Note 12)	95,753	89,160
Accrued compensation and related benefits	125,576	114,911
Estimated third-party settlements (Note 3)	41,141	27,433
Total current liabilities	269,245	253,081
Long-term debt, excluding current portion (Note 9)	752,975	616,403
Insurance deposits and related liabilities (Note 11)	55,516	50,960
Interest rate swaps (Notes 6 and 9)	-	20,916
Liability for pension and other postretirement plan benefits, excluding current portion (Note 10)	242,227	282,971
Other liabilities	88,127	90,548
Total liabilities	1,408,090	1,314,879
Commitments and contingencies (Notes 3, 5, 6, 9, and 12)		
Net assets		
Unrestricted (Note 8)	524,102	424,947
Temporarily restricted (Notes 7 and 8)	82,439	94,917
Permanently restricted (Notes 7 and 8)	55,394	54,165
Total net assets	661,935	574,029
Total liabilities and net assets	$ 2,070,025	$ 1,888,908

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, 2018 and 2017

(in thousands of dollars)	2018	2017
Unrestricted revenue and other support		
Net patient service revenue, net of contractual allowances and discounts	$ 1,899,095	$ 1,859,192
Provision for bad debts (Note 1 and 3)	47,367	63,645
Net patient service revenue less provision for bad debts	1,851,728	1,795,547
Contracted revenue (Note 2)	54,969	43,671
Other operating revenue (Note 2 and 4)	148,946	119,177
Net assets released from restrictions	13,461	11,122
Total unrestricted revenue and other support	2,069,104	1,969,517
Operating expenses		
Salaries	989,263	966,352
Employee benefits	229,683	244,855
Medical supplies and medications	340,031	306,080
Purchased services and other	291,372	289,805
Medicaid enhancement tax (Note 3)	67,692	65,069
Depreciation and amortization	84,778	84,562
Interest (Note 9)	18,822	19,838
Total operating expenses	2,021,641	1,976,561
Operating income (loss)	47,463	(7,044)
Non-operating gains (losses)		
Investment gains (Notes 4 and 9)	40,387	51,056
Other losses	(2,908)	(4,153)
Loss on early extinguishment of debt	(14,214)	-
Loss due to swap termination	(14,247)	-
Contribution revenue from acquisition	-	20,215
Total non-operating gains, net	9,018	67,118
Excess of revenue over expenses	$ 56,481	$ 60,074

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, 2018 and 2017

(in thousands of dollars)	2018	2017
Unrestricted net assets		
Excess of revenue over expenses	$ 56,481	$ 60,074
Net assets released from restrictions	16,313	1,839
Change in funded status of pension and other postretirement benefits (Note 10)	8,254	(1,587)
Other changes in net assets	(185)	(3,364)
Change in fair value of interest rate swaps (Note 9)	4,190	7,802
Change in interest rate swap effectiveness	14,102	-
Increase in unrestricted net assets	99,155	64,764
Temporarily restricted net assets		
Gifts, bequests, sponsored activities	13,050	26,592
Investment gains	2,964	1,677
Change in net unrealized gains on investments	1,282	3,775
Net assets released from restrictions	(29,774)	(12,961)
Contribution of temporarily restricted net assets from acquisition	-	103
(Decrease) increase in temporarily restricted net assets	(12,478)	19,186
Permanently restricted net assets		
Gifts and bequests	1,121	300
Investment gains in beneficial interest in trust	108	245
Contribution of permanently restricted net assets from acquisition	-	30
Increase in permanently restricted net assets	1,229	575
Change in net assets	87,906	84,525
Net assets		
Beginning of year	574,029	489,504
End of year	$ 661,935	$ 574,029

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, 2018 and 2017

(in thousands of dollars)	2018	2017
Cash flows from operating activities		
Change in net assets	$ 87,906	$ 84,525
Adjustments to reconcile change in net assets to net cash provided by operating and non-operating activities		
Change in fair value of interest rate swaps	(4,897)	(8,001)
Provision for bad debt	47,367	63,645
Depreciation and amortization	84,947	84,711
Contribution revenue from acquisition	-	(20,348)
Change in funded status of pension and other postretirement benefits	(8,254)	1,587
(Gain) loss on disposal of fixed assets	(125)	1,703
Net realized gains and change in net unrealized gains on investments	(45,701)	(57,255)
Restricted contributions and investment earnings	(5,460)	(4,374)
Proceeds from sales of securities	1,531	809
Loss from debt defeasance	14,214	381
Changes in assets and liabilities		
Patient accounts receivable, net	(29,335)	(35,811)
Prepaid expenses and other current assets	(8,299)	7,386
Other assets, net	(11,665)	(8,934)
Accounts payable and accrued expenses	19,693	(17,820)
Accrued compensation and related benefits	10,665	10,349
Estimated third-party settlements	13,708	7,783
Insurance deposits and related liabilities	4,556	(5,927)
Liability for pension and other postretirement benefits	(32,399)	8,935
Other liabilities	(2,421)	11,431
Net cash provided by operating and non-operating activities	136,031	124,775
Cash flows from investing activities		
Purchase of property, plant, and equipment	(77,598)	(77,361)
Proceeds from sale of property, plant, and equipment	-	1,087
Purchases of investments	(279,407)	(259,201)
Proceeds from maturities and sales of investments	273,409	276,934
Cash received through acquisition	-	3,564
Net cash used in investing activities	(83,596)	(54,977)
Cash flows from financing activities		
Proceeds from line of credit	50,000	65,000
Payments on line of credit	(50,000)	(101,550)
Repayment of long-term debt	(413,104)	(48,506)
Proceeds from issuance of debt	507,791	39,064
Repayment of interest rate swap	(16,019)	-
Payment of debt issuance costs	(4,892)	(274)
Restricted contributions and investment earnings	5,460	4,374
Net cash provided by (used in) financing activities	79,236	(41,892)
Increase in cash and cash equivalents	131,671	27,906
Cash and cash equivalents		
Beginning of year	68,498	40,592
End of year	$ 200,169	$ 68,498
Supplemental cash flow information		
Interest paid	$ 18,029	$ 23,407
Net assets acquired as part of acquisition, net of cash aquired	-	16,784
Non-cash proceeds from issuance of debt	137,281	-
Use of non-cash proceeds to refinance debt	(137,281)	-
Building construction in process financed by a third party	-	8,426
Construction in progress included in accounts payable and accrued expenses	1,569	14,669
Equipment acquired through issuance of capital lease obligations	17,670	-
Donated securities	1,531	809

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 and Subsidiaries (DHC), Mary Hitchcock Memorial Hospital and Subsidiaries (MHMH), (DHC and MHMH together are referred to as D-H), The New London Hospital Association and Subsidiaries (NLH), Windsor Hospital Corporation (d/b/a MT. Ascutney Hospital and Health Center) and Subsidiaries (MAHHC), Cheshire Medical Center and Subsidiaries (Cheshire), Alice Peck Day Memorial Hospital (APD), and the Visiting Nurse and Hospice of NH and VT and Subsidiaries (VNH). The "Health System" consists of D-HH, its affiliates 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 nursing home 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, MHMH, DHC, 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.

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.

The Health System files annual Community Benefits Reports with the State of NH which outlines the community and charitable benefits it 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 lectures, 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.).

- *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 to participate 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.
- *Community health-related initiatives* occur outside of the organization(s) through various financial contributions of cash, in-kind, and grants to local organizations.
- *Community-building activities* include cash, in-kind donations, and budgeted expenditures for the development of programs and partnerships intended to address 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 (financial assistance)* represents services provided to patients who cannot afford healthcare services due to inadequate financial resources which result from being uninsured or underinsured. For the years ended June 30, 2018 and 2017, the Health System provided financial assistance to patients in the amount of approximately $39,446,000 and $29,934,000, respectively, as measured by gross charges. The estimated cost of providing this care for the years ended June 30, 2018 and 2017 was approximately $15,559,000 and $12,173,000, respectively. The estimated costs of providing charity care services are determined applying a ratio of costs to charges to the gross uncompensated charges associated with providing care to charity patients. The ratio of costs to charges is calculated using total expenses, less bad debt, divided by gross revenue.
- *Government-sponsored healthcare services* are provided to Medicaid and Medicare patients at reimbursement levels that are significantly below the cost of the care provided.
- *The uncompensated cost of care for Medicaid* patients reported in the unaudited Community Benefits Reports for 2017 was approximately $126,867,000. The 2018 Community Benefits Reports are expected to be filed in February 2019.

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, 2017:

(Unaudited, in thousands of dollars)

Government-sponsored healthcare services	$	287,845
Health professional education		33,197
Subsidized health services		30,447
Charity care		11,070
Community health services		6,829
Research		3,308
Community building activities		1,487
Financial contributions		1,417
Community benefit operations		913
Total community benefit value	$	376,513

The Health System also provides a significant amount of uncompensated care to its patients that are reported as provision for bad debts, which is not included in the amounts reported above. During the years ended June 30, 2018 and 2017, the Health System reported a provision for bad debt expense of approximately $47,367,000 and $63,645,000, 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, unrestricted net assets are amounts not subject to donor-imposed stipulations and are available for operations. Temporarily restricted net assets are those whose use has been limited by donors to a specific time period or purpose. Permanently restricted net assets have 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 the allowance for estimated uncollectible accounts and contractual allowances, valuation of certain investments, estimated third-party settlements, insurance reserves, and pension obligations. Actual results may differ from those estimates.

Excess of Revenue over Expenses

The consolidated statements of operations and changes in net assets include the excess of revenue over expenses. Operating revenues consist of those items attributable to the care of patients, including contributions and investment income on unrestricted investments, which are utilized to provide charity and other operational support. Peripheral activities, including unrestricted contribution income from acquisitions, loss on early extinguishment of debt, loss due to swap termination, realized gains/losses on sales of investment securities and changes in unrealized gains/losses in investments are reported as non-operating gains (losses).

Changes in unrestricted net assets which are excluded from the excess of revenue over expenses, consistent with industry practice, include contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purpose of acquiring such assets), change in funded status of pension and other postretirement benefit plans, and the effective portion of the change in fair value of interest rate swaps.

Charity Care and Provision for Bad Debts

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. Additions to the allowance for uncollectible accounts are made by means of the provision for bad debts. Accounts written off as uncollectible are deducted from the allowance and subsequent recoveries are added. The amount of the provision for bad debts 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 3).

Net Patient Service Revenue
Net patient service revenue is reported at the estimated net realizable amounts from patients, third party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors and bad debt expense. 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 3).

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. This revenue includes retail pharmacy, joint operating agreements, grant revenue, cafeteria sales, meaningful use incentive payments and other support service revenue.

Cash Equivalents
Cash equivalents include investments in highly liquid investments with maturities of three months or less when purchased, excluding amounts where use is limited by internal designation or other arrangements under trust agreements or by donors.

Investments and Investment Income
Investments in equity securities with readily determinable fair values, mutual funds and pooled/comingled funds, and all investments in debt securities are considered to be trading securities reported at fair value with changes in fair value included in the excess of revenues over expenses. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date (Note 6).

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 of revenues over expenses. All investments, whether held at fair value or under the equity method of accounting, are reported at what the Health System believes to be the amount they would expect to receive if it liquidated its investments at the balance sheet dates on a nondistressed basis.

Certain affiliates 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 permanently restricted assets were invested in these pooled funds by purchasing units based on the fair 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 unrestricted investments, change in value of equity method investments, interest, and dividends) are included in the excess of revenue over expenses and classified as non-operating gains and losses, unless the income or loss is restricted by donor or law (Note 8).

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 Health System applies the accounting provisions of Accounting Standards Update (ASU) 2009-12, *Investments in Certain Entities That Calculate Net Asset Value per Share (or its Equivalent)* (ASU 2009-12). ASU 2009-12 allows for the estimation of fair value of investments for which the investment does not have a readily determinable fair value, to use net asset value (NAV) per share or its equivalent as a practical expedient, subject to the Health System's ability to redeem its investment.

The carrying amount of patient accounts receivable, prepaid and other current assets, accounts payable and accrued expenses approximates 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 unrestricted support, and excluded from the excess of revenue over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of capital assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire capital assets are reported as restricted support. Absent explicit donor stipulations about how long those capital assets must be maintained, expirations of donor restrictions are reported when the donated or acquired capital assets are placed in service.

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

Trade Names
The Health System records trade names as intangible assets within other assets on the consolidated statements of financial position. The Health System considers trade names 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 $2,462,000 and $2,700,000 as intangible assets associated with its affiliations as of June 30, 2018 and 2017, respectively.

Derivative Instruments and Hedging Activities
The Health System applies the provisions of ASC 815, *Derivatives and Hedging*, to its derivative instruments, which require that all derivative instruments be recorded at their respective fair values in the consolidated balance sheets.

On the date a derivative contract is entered into, the Health System designates the derivative as a cash-flow hedge of a forecasted transaction or the variability of cash flows to be received or paid related to a recognized asset or liability. For all hedge relationships, the Health System formally documents the hedging relationship and its risk-management objective and strategy for undertaking the hedge, the hedging instrument, the nature of the risk being hedged, how the hedging instrument's effectiveness in offsetting the hedged risk will be assessed, and a description of the method of measuring ineffectiveness. This process includes linking cash-flow hedges to specific assets and liabilities on the consolidated balance sheets, specific firm commitments or forecasted transactions. The Health System also formally assesses, both at the hedge's inception and on an ongoing basis, whether the derivatives that are used in hedging transactions are highly effective in offsetting changes in variability of cash flows of hedged items. Changes in the fair value of a derivative that is highly effective and that is designated and qualifies as a cash-flow hedge are recorded in unrestricted net assets until earnings are affected by the variability in cash

flows of the designated hedged item. The ineffective portion of the change in fair value of a cash flow hedge is reported in excess of revenue over expenses in the consolidated statements of operations and changes in net assets.

The Health System discontinues hedge accounting prospectively when it is determined: (a) the derivative is no longer effective in offsetting changes in the cash flows of the hedged item; (b) the derivative expires or is sold, terminated, or exercised; (c) the derivative is undesignated as a hedging instrument because it is unlikely that a forecasted transaction will occur; (d) a hedged firm commitment no longer meets the definition of a firm commitment; and (e) management determines that designation of the derivative as a hedging instrument is no longer appropriate.

In all situations in which hedge accounting is discontinued, the Health System continues to carry the derivative at its fair value on the consolidated balance sheets and recognizes any subsequent changes in its fair value in excess of revenue over expenses.

Gifts and Bequests
Unrestricted gifts and bequests 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 as either temporarily or permanently restricted 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, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions.

Recently Issued Accounting Pronouncements
In May 2014, the FASB issued ASU 2014-09 - *Revenue from Contracts with Customers* and in August 2015, the FASB amended the guidance to defer the effective date of this standard by one year. ASU 2014-09 affects any entity that either enters into contracts with customers to transfer goods or services or enters into contracts for the transfer of nonfinancial assets unless those contracts are within the scope of other standards. The core principle of the guidance in ASU 2014-09 is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The Health System is in the process of completing an evaluation of the requirements of the new standard, which became effective on July 1, 2018. In addition, the Health System is in the process of drafting the new disclosures required post implementation. The Health System plans to use a modified retrospective method of application to adopt ASU 2014-09 on July 1, 2018. The Health System will use a portfolio approach to apply the new model to classes of payers with similar characteristics and analyze cash collection trends over an appropriate collection look-back period depending on the payer. Adoption of ASU 2014-09 will result in changes to the presentation for and disclosure of revenue related to uninsured or underinsured patients. Prior to the adoption of ASU 2014-09, a significant portion of the provision for doubtful accounts related to self-pay patients, as well as co-pays and deductibles owed to the Health System by patients. Under ASU 2014-09, the estimated uncollectible amounts due from these patients are generally considered a direct reduction to net operating revenues and, correspondingly, result in a material reduction in the amounts presented separately as provision for doubtful accounts. The Health System is also in the process of completing an assessment of the impact of the new standard on other operating revenue and various reimbursement programs that represent variable consideration. These include supplemental state Medicaid programs, disproportionate share payments and settlements with third party payers. The payment mechanisms for these types of programs vary by state. While the adoption of ASU 2014-09 will

have a material effect on the presentation of net operating revenues in the Health System's consolidated statements of operations and changes in net assets, and will impact certain disclosures, it will not materially impact the financial position, results of operations or cash flows.

In February 2016, the FASB issued ASU 2016-02 - *Leases*, which requires a lessee to recognize a right-of-use asset and a lease liability, initially measured at the present value of the lease payments, on its balance sheet. The standard also requires a lessee to recognize a single lease cost, calculated so that the cost of the lease is allocated over the lease term, on a generally straight-line basis. The guidance also expands the required quantitative and qualitative disclosures surrounding leases. The ASU is effective for fiscal years beginning after December 15, 2018, or fiscal year 2020 for the Health System. The Health System is evaluating the impact of the new guidance on the consolidated financial statements.

In January 2016, the FASB issued ASU 2016-01- *Recognition and Measurement of Financial Assets and Financial Liabilities*, which address certain aspects of recognition, measurement, presentation and disclosure of financial instruments. This guidance allows an entity to choose, investment-by-investment, to report an equity investment that neither has a readily determinable fair value, nor qualifies for the practical expedient for fair value estimation using NAV, at its cost minus impairment (if any), plus or minus changes resulting from observable price changes in orderly transactions for the identical or similar investment of the same issue. Impairment of such investments must be assessed qualitatively at each reporting period. Entities must disclose their financial assets and liabilities by measurement category and form of asset either on the face of the balance sheet or in the accompanying notes. The ASU is effective for annual reporting periods beginning after December 15, 2018 or fiscal year 2020 for the Health System. The provision to eliminate the requirement to disclose the fair value of financial instruments measured at cost (such as the fair value of debt) was early adopted during the year ended June 30, 2017.

In August 2016, the FASB issued ASU 2016-14 - *Presentation of Financial Statements for Not-for-Profit Entities*. The new pronouncement amends certain financial reporting requirements for not-for-profit entities, including revisions to the classification of net assets and expanded disclosure requirements concerning expenses and liquidity. The ASU is effective for the Health System for the year ending June 30, 2019. The Health System is evaluating the impact of the new guidance on the consolidated financial statements.

3. Patient Service Revenue and Accounts Receivable

Patient service revenue is reported net of contractual allowances and the provision for bad debts as follows for the years ended June 30, 2018 and 2017:

(in thousands of dollars)	2018	2017
Gross patient service revenue	$ 5,180,649	$ 4,865,332
Less: Contractual allowances	3,281,554	3,006,140
Provision for bad debt	47,367	63,645
Net patient service revenue	$ 1,851,728	$ 1,795,547

Accounts receivable are reduced by an allowance for estimated uncollectibles. In evaluating the collectability of accounts receivable, the Health System analyzes past collection history and identifies trends for several categories of self-pay accounts (uninsured, residual balances, pre-collection accounts and charity) to estimate the appropriate allowance percentages in establishing

the allowance for bad debt expense. Management performs collection rate look-back analyses on a quarterly basis to evaluate the sufficiency of the allowance for estimated uncollectibles. Throughout the year, after all reasonable collection efforts have been exhausted, the difference between the standard rates and the amounts actually collected, including contractual adjustments and uninsured discounts, will be written off against the allowance for estimated uncollectibles. In addition to the review of the categories of revenue, management monitors the write offs against established allowances as of a point in time to determine the appropriateness of the underlying assumptions used in estimating the allowance for estimated uncollectibles.

Accounts receivable, prior to adjustment for estimated uncollectibles, are summarized as follows at June 30, 2018 and 2017:

(in thousands of dollars)	2018	2017
Receivables		
Patients	$ 94,104	$ 90,786
Third-party payors	250,657	263,240
Nonpatient	6,695	4,574
	$ 351,456	$ 358,600

The allowance for estimated uncollectibles is $132,228,000 and $121,340,000 as of June 30, 2018 and 2017.

The following table categorizes payors into five groups and their respective percentages of gross patient service revenue for the years ended June 30, 2018 and 2017:

	2018	2017
Medicare	43 %	43 %
Anthem/Blue Cross	18	18
Commercial insurance	20	20
Medicaid	13	13
Self-pay/other	6	6
	100 %	100 %

The Health System has agreements with third-party payors that provide for payments at amounts different from their established rates. A summary of the acute care payment arrangements in effect during the years ended June 30, 2018 and 2017 with major third-party payors follows:

Medicare
The Health System's inpatient acute care services provided to Medicare program beneficiaries are paid at prospectively determined rates-per-discharge. These rates vary according to a patient classification system that is 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. Under this system, outpatient services are reimbursed based on a pre-determined amount for each outpatient procedure, subject to various mandated modifications. The Health System is reimbursed during the year for services to Medicare beneficiaries based on varying interim

payment methodologies. Final settlement is determined after the submission of an annual cost report and subsequent audit of this report by the Medicare fiscal intermediary.

Certain of the Health System's affiliates qualify as Critical Access Hospitals (CAH), which are reimbursed by Medicare at 101% of reasonable costs, subject to 2% sequestration, for its inpatient acute, swing bed, and outpatient services, excluding ambulance services and inpatient hospice care. They are reimbursed at an interim rate for cost based services with a final settlement determined by the Medicare Cost Report filing. The nursing home and Rehabilitation distinct part units are not impacted by CAH designation. Medicare reimburses both services based on an acuity driven prospective payment system with no retrospective settlement.

Certain of the Health System's affiliates qualify as Home Health and Hospice Providers. Providers of home health services to clients 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 client at a rate determined by federal guidelines. Hospice services to clients 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. Revenue is recognized as the services are performed based on the fixed rate amount.

Medicaid
The Health System's payments for inpatient services rendered to NH Medicaid beneficiaries are based on a prospective payment system, while outpatient services are reimbursed on a retrospective cost basis or fee schedules. NH Medicaid Outpatient Direct Medical Education costs are reimbursed, as a pass-through, based on the filing of the Medicare cost report. Payment for inpatient and outpatient services rendered to VT Medicaid beneficiaries are based on prospective payment systems and the skilled nursing facility is reimbursed on a prospectively determined per diem rate.

During the years ended June 30, 2018 and 2017, the Health System recorded State of NH Medicaid Enhancement Tax (MET) and State of VT Provider Tax of $67,692,000 and $65,069,000, respectively. The taxes are calculated at 5.4% for NH and 6% for VT of certain net patient revenues in accordance with instructions received from the States. The provider taxes are included in Medicaid enhancement tax in the consolidated statements of operations and changes in net assets.

During fiscal year 2016, Vermont state legislation passed changes to the tax base for home health providers from 19.30% of core home health care services (primarily Medicaid services) with a cap of 6% of net patient service revenue to 3.63% of net patient revenue for fiscal year 2017 and fiscal year 2018. Home health provider tax paid, which is included in purchased services and other in the consolidated statements of operations and changes in net assets, was $737,000 and $645,000 in 2018 and 2017, respectively.

On June 30, 2014, the NH Governor signed into law a bi-partisan legislation reflecting an agreement between the State of NH and 25 NH hospitals on the Medicaid Enhancement Tax "SB 369". As part of this agreement the parties have agreed to resolve all pending litigation related to MET and Medicaid Rates, including the Catholic Medical Center Litigation, the Northeast Rehabilitation Litigation, 2014 DRA Refund Requests, and the State Rate Litigation.

In May of 2018, the State of NH and NH Hospitals reached a new seven-year agreement through 2024. Under the terms of this agreement, the hospitals agreed to accept approximately $28 million less in DSH payments to which they are entitled in fiscal year 2018 and fiscal year 2019 in exchange for greater certainty about both future DSH payments and increases in Medicaid reimbursement rates. The new agreement contains a number of safeguards. In the event of adverse federal legislative or administrative changes to the DSH program, the agreement provides for alternative payments (e.g., other Medicaid supplemental payments or rate increases that will compensate the hospitals for any loss of DSH revenue). Additionally, the hospitals have filed a declaratory judgment petition based on the terms of the 2018 agreement, to which the State of NH has consented and on which a court order has been entered. If the State of NH breaches any term of the 2018 agreement, the hospitals are entitled to recoup the balance of DSH payments forfeited in fiscal year 2018 and fiscal year 2019.

Pursuant to this agreement, the State of NH made DSH payments to D-HH member hospitals in NH in the aggregate amount of approximately $66,383,000 for fiscal year 2018. In fiscal year 2017, D-HH member hospitals in NH received approximately $59,473,000.

The Health Information Technology for Economic and Clinical Health (HITECH) Act included in the American Recovery and Reinvestment Act (ARRA) provides incentives for the adoption and use of health information technology by Medicare and Medicaid providers and eligible professionals. The Health System has recognized meaningful use incentives of $344,000 and $1,156,000 for both the Medicare and Vermont Medicaid programs during the years ended June 30, 2018 and 2017, respectively.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. Compliance with laws and regulations can be subject to future government review and interpretation as well as significant regulatory action; failure to comply with such laws and regulations can result in fines, penalties and exclusion from the Medicare and Medicaid programs.

Other

For services provided to patients with commercial insurance, the Health System receives payment for inpatient services at prospectively determined rates-per-discharge, prospectively determined per diem rates or a percentage of established charges. Outpatient services are reimbursed on a fee schedule or at a discount from established charges.

Non-acute and physician services are paid at various rates under different arrangements with governmental payors, commercial insurance carriers and health maintenance organizations. The basis for payments under these arrangements includes prospectively determined per visit rates, discounts from established charges, fee schedules, and reasonable cost subject to limitations.

The Health System has provided for its estimated final settlements with all payors based upon applicable contracts and reimbursement legislation and timing in effect for all open years (2013 - 2018). The differences between the amounts provided and the actual final settlement, if any, is recorded as an adjustment to net patient service revenue as amounts become known or as years are no longer subject to audits, reviews and investigations. During 2018 and 2017, changes in prior estimates related to the Health System's settlements with third-party payors resulted in (decreases) increases in net patient service revenue of ($5,604,000) and $2,000,000 respectively, in the consolidated statements of operations and changes in net assets.

4. Investments

The composition of investments at June 30, 2018 and 2017 is set forth in the following table:

(in thousands of dollars)	2018	2017
Assets limited as to use		
Internally designated by board		
Cash and short-term investments	$ 8,558	$ 9,923
U.S. government securities	50,484	44,835
Domestic corporate debt securities	109,240	100,953
Global debt securities	110,944	105,920
Domestic equities	142,796	129,548
International equities	106,668	95,167
Emerging markets equities	23,562	33,893
Real Estate Investment Trust	816	791
Private equity funds	50,415	39,699
Hedge funds	32,831	30,448
	636,314	591,177
Investments held by captive insurance companies (Note 11)		
U.S. government securities	30,581	18,814
Domestic corporate debt securities	16,764	21,681
Global debt securities	4,513	5,707
Domestic equities	8,109	9,048
International equities	7,971	13,888
	67,938	69,138
Held by trustee under indenture agreement (Note 9)		
Cash and short-term investments	1,872	2,008
Total assets limited as to use	706,124	662,323
Other investments for restricted activities		
Cash and short-term investments	4,952	5,467
U.S. government securities	28,220	28,096
Domestic corporate debt securities	29,031	27,762
Global debt securities	14,641	14,560
Domestic equities	20,509	18,451
International equities	17,521	15,499
Emerging markets equities	2,155	3,249
Real Estate Investment Trust	954	790
Private equity funds	4,878	3,949
Hedge funds	8,004	6,676
Other	31	30
Total other investments for restricted activities	130,896	124,529
Total investments	$ 837,020	$ 786,852

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 when debt securities or equity securities 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. All investments, whether the fair value or equity method of accounting is used, are reported at what the Health System believes to be the amount that the Health System would expect to receive if it liquidated its investments at the balance sheets date on a non-distressed basis.

The following tables summarize the investments by the accounting method utilized, as of June 30, 2018 and 2017. Accounting standards require disclosure of additional information for those securities accounted for using the fair value method, as shown in Note 6.

	2018		
(in thousands of dollars)	**Fair Value**	**Equity**	**Total**
Cash and short-term investments	$ 15,382	$ -	$ 15,382
U.S. government securities	109,285	-	109,285
Domestic corporate debt securities	95,481	59,554	155,035
Global debt securities	49,104	80,994	130,098
Domestic equities	157,011	14,403	171,414
International equities	60,002	72,158	132,160
Emerging markets equities	1,296	24,421	25,717
Real Estate Investment Trust	222	1,548	1,770
Private equity funds	-	55,293	55,293
Hedge funds	-	40,835	40,835
Other	31		31
	$ 487,814	$ 349,206	$ 837,020

	2017		
(in thousands of dollars)	**Fair Value**	**Equity**	**Total**
Cash and short-term investments	$ 17,398	$ -	$ 17,398
U.S. government securities	91,745	-	91,745
Domestic corporate debt securities	121,631	28,765	150,396
Global debt securities	45,660	80,527	126,187
Domestic equities	144,618	12,429	157,047
International equities	29,910	94,644	124,554
Emerging markets equities	1,226	35,916	37,142
Real Estate Investment Trust	128	1,453	1,581
Private equity funds	-	43,648	43,648
Hedge funds	-	37,124	37,124
Other	30	-	30
	$ 452,346	$ 334,506	$ 786,852

Investment income is comprised of the following for the years ended June 30, 2018 and 2017:

(in thousands of dollars)	2018	2017
Unrestricted		
Interest and dividend income, net	$ 12,324	$ 4,418
Net realized gains on sales of securities	24,411	16,868
Change in net unrealized gains on investments	4,612	30,809
	41,347	52,095
Temporarily restricted		
Interest and dividend income, net	1,526	1,394
Net realized gains on sales of securities	1,438	283
Change in net unrealized gains on investments	1,282	3,775
	4,246	5,452
Permanently restricted		
Change in net unrealized gains on beneficial interest in trust	108	245
	108	245
	$ 45,701	$ 57,792

For the years ended June 30, 2018 and 2017 unrestricted investment income is reflected in the accompanying consolidated statements of operations and changes in net assets as operating revenue of approximately $960,000 and $1,039,000 and as non-operating gains of approximately $40,387,000 and 51,056,000, respectively.

Private equity limited partnership shares are not eligible for redemption from the fund or general partner, but can be sold to third party buyers in private transactions that typically can be completed in approximately 90 days. 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, 2018 and 2017, the Health System has committed to contribute approximately $137,219,000 and $119,719,000 to such funds, of which the Health System has contributed approximately $91,942,000 and $81,982,000 and has outstanding commitments of $45,277,000 and $37,737,000, respectively.

5. Property, Plant, and Equipment

Property, plant, and equipment are summarized as follows at June 30, 2018 and 2017:

(in thousands of dollars)	2018	2017
Land	$ 38,058	$ 38,058
Land improvements	42,295	37,579
Buildings and improvements	876,537	818,831
Equipment	818,902	766,667
Equipment under capital leases	20,966	20,495
	1,796,758	1,681,630
Less: Accumulated depreciation and amortization	1,200,549	1,101,058
Total depreciable assets, net	596,209	580,572
Construction in progress	11,112	29,403
	$ 607,321	$ 609,975

As of June 30, 2018, construction in progress primarily consists of the building renovations taking place at the birthing pavilion in Lebanon, NH as well as the information systems PeopleSoft project for APD and Cheshire. The estimated cost to complete the birthing pavilion at June 30, 2018 is $200,000 and the estimated cost to complete the PeopleSoft project is $2,775,000.

The construction in progress for the Hospice & Palliative Care building reported as of June 30, 2017 was completed during the second quarter of fiscal year 2018 and APD's medical office building was completed in the fourth quarter of fiscal year 2018.

Depreciation and amortization expense included in operating and non-operating activities was approximately $84,947,000 and $84,711,000 for 2018 and 2017, respectively.

6. 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.

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).

Interest Rate Swaps
The fair value of interest rate swaps, are determined using the present value of the fixed and floating legs of the swaps. Each series of cash flows are discounted by observable market interest rate curves and credit risk. All interest rate swaps held by the Health System were extinguished as part of Series 2018A and Series 2018B bond issuance (Note 9).

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 management 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, 2018 and 2017:

	2018					
(in thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Assets						
Investments						
Cash and short term investments	$ 15,382	$ -	$ -	$ 15,382	Daily	1
U.S. government securities	109,285	-	-	109,285	Daily	1
Domestic corporate debt securities	41,488	53,993	-	95,481	Daily–Monthly	1–15
Global debt securities	32,874	16,230	-	49,104	Daily–Monthly	1–15
Domestic equities	157,011	-	-	157,011	Daily–Monthly	1–10
International equities	59,924	78	-	60,002	Daily–Monthly	1–11
Emerging market equities	1,296	-	-	1,296	Daily–Monthly	1–7
Real estate investment trust	222	-	-	222	Daily–Monthly	1–7
Other	-	31	-	31	Not applicable	Not applicable
Total investments	417,482	70,332	-	487,814		
Deferred compensation plan assets						
Cash and short-term investments	2,637	-	-	2,637		
U.S. government securities	38	-	-	38		
Domestic corporate debt securities	3,749	-	-	3,749		
Global debt securities	1,089	-	-	1,089		
Domestic equities	18,470	-	-	18,470		
International equities	3,584	-	-	3,584		
Emerging market equities	28	-	-	28		
Real estate	9	-	-	9		
Multi strategy fund	46,680	-	-	46,680		
Guaranteed contract	-	-	86	86		
Total deferred compensation plan assets	76,284	-	86	76,370	Not applicable	Not applicable
Beneficial interest in trusts	-	-	9,374	9,374	Not applicable	Not applicable
Total assets	$ 493,766	$ 70,332	$ 9,460	$ 573,558		

(in thousands of dollars)	2017 Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Assets						
Investments						
Cash and short term investments	$ 17,398	$ -	$ -	$ 17,398	Daily	1
U.S. government securities	91,745	-	-	91,745	Daily	1
Domestic corporate debt securities	66,238	55,393	-	121,631	Daily–Monthly	1–15
Global debt securities	28,142	17,518	-	45,660	Daily–Monthly	1–15
Domestic equities	144,618	-	-	144,618	Daily–Monthly	1–10
International equities	29,870	40	-	29,910	Daily–Monthly	1–11
Emerging market equities	1,226	-	-	1,226	Daily–Monthly	1–7
Real estate investment trust	128	-	-	128	Daily–Monthly	1–7
Other	-	30	-	30	Not applicable	Not applicable
Total investments	379,365	72,981	-	452,346		
Deferred compensation plan assets						
Cash and short-term investments	2,633	-	-	2,633		
U.S. government securities	37	-	-	37		
Domestic corporate debt securities	8,802	-	-	8,802		
Global debt securities	1,095	-	-	1,095		
Domestic equities	28,609	-	-	28,609		
International equities	9,595	-	-	9,595		
Emerging market equities	2,706	-	-	2,706		
Real estate	2,112	-	-	2,112		
Multi strategy fund	13,083	-	-	13,083		
Guaranteed contract	-	-	83	83		
Total deferred compensation plan assets	68,672	-	83	68,755	Not applicable	Not applicable
Beneficial interest in trusts	-	-	9,244	9,244	Not applicable	Not applicable
Total assets	$ 448,037	$ 72,981	$ 9,327	$ 530,345		
Liabilities						
Interest rate swaps	$ -	$ 20,916	$ -	$ 20,916	Not applicable	Not applicable
Total liabilities	$ -	$ 20,916	$ -	$ 20,916		

The following table is a rollforward of the statements of financial instruments classified by the Health System within Level 3 of the fair value hierarchy defined above.

(in thousands of dollars)	2018 Beneficial Interest in Perpetual Trust	Guaranteed Contract	Total
Balances at beginning of year	$ 9,244	$ 83	$ 9,327
Purchases	-	-	-
Sales	-	-	-
Net unrealized gains	130	3	133
Net asset transfer from affiliate	-	-	-
Balances at end of year	$ 9,374	$ 86	$ 9,460

	2017		
(in thousands of dollars)	Beneficial Interest in Perpetual Trust	Guaranteed Contract	Total
Balances at beginning of year	$ 9,087	$ 80	$ 9,167
Purchases	-	-	-
Sales	-	-	-
Net unrealized gains	157	3	160
Net asset transfer from affiliate	-	-	-
Balances at end of year	$ 9,244	$ 83	$ 9,327

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, 2018 and 2017.

7. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at June 30, 2018 and 2017:

(in thousands of dollars)	2018	2017
Healthcare services	$ 19,570	$ 32,583
Research	24,732	25,385
Purchase of equipment	3,068	3,080
Charity care	13,667	13,814
Health education	18,429	17,489
Other	2,973	2,566
	$ 82,439	$ 94,917

Permanently restricted net assets consist of the following at June 30, 2018 and 2017:

(in thousands of dollars)	2018	2017
Healthcare services	$ 23,390	$ 22,916
Research	7,821	7,795
Purchase of equipment	6,310	6,274
Charity care	8,883	6,895
Health education	8,784	10,228
Other	206	57
	$ 55,394	$ 54,165

Income earned on permanently restricted net assets is available for these purposes.

8. 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 classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, 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.

Unrestricted net assets include funds designated by the Board of Trustees to function as endowments and 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. Temporarily restricted net assets 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 temporary restrictions on these funds have been met, the funds are reclassified to unrestricted net assets.

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, 2018 and 2017.

Endowment net asset composition by type of fund consists of the following at June 30, 2018 and 2017:

	2018			
(in thousands of dollars)	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ -	$ 31,320	$ 46,877	$ 78,197
Board-designated endowment funds	29,506	-	-	29,506
Total endowed net assets	$ 29,506	$ 31,320	$ 46,877	$ 107,703

	2017			
(in thousands of dollars)	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ -	$ 29,701	$ 45,756	$ 75,457
Board-designated endowment funds	26,389	-	-	26,389
Total endowed net assets	$ 26,389	$ 29,701	$ 45,756	$ 101,846

Changes in endowment net assets for the year ended June 30, 2018:

	2018			
(in thousands of dollars)	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Balances at beginning of year	$ 26,389	$ 29,701	$ 45,756	$ 101,846
Net investment return	3,112	4,246	-	7,358
Contributions	-	-	1,121	1,121
Transfers	5	(35)	-	(30)
Release of appropriated funds	-	(2,592)	-	(2,592)
Balances at end of year	$ 29,506	$ 31,320	46,877	$ 107,703
Balances at end of year			46,877	
Beneficial interest in perpetual trust			8,517	
Permanently restricted net assets			$ 55,394	

Changes in endowment net assets for the year ended June 30, 2017:

	2017			
(in thousands of dollars)	**Unrestricted**	**Temporarily Restricted**	**Permanently Restricted**	**Total**
Balances at beginning of year	$ 26,205	$ 25,780	$ 45,402	$ 97,387
Net investment return	283	5,285	2	5,570
Contributions	-	210	300	510
Transfers	-	(26)	22	(4)
Release of appropriated funds	(99)	(1,548)	-	(1,647)
Net asset transfer from affiliates	-	-	30	30
Balances at end of year	$ 26,389	$ 29,701	$ 45,756	$ 101,846

Balances at end of year	45,756
Beneficial interest in perpetual trust	8,409
Permanently restricted net assets	$ 54,165

9. Long-Term Debt

A summary of long-term debt at June 30, 2018 and 2017 is as follows:

(in thousands of dollars)	2018	2017
Variable rate issues		
New Hampshire Health and Education Facilities Authority (NHHEFA) Revenue Bonds		
Series 2018A, principal maturing in varying annual amounts, through August 2036 (1)	$ 83,355	$ -
Series 2016A, principal maturing in varying annual amounts, through August 2046 (3)	-	24,608
Series 2015A, principal maturing in varying annual amounts, through August 2031 (4)	-	82,975
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	-
Series 2017A, principal maturing in varying annual amounts, through August 2039 (2)	122,435	-
Series 2017B, principal maturing in varying annual amounts, through August 2030 (2)	109,800	-
Series 2016B, principal maturing in varying annual amounts, through August 2046 (3)	10,970	10,970
Series 2014A, principal maturing in varying annual amounts, through August 2022 (6)	26,960	26,960
Series 2014B, principal maturing in varying annual amounts, through August 2033 (6)	14,530	14,530
Series 2012A, principal maturing in varying annual amounts, through August 2031 (7)	-	71,700
Series 2012B, principal maturing in varying annual amounts, through August 2031 (7)	-	39,340
Series 2012, principal maturing in varying annual amounts, through July 2039 (11)	25,955	26,735
Series 2010, principal maturing in varying annual amounts, through August 2040 (9)	-	75,000
Series 2009, principal maturing in varying annual amounts, through August 2038 (10)	-	57,540
Total variable and fixed rate debt	$ 697,107	$ 430,358

A summary of long-term debt at June 30, 2018 and 2017 is as follows (continued):

(in thousands of dollars)	2018	2017
Other		
Revolving Line of Credit, principal maturing through March 2019 (5)	$ -	$ 49,750
Series 2012, principal maturing in varying annual amounts, through July 2025 (8)	-	136,000
Series 2010, principal maturing in varying annual amounts, through August 2040 (12)*	15,498	15,900
Note payable to a financial institution payable in interest free monthly installments through July 2015; collateralized by associated equipment*	646	811
Note payable to a financial institution with entire principal due June 2029 that is collateralized by land and building. The note payable is interest free*	380	437
Mortgage note payable to the US Dept of Agriculture; monthly payments of $10,892 include interest of 2.375% through November 2046*	2,697	2,763
Obligations under capital leases	18,965	3,435
Total other debt	38,186	209,096
Total variable and fixed rate debt	697,107	430,358
Total long-term debt	735,293	639,454
Less: Original issue discounts and premiums, net	(26,862)	862
Bond issuance costs, net	5,716	3,832
Current portion	3,464	18,357
	$ 752,975	$ 616,403

*Represents nonobligated group bonds

Aggregate annual principal payments required under revenue bond agreements and capital lease obligations for the next five years ending June 30 and thereafter are as follows:

(in thousands of dollars)	2018
2019	$ 3,464
2020	10,495
2021	10,323
2022	10,483
2023	7,579
Thereafter	692,949
	$ 735,293

Dartmouth-Hitchcock Obligated Group (DHOG) Bonds.
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 MHMH, DHC, Cheshire, NLH and MAHHC. 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 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. A loss on the extinguishment of debt of approximately $13,636,000 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 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.

(3) Series 2016A and 2016B Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds, Series 2016A and 2016B in July 2016 through a private placement with a financial institution. The Series 2016A Revenue Bonds were primarily used to refund Series 2013A and Series 2013B and the Series 2016B Revenue Bonds were used to finance 2016 projects. Interest is equal to the sum of .70 times one month LIBOR plus .70 times the spread. The variable rate as of June 30 2017 was 1.48% The Series 2016B is fixed with an interest rate of 1.78% and matures at various dates through 2046. The Series 2016A Revenue Bonds were refunded in February 2018.

(4) Series 2015A Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds, Series 2015A in September 2015 through a private placement with a financial institution. The Series 2015A Revenue Bonds were primarily used to refinance a portion of the Series 2011 Revenue Bonds and to cover cost of issuance. The Series 2015A Revenue Bonds accrue interest variably and mature at various dates through 2031 based on the one-month London Interbank Offered Rate (LIBOR). The Series 2015A Revenue Bonds were refunded in February 2018.

(5) Revolving Line of Credit

The DHOG entered into a Revolving Line of Credit with TD Bank, N.A. (TD Bank). Interest on the TD Bank loan accrues variably and matures at various dates through March 2019. The Revolving Line of Credit was refunded in February 2018.

(6) 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.

(7) Series 2012A and 2012B Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds, Series 2012A and Series 2012B in November 2012. The proceeds from the Series 2012A and 2012B were used to advance refund the Series 2002 Revenue Bonds and to cover cost of issuance. Interest on the 2012A Revenue Bonds is fixed with an interest rate of 2.29% and matures at various dates through 2031. Interest on the Series 2012B Revenue Bonds is fixed with an interest rate of 2.33% and matures at various dates through 2031. The Series 2012A and Series 2012B Revenue Bonds were refunded in December 2017.

(8) Series 2012 Bank Loan

The DHOG issued the Bank of America, N.A. Series 2012 note, in July 2012. The proceeds from the Series 2012 note were used to prefund the D-H defined benefit pension plan. Interest on the Series 2012 note accrues at a fixed rate of 2.47% and matures at various dates through 2025. The Series 2012 Bank Loan was refunded in February 2018.

(9) Series 2010 Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds, Series 2010, in June 2010. The proceeds from the Series 2010 Revenue Bonds were primarily used to construct a 140,000 square foot ambulatory care facility in Nashua, NH as well as various equipment. Interest on the bonds accrue at a fixed rate of 5.00% and mature at various dates through August 2040. The Series 2010 Revenue Bonds were defeased in December 2017.

(10)Series 2009 Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds, Series 2009, in August 2009. The proceeds from the Series 2009 Revenue Bonds were primarily used to advance refund the Series 2008 Revenue Bonds. Interest on the Series 2009 Revenue Bonds accrue at varying fixed rates between 5.00% and 6.00% and mature at various dates through August 2038. The Series 2009 Revenue Bonds were defeased in December 2017.

(11)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%). Principal is payable in annual installments ranging from $780,000 to $1,750,000 through July 2039. The Series 2012 Revenue Bonds were refunded in February 2018.

Outstanding joint and several indebtedness of the DHOG at June 30, 2018 and 2017 approximates $697,107,000 and $616,108,000, respectively.

Non Obligated Group Bonds

(12)Series 2010 Revenue Bonds

The Business Finance Authority (BFA) of the State of NH issued Revenue Bonds, Series 2010. Interest is based on an annual percentage rate equal to the sum of (a) 69% of the 1-Month LIBOR rate plus (b) 1.8975/5. APD may prepay certain of these bonds according to the terms of the loan and trust agreement. The bonds are redeemable at any time by APD at par value plus any accrued interest. The bonds are also subject to optional tender for purchase (as a whole) in November 2020 at par plus accrued interest.

The Health System Indenture agreements require establishment and maintenance of debt service reserves and other trustee held funds. Trustee held funds of approximately $1,872,000 and $2,008,000 at June 30, 2018 and 2017, respectively, are classified as assets limited as to use in the accompanying consolidated balance sheets (Note 4). The debt service reserves are mainly comprised of escrowed funds held for future interest payments for the Cheshire debt.

For the years ended June 30, 2018 and 2017 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 $18,822,000 and $19,838,000 and is included in other non-operating losses of $2,793,000 and $3,135,000, respectively.

Swap Agreements
The Health System is subject to market risks such as changes in interest rates that arise from normal business operation. The Health System regularly assesses these risks and has established business strategies to provide natural offsets, supplemented by the use of derivative financial instruments to protect against the adverse effect of these and other market risks. The Health System has established clear policies, procedures, and internal controls governing the use of derivatives and does not use them for trading, investment, or other speculative purposes.

A summary of the Health System's derivative financial instruments is as follows:

- A Fixed Payor Swap designed as a cash flow hedge of the NHHEFA Series 2011 Revenue Bonds. The Swap had an initial notional amount of $91,040,000. The Swap Agreement requires the Health System to pay the counterparty a fixed rate of 4.56% in exchange for the counterparty's payment of 67% of USD-LIBOR-BBA. The Swap's term matches that of the associated bonds. The 2011 interest rate swap was not integrated with the 2011 bonds. When the 2011 bonds were refinanced, the swap became associated with the 2015 bond. The Fixed Payor Swap was terminated in February 2018.

- An Interest Rate Swap to hedge the interest rate risk associated with the NHHEFA Series 2013 Revenue Bonds. The Swap had an initial notional amount of $15,000,000. The Swap Agreement requires the Health System to pay the counterparty a fixed rate of 3.94% in exchange for the counterparty's payment at 67% of USD-LIBOR-BBA. The Swap term matches that of the associated bonds. The Interest Rate Swap was terminated in February, 2018.

- An Interest Rate Swap to hedge the interest rate risk associated with the VEHFBA Series 2010A Revenue Bonds. The Swap had an initial notional amount of $7,244,000. The Swap Agreement requires the Health System to pay the counterparty a fixed rate of 2.41% in exchange for the counterparty's payment of 69% of USD-LIBOR-BBA. The swap was terminated in September 2016, while the bonds will remain outstanding until 2030.

The obligation of the Health System to make payments on its bonds with respect to interest is in no way conditional upon the Health System's receipt of payments from the interest rate swap agreement counterparty.

As of June 30, 2018, there was no liability for interest rate swaps as all remaining swaps were terminated in February 2018. For the year ended June 30, 2018, the Health System recognized a non-operating loss due to swap termination of $14,247,000 relating to the swap termination. As of June 30, 2017, the fair value of the Health System's interest rate swaps was a liability of $20,916,000. The change in fair value during the years ended June 30, 2018 and 2017 was a decrease of $4,897,000 and $8,002,000, respectively. For the years ended June 30, 2018 and 2017 the Health System recognized a non-operating gain of $145,000 and $124,000 resulting from hedge ineffectiveness and amortization of frozen swaps.

10. Employee Benefits

All eligible employees of the Health System are covered under various defined benefit and/or define contribution plans. In addition, certain affiliates 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 or had been approved by the applicable Board of Trustees to be frozen by January 31, 2017.

In December of 2016 the Board of Trustees approved to accelerate the freeze date on the remaining pension plan from December 31, 2017 to January 31, 2017. Effective with that date, the last of the participants earning benefits in any of the Health System's defined benefit plans will no longer earn benefits under the 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, 2018 and 2017:

(in thousands of dollars)	2018	2017
Service cost for benefits earned during the year	$ 150	$ 5,736
Interest cost on projected benefit obligation	47,190	47,316
Expected return on plan assets	(64,561)	(64,169)
Net prior service cost	-	109
Net loss amortization	10,593	20,267
Special/contractural termination benefits	-	119
One-time benefit upon plan freeze acceleration	-	9,519
	$ (6,628)	$ 18,897

The following assumptions were used to determine net periodic pension expense as of June 30, 2018 and 2017:

	2018	2017
Discount rate	4.00 % – 4.30 %	4.20 % – 4.90 %
Rate of increase in compensation	N/A	Age Graded - N/A
Expected long-term rate of return on plan assets	7.50 % – 7.75 %	7.50 % – 7.75 %

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, 2018 and 2017:

(in thousands of dollars)	2018	2017
Change in benefit obligation		
Benefit obligation at beginning of year	$ 1,122,615	$ 1,096,619
Service cost	150	5,736
Interest cost	47,190	47,316
Benefits paid	(47,550)	(43,276)
Expenses paid	(172)	(183)
Actuarial (gain) loss	(34,293)	6,884
One-time benefit upon plan freeze acceleration	-	9,519
Benefit obligation at end of year	1,087,940	1,122,615
Change in plan assets		
Fair value of plan assets at beginning of year	878,701	872,320
Actual return on plan assets	33,291	44,763
Benefits paid	(47,550)	(43,276)
Expenses paid	(172)	(183)
Employer contributions	20,713	5,077
Fair value of plan assets at end of year	884,983	878,701
Funded status of the plans	(202,957)	(243,914)
Less: Current portion of liability for pension	(45)	(46)
Long term portion of liability for pension	(202,912)	(243,868)
Liability for pension	$ (202,957)	$ (243,914)

For the years ended June 30, 2018 and 2017 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 unrestricted net assets include approximately $418,971,000 and $429,782,000 of net actuarial loss as of June 30, 2018 and 2017, respectively.

The estimated amounts to be amortized from unrestricted net assets into net periodic pension expense in fiscal year 2019 for net actuarial losses is $10,357,000.

The accumulated benefit obligation for the defined benefit pension plans was approximately $1,087,991,000 and $1,123,010,000 at June 30, 2018 and 2017, respectively.

The following table sets forth the assumptions used to determine the benefit obligation at June 30, 2018 and 2017:

	2018	2017
Discount rate	4.20 % – 4.50 %	4.00 % – 4.30 %
Rate of increase in compensation	N/A	N/A - 0.00 %

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, 2018 and 2017, it is expected that the LDI strategy will hedge approximately 60% and 55%, respectively, of the interest rate risk associated with pension liabilities. 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	38
Global debt securities	6–26	8
Domestic equities	5–35	19
International equities	5–15	11
Emerging market equities	3–13	5
Real estate investment trust funds	0–5	0
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 6. 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 these funds rather than in securities underlying each fund and, therefore, are

generally required to consider such investments as Level 2 or 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, 2018 and 2017:

	2018					
(in thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Investments						
Cash and short-term investments	$ 142	$ 35,817	$ -	$ 35,959	Daily	1
U.S. government securities	46,265	-	-	46,265	Daily–Monthly	1–15
Domestic debt securities	144,131	220,202	-	364,333	Daily–Monthly	1–15
Global debt securities	470	74,676	-	75,146	Daily–Monthly	1–15
Domestic equities	158,634	17,594	-	176,228	Daily–Monthly	1–10
International equities	18,656	80,803	-	99,459	Daily–Monthly	1–11
Emerging market equities	382	39,881	-	40,263	Daily–Monthly	1–17
REIT funds	371	2,686	-	3,057	Daily–Monthly	1–17
Private equity funds	-	-	23	23	See Note 6	See Note 6
Hedge funds	-	-	44,250	44,250	Quarterly–Annual	60–96
Total investments	$ 369,051	$ 471,659	$ 44,273	$ 884,983		

	2017					
(in thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Investments						
Cash and short-term investments	$ 23	$ 29,792	$ -	$ 29,815	Daily	1
U.S. government securities	7,875	-	-	7,875	Daily–Monthly	1–15
Domestic debt securities	140,498	243,427	-	383,925	Daily–Monthly	1–15
Global debt securities	426	90,389	-	90,815	Daily–Monthly	1–15
Domestic equities	154,597	16,938	-	171,535	Daily–Monthly	1–10
International equities	9,837	93,950	-	103,787	Daily–Monthly	1–11
Emerging market equities	2,141	45,351	-	47,492	Daily–Monthly	1–17
REIT funds	362	2,492	-	2,854	Daily–Monthly	1–17
Private equity funds	-	-	96	96	See Note 6	See Note 6
Hedge funds	-	-	40,507	40,507	Quarterly–Annual	60–96
Total investments	$ 315,759	$ 522,339	$ 40,603	$ 878,701		

The following table presents additional information about the changes in Level 3 assets measured at fair value for the years ended June 30, 2018 and 2017:

	2018		
(in thousands of dollars)	Hedge Funds	Private Equity Funds	Total
Balances at beginning of year	$ 40,507	$ 96	$ 40,603
Sales	-	(51)	(51)
Net realized (losses) gains	-	(51)	(51)
Net unrealized gains	3,743	29	3,772
Balances at end of year	$ 44,250	$ 23	$ 44,273

	2017		
(in thousands of dollars)	Hedge Funds	Private Equity Funds	Total
Balances at beginning of year	$ 38,988	$ 255	$ 39,243
Sales	(880)	(132)	(1,012)
Net realized (losses) gains	33	36	69
Net unrealized gains	2,366	(63)	2,303
Balances at end of year	$ 40,507	$ 96	$ 40,603

The total aggregate net unrealized gains (losses) included in the fair value of the Level 3 investments as of June 30, 2018 and 2017 were approximately $14,743,000 and $7,965,000, respectively. There were no transfers into and out of Level 3 measurements during the years ended June 30, 2018 and 2017.

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, 2018 and 2017.

The weighted average asset allocation for the Health System's Plans at June 30, 2018 and 2017 by asset category is as follows:

	2018	2017
Cash and short-term investments	4 %	3 %
U.S. government securities	5	1
Domestic debt securities	41	44
Global debt securities	9	10
Domestic equities	20	20
International equities	11	12
Emerging market equities	5	5
Hedge funds	5	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 $20,480,000 to the Plans in 2019 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)

2019	$ 49,482
2020	51,913
2021	54,249
2022	56,728
2023	59,314
2024 – 2027	329,488

Defined Contribution Plans
The Health System has an employer-sponsored 401(a) plan for certain of its affiliates, 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 $38,563,000 and $33,375,000 in 2018 and 2017, 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 affiliate and plan. No employer contributions were made to any of these plans in 2018 and 2017 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, 2018 and 2017:

(in thousands of dollars)	2018	2017
Service cost	$ 533	$ 448
Interest cost	1,712	2,041
Net prior service income	(5,974)	(5,974)
Net loss amortization	10	689
	$ (3,719)	$ (2,796)

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, 2018 and 2017:

(in thousands of dollars)	2018	2017
Change in benefit obligation		
Benefit obligation at beginning of year	$ 42,277	$ 51,370
Service cost	533	448
Interest cost	1,712	2,041
Benefits paid	(3,174)	(3,211)
Actuarial loss (gain)	1,233	(8,337)
Employer contributions	-	(34)
Benefit obligation at end of year	42,581	42,277
Funded status of the plans	$ (42,581)	$ (42,277)
Current portion of liability for postretirement medical and life benefits	$ (3,266)	$ (3,174)
Long term portion of liability for postretirement medical and life benefits	(39,315)	(39,103)
Liability for postretirement medical and life benefits	$ (42,581)	$ (42,277)

For the years ended June 30, 2018 and 2017 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 unrestricted net assets are as follows:

(in thousands of dollars)	2018	2017
Net prior service income	$ (15,530)	$ (21,504)
Net actuarial loss	3,336	2,054
	$ (12,194)	$ (19,450)

The estimated amounts that will be amortized from unrestricted net assets into net periodic postretirement income in fiscal year 2019 for net prior service cost is $5,974,000.

The following future benefit payments, which reflect expected future service, as appropriate, are expected to be paid for the year ending June 30, 2019 and thereafter:

(in thousands of dollars)	
2019	$ 3,266
2020	3,298
2021	3,309
2022	3,315
2023	3,295
2024-2027	15,156

In determining the accumulated postretirement medical and life benefit obligation, the Health System used a discount rate of 4.50% in 2018 and an assumed healthcare cost trend rate of 6.00%, trending down to 4.75% in 2021 and thereafter. Increasing the assumed healthcare cost trend rates by one percentage point in each year would increase the accumulated postretirement medical benefit obligation as of June 30, 2018 and 2017 by $1,088,000 and $1,067,000 and the net periodic postretirement medical benefit cost for the years then ended by $81,000 and $110,000, respectively. Decreasing the assumed healthcare cost trend rates by one percentage point in each year would decrease the accumulated postretirement medical benefit obligation as of June 30, 2018 and 2017 by $996,000 and $974,000 and the net periodic postretirement medical benefit cost for the years then ended by $72,000 and $96,000, respectively.

11. Professional and General Liability Insurance Coverage

D-H, along with Dartmouth College, Cheshire, NLH and MAHHC 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, 2017 VNH 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.

APD are covered for malpractice claims under a modified claims-made policy purchased through New England Alliance for Health (NEAH). While APD remain in the current insurance program under this policy, the coverage year is based on the date the claim is filed; subject to a medical incident arising after the retroactive date (includes prior acts). The policy provides modified claims-made coverage for former insured providers for claims that relate to the employee's period of employment at APD and for services that were provided within the scope of the employee's duties. Therefore, when the employee leaves the corporation, tail coverage is not required.

Selected financial data of HAC and RRG, taken from the latest available audited and unaudited financial statements, respectively at June 30, 2018 and 2017 are summarized as follows:

	2018		
	HAC	RRG	Total
(in thousands of dollars)	*(audited)*	*(unaudited)*	
Assets	$ 72,753	$ 2,068	$ 74,821
Shareholders' equity	13,620	50	13,670
Net income	-	(751)	(751)

	2017		
	HAC	RRG	Total
(in thousands of dollars)	*(audited)*	*(unaudited)*	
Assets	$ 76,185	$ 2,055	$ 78,240
Shareholders' equity	13,620	801	14,421
Net income	-	(5)	(5)

12. 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.

Operating Leases and Other Commitments
The Health System leases certain facilities and equipment under operating leases with varying expiration dates. The Health System's rental expense totaled approximately $14,096,000 and $15,802,000 for the years ended June 30, 2018 and 2017, respectively.

Minimum future lease payments under noncancelable operating leases at June 30, 2018 were as follows:

(in thousands of dollars)

2019	$ 12,393
2020	10,120
2021	8,352
2022	5,175
2023	3,935
Thereafter	10,263
	$ 50,238

Lines of Credit
The Health System has entered into Loan Agreements with financial institutions establishing access to revolving loans ranging from $2,000,000 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 29, 2019. There was no outstanding balance under the lines of credit as of June 30, 2018 and 2017. Interest expense was approximately $232,000 and $915,000, respectively, and is included in the consolidated statements of operations and changes in net assets.

13. Functional Expenses

Operating expenses of the Health System by function are as follows for the years ended June 30, 2018 and 2017:

(in thousands of dollars)	2018	2017
Program services	$ 1,715,760	$ 1,662,413
Management and general	303,527	311,820
Fundraising	2,354	2,328
	$ 2,021,641	$ 1,976,561

14. Subsequent Events

The Health System has assessed the impact of subsequent events through November 7, 2018, 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.

Effective July 1, 2018, APD became the sole corporate member of APD LifeCare Center Inc. APD LifeCare Center Inc. owns and operates Harvest Hill, an assisted living facility, the Woodlands, a residential living community and the Elizabeth S. Hughes Care Unit, which provides hospice care.

APD and APD LifeCare Center (LifeCare) were jointly liable for their Series 2010 Revenue Bonds; $26,000,000 outstanding as of June 30, 2018. As described in Note 9 to the financial statements, APD's portion was approximately $15,500,000 as of June 30, 2018. LifeCare's outstanding portion of approximately $10,500,000 was appropriately excluded from the consolidated financial statements as LifeCare was not affiliated with any of the members of the Health System as of June 30, 2018. On August 15, 2018, APD joined the DHOG and simultaneously issued NHHEFA Revenue Bonds, Series 2018C. The Series 2018C Revenue Bonds were used primarily to refinance the joint (APD and LifeCare) Series 2010 Revenue Bonds.

Consolidating Supplemental Information – Unaudited

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2018

(In thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	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	$ 134,634	$ 22,544	$ 6,688	$ 9,419	$ 6,604	$ -	$ 179,889	$ 20,280	$ -	$ 200,169
Patient accounts receivable, net	-	176,881	17,163	8,302	5,055	-	207,521	11,707	-	219,228
Prepaid expenses and other current assets	11,954	143,893	6,551	5,253	2,313	(72,361)	97,613	4,766	(4,877)	97,502
Total current assets	146,588	343,418	30,422	22,974	13,972	(72,361)	485,023	36,753	(4,877)	516,899
Assets limited as to use	8	616,829	17,436	12,821	10,829	-	658,025	48,099	-	706,124
Notes receivable, related party	564,771	-	-	-	-	(564,771)	-	-	-	-
Other investments for restricted activities	-	87,613	8,591	2,861	8,238	-	105,423	25,473	-	130,896
Property, plant, and equipment, net	36	443,154	86,759	42,438	17,356	-	589,743	37,578	-	607,321
Other assets	24,663	101,078	1,370	9,906	4,260	(10,870)	129,527	3,804	(21,346)	108,785
Total assets	$ 726,276	$ 1,592,192	$ 124,580	$ 87,120	$ 52,675	$ (638,102)	$ 1,944,741	$ 151,907	$ (26,223)	$ 2,070,025
Liabilities and Net Assets										
Current liabilities										
Current portion of long-term debt	$ -	$ 1,031	$ 610	$ 572	$ 187	$ -	$ 2,800	$ 864	$ -	$ 3,464
Current portion of liability for pension and other postretirement plan benefits	-	3,311	-	-	-	-	3,311	-	-	3,311
Accounts payable and accrued expenses	54,986	82,081	20,107	6,705	3,029	(72,361)	94,536	8,094	(4,877)	85,753
Accrued compensation and related benefits	-	108,486	5,730	2,467	3,796	-	118,498	7,078	-	125,576
Estimated third-party settlements	3,022	24,411	-	9,855	1,625	-	38,893	2,448	-	41,141
Total current liabilities	57,997	217,298	26,647	19,419	8,637	(72,361)	257,638	18,484	(4,877)	269,245
Notes payable, related party	-	527,348	-	27,425	-	(564,771)	-	-	-	-
Long-term debt, excluding current portion	644,520	82,878	25,364	1,178	11,270	(10,970)	724,231	28,744	-	752,975
Insurance deposits and related liabilities	-	54,618	465	155	240	-	55,476	40	-	95,516
Liability for pension and other postretirement plan benefits, excluding current portion	-	232,606	4,215	-	5,316	-	242,227	-	-	242,227
Other liabilities	-	85,577	1,107	1,405	-	-	88,089	38	-	88,127
Total liabilities	702,517	1,170,412	57,798	49,583	25,463	(638,102)	1,367,661	45,306	(4,877)	1,408,090
Commitments and contingencies										
Net assets										
Unrestricted	23,759	334,882	61,828	32,887	19,812	-	473,178	72,230	(21,308)	524,102
Temporarily restricted	-	54,686	4,964	483	1,540	-	61,663	20,816	(40)	82,439
Permanently restricted	-	32,232	-	4,147	5,860	-	42,239	13,155	-	55,394
Total net assets	23,759	421,780	66,792	37,537	27,212	-	577,080	106,201	(21,348)	661,935
Total liabilities and net assets	$ 726,276	$ 1,592,192	$ 124,580	$ 87,120	$ 52,675	$ (638,102)	$ 1,944,741	$ 151,907	$ (26,223)	$ 2,070,025

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2018

(in thousands of dollars)	D-HH (Parent)	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	$ 134,634	$ 23,094	$ 8,621	$ 9,982	$ 6,654	$ 12,144	$ 5,040	$ -	$ 200,168
Patient accounts receivable, net	-	176,881	17,163	8,302	5,109	7,998	3,657	-	219,228
Prepaid expenses and other current assets	11,954	144,755	5,520	5,276	2,294	4,443	488	(77,238)	97,502
Total current assets	146,588	344,830	31,324	23,560	14,057	24,583	9,185	(77,238)	516,899
Assets limited as to use	8	635,028	17,436	12,621	11,862	9,612	19,355	-	706,124
Notes receivable, related party	554,771	-	-	-	-	-	-	(554,771)	-
Other investments for restricted activities	-	95,772	25,873	2,981	6,238	32	-	-	130,896
Property, plant, and equipment, net	36	445,829	70,807	42,920	19,065	25,725	3,139	-	607,321
Other assets	24,883	101,235	7,526	5,333	1,886	130	128	(32,316)	108,785
Total assets	$ 726,276	$ 1,622,694	$ 152,768	$ 87,615	$ 53,108	$ 60,082	$ 31,807	$ (664,325)	$ 2,070,025
Liabilities and Net Assets									
Current liabilities									
Current portion of long-term debt	$ -	$ 1,031	$ 810	$ 572	$ 245	$ 739	$ 67	$ -	$ 3,464
Current portion of liability for pension and other postretirement plan benefits	-	3,311	-	-	-	-	-	-	3,311
Accounts payable and accrued expenses	54,995	82,813	20,052	6,714	3,092	3,596	1,829	(77,238)	95,753
Accrued compensation and related benefits	-	106,485	5,730	2,487	3,831	5,814	1,229	-	125,576
Estimated third-party settlements	3,002	24,411	-	9,655	1,629	2,448	-	-	41,141
Total current liabilities	57,997	217,851	26,592	19,428	8,793	12,597	3,225	(77,238)	269,245
Notes payable, related party	-	527,346	-	27,425	-	-	-	(554,771)	-
Long-term debt, excluding current portion	644,520	52,878	25,354	1,179	11,583	25,792	2,629	(10,970)	752,975
Insurance deposits and related liabilities	-	54,816	465	155	241	-	39	-	55,516
Liability for pension and other postretirement plan benefits, excluding current portion	-	232,696	4,215	-	5,316	-	-	-	242,227
Other liabilities	-	85,577	1,117	1,405	-	26	-	-	88,127
Total liabilities	702,517	1,170,964	57,743	49,592	25,943	38,417	5,893	(642,979)	1,408,080
Commitments and contingencies									
Net assets									
Unrestricted	23,759	356,518	65,069	33,383	19,784	21,031	25,884	(21,306)	524,102
Temporarily restricted	-	80,836	19,196	493	1,539	415	-	(40)	82,439
Permanently restricted	-	34,376	10,760	4,147	5,862	219	30	-	55,394
Total net assets	23,759	451,730	95,025	38,023	27,165	21,665	25,914	(21,346)	661,935
Total liabilities and net assets	$ 726,276	$ 1,622,694	$ 152,768	$ 87,615	$ 53,108	$ 60,082	$ 31,807	$ (664,325)	$ 2,070,025

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2017

(In thousands of dollars)	Dartmouth-Hitchcock	Cheshire Medical Center	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	OH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Assets									
Current assets									
Cash and cash equivalents	$ 27,328	$ 10,645	$ 7,797	$ 6,662	$ -	$ 52,432	$ 16,066	$ -	$ 68,498
Patient accounts receivable, net	193,733	17,723	8,539	4,659	-	224,654	12,606	-	237,260
Prepaid expenses and other current assets	93,816	6,945	3,850	1,351	(18,585)	89,177	8,034	(8,008)	89,203
Total current assets	314,877	35,313	19,986	12,672	(18,585)	366,263	36,706	(8,008)	394,961
Assets limited as to use	580,254	19,104	11,784	8,058	-	620,200	42,123	-	662,323
Other investments for restricted activities	86,398	4,784	2,833	6,079	-	100,074	24,455	-	124,529
Property, plant, and equipment, net	448,743	64,833	43,264	17,167	-	574,107	35,868	-	609,975
Other assets	89,650	2,543	5,985	4,095	(11,520)	90,733	27,674	(21,287)	97,120
Total assets	$ 1,519,922	$ 126,657	$ 83,832	$ 49,071	$ (28,105)	$ 1,751,377	$ 166,826	$ (29,295)	$ 1,888,908
Liabilities and Net Assets									
Current liabilities									
Current portion of long-term debt	$ 18,034	$ 780	$ 737	$ 80	$ -	$ 17,631	$ 726	$ -	$ 18,357
Line of credit	-	-	-	550	(550)	-	-	-	-
Current portion of liability for pension and other postretirement plan benefits	3,220	-	-	-	-	3,220	-	-	3,220
Accounts payable and accrued expenses	72,362	19,715	5,356	2,854	(18,585)	83,702	13,466	(8,008)	89,160
Accrued compensation and related benefits	89,638	5,428	2,335	3,448	-	110,849	4,062	-	114,911
Estimated third-party settlements	11,322	-	7,265	1,915	-	20,502	6,931	-	27,433
Total current liabilities	202,576	25,923	15,693	8,847	(17,135)	235,904	25,185	(8,008)	253,081
Long-term debt, excluding current portion	545,100	26,185	26,402	10,976	(10,970)	597,693	18,710	-	616,403
Insurance deposits and related liabilities	50,960	-	-	-	-	50,960	-	-	50,960
Interest rate swaps	17,606	-	3,310	-	-	20,916	-	-	20,916
Liability for pension and other postretirement plan benefits, excluding current portion	267,409	8,761	-	6,801	-	282,971	-	-	282,971
Other liabilities	77,822	2,636	1,426	-	-	81,884	8,864	-	90,548
Total liabilities	1,161,273	63,505	46,831	26,624	(28,105)	1,270,128	52,759	(8,008)	1,314,879
Commitments and contingencies									
Net assets									
Unrestricted	258,687	58,250	32,504	15,247	-	364,888	81,344	(21,285)	424,947
Temporarily restricted	68,473	4,902	345	1,363	-	75,083	19,836	(2)	94,917
Permanently restricted	31,289	-	4,152	5,837	-	41,278	12,887	-	54,165
Total net assets	358,649	63,152	37,001	22,447	-	481,249	114,067	(21,287)	574,029
Total liabilities and net assets	$ 1,519,922	$ 126,657	$ 83,832	$ 49,071	$ (28,105)	$ 1,751,377	$ 166,826	$ (29,295)	$ 1,888,908

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2017

(In thousands of dollars)	D-HH (Parent)	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	$ 1,166	$ 27,760	$ 11,601	$ 6,280	$ 6,958	$ 8,129	$ 4,584	$ -	$ 66,498
Patient accounts receivable, net	-	193,733	17,723	6,539	4,681	8,878	3,706	-	237,260
Prepaid expenses and other current assets	3,884	94,305	5,899	3,671	1,340	4,179	518	(24,583)	89,203
Total current assets	5,050	315,798	35,223	20,490	12,979	21,186	8,818	(24,583)	394,961
Assets limited as to use	-	596,904	19,104	11,782	9,889	8,168	16,476	-	662,323
Other investments for restricted activities	6	94,210	21,204	2,833	6,079	197	-	-	124,529
Property, plant, and equipment, net	50	451,418	68,921	43,751	18,935	23,447	3,453	-	609,975
Other assets	23,866	89,819	8,586	5,378	1,812	283	183	(32,807)	97,120
Total assets	$ 28,972	$ 1,548,149	$ 153,038	$ 84,234	$ 49,704	$ 53,281	$ 28,930	$ (57,400)	$ 1,888,908
Liabilities and Net Assets									
Current liabilities									
Current portion of long-term debt	$ -	$ 16,034	$ 780	$ 737	$ 137	$ 803	$ 66	$ -	$ 18,357
Line of credit	-	-	-	-	550	-	-	(550)	-
Current portion of liability for pension and other postretirement plan benefits	-	3,220	-	-	-	-	-	-	3,220
Accounts payable and accrued expenses	5,996	72,908	19,718	5,365	2,946	5,048	1,874	(24,583)	89,160
Accrued compensation and related benefits	-	99,638	5,428	2,335	3,480	2,996	1,032	-	114,911
Estimated third-party settlements	6,165	11,322	-	7,265	1,915	766	-	-	27,433
Total current liabilities	12,161	203,020	25,926	15,702	9,028	9,415	2,972	(25,143)	253,081
Long-term debt, excluding current portion	-	545,100	26,185	26,402	11,356	15,633	2,697	(10,870)	616,403
Insurance deposits and related liabilities	-	50,960	-	-	-	-	-	-	50,960
Interest rate swaps	-	17,606	-	3,310	-	-	-	-	20,916
Liability for pension and other postretirement plan benefits, excluding current portion	-	267,409	8,761	-	6,801	-	-	-	282,971
Other liabilities	-	77,622	2,531	1,426	-	8,969	-	-	90,548
Total liabilities	12,161	1,161,717	63,403	46,840	27,185	34,017	5,669	(36,113)	1,314,879
Commitments and contingencies									
Net assets									
Unrestricted	16,367	278,695	60,758	32,897	15,319	18,865	23,231	(21,285)	424,947
Temporarily restricted	444	74,304	18,198	345	1,363	265	-	(2)	94,917
Permanently restricted	-	33,433	10,678	4,152	5,837	34	30	-	54,165
Total net assets	16,811	386,432	89,635	37,394	22,519	19,264	23,261	(21,287)	574,029
Total liabilities and net assets	$ 28,972	$ 1,548,149	$ 153,038	$ 84,234	$ 49,704	$ 53,281	$ 28,930	$ (57,400)	$ 1,888,908

Dartmouth-Hitchcock Health and Subsidiaries

Consolidating Statements of Operations and Changes in Unrestricted Net Assets

Year Ended June 30, 2018

(in thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Obligated Group Affiliates	Eliminations	Health System Consolidated
Unrestricted revenues and other support										
Net patient service revenue, net of contractual allowances and discounts	$ -	$ 1,475,314	$ 216,736	$ 88,486	$ 92,014	$ -	$ 1,884,550	$ 94,548	$ -	$ 1,889,098
Provisions for bad debts	-	31,308	16,997	1,954	1,440	-	49,319	2,048	-	47,367
Net patient service revenue less provisions for bad debts	-	1,443,886	399,799	86,532	90,574	-	1,788,231	92,497	-	1,881,736
Contracted revenue	(2,985)	97,381	-	-	2,189	(42,979)	54,386	716	(32)	54,969
Other operating revenue	9,788	134,481	3,388	4,188	1,814	(10,864)	143,084	6,978	(1,088)	148,946
Net assets released from restrictions	854	11,809	879	52	44	-	13,879	482	-	13,481
Total unrestricted revenue and other support	8,177	1,687,313	209,754	83,153	94,691	(53,424)	1,999,549	100,973	(1,118)	2,099,104
Operating expenses										
Salaries	-	806,344	109,607	38,389	34,654	(21,542)	946,623	42,036	1,606	988,263
Employee benefits	-	161,833	36,343	7,252	7,000	(3,366)	219,043	10,221	419	229,683
Medical supplies and medications	-	298,327	31,265	8,161	3,055	-	339,536	10,186	-	349,631
Purchased services and other	5,809	216,073	33,088	13,987	13,988	(10,364)	284,609	39,386	(2,616)	291,372
Medicaid enhancement tax	-	53,044	8,979	2,689	1,744	-	66,317	2,178	-	67,682
Depreciation and amortization	33	66,973	10,217	3,934	3,639	-	83,277	2,981	-	84,778
Interest	8,864	15,773	1,004	991	224	(6,847)	17,797	1,026	-	18,822
Total operating expenses	17,216	1,627,465	217,995	84,934	82,897	(25,207)	1,924,879	97,956	(794)	2,821,841
Operating (loss) margin	(9,039)	59,847	(8,241)	(1,781)	1,734	1,779	44,670	3,117	(324)	47,453
Non-operating (losses) gains										
Investment (losses) gains	(28)	33,629	1,408	1,191	858	(998)	36,021	3,988	-	40,387
Other, net	(1,364)	(2,989)	-	1,778	388	(1,581)	(4,822)	733	361	(2,888)
Loss on early extinguishment of debt	-	(13,809)	-	(388)	-	-	(14,214)	-	-	(14,214)
Loss on swap termination	-	(14,247)	-	-	-	-	(14,247)	-	-	(14,247)
Total non-operating (losses) gains, net	(1,392)	2,673	1,408	2,122	1,124	(1,779)	4,256	4,256	361	8,018
(Deficiency) excess of revenue over expenses	(10,464)	62,720	(6,437)	341	2,858	-	48,926	7,416	37	56,481
Unrestricted net assets										
Net assets released from restrictions (Note 7)	-	10,836	-	4	252	-	10,384	10	-	10,313
Change in funded status of pension and other postretirement benefits	-	4,300	2,827	-	1,127	-	8,254	-	-	8,254
Net assets transferred to (from) affiliates	17,791	(25,366)	7,186	48	326	-	-	-	-	-
Additional paid in capital	-	-	-	-	-	-	-	94	(94)	-
Other changes in net assets	-	-	-	-	-	-	-	(185)	-	(185)
Change in fair value on interest rate swaps	-	4,180	-	-	-	-	4,180	-	-	4,180
Change in funded status of interest rate swaps	-	14,107	-	-	-	-	14,107	-	-	14,107
Increase in unrestricted net assets	$ 7,327	$ 75,995	$ 3,576	$ 393	$ 4,565	$ -	$ 91,866	$ 7,335	$ (21)	$ 99,153

Dartmouth-Hitchcock Health and Subsidiaries

Consolidating Statements of Operations and Changes in Unrestricted Net Assets

Year Ended June 30, 2018

(in thousands of dollars)	D-HH (Parent)	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD	VNH and Subsidiaries	Eliminations	Health System Consolidated
Unrestricted revenue and other support									
Net patient service revenue, net of contractual allowances and discounts	$ -	$ 1,475,314	$ 216,736	$ 90,488	$ 92,014	$ 71,488	$ 23,087	$ -	$ 1,868,080
Provision for bad debts	-	31,308	10,967	1,954	1,440	1,990	388	-	47,347
Net patient service revenue less provision for bad debt	-	1,443,986	205,769	88,532	90,574	69,778	22,719	-	1,851,728
Contracted revenue	(2,309)	96,007	-	-	2,189	-	-	(42,822)	54,065
Other operating revenue	9,789	137,342	4,681	4,166	3,188	1,897	463	(11,840)	148,946
Net assets released from restrictions	656	11,864	670	82	44	103	-	-	13,481
Total unrestricted revenue and other support	8,152	1,691,196	210,450	93,190	95,955	71,878	23,172	(54,662)	2,099,104
Operating expenses									
Salaries	-	808,344	105,607	30,380	29,982	29,215	12,082	(19,937)	988,393
Employee benefits	-	181,833	28,343	7,252	7,162	7,406	2,853	(4,866)	229,983
Medical supplies and medications	-	288,327	31,393	6,181	2,857	6,464	1,709	-	340,031
Purchased services and other	8,812	216,880	33,491	13,432	14,264	19,220	8,846	(22,212)	291,372
Medicaid enhancement tax	-	83,044	8,670	2,888	1,743	2,178	-	-	97,882
Depreciation and amortization	23	66,673	10,357	3,838	2,148	1,831	410	-	84,778
Interest	8,884	15,772	1,004	981	723	973	85	(8,852)	19,572
Total operating expenses	17,719	1,831,083	218,105	64,764	64,276	69,307	22,884	(55,867)	2,021,841
Operating (loss) margin	(9,567)	(60,106)	(7,655)	(1,574)	1,679	2,571	288	1,405	47,463
Non-operating (losses) gains									
Investment (losses) gains	(29)	36,177	1,864	1,087	782	269	1,365	(196)	40,367
Other, net	(1,384)	(2,999)	(9)	1,276	273	(223)	882	(1,230)	(2,809)
Loss on early extinguishment of debt	-	(13,808)	-	(306)	-	-	-	-	(14,214)
Loss on swap termination	-	(14,247)	-	-	-	-	-	-	(14,247)
Total non-operating (losses) gains, net	(1,380)	4,422	1,871	2,068	1,055	(20)	2,349	(1,418)	9,018
(Deficiency) excess of revenue over expenses	(10,457)	64,328	(5,784)	434	2,738	2,251	2,653	37	56,481
Unrestricted net assets									
Net assets released from restrictions (Note 7)	-	18,058	-	4	231	-	-	-	18,313
Change in funded status of pension and other postretirement benefits	-	4,300	2,627	-	1,127	-	-	-	8,254
Net assets transferred to (from) affiliates	17,791	(23,308)	7,198	48	328	-	-	-	-
Additional paid in capital	58	-	-	-	-	-	-	(58)	-
Other changes in net assets	-	-	-	-	-	(188)	-	-	(188)
Change in fair value on interest rate swaps	-	4,180	-	-	-	-	-	-	4,180
Change in funded status of interest rate swaps	-	14,102	-	-	-	-	-	-	14,102
Increase in unrestricted net assets	$ 7,392	$ 77,623	$ 4,311	$ 486	$ 4,446	$ 2,088	$ 2,653	$ (21)	$ 99,156

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Unrestricted Net Assets
Year Ended June 30, 2017

(In thousands of dollars)	Dartmouth-Hitchcock	Cheshire Medical Center	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
Unrestricted revenue and other support									
Net patient service revenue, net of contractual allowances and discounts	$ 1,447,661	$ 214,268	$ 89,828	$ 48,072	$ (19)	$ 1,779,207	$ 86,995	$ -	$ 1,866,192
Provisions for bad debts	42,883	14,123	2,010	1,705	-	60,823	2,842	-	63,645
Net patient service revenue less provisions for bad debts	1,404,888	200,140	87,818	46,367	(19)	1,718,404	84,143	-	1,788,547
Contracted revenue	88,620	-	-	1,881	(41,771)	48,710	(4,868)	(44)	43,671
Other operating revenue	104,811	3,045	3,838	1,982	(1,148)	111,838	6,418	820	119,177
Net assets released from restrictions	9,350	636	116	61	-	10,266	756	-	11,122
Total unrestricted revenue and other support	1,607,779	203,824	91,873	48,861	(42,939)	1,889,418	86,322	776	1,899,517
Operating expenses									
Salaries	787,644	102,769	30,311	23,548	(21,784)	922,488	42,327	1,836	966,302
Employee benefits	202,178	30,832	7,071	9,523	(5,322)	236,082	8,392	381	244,855
Medical supplies and medications	257,100	30,882	6,143	2,903	(273)	296,857	9,313	-	306,090
Purchased services and other	308,671	36,096	12,799	13,234	(17,329)	348,433	45,331	(869)	388,809
Medicaid enhancement tax	80,118	7,900	1,823	1,820	-	92,461	2,806	-	95,268
Depreciation and amortization	66,067	10,236	3,881	2,138	-	82,324	2,236	-	84,562
Interest	17,352	1,127	816	248	(209)	19,334	900	-	19,634
Total operating expenses	1,809,130	207,376	63,843	49,205	(44,917)	1,884,884	110,809	876	1,879,961
Operating margin (loss)	18,648	(3,572)	(5,970)	673	1,978	13,729	(22,987)	(182)	(7,044)
Non-operating gains (losses)									
Investment gains (losses)	42,464	1,376	1,570	864	(208)	46,207	4,849	-	51,056
Other, net	(3,003)	-	(679)	570	(1,767)	(5,079)	740	186	(4,153)
Contribution revenue from separation	-	-	-	-	-	-	20,215	-	20,215
Total non-operating gains (losses), net	39,461	1,376	891	1,354	(1,975)	41,128	25,804	186	67,118
Excess (deficiency) of revenue over expenses	58,130	(2,134)	(1,379)	2,227	(1)	56,853	3,317	4	60,074
Unrestricted net assets									
Net assets released from restrictions (Note 7)	993	-	9	442	-	1,434	405	-	1,839
Change in funded status of pension and other postretirement benefits	(5,287)	4,031	-	(321)	-	(1,557)	-	-	(1,557)
Net assets transferred (from) to affiliates	(16,360)	900	143	988	-	(16,351)	16,351	-	-
Additional paid in capital	-	-	-	-	-	-	6,309	(6,309)	-
Other changes in net assets	-	-	-	(2,288)	-	(2,288)	(1,078)	-	(3,364)
Change in fair value on interest rate swaps	6,418	-	1,337	47	-	7,802	-	-	7,802
Increase in unrestricted net assets	$ 41,954	$ 2,807	$ 110	$ 1,095	$ (1)	$ 45,895	$ 25,294	$ (6,305)	$ 64,784

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Unrestricted Net Assets
Year Ended June 30, 2017

(In thousands of dollars)	D-HH (Parent)	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD	VNH and Subsidiaries	Eliminations	Health System Consolidated
Unrestricted revenue and other support									
Net patient service revenue, net of contractual allowances and discounts	$ -	$ 1,447,861	$ 214,285	$ 59,836	$ 46,972	$ 65,838	$ 23,190	$ (19)	$ 1,858,163
Provisions for bad debts	-	43,853	14,175	2,010	1,709	2,278	667	-	63,845
Net patient service revenue less provisions for bad debts	-	1,404,886	200,140	57,918	45,367	63,860	22,563	(19)	1,794,347
Contracted revenue	(5,802)	69,427	-	-	1,861	-	-	(41,819)	43,671
Other operating revenue	673	108,775	3,264	3,837	3,038	1,837	381	(328)	119,177
Net assets released from restrictions	-	10,200	639	119	61	106	-	-	11,122
Total unrestricted revenue and other support	(5,129)	1,611,400	204,043	61,871	51,327	65,203	22,944	(42,167)	1,869,317
Operating expenses									
Salaries	1,009	797,844	102,798	30,311	34,273	39,397	11,187	(20,248)	996,352
Employee benefits	265	202,176	26,632	7,071	8,888	8,832	2,464	(4,841)	244,886
Medical supplies and medications	-	257,100	39,882	6,143	2,808	7,760	1,793	(773)	308,090
Purchased services and other	16,021	212,414	29,802	12,663	13,836	16,364	6,937	(18,262)	289,805
Medicaid enhancement tax	-	80,116	7,600	2,823	1,830	2,838	-	-	95,088
Depreciation and amortization	36	66,087	10,398	3,888	2,242	1,332	413	-	84,562
Interest	-	17,262	1,177	819	249	467	33	(709)	19,638
Total operating expenses	17,349	1,652,873	209,318	63,809	90,601	63,990	22,707	(43,833)	1,878,581
Operating (loss) margin	(22,478)	18,527	(5,275)	(1,938)	726	1,343	237	1,791	(7,044)
Non-operating gains (losses)									
Investment (losses) gains	(321)	44,748	2,134	1,516	1,046	438	1,718	(209)	51,056
Other, net	-	(3,003)	-	(679)	581	(181)	886	(1,579)	(4,153)
Contribution revenue from acquisition	20,215	-	-	-	-	-	-	-	20,215
Total non-operating gains, net	19,894	41,745	2,134	837	1,626	276	2,604	(1,788)	67,118
(Deficiency) excess of revenue over expenses	(2,584)	60,270	(3,151)	(1,298)	2,352	1,621	2,861	3	60,074
Unrestricted net assets									
Net assets released from restrictions (Note 7)	-	1,075	-	8	442	156	156	-	1,838
Change in funded status of pension and other postretirement benefits	-	(8,287)	4,031	-	(321)	-	-	-	(1,567)
Net assets transferred (from) to affiliates	(3,864)	(18,380)	900	143	668	-	20,215	-	-
Additional paid in capital	6,309	-	-	-	-	-	-	(6,309)	-
Other changes in net assets	-	-	-	-	(2,288)	(1,078)	-	-	(3,364)
Change in fair value on interest rate swaps	-	8,418	-	1,337	47	-	-	-	7,802
(Decrease) increase in unrestricted net assets	$ (99)	$ 44,096	$ 1,780	$ 181	$ 1,220	$ 701	$ 23,231	$ (6,306)	$ 64,784

Dartmouth-Hitchcock Health and Subsidiaries
Notes to Supplemental Consolidating Information
June 30, 2018 and 2017

1. Basis of Presentation

The accompanying supplemental consolidating information includes the consolidating balance sheet and the consolidating statement of operations and changes in unrestricted net assets of D-HH and subsidiaries. All intercompany accounts and transactions between D-HH and subsidiaries have been eliminated. The consolidating information presented is prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America consistent with the consolidated financial statements. The consolidating information is presented for purposes of additional analysis of the consolidated financial statements and is not required as part of the basic financial statements.

Schedule of Expenditures of Federal Awards

Dartmouth-Hitchcock Health and Subsidiaries
Schedule of Expenditures of Federal Awards
Year Ended June 30, 2018

Federal Program	CFDA number	Award number/pass-through identification number	Funding source	Pass-through entity	Total expenditures	Amount passed subrecipients
Research and Development Cluster						
U.S. Department of Health and Human Services						
Research on Healthcare Costs, Quality and Outcomes	93.226	1P30HS024403	Direct		$ 701,304	$ 87,600
Total U.S. Department of Health and Human Services					701,304	87,600
Total Research and Development Cluster					701,304	87,600
Other Sponsored Programs						
U.S. Department of Justice						
Crime Victim Assistance	16.575	Not Provided	Pass-Through	(1)	148,032	-
Crime Victim Assistance	16.575	Not Provided	Pass-Through	(1)	19,897	-
Subtotal 16.575					165,929	-
Improving the Investigation and Prosecution of Child Abuse and the Regional and Local Children's Advocacy Centers	16.758	Not Provided	Pass-Through	(2)	7,400	-
Total U.S. Department of Justice					173,329	-
National Endowment for the Arts						
Promotion of the Arts Partnership Agreements	45.025	96,828,653	Pass-Through	(7)	9,580	-
Total National Endowment for the Arts					9,580	-
U.S. Department of Education						
Race to the Top Early Learning Challenge	84.412	03440-34119-18-ELC024	Pass-Through	(8)	22,830	-
Race to the Top Early Learning Challenge	84.412	03420-69518	Pass-Through	(6)	96,576	-
Total U.S. Department of Education					119,406	-
U.S. Department of Health and Human Services						
Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Aligned Cooperative Agreements	93.074	05-95-90-901010-5362-102-500731	Pass-Through	(3)	137,024	-
Maternal and Child Health Federal Consolidated Programs	93.110	H30MC24048	Pass-Through	(4)	22,620	-
Coordinated Services and Access to Research for Women, Infants, Children	93.153	H12HA31112	Direct		328,309	
Coordinated Services and Access to Research for Women, Infants, Children	93.153	5H12HA24861-03-00	Pass-Through	(5)	41,096	-
Subtotal 93.153					369,405	-
Substance Abuse and Mental Health Services Projects of Regional and National Significance	93.243	05-95-90-901010-5362-102-500731	Pass-Through	(3)	197,881	-
Substance Abuse and Mental Health Services Projects of Regional and National Significance	93.243	03420-A180558, 03420-A171058	Pass-Through	(6)	221,190	-
Subtotal 93.243					419,071	-
Drug Free Communities Support Program Grants	93.276	1H79SP020382	Direct		114,190	-
Centers for Disease Control and Prevention: Investigations, Technical Assistance	93.283	Not Provided	Pass-Through	(3)	10,122	
Partnerships to Improve Community Health	93.331	MU58DP005821	Direct		125,214	
Health Care Innovation Awards (HCIA)	93.610	GT-32013-04	Pass-Through	(9)	44,411	-
Affordable Care Act Implementation Support for State Demonstrations to Integrate Care for Medicare-Medicaid Enrollees	93.626	05-95-90-901010-5362-102-500731	Pass-Through	(3)	84,083	-
Preventive Health and Health Services Block Grant funded solely with Prevention and Public Health Funds (PPHF)	93.758	05-95-90-901010-5362-102-500731	Pass-Through	(3)	83,950	
Opioid STR	93.788	05-95-92-920510-25990000	Pass-Through	(3)	219,760	-
Organized Approaches to Increase Colorectal Cancer Screening	93.800	1NU58DP006066	Direct		839,452	-
Hospital Preparedness Program (HPP) Ebola Preparedness and Response Activities	93.817	03420-67558	Pass-Through	(6)	2,276	-
Maternal, Infant and Early Childhood Home Visiting Grant Program	93.870	03420-69518	Pass-Through	(6)	217,618	-
National Bioterrorism Hospital Preparedness Program	93.889	03420-70996	Pass-Through	(6)	2,851	-
National Bioterrorism Hospital Preparedness Program	93.889	Not Provided	Pass-Through	(3)	8,152	
National Bioterrorism Hospital Preparedness Program	93.889	Not Provided	Pass-Through	(3)	60,483	-
Subtotal 93.889					71,486	-

See accompanying notes to the Schedule of Expenditures of Federal Awards

Dartmouth-Hitchcock Health and Subsidiaries
Schedule of Expenditures of Federal Awards
Year Ended June 30, 2018

Federal Program	CFDA number	Award number/pass-through identification number	Funding source	Pass-through entity	Total expenditures	Amount passed subrecipients
Rural Health Care Services Outreach, Rural Health Network Development and Small Health Care Provider Quality Improvement Program	93.912	D06RH31057	Direct		237,563	
Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease	93.918	2H76HA00812-12-01	Pass-Through	(5)	200,232	-
Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease	93.918	H76HA31654	Direct		74,988	-
Subtotal 93.918					275,220	-
Block Grants for Community Mental Health Services	93.958	05-95-622010-4120-102	Pass-Through	(3)	66,772	-
Block Grants for Prevention and Treatment of Substance Abuse	93.959	03420-A180338	Pass-Through	(6)	54,958	-
Block Grants for Prevention and Treatment of Substance Abuse	93.959	05-95-90-901010-6362-102-500731	Pass-Through	(3)	182,033	-
Subtotal 93.959					216,991	
Maternal and Child Health Services Block Grant to the States	93.994	Not Provided	Pass-Through	(3)	120,523	-
Medicaid Cluster						
Medical Assistance Program	93.778	05-95-48-481010-33170000	Pass-Through	(3)	3,067,599	290,484
Medical Assistance Program	93.778	05-95-47-470010-62010000	Pass-Through	(3)	925,674	-
Medical Assistance Program	93.778	03420-69966	Pass-Through	(6)	59,481	-
Medical Assistance Program	93.778	03410-1730-16	Pass-Through	(6)	108,630	-
Total Medicaid Cluster					4,181,383	290,484
Total U.S Department of Health and Human Services					7,808,186	290,484
Corporation for National and Community Service						
AmeriCorps	94.006	17ACHNH0010001	Pass-Through	(10)	39,951	
Total Corporation for National and Community Service					39,951	
Total Federal Other Sponsored Programs					6,150,442	290,484
Total Expenditures of Federal Awards					$ 8,851,746	$ 378,084

Pass-through entities referenced in this schedule are indicated below:

(1) New Hampshire Department of Justice
(2) National Children's Alliance
(3) New Hampshire Department of Health and Human Services
(4) Icahn School of Medicine at Mount Sinai
(5) Trustees of Dartmouth College
(6) Vermont Department of Health
(7) New Hampshire State Council on the Arts
(8) Vermont Agency of Human Services
(9) Association of American Medical Colleges
(10) Volunteer New Hampshire

See accompanying notes to the Schedule of Expenditures of Federal Awards

Dartmouth-Hitchcock Health and Subsidiaries
Notes to Schedule of Expenditures of Federal Awards
Year Ended June 30, 2018

1. Basis of Presentation

The accompanying schedule of expenditures of federal awards (the "Schedule") presents the activity of federal award programs administered by Dartmouth-Hitchcock Health and Subsidiaries (the "Health System") as defined in the notes to the consolidated financial statements and is presented on an accrual basis. The purpose of this Schedule is to present a summary of those activities of the Health System for the year ended June 30, 2018 which have been financed by the United States government ("federal awards"). For purposes of this Schedule, federal awards include all federal assistance entered into directly between the Health System and the federal government and subawards from nonfederal organizations made under federally sponsored agreements. The information in this Schedule in presented in accordance with the requirements of the Uniform Guidance. Pass-through entity identification numbers and CFDA numbers have been provided where available.

Visiting Nurse and Hospice of NH and VT ("VNH") received a Community Facilities Loan, CFDA #10.766, of which the proceeds were expended in the prior fiscal year. The VNH had an outstanding balance of $2,696,512 as of June 30, 2018. As this loan was related to a project that was completed in the prior audit period and the terms and conditions do not impose continued compliance requirements other than to repay the loan, we have properly excluded the outstanding loan balance from the Schedule.

2. Indirect Expenses

Indirect costs are charged to certain federal grants and contracts at a federally approved predetermined indirect rate, negotiated with the Division of Cost Allocation. The predetermined rate provided for the year ended June 30, 2018 was 29.3%. Indirect costs are included in the reported federal expenditures.

3. Related Party Transactions

The Health System has an affiliation agreement with Dartmouth College dated June 4, 1996 in which the Health System and the Geisel School of Medicine at Dartmouth College affirm their mutual commitment to providing high quality medical care, medical education and medical research at both organizations. Pursuant to this affiliation agreement, certain clinical faculty of the Health System participate in federal research programs administered by Dartmouth College. During the fiscal year ended June 30, 2018, Health System expenditures, which Dartmouth College reimbursed, totaled $3,979,033. Based on the nature of these transactions, the Health System and Dartmouth College do not view these arrangements to be subrecipient transactions but rather view them as Dartmouth College activity. Accordingly, this activity does not appear in the Health System's schedule of expenditures of federal awards for the year ended June 30, 2018.

Part II
Reports on Internal Control and Compliance

Report of Independent Auditors on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

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

We have audited, in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the consolidated financial statements of Dartmouth-Hitchcock Health and its subsidiaries (the "Health System"), which comprise the consolidated balance sheet as of June 30, 2018, and the related consolidated statements of operations, changes in net assets and cash flows for the year then ended, and the related notes to the consolidated financial statements, and have issued our report thereon dated November 7, 2018.

Internal Control Over Financial Reporting

In planning and performing our audit of the consolidated financial statements, we considered the Health System's internal control over financial reporting ("internal control") to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the consolidated financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Health System's internal control. Accordingly, we do not express an opinion on the effectiveness of the Health System's internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

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Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Health System's consolidated financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Health System's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Health System's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

PricewaterhouseCoopers LLP

Boston, Massachusetts
November 7, 2018

Report of Independent Auditors on Compliance with Requirements That Could Have a Direct and Material Effect on Each Major Program and on Internal Control Over Compliance in Accordance with the Uniform Guidance

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

Report on Compliance for Each Major Federal Program

We have audited Dartmouth-Hitchcock Health and its subsidiaries' (the "Health System") compliance with the types of compliance requirements described in the *OMB Compliance Supplement* that could have a direct and material effect on each of the Health System's major federal programs for the year ended June 30, 2018. The Health System's major federal programs are identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with federal statutes, regulations and the terms and conditions of its federal awards applicable to its federal programs.

Auditors' Responsibility

Our responsibility is to express an opinion on compliance for each of the Health System's major federal programs based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and the audit requirements of Title 2 U.S. *Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Those standards and the Uniform Guidance require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about the Health System's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for each major federal program. However, our audit does not provide a legal determination of the Health System's compliance.

Opinion on Each Major Federal Program

In our opinion, Dartmouth-Hitchcock Health and its subsidiaries complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended June 30, 2018.

Report on Internal Control Over Compliance

Management of the Health System is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered the Health System's internal control over compliance with the types of requirements that could have a direct and material effect on each major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for each major federal program and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the Health System's internal control over compliance.

A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

PricewaterhouseCoopers LLP

Boston, Massachusetts
November 7, 2018

Part III
Findings and Questioned Costs

Dartmouth-Hitchcock and Subsidiaries
Schedule of Findings and Questioned Costs
Year Ended June 30, 2018

I. Summary of Auditor's Results

Financial Statements

Type of auditor's report issued	Unmodified
Internal control over financial reporting	
Material weakness (es) identified?	No
Significant deficiency (ies) identified that are not considered to be material weakness (es)?	None reported
Noncompliance material to financial statements	No

Federal Awards

Internal control over major programs	
Material weakness (es) identified?	No
Significant deficiency (ies) identified that are not considered to be material weakness (es)?	None reported
Type of auditor's report issued on compliance for major programs	Unmodified
Audit findings disclosed that are required to be reported in accordance with 2 CFR 200.516(a)?	No

Identification of major programs

CFDA Number	Name of Federal Program or Cluster
93.778	Medical Assistance Program
93.153	Coordinated Services and Access to Research for Women, Infants, Children, and Youth

Dollar threshold used to distinguish between Type A and Type B programs	$750,000
Auditee qualified as low-risk auditee?	Yes

II. Financial Statement Findings

None Noted

III. Federal Award Findings and Questioned Costs

None Noted

Dartmouth-Hitchcock and Subsidiaries
Summary Schedule of the Status of Prior Audit Findings
Year Ended June 30, 2018

There are no findings from prior years that require an update in this report.

DARTMOUTH-HITCHCOCK (D-H)

BOARDS OF TRUSTEES AND OFFICERS

Effective: April 1, 2019

Jocelyn D. Chertoff, MD, MS, FACR Clinical Chair/Center Director) Trustee *Chair, Dept. of Radiology*	**Robert A. Oden, Jr., PhD** Public Trustee *Retired President, Carleton College*
Duane A. Compton, PhD Trustee *Ex-Officio: Dean, Geisel School of Medicine at Dartmouth*	**Charles G. Plimpton, MBA** Public Trustee | Boards Treasurer & Secretary *Retired Investment Banker*
William J. Conaty Public Trustee *President, Conaty Consulting, LLC*	**Kurt K. Rhynhart, MD, FACS** D-H Lebanon Physician Trustee *DHMC Trauma Medical Director and Divisional Chief of Trauma and Acute Care Surgery*
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Senator Judd A. Gregg Public Trustee *Senior Advisor to SIFMA*	**Jon W. Wahrenberger, MD, FAHA, FACC** Lebanon Physician Trustee *Clinical Cardiologist, Cardiovascular Medicine*
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Cherie A. Holmes, MD, MSc Community Group Practice Trustee *Medical Director, Acute Care Services, D-H Keene/Cheshire Medical Center*	
Laura K. Landy, MBA Public Trustee *President and CEO of the Fannie E. Rippel Foundation*	

CURRICULUM VITAE

Date Prepared: June 4, 2019

NAME: Julia Renee Frew, MD

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Dartmouth-Hitchcock Medical Center
Lebanon, NH 03756
Julia.R.Frew@hitchcock.org
603-650-5824 office
603-650-0404 fax

EDUCATION:

DATE	INSTITUTION	DEGREE
1992-1996	Kenyon College	B.A., summa cum laude
1998-1999	New York University	Postbaccalaureate Premedical Program
2000-2005	Brown Medical School (Brown-Dartmouth Program in Medical Education)	M.D.

POST-DOCTORAL TRAINING:

DATE	SPECIALTY	INSTITUTION
2006-2010	Psychiatry	Geisel School of Medicine at Dartmouth
2009-2010	Psychiatry- Chief Resident	Geisel School of Medicine at Dartmouth

LICENSURE AND CERTIFICATION:

DATE	LICENSURE/CERTIFICATION
2010-	New Hampshire Board of Medicine #14795
2010-	Vermont Board of Medical Practice #042-0011941
2011-	Diplomate, American Board of Psychiatry and Neurology (Psychiatry)
2019-	Addiction Medicine Board Certification, American Board of Preventive Medicine

ACADEMIC APPOINTMENTS:

DATE	ACADEMIC TITLE	INSTITUTION
2009-2011	Instructor in Psychiatry	Geisel School of Medicine at Dartmouth
2011-	Assistant Professor of Psychiatry	Geisel School of Medicine at Dartmouth
2016-	Assistant Professor of Obstetrics	Geisel School of Medicine at Dartmouth

	and Gynecology	
2017-	Assistant Professor of Medical Education	Geisel School of Medicine at Dartmouth

HOSPITAL APPOINTMENTS:

DATE	HOSPITAL TITLE	INSTITUTION
2010	Inpatient Psychiatrist (per diem)	Central Vermont Medical Center
2010-	Attending Psychiatrist	Dartmouth-Hitchcock Medical Center
2010-	Director, Women's Mental Health Program	Dartmouth-Hitchcock Medical Center
2010-2015	Consulting Psychiatrist, Live Well/ Work Well Employee Wellness Program	Dartmouth-Hitchcock Medical Center
2016-	Director, Moms in Recovery Program	Dartmouth-Hitchcock Medical Center

COMMITTEE ASSIGNMENTS:

DATE	COMMITTEE	INSTITUTION
2008-	Education Policy Committee	Geisel Department of Psychiatry
2009-2010	Residency Curriculum Committee	Geisel Department of Psychiatry
2009-2010	Quality Improvement Committee	Dartmouth-Hitchcock Psychiatric Associates
2009-2010	Psychiatry Grand Rounds Committee	Geisel Department of Psychiatry
2010-2011	Guardianship Policy Committee	Dartmouth-Hitchcock Medical Center
2011-2016	Faculty Council (Psychiatry representative)	Geisel School of Medicine at Dartmouth
2012-2018	Clinical Education Course Director Committee	Geisel School of Medicine at Dartmouth
2012-	Psychiatry Residency Selection Committee	Geisel Department of Psychiatry
2013-	Graduate Medical Education Committee	Dartmouth-Hitchcock Medical Center
2013-	Chair, Residency Program Clinical Competency Committee	Geisel Department of Psychiatry
2014-	Residency Program Evaluation Committee	Geisel Department of Psychiatry
2015-	Graduate Medical Education Curriculum Committee	Dartmouth-Hitchcock Medical Center
2016-	Substance Use and Mental Health Initiative	Dartmouth-Hitchcock Medical Center
2018-	Opioid Addiction Treatment Collaborative	Dartmouth-Hitchcock Medical Center

MEMBERSHIP IN PROFESSIONAL SOCIETIES:

DATE	SOCIETY	ROLE
2008-2010	American Psychiatric Association	Member-in-Training
2009-	North American Society for Psycho-Social Obstetrics & Gynecology	Member
2010-2015	Academy of Psychosomatic Medicine	Member, Founding Member of Women's Mental Health Special Interest Group

2012-	International Association for Women's Mental Health	Member
2013-2018	Association of Directors of Medical Student Education in Psychiatry	Member
2013-	American Association of Directors of Psychiatry Residency Training	Member
2014-	Postpartum Support International	Member
2017-	Perinatal Mental Health Society/ Marcé of North America	Member

AWARDS AND HONORS:

DATE	AWARD
1992-1996	National Merit Scholarship
1992-1996	Kenyon College Honors Scholarship
1996	Phi Beta Kappa
2000	Volunteer of the Year, St. Vincent's Hospital and Medical Center, NYC
2004	"Best Platform Research Presentation", Academy of Breastfeeding Medicine Annual Meeting
2005	Patricia McCormick Prize, given to the outstanding female student in the graduating class of Brown Medical School
2016	Inducted into Geisel Academy of Master Educators
2018	Inducted as faculty member of Geisel chapter of Alpha Omega Alpha
2018	Leonard Tow Humanism in Medicine Award
2019	Addiction Policy Forum New Hampshire Innovations to Address the Opioid Epidemic
2019	Case Western Reserve University Scholarship in Teaching Award (National Curriculum in Reproductive Psychiatry)
2019	Academic Pediatric Association Miller-Sarkin and Pillar Health Care Delivery Award (Center for Addiction Recovery in Pregnancy and Parenting)

CLINICAL AND RESEARCH INTERESTS

Reproductive psychiatry, perinatal addiction treatment, psychosomatic medicine, psychiatric education of medical students and residents

ADVISING/MENTORING

Medical Students

- Serve as Geisel Residency/Career Adviser for students applying for psychiatry residency, generally 1-6 students per year
- Served as research and career mentor for Raphaela Gold, Geisel Class of 2018

Residents

- Serve as research and career mentor for Cybele Arsan, Psychiatry Residency Class of 2020

Nurse Practitioner

- Serve as clinical supervisor and mentor to Psychiatric and Mental Health Nurse Practitioner Rebecca Casey, PMHNP

MPH Student, The Dartmouth Institute for Health Policy & Clinical Practice
- Served as internship preceptor for Alex Zagaria for MPH internship, Spring 2019

External Mentoring
- International Marce Mentorship Program. Serve as Mentor to external perinatal psychiatrist.

TEACHING EXPERIENCE/CURRENT TEACHING RESPONSIBILITIES

Geisel School of Medicine at Dartmouth:

DATE	TEACHING
2010-	OB/Gyn Residency Program: Teach on perinatal psychiatry topics
2012	Created and implemented Frontiers in Brain and Behavior preclinical elective for first and second year medical students
2012-2018	Co-director, Psychiatry Clerkship - Didactic and small group teaching since 2008 - Assumed Co-directorship in 2012: assist with administration of the course including attending weekly clerkship oversight meetings, grading student write-ups, overseeing residents involved in teaching in the clerkship, and assigning final grades
2012-	Residency/Career Advisor for Geisel students interested in pursuing careers in psychiatry
2013-	SBM- Psychiatry Course Director - Facilitate small group sessions to teach 2nd year medical students psychiatric interviewing skills since 2006. - Teach topics such as psychiatric interviewing, delirium, psychiatric ethics since 2010 - Assumed Directorship of course in 2013: oversee all aspects of the course including faculty recruitment, curriculum oversight, final examination, and small group interviewing component
2013-	Associate Director, Psychiatry Residency Program - Teach and directly supervise residents since 2010 - Assumed Associate Directorship in 2013: assist with administration of Adult Psychiatry Residency Program including participating in recruitment, designing and implementing evaluation methods for residents, overseeing teaching activities of senior residents, and meeting regularly with residents regarding their progress
2013-	SBM Reproduction Course: Teach session on perinatal psychiatry
2013-	Travel yearly to Providence, RI to provide mock oral board exams for Brown Psychiatry Residents
2014-2017	Co-Director, Scientific Basis of Medicine Program (2nd year medical school curriculum at Geisel School of Medicine) - Oversee Scientific Basis of Medicine Program, including course review, recruitment and evaluation of PBL tutors, review of examinations, determination of final grades, advising for students, and strategic planning

West Central Behavioral Health:

DATE	TEACHING
2009	Led in-service training sessions for case managers at community mental health center

	on psychopharmacology and substance abuse
2009	Provided psychoeducation about psychopharmacology to clients in Illness Management and Recovery Program

EXTERNAL FUNDING

2016-2017	D-H Population Health Initiative grant for expansion and enhancement of Perinatal Addiction Treatment Program. $145,635 over 12 months. Medical Director.
2017-2018	New Hampshire Charitable Foundation planning grant for Center for Addiction Recovery in Pregnancy and Parenting (CARPP). $61,650 over 6 months. Director.
2017-2019	New Hampshire Charitable Foundation grant for CARPP consultation to providers regarding perinatal substance use disorders. $104,750 over 12 months; renewed for additional year. Medical Director.
2017-2018	New Hampshire Medicaid DSRIP 1115 waiver program grant for development of Intensive Outpatient Program for Perinatal and Parenting Women with Opioid Use Disorders. $186,000 over 12 months (renewable). Medical Director.
2018-2020	New Hampshire DHHS contract for Integrated Medication Assisted Treatment for Pregnant and Postpartum Women. $2,755,442 over 18 months; renewed for additional year. Medical Director.

JOURNAL REFEREE ACTIVITY

2018-	Journal of Women's Health

INVITED PRESENTATIONS

Local/Regional

DATE	TOPIC	ORGANIZATION	LOCATION
2011	Depression 101: Treatment of Depression	DHMC Live Well/Work Well Program	Lebanon, NH
2011	Effective Treatment of Anxiety	DHMC Live Well/Work Well Program	Lebanon, NH
2011	Women's Mental Health	DHMC Live Well/Work Well Program	Lebanon, NH
2012	Postpartum Depression	Geisel OB/Gyn Interest Group	Hanover, NH
2012	Access to Mental Health Care for Perinatal Women	Northern New England Perinatal Quality	Lebanon, NH

		Improvement Network	
2012	Access to Mental Health Care for Perinatal Women	Dartmouth-Hitchcock OB/Gyn Grand Rounds	Lebanon, NH
2012-14	Women's Mental Health In Primary Care	"What's New in Psychiatry for Non-Psychiatric Providers" CME event	Lebanon & Manchester, NH
2013	Perinatal Psychiatry	Geisel OB/Gyn and Psychiatry Interest Groups	Hanover, NH
2014	Management of Bipolar Disorder in Pregnancy and Lactation	Psychiatry Grand Rounds Dartmouth-Hitchcock	Lebanon, NH
2014	Management of Bipolar Disorder in Pregnancy and Lactation	Psychiatry Grand Rounds University of Vermont	Burlington, VT
2015	Assessment and Management of Depression and Anxiety in Primary Care Patients; Management of Stressful Encounters and Difficult Patients in Primary Care	"What's New in Psychiatry for Non-Psychiatric Providers" CME event	Lebanon, NH
2016	Perinatal Psychiatric Illness	Mental Health Center Of Greater Manchester Grand Rounds	Manchester, NH
2017	Building a Life Worth Living: Treating Moms With Opioid Use Disorders	New Hampshire Association for Infant Mental Health	Concord, NH
2017	Moms in Recovery: Treatment for Pregnant and Parenting Women with Substance Use Disorders: Typical Treatment Dilemmas	Dartmouth-Hitchcock Pediatric Schwartz Rounds	Lebanon, NH
2017	Co-occurring Disorders In Perinatal Women with Substance Use Disorders	Perinatal Opioid Use Disorders Learning Collaborative	Lebanon, NH/Webinar
2017	Tackling the New Hampshire Opioid Crisis	Northeast Node/NIDA Clinical Trials Node/	Hanover, NH

	(Perinatal Addiction Treatment)	Center for Technology and Behavioral Health	
2017	No Health without Mental Health (Perinatal Addiction Treatment)	Dartmouth-Hitchcock Departments of Psychiatry and Population Health	Lebanon, NH
2017	Opiate Crisis: Stories and Solutions (panel discussion)	VT PBS	Rutland, VT
2018	Trauma and Reproductive Health (co-presenter)	Dartmouth-Hitchcock OB/Gyn Grand Rounds	Lebanon, NH
2018	Co-occurring Psychiatric Disorders in Perinatal Women with Substance Use Disorders	Northern New England Perinatal Quality Improvement Network	Lebanon, NH
2018	Perinatal Substance Use	Project ECHO	Vermont, New Hampshire, Maine (multiple sites)
2018	A Multidisciplinary Approach to the Care of Pregnant and Parenting Women with Opioid Use Disorders	Dartmouth-Hitchcock Psychiatry Grand Rounds	Lebanon, NH
2018	Perinatal Psychiatric Illness	New Hampshire Hospital Grand Rounds	Concord, NH
2018	Nurturing OUD-affected Mothers and their Babies	Opioid Collaborative Forum: Our Families, Our Children, Our Future	Concord, NH
2018	Opioid-exposed Newborns: A Baby-friendly, Family-Centered Approach	Northern New England Society of Addiction Medicine	Stowe, VT
2019	The Opioid Crisis and the Science of Addiction: from Bench to Bedside and Back	Dartmouth Science Pub	Lebanon, NH
2019	Moms in Recovery: Providing a recovery friendly practice environment for pregnant and parenting women with substance use	Improving the Care of Opioid-Exposed Newborns	Burlington, VT

	disorders		
2019	Treatment of Pregnant And Parenting Women with Substance Use Disorders	Northeast Regional Psychiatric Nursing Conference	Concord, NH
2019	Treatment of Pregnant And Parenting Women with Substance Use Disorders	New Hampshire Psychiatric Society Annual Scientific Meeting	New London, NH
2019	False Positives and False Negatives: Interpreting Toxicology Results in Perinatal Substance Use Treatment	Northern New England Perinatal Quality Improvement Network	Lebanon, NH

National/International

DATE	TOPIC	ORGANIZATION	LOCATION
2004	First Steps Breastfeeding Education Project	Academy of Breastfeeding Medicine Annual Meeting	Orlando, FL
2016	Moms and Moms-to-Be in Recovery: a Perinatal Addiction Treatment Program	North American Society for Psychosocial Obstetrics & Gynecology	New York, NY
2016	The Earlier the Better: Developing a system of integrated care for child-bearing families with substance use disorders	National Drug Abuse Treatment Clinical Trials Network/ Center for Substance Abuse Treatment	Webinar
2017	Pregnancy and Psychiatric Medication	Recovery Library by Pat Deegan	Online resource
2017	Moms in Recovery: Integrated care for perinatal women with opioid use disorders	Perinatal Mental Health Society	Chicago, IL
2018	Reproductive Psychiatry Education, Creation of the National Curriculum	American Association of Directors of Psychiatry Residency Training	New Orleans, LA
2018	The Dartmouth-Hitchcock Center for Addiction Recovery in Pregnancy and	North American Society for Psychosocial Obstetrics & Gynecology	Philadelphia, PA

Parenting: Leveraging a successful clinical program to support dissemination of integrated care models for perinatal women with substance use disorders

BIBLIOGRAPHY

Curriculum

Contributing author of the National Curriculum in Reproductive Psychiatry (Module Leader for Perinatal Substance Use Disorders Module and Contributor to Perinatal Anxiety Module).

Original Articles:

Frew, J & Taylor, J. First Steps: A program for medical students to teach high school students about breastfeeding. *Medicine and Health / Rhode Island.* 2005; 88:48-50.

Frew, J. Psychopharmacology of Bipolar I Disorder During Lactation: a case report of use of lithium and aripiprazole in a nursing mother. *Archives of Women's Mental Health.* 2015; 18(1):135-136.

Posters:

Frew, J & Taylor, J. First Steps Breastfeeding Education Project. Society of Teachers of Family Medicine Predoctoral Education National Conference, New Orleans, LA. 2004.

Larusso, E, Frew, J & Krishnan, N. Integrating Mental Health Care into Obstetrics & Gynecology: Results from an embedded psychiatry consultation clinic and implications for quality improvement. North American Society for Psychosocial Obstetrics & Gynecology Annual Meeting, Providence, RI. 2012.

Frew, J & LaRusso, E. Psychiatric consultation in obstetrics/gynecology (OB/GYN): Updated results from a reproductive psychiatry consultation clinic and implications for quality improvement. Perinatal Mental Health Meeting, Chicago, IL. 2013.

Frew, J. Psychopharmacology of bipolar I disorder during lactation: A case report of use of lithium and aripiprazole in a nursing mother. Perinatal Mental Health Meeting, Chicago, IL. 2013.

Goodman, D & Frew, J. Dismantling Barriers to Addiction Treatment and Maternity Care: Results from an Integrated Program. American Society of Addiction Medicine, New Orleans, LA. 2017.

Mowchun, J, Frew, J & Shoop, G. Can Students Help Bridge the Great Divide? Student Perceptions of Neurology and Psychiatry Clerkship Integration. American Academy of Neurology, Philadelphia, PA. 2019.

CURRICULUM VITAE

Date prepared: 11/18/2018

NAME: Daisy Goodman, DNP, MPH, CNM, CARN-AP

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Lebanon, NH 03756
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daisy.j.goodman@hitchcock.org
daisy.j.goodman@dartmouth.edu

I. EDUCATION

INSTITUTION	DEGREE	DATES
Geisel School of Medicine at Dartmouth	Master of Public Health	2014
Massachusetts General Hospital (MGH) Institute of Health Professions	Doctor of Nursing Practice	2010
State University of NY at Stony Brook	Master of Science	2004
Frontier School of Midwifery and Family Nursing	Certified Nurse Midwife Nurse Practitioner, Women's Hlth	2002 2002
N.H. Community Technical College	Associate Registered Nurse	1998
Yale University	Bachelor of Arts	1985
College of the Atlantic		1982

II. POSTDOCTORAL TRAINING

INSTITUTION	SPECIALTY	DATES
Veterans Health Administration	Quality Scholars Fellow	2012-2015
Dartmouth Collaboratory for Implementation Science	Collaboratory Scholar	2017-2018

III. PROFESSIONAL DEVELOPMENT ACTIVITIES

DATES	INSTITUTION	TITLE	CREDITS
7/2017	The Dartmouth Institute	Health Educators Summer Symposium	20.75 (CE)

2/2017	Am. Society of Addiction Medicine	APRN Waiver Completion Course	16.00 (CE)
11/2016	American Osteopathic Academy	Buprenorphine Waiver Training	8.00 (CE)
7/2016	The Dartmouth Institute	Health Educators Summer Symposium	20.75 (CE)
12/2015	Dartmouth College	9th Annual Active Learning Institute	--
7/2015	The Dartmouth Institute	Health Educators Summer Symposium	20.75 (CE)
7/2014	The Dartmouth Institute	Health Educators Summer Symposium	20.5 (CE)
7/2014	The Dartmouth Institute	Health Educators Summer Symposium	20.75 (CE)

IV. ACADEMIC APPOINTMENTS

DATES	INSTITUTION	TITLE
2018-	Geisel School of Medicine	Assistant Professor o Obstetrics and Gynecology o Community and Family Medicine o The Dartmouth Institute
2017	Colby-Sawyer College,	Adjunct Professor of Nursing
2016-18 2013-15	Geisel School of Medicine	Clinical Assistant Professor Instructor o Obstetrics and Gynecology o Community and Family Medicine o The Dartmouth Institute
2015	Geisel School of Medicine	Instructor o Obstetrics and Gynecology o Community and Family Medicine o The Dartmouth Institute
2013-14	Frontier Nursing University	Teaching Associate
2011-13	Philadelphia University, Continuing Medical/Professional Ed	Adjunct Faculty
2011-12	Tufts School of Medicine	Clinical Instructor

V. INSTITUTIONAL LEADERSHIP ROLES:

DATES	INSTITUTION	TITLE
2017-2018	Dartmouth-Hitchcock	Director of Women's Health Services, *Moms in Recovery Program*

VI. LICENSURE AND CERTIFICATION (IF APPLICABLE):

DATE	LICENSURE/CERTIFICATION

2002-2018	American College of Nurse Midwives: certificate #10710
2002-2018	National Certification Corporation: certificate # GOO104259401
Current:	NH- RN license: 045117-21
	NH APRN license: 045116-23

VII. HOSPITAL APPOINTMENTS (IF APPLICABLE):

DATES	INSTITUTION	POSITION/TITLE
2013-2018	Dartmouth-Hitchcock Medical Ctr Lebanon, NH	APRN/CNM
2006-2013	Franklin Memorial Hospital Farmington, ME	CNM
2002-2006	Rumford Community Hospital Rumford, ME	CNM

VIII. OTHER PROFESSIONAL POSITIONS (NON-DARTMOUTH):

DATES	INSTITUTION	POSITION/TITLE
2006-2013	Franklin Health Women's Care	Certified Nurse Midwife
2002-2006	Swift River Health Care	Certified Nurse Midwife
2002	Maine General Medical Center	Registered Nurse, Mat-Child Hlth
2000	Weeks Memorial Hospital	Staff Nurse, Obstetrics
1999-2000	Weeks Medical Center	Office Nurse, Primary Care
1997-2000	Coos County Nursing Hospital	Staff/Charge Nurse
1998-1999	Weeks Memorial Hospital	Staff Nurse, Medical Surgical

IX. TEACHING ACTIVITIES:

A. UNDERGRADUATE (COLLEGE) EDUCATION
N/A

B. GRADUATE EDUCATION Ph.D. or Masters students

Colby-Sawyer College, Clinical Nurse Leader Program (CNL)
a. Dates taught: Summer- Fall, 2017

b. Institution: Colby Sawyer
c. Title: Applied Healthcare Improvement, 1&2
d. Role: Adjunct Professor of Nursing
e. Hours: 4 CR/semester

The Dartmouth Institute for Health Policy and Clinical Practice (MPH)

Continual Improvement of Health Care

a. Dates taught: 2015-2018, current faculty
b. Institution: The Dartmouth Institute, Residential MPH program
c. Title: Continual Improvement of Health Care (PH117)
d. Role: Course Co-Director
e. Hours: 4 CR

Introduction to Healthcare Improvement

a. Dates taught: 2017-18, current faculty
b. Institution: The Dartmouth Institute, Hybrid MPH program (PH201)
c. Title: Introduction to Healthcare Improvement
d. Role: Course Director
e. Hours: 2-week hybrid course

Coproducing Healthcare Service in Systems

a. Dates taught: 2016
b. Institution: The Dartmouth Institute, Hybrid MPH program
c. Title: Coproducing Healthcare Service in Systems (PH201)
d. Role: Course Co-Director
e. Hours: 2-week hybrid course

Improvement Methods

a. Dates taught: 2019
b. Institution: The Dartmouth institute, Hybrid MPH program
c. Improvement Methods (PH233)
d. Role: Course Co-Director
e. Hours: 5-week hybrid course

MPH Practicum

a. Dates taught: 2016-2017, current faculty 2019-2020
b. Institution: The Dartmouth Institute, Hybrid MPH program
c. Title: MPH Practicum
d. Faculty Advisor
e. Hours: 2 hrs/week (ongoing)

C. UNDERGRADUATE MEDICAL EDUCATION:

i. CLASSROOM TEACHING:

History, Society, and the Physician (small group facilitator)

a. Dates taught: 2016
b. Institution: Geisel School of Medicine
c. Title: History, Society, and the Physician
d. Role: Co-facilitator (with Glenda Shoop)
e. Hours: 5-week interprofessional learning experience

ii. CLERKSHIP TEACHING

Dartmouth-Hitchcock Perinatal Addiction Treatment Program ("Moms in Recovery" program)

a. Dates taught: 2017-2018
b. Institution: Geisel/Dartmouth-Hitchcock
c. Title: Perinatal Substance Use Integrated Care Experience
d. Role: Clinical Preceptor
e. Hours: each student spends 1 clinical day at Moms in Recovery during third year OB rotation

Tufts Longitudinal Integrated Program

a. Dates taught: 2012
b. Institution: Tufts School of Medicine/Franklin Memorial Hospital
c. Title: Rural Longitudinal Integrated Clerkship
d. Role: Clinical Preceptor
e. Hours: weekly during call rotation

D. GRADUATE MEDICAL EDUCATION

Inclusive of instruction of residents and fellows during clinical practice

PGY2 Training: Comprehensive Care of the Gravida with Perinatal Substance Use

a. Dates: 2017-2018
b. Institution: Dartmouth-Hitchcock
c. Title: Purple Pod Clinic
d. Role: Clinical Preceptor
e. Hours: 4 hrs/week

E. OTHER CLINICAL EDUCATION (e.g., PA programs)

Continuing Medical Education: Advanced Pharmacology and Therapeutics in Women's Health

a. Dates course was taught: Annually, 2011-2013
b. Institution: Philadelphia University, Continuing Medical/Professional Education Program
c. Title: *Clinical Applications of Advanced Pharmacology and Therapeutics in Women's Health*
d. Role: Adjunct faculty
e. Hours: 60 contact hours

X. ADVISING/MENTORING

A. UNDERGRADUATE STUDENTS

N/A

B. GRADUATE STUDENTS

DATES	STUDENT'S NAME	PROGRAM NAME	DEGREE
2017	Deirdre Martinez-Meehan	TDI	MPH
2017-18	Laura Ward	TDI	MPH
2017-18	Joanna Sullivan	TDI	MPH
2017-18	Jennifer York	TDI	MPH
2018	Wambui Onsando	TDI	MPH
2019	Staffany Humala	TDI	MPH

C. MEDICAL STUDENTS

DATES	STUDENT'S NAME	PROGRAM NAME (if applicable)
2017-18	Kyra Bonasia	Mentored project: Perinatal substance use disorders
2018-19	Meera Nagarajan	Mentored project: Nutrition and substance use
2018-19	Kathryn Collier	Mentored project: Models of care for Perinatal
2019	Sarah Bennett	Non-clinical elective: Contraceptive preferences

D. RESIDENTS/FELLOWS

DATES	MENTEE'S NAME	SPECIALTY
N/A		

E. FACULTY
N/A

XI. RESEARCH TEACHING/MENTORING

A. UNDERGRADUATE STUDENTS

DATES	STUDENT'S NAME
2018	Katherine Harris, Psychology Research Independent Study

B. GRADUATE STUDENTS

N/A

C. MEDICAL STUDENTS

DATES	STUDENT'S NAME	PROGRAM NAME (if applicable)
2017-2019	Rachel Mazzumaro-Romer	Obstetrics and Gynecology SBIRT program evaluation
2019	Sarah Bennett	Non-clinical research, Contraception and SUD Clinical elective, perinatal substance use disorders
2019	Michael Hoggard	Non-clinical research, treatment retention in women
2019	Sadhana Puri	Schweizer Fellowship, nutrition and SUD in women
2019	Jonathan Busam	Schweitzer Fellowship, nutrition and SUD in women

D. RESIDENTS/FELLOWS/RESEARCH ASSOCIATES

2017-18	Julia MacCallum, MD	Leadership in Preventative Medicine (project advisor)
2018-19	Meredith Pavicic, MD	Obstetrics and Gynecology (mentored research)
2018-19	Tara Higgins, MD	Obstetrics and Gynecology (journal submission)
2019	Shilpa Daravimula	Obstetrics and Gynecology (project advisor)

E. FACULTY
N/A

XII. COMMUNITY SERVICE, EDUCATION, AND ENGAGEMENT:
Member, NH Maternal Mortality Review Committee

a. Dates: Appointed 2018, current
b. Institution: State of NH

c. Role: Review Committee member
d. Hours: Variable depending on case load

Member, Institute for Healthcare Improvement Maternal Health Advisory Board
a. Dates: Appointed 2017, current
b. Institution: Institute for Healthcare Improvement (IHI)
c. Role: Advisory group member
d. Hours: Variable

Member, Alliance for Innovation in Maternal Health Maternal Substance Use Expert Team
a. Dates: Appointed 2018, current
b. Institution: Alliance for Innovation in Maternal Health, American College of Obstetrics and Gynecology
c. Role: Team member
d. Hours: variable

Sexual Assault Forensic Nurse Examiner (SAFE) trainer
a. Dates: 2010-2012
b. Institution: State of Maine Sexual Assault Forensic Examiner Program
c. Course : SAFE training
d. Role: Preceptor
e. Hours: 4 hours/year

XIII. RESEARCH FUNDING:

A. CURRENT SUPPORT

Moms in Recovery (MORE): Defining optimal care for pregnant women and infants.
a. Dates: 9/2018-7/2022
b. Project title and award number:
c. Your Role: Co-Principal Investigator, with Sarah Lord, PhD
d. Percent Effort: 25%
e. Sponsoring agency: Patient Centered Outcomes Research Institute (PCORI)
f. Annual Direct Costs of the Award: $5.3m/ 4 years

NH State Targeted Response (STR) (NIHTracking # GRANT12547450): *Mindful Moms in Recovery: Yoga-based mindfulness relapse prevention for pregnant women with opioid disorder.*
a. Dates: 9/2018-2/2019
b. Project title and award number: Mindful Moms in Recovery
c. Your Role: Co-Principal Investigator with Sarah Lord, PhD
d. Percent Effort: 5%
e. Sponsoring agency: NIDA

Integrated MAT for Pregnant and Postpartum Women
a. Dates: 1/2018-7/2020
b. Project title and award number: Integrated Medication Assisted Treatment for Pregnant and Postpartum Women (RFP- 2018-BDAS-05-INTEG)
c. Your Role: Director of Women's Health Services (Medical Director: Julia Frew, MD)

d. Percent Effort: 20%
e. Sponsoring agency: NH Department of Health and Human Services
f. Annual Direct Costs of the Award: $2.7m/ 18 months; year 3 award pending

Advancing the Standard of Care for Women and Children Affected by Substance Use Disorder

a. Dates: 8/2017-7/2018
b. Project title and award number: Advancing the Standard of Care for Women and Children Affected by Substance Use Disorder (NHCF 2017)
c. Your Role: Co-investigator, with Julia Frew, MD (Program Director)
d. Percent Effort: 10%
e. Sponsoring agency: New Hampshire Charitable Foundation
f. Annual Direct Costs of the Award: $194,000

Improving Care for Women with Perinatal Substance Use Disorders Learning Collaborative

a. Dates: 1/2/2018-12/31/2018
b. Project title and award number: To support NNEPQIN in learning collaborative to standardize best practices in caring for women with perinatal substance use disorders (INV-P-2017-2005)
c. Role: Principal investigator
d. Percent Effort: 15%
e. Sponsoring agency: New Hampshire Charitable Foundation
f. Annual Direct Costs of the Award: $40,995

Empowering Pregnant Mothers with Opioid Use Disorder to Create and Implement a Plan of Safe Care for their Infants using Technology

a. Dates: 5/1/2017-4/30/2018
b. Project title and award number: Empowering Pregnant Mothers with Opioid Use Disorder to Create and Implement a Plan of Safe Care for their Infants using Technology (2017 Dartmouth Synergy Community Engagement Research Pilot Award)
c. Role: Co-Principal Investigator, with Sarah Lord, PhD
d. Percent Effort: 15%
e. Sponsoring agency: Dartmouth Synergy
f. Annual Direct Costs of the Award: $50,000

Improving Safety and Quality in the Care of Women with Perinatal Substance Use Disorders

a. Dates: 12/21/2015-6/30/2018
b. Project title and award number: To support NNEPQIN in learning collaborative to standardize best practices in caring for women with perinatal substance use disorders (INV-P-2017-2005)
c. Role: Principal Investigator
d. Percent Effort: 15%
e. Sponsoring agency: March of Dimes Foundation
f. Annual Direct Costs of the Award: $84,995 over 2.5 years

B. PAST SUPPORT

SBIRT in Maternity Care

a. Dates: 7/2015-7/2017
b. Project title and award number: Adolescent SBIRT Initiative (NHCF 2015-2017)
c. Role: Project lead

d. Percent Effort: N/A
e. Sponsoring agency: New Hampshire Charitable Foundation
f. Annual Direct Costs of the Award: $2,500; $7,406

In their own words: Perceived barriers to care for pregnant women with opioid dependence. A qualitative study of barriers and facilitators to care for prenatal and postpartum women with opioid dependence

a. Dates (6/2015-6/2016)
b. Project title and award number: In their own words:
c. Role: Principal Investigator
d. Percent Effort: N/A
e. Sponsoring agency: Saul Blattman Fund, Dept. of Obstetrics and Gynecology
f. Annual Direct Costs of the Award: $2,800

C. PENDING SUPPORT

(Proposals submitted, under review):

XIV. PROGRAM DEVELOPMENT

I am a member of the leadership team for Dartmouth-Hitchcock's Perinatal Addiction Treatment Program ("Moms in Recovery"), and co-developer of the Ob/Gyn Purple Pod Resident Clinic with Residency Program Director Timothy Fisher, MD.

XV. ENTREPRENEURIAL ACTIVITIES

N/A

XVI. MAJOR COMMITTEE ASSIGNMENTS:

National/international

DATES	COMMITTEE	ROLE	INSTITUTION
2017-2019	Maternal Health Advisory Board member		Institute for Healthcare Improvement
2016-2018	Opioid Workgroup	Member	Alliance for Innovation in Maternal Health

Regional

DATES	COMMITTEE	ROLE	INSTITUTION
2018-2019	NH Perinatal Substance Exposure	Task Force member	NH- DHHS*
2013- 2016	NH Perinatal Substance Exposure	Task Force member	NH- DHHS
2011-2013	Snuggle ME work group	Co-author	ME- CDC**
2009	Maine State Board of Nursing APRN Advisory Board		ME-Board of Nursing

*DHHS: Department of Health and Human Services
**CDC: Center for Disease Control

Institutional

DATES	COMMITTEE	ROLE	INSTITUTION
2017-19	Ctr for Addiction Recovery in Pregnancy and Parenting	Member	Dartmouth Hitchcock

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

DATES	SOCIETY	ROLE
2002-2018	American College of Nurse-Midwives	Member
2014-2018	American Society for Addiction Medicine	Member

XVIII. EDITORIAL BOARDS:
N/A

XIX. JOURNAL REFEREE ACTIVITY:

DATES	JOURNAL NAME
2018-2019	Addictive Behaviors
2017	BMJ Quality and Safety
2014-2019	Journal of Midwifery and Women's Health
2016	Journal of Substance Abuse Treatment

XX. AWARDS AND HONORS:

DATE		AWARD
2019	Academic Pediatric Association	Health Care Delivery Award [Co-recipient]
2019	New Hampshire Nurses Association/NH Magazine	Excellence in Advanced Practice Nursing
2019	Addiction Policy Forum	Innovation Award
2015	Blatman Scholar's Award:	Dartmouth Hitchcock Obstetrics and Gynecology,
2014	The Dartmouth Institute	Masters of Public Health Program: TDI Leadership Award
2012	Maine Affiliate, American	Maine Midwife of the Year

	College of Nurse -Midwives	
2010	MGH Institute of Health Professions	Lavinia Dock Scholarly Writing Award
2008	MGH Institute of Health Professions	Clapham Merit Scholarship
2001	Frontier School of Midwifery and Family Nursing	Mardi Perry Merit Scholarship:
1998	New Hampshire Technical College	Nursing Faculty Award Scholarship
1997	Androscoggin Valley Hospital Scholarship Award	Merit scholarship

XXI. INVITED PRESENTATIONS:

A. International:
N/A

B. National:

2019 Understanding the Experience of Peripartum Women with Mental Health and Substance Use Disorders. Council of State and Territorial Epidemiologists Conference, Raleigh, NC (5/2019).

2018 Co-producing Your Way to Better Maternal Health. Joint workshop for the Institute for Healthcare Improvement (IHI) National Forum, Orlando, FL (12/2018). Co-presented with IHI Staff (*^)

2018 Should Maternity Care and Substance Use Treatment be Integrated? Learning Lab on integration of maternity care and treatment for opioid use disorders at the Institute for Healthcare Improvement (IHI) National Forum, Orlando, FL (12/2018).

2018 Maternal Mortality Committee Mock Review. Case presentation at the CityMATCH Maternal-Child Health Epidemiology Conference (9/2018). Co-presented with Centers for Disease control (CDC) staff.

2018 Facilitating Best Practice in the Perinatal Care of Women with Opioid Use Disorders. Addiction Health Research Conference, Savannah, GA (10/2018).

2018 Building Partnerships to Address Perinatal Opioid Use in New Hampshire. Association of State and Territorial Organizations. Webinar (8/2018)

2017 A Population Health Approach to Maternal Substance Use in Pregnancy. Joint workshop for the Institute for Healthcare Improvement (IHI) National Forum, Orlando, FL (12/2017). Co-presented with IHI Staff (*^)

2017 Publish Your Work to Improve Healthcare. Learning Lab on the SQUIRE Guidelines for the Insitute of Healthcare Improvement (IHI) National Forum, Orlando, FL (12/2017). Co-presenters David Stevens, MD, Gregory Ogrinc, MD (#^)

2017 A Collaborative Approach to Improving Perinatal Care for Women with Opioid Use Disorder. Presentation to the 10th Annual Conference on Dissemination and Implementation in Health, co-hosted by the National Institutes of Health and Academy Health, Washington, DC (12/2017). (#)

2017 Uncovering Opioid Related Maternal Mortality: What are We Missing?. Presentation to CDC Northeast Region Maternal Mortality Review Training, Boston, MA (9/2017). (*)

2017 Supporting the Mother Infant Dyad: Caring for the Mother-Infant Dyad in an Integrated Model. Presentation to National TANF Directors conference, Washington, DC (9/2017). (*^)

2017 Integrated Care for Pregnant and Parenting Women with Opioid Use Disorders: Expanding the Role of Midwives. American College of Nurse Midwives National Convention: Chicago, IL (5/2017). (#^)

2017 Nurturing Trust. Institute for Healthcare Improvement Virtual Expedition Webinar (3/2017). (*)

2016 Can Improvement Cause Harm Institute for Healthcare Improvement National Forum (Co-presenters Greg Ogrinc, MD and William Nelson, PhD). Orlando, FL (12/2016). (#^)

2016 The SQUIRE Guidelines. Institute for Healthcare Improvement Scientific Symposium (Co-presenters Greg Ogrinc, MD and Louise Davies, MD). Orlando, FL (12/2016). (#^)

2016 The Nation's Opioid Crisis: Your Practice, Your Responsibility. American Association of Colleges of Nursing Webinar (10/2016). (*^)

2016 Institute for Healthcare Improvement: WIHI program on integrated care models for treatment of perinatal substance use (6/2016). (*)

2016 Quality and Safety in Nursing Education: Demystifying the SQUIRE guidelines. San Antonio, TX (5/2106). (*^)

2015 Publish your Improvement Work. Institute for Healthcare Improvement (IHI) 27th National Forum, with Greg Ogrinc, MD, Louise Davies, MD, David Stevens, MD. Orlando, FL (12/2015). (#^)

2015 International SQUIRE writing conference, conference faculty. Hanover, NH (11/2015) (*^)

2015 Revising the SQUIRE Guidelines for quality improvement reporting excellence: a case study in improvement. Academy for Healthcare Improvement National Conference Baltimore, MD (10/2015). (#^)

2015 Treating Perinatal Opioid Use Disorders. American College of Nurse Midwives' National Conference Denver, CO (6/2015). (#^)

2015 The SQUIRE publication guidelines. Case Western University Medical Center Grand Rounds Presentation. Center for Clinical Research and Technology: (co-presented with Greg Ogrinc, MD). Cleveland, OH (5/2015). (*^)

C. Regional/Local:

2019 Improving Safety and Quality in the Perinatal Care of Women with Opioid Use Disorders. Keynote at Massachusetts Perinatal Quality Collaborative conference, Boston, MA (5/2019).

2018 Comparative Effectiveness of Integrated vs Non-integrated Care Models for Pregnant Women with Opioid Use Disorders. Center for Technology and Behavioral Health Research Seminar. Lebanon, NH (12/2018).

2018 Perinatal Substance Use Learning Collaborative project update. Northern New England Perinatal Quality Improvement Network annual conference (11/2018).

2018 How to avoid your own mental health emergency while caring for that of your patient in a 15 minute prenatal appointment. Northern New England Perinatal Quality Improvement Network annual conference (11/2018).

2018 Facilitating Best Practice in the Perinatal Care of Women with Opioid Use Disorders. Maine Medical Center Opioid Steering Committee. Portland, ME (10/2018)

2018 Dartmouth-Hitchcock Department of Obstetrics and Gynecology Grand Rounds Presentation: Research in Progress (10/2018)

2018 Moms in Recovery (MORE): Defining Optimal Care for Pregnant Women and Infants. New England Perinatal Quality Improvement Network annual conference: Poster presentation. Twin Mountain, NH (11/2018).

2018 Opioid Exposed Newborns: A Baby friendly, Family-Centered Approach. Northern New England Society for Addiction Medicine Annual Conference (with Julia Frew, MD and Bonny Whalen, MD). Stowe, VT (10/2018).

2017 Annual New England Regional Child Fatality Meeting: Supporting the Mother-Infant Dyad: Integrated Care for Pregnant and Parenting Women with Opioid Use Disorders (Nashua, NH (6/2017). (*)

2016 Northern New England Perinatal Quality Improvement Network: "A Collaborative Project to Improve Quality and Safety for Pregnant and Parenting Women with Opioid Use Disorders: Project update." (11/2016) (*^)

2016 American College of Nurse Midwives/Association of Women's Health Obstetric and Neonatal Nurses, Maine affiliates: Integrated Care for Pregnant and Parenting Women with Opioid Use Disorders. Falmouth, ME (10/2016). (*^)

2016 NIDA Clinical Trials Network, Northeast Node: Integrated Care for Pregnant and Parenting Women with Opioid Use Disorders, Lebanon, NH (10/2016) (*)

2016 Northeast Medical Association (NEMA) annual meeting: "Moms and Moms-to-be in Recovery: Perinatal Addiction Treatment Programs" Conway, NH (3/2016). (*^)

2016 Northern New England Perinatal Quality Improvement Network [NNEPQIN] Winter Conference: "A collaborative project to improve safety and quality of care for pregnant and postpartum women with opioid use disorders" Lebanon, NH (1/2016). (*^)

2015 11th Annual Dartmouth Symposium on Taking Action to Reduce Opioid-related Harm: "SBIRT in Healthcare: focus on perinatal care." Hanover, NH (5/2015) (*)

XXII. BIBLIOGRAPHY:

A. Original articles:

Higgins, T, **Goodman, D**, Meyer, M. Treating perinatal opioid use disorder in rural settings: Challenges and opportunities. *J. Preventive Medicine* 2019.

Krans, E, Campopiano, M, Cleveland, L, **Goodman, D** et al. National Partnership for Maternal Safety Consensus Bundle on Obstetric Care for Women With Opioid Use Disorder. *Obstetrics and Gynecology* 2019.

Goodman, D, Zagaria, A, Flanagan, A et al. Feasibility and acceptability of a checklist and learning collaborative to promote quality and safety in the perinatal care of women with opioid use disorders. *J. Midwifery and Women's Health* 2019.

Murphy, J, **Goodman, D**, Johnson, T, Terplan, M. The Comprehensive Addiction Treatment and Recovery Act (CARA): Opioid Use Disorder and Midwifery Practice. *Obstetrics and Gynecology* 2018.

Goodman, D, Ogrinc, G, Davies, L, et al. Explanation and Elaboration of the SQUIRE [Standards for Quality Improvement Reporting Excellence] Guidelines, version 2.0: Examples of SQUIRE elements in the healthcare improvement literature. *BMJ Quality and Safety* 2016;0: 1–24.

Goodman, D. Improving access to maternity care for pregnant women with opioid use disorders: co-location of midwifery services in the Dartmouth-Hitchcock Perinatal Addiction Treatment Program. *Journal of Midwifery and Women's Health* 2015;60;6:706-712.

Goodman, D, Milliken, C, Theiler, R, Nordstrom, B, Akerman, S. A Multidisciplinary Approach to the Treatment of Co-occurring Opioid Use Disorder and Posttraumatic Stress Disorder in Pregnancy: A Case Report. *Journal of Dual Diagnosis* 2015 (ePub ahead of print).

Akerman, S, Brunette, M, Green, A., **Goodman, D**, Blunt, Heil, S. Treating tobacco use disorder in pregnant women on opioid substitution therapy: A systematic review. *Journal of Substance Abuse Treatment* 2015; 52:40-7.

Ogrinc, G, Davies, L, **Goodman, D**, Batalden, P, Davidoff, F, Stevens, D. SQUIRE 2.0: (Standards for Quality Improvement Reporting Excellence): Revised Publication Guidelines from a Detailed Consensus Process. *The Joint Commission Journal on Quality and Safety* 2015;41;10:471-479.

Davies, L, Donnelly, K, **Goodman, D**, Ogrinc, G. Findings from a novel approach to publication guideline revision: User road testing of a draft version of SQUIRE 2.0. *BMJ Quality and Safety* 2015 (ePub ahead of print).

Bowden, K., **Goodman, D**. Barriers to employment for postpartum women with substance use disorders. *Work: A Journal of Assessment, Prevention & Rehabilitation* 2015; 50; 3: 425-31

Akerman, S, **Goodman, D**. Treating Opioid Use Disorders in Pregnant Women: Are We Doing Enough? *Newsletter of the American Association of Addiction Psychiatry* June, 2014.

Goodman, D, Wolff, K. Screening for substance abuse in women's health: a public health imperative. *Journal of Midwifery and Women's Health* 2013;58;3:278-287.

Goodman, D. Buprenorphine for the treatment of perinatal opioid dependence: pharmacology and implications for antepartum, intrapartum, and postpartum care. *Journal of Midwifery and Women's Health,* 2010;56;3: 240-247.

Reviews:

N/A

Book chapters:

Goodman, D, Bowden, K, O'Connor, A. Substance abuse during pregnancy. In Engstrom, J, Marfel, J, Jordan, R. *Prenatal and Postnatal Care: A Guide for Nurse Practitioners and Midwives, 2nd ed.* 2018. New Jersey: Wiley-Blackwell.

Goodman, D. Substance use disorders. In Thorpe, N, Farley, C, Jordan, R. *Clinical Practice Guidelines for Midwifery and Women's Health (5th ed).* 2016. Jones and Bartlett.

Goodman, D, O'Connor, A, Bowden, K. Substance abuse during pregnancy. In Engstrom, J, Marfel, J, Jordan, R. *Prenatal and Postnatal Care: A Guide for Nurse Practitioners and Midwives, 1st ed.* 2013. New Jersey: Wiley-Blackwell

Goodman, D. (contributor). The Capstone Project: Students' Experience. (2012). In Ahmed, S, Andrist, L, Davis, S, Fuller, V. (Eds). *The DNP – Redesigning Advance Practice Roles for the 21st Century: Education, Practice, and Policy*. 2012. New York: Springer.

B. Other scholarly work in print or other media

Technical Reports:

Snuggle ME Workgroup (2013). *Embracing Drug Affected Babies and their Families in the*

First Year of Life to Improve Medical Care and Outcomes in Maine. (Contributing author). Accessible from: https://www1.maine.gov/dhhs/mecdc/documents/SnuggleME-Project.pdf

A Toolkit for the Perinatal Care of Women with Substance Use Disorders. Sponsored by the Northern New England Perinatal Quality Improvement Network. Accessible from: http://www.nnepqin.org/a-toolkit-for-the-perinatal-care-of-women-with-opioid-use-disorders/

C. Abstracts: Include both oral, exhibit and poster presentations. Indicate with (#) abstracts that were reviewed (e.g., by a professional society) prior to being accepted for presentation.

2017 American Society for Addiction Medicine National Conference (poster presentation): "Dismantling Barriers to Addiction Treatment and Maternity Care: Results from an Integrated Program." Poster presentation (co-author: Julia Frew, MD). New Orleans, LA (4/2017).

2015 American College of Nurse Midwives' National Conference "Double Jeopardy: The intersection of PTSD, substance use disorders, and pregnancy," Poster presentation. Denver, CO (6/2015).

XXIII. Personal Statement:

As an advanced practice nurse, the focus of my work for the past 16 years has been to improve access and quality of care for women in underserved rural communities. I have had the opportunity to practice in federally qualified health care centers, critical access and community hospitals, and in the academic medical center. This experience has strengthened my commitment to seek cost-effective solutions to providing high quality women's health care in low resource settings. Fellowship training in healthcare improvement has prepared me to teach quality improvement methods to the aspiring medical professionals, medical students, residents, and seasoned healthcare professionals in the TDI residential and hybrid MPH programs. These approaches are integrated on the practice level during OB clerkship at our perinatal substance use treatment program, and in PGY2 training in a dedicated obstetric clinic for women with substance use disorders.

A growing awareness of the opioid epidemic and its impact on maternal-child health has focused my work in healthcare improvement in the area of perinatal substance use. My doctoral work involved the development and validation of a guideline for managing perinatal opioid use disorders utilizing what was, in 2009, a novel therapy (buprenorphine), and since then I have been engaged in dissemination and implementation. At Dartmouth-Hitchcock, I have built on this work as a member of a multidisciplinary team designing and evaluating innovative approaches to care delivery in the area of perinatal substance use. A central part of our program mission is to help learners develop knowledge and skills in interprofessional collaboration necessary to delivery of high quality, integrated services for substance use disorders in the maternity care context.

The ability to develop meaningful partnerships is essential to improve outcomes for marginalized women. My scholarship has focused on perceived barriers and facilitators of engagement with the healthcare system for pregnant and parenting women with substance use disorders, and the development of integrated care models. However, further research on clinical and patient-centered outcomes associated with this approach is urgently needed to help clinicians optimize care for both mothers and infants. This field provides a rich opportunity for mentoring students interested in the topic of perinatal substance use, either from the quality improvement or research perspectives.

In collaboration with our Clerkship Administrator, I have worked to develop opportunities for experiential learning for undergraduate medical students through including a rotation in our integrated perinatal treatment program during the OB clerkship. In addition, I collaborated with our Residency Program Director to develop a year-long curriculum in the management of perinatal substance use. I currently precept our PGY2 Ob/Gyn residents who staff a weekly dedicated clinic for women with substance use disorders, and mentored one of our Leadership in Preventative Medicine Residents in improving substance use screening, brief intervention, and referral processes in the Department of Ob/Gyn. I was one of the first wave of advanced practice nurses to obtain a waiver to prescribe buprenorphine, have co-presented buprenorphine training for advanced practice nurses with colleagues from the American College of Obstetricians and Gynecologists, and have the privilege of advising nurse-midwife colleagues working through this process.

Over the past four years, our integrated program has moved from model development to refinement, dissemination and implementation. Looking forward to the next 5 years, my goals include the expansion of our current academic-practice partnership, further building our curriculum in the area of perinatal substance use, and publication of our unique educational approach.

Updated by: DJG

Date: 8/15/19

CURRICULUM VITAE November, 2018

Steven Holmes Chapman, M.D.

Personal Information

Work Address:
Boyle Community Pediatrics Program
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Dartmouth Hitchcock Medical Center
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Lebanon, NH 03756
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Hanover, NH 03755
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Spouse: Catherine D. Shubkin, M.D.
Children: Ella Chapman 12/04/2000, Natalie Chapman 10/29/2002

Date of Birth: April 13, 1962
Place of Birth: Columbus, Ohio
Citizenship: U.S.

EDUCATION

DATES	INSTITUTION	DEGREE
2015	Value Institute, DHMC	Greenbelt
1990-1993	National Health Service Corp	Scholar
1989-1993	University of Pennsylvania	M.D.
1980-84	Brown University	A.B.

POSTDOCTORAL TRAINING

DATES	INSTITUTION	SPECIALTY
1996-2000	National Health Service Corp, Lawrence MA	Pediatrics, Underserved Populations
1994-1996	University of Washington/Seattle Children's Medical Center	Pediatric Resident
1993-1994	University of Washington/Seattle Children's Medical Center	Pediatric Intern

PROFESSIONAL DEVELOPMENT ACTIVITES

DATE	INSTITUTION	TITLE/ACTIVITY
2018-Ongoing	Northern New England Advocacy Collaborative (NH, Maine, Vermont)	Medical Director; Advocacy Curricula Development across three Northern New England States
2009-Present (Annually)	Geisel/CHaD OCER Pediatric Training Retreat	Annual Residency Retreat for Rotation Directors
2013-Present (Annually)	Geisel/CHaD	Design and Direct Annual Faculty Development Sessions for Family Faculty – Boyle Program
2013-Present (Annually)	Geisel/CHaD	Design and Direct Annual Faculty Development Session for Community Faculty – Boyle Program
2015	AAP Community Pediatrics Training Initiative – Ben Hoffman MD Visiting Professor	Designed and Co-led 3 day Advocacy and Community Pediatrics Training Retreat
2000-2008 (4 sessions/year)	University of Washington	Visiting Professor Teaching Retreats
1999	University of Massachusetts	Teaching with GNOME – Goals, Needs Assessments, Objectives, Methods, Evaluation
1998	McGill School of Medicine	Effective and Efficient Teaching – Identifying Needs and Goals of Learners

ACADEMIC APPOINTMENTS

DATES	INSTITUTION	TITLE
2008- Present	Geisel/Dartmouth Medical School	Assistant Professor
2005-2008	University of Washington	Associate Clinical Professor
2001-2005	University of Washington	Assistant Clinical Professor
2000-2001	University of Washington	Instructor
1998-2000	University of Massachusetts	Assistant Clinical Professor
1996-2000	Tufts University	Assistant Clinical Professor

INSTITUTIONAL LEADERSHIP ROLES:

DATES	INSTITUTION	TITLE
2017-Present	Center for Addiction, Recovery, Pregnancy and Parenting, DHMC	Director of Child Health
2017-Present	Moms In Recovery, DHMC	Pediatrics Lead
2016-Present	Substance Use Mental Health Taskforce, DHMC	Lead, SBIRT Subgroup; Pediatric Lead, Perinatal Addiction Subgroup
2010- Present	Boyle Community Pediatrics Program, CHaD	Director
2010-Present	Family Advisory Board, CHaD	Lead Faculty Advisor and Member
2010-Present	Molly's Place Family Resource Center, CHaD	Medical Director
2012-Present	Pediatric Schwartz Rounds, DHMC, Geisel	Medical Director
2009-Present	Homeless Healthcare Project – Pediatric Residency, CHaD	Medical Director
2010-2016	Healthy Eating Active Living -- CHaD	Steering Committee Member
2008-Present	Pediatric Ambulatory Education Committee	Lead Preceptor
2009-2013	Pediatric Medical Home Implementation Committee, CHaD	Co-Founder and Chair
2012-2014	Primary Care Data and Measurement Committee, DHMC	Pediatric Lead
2012-2014	Center for Primary Care and Population Health, DHMC	Associate Director of Child Health
2012-2014	Primary Care Council, DHMC	Pediatric Lead
2009-2012	Regional Primary Care Council Leadership, DHMC	Steering Committee Member
2009-2011	Ambulatory Resource Quality Committee, CHaD	Pediatric Primary Care Director
2009-2011	Lebanon CHaD General Pediatrics Clinic, CHaD	Medical Director
2008-2011	Green Team, CHaD Primary Care	Team Leader
2009-2010	Pediatric Department Council, CHaD, Pediatric Residency	Primary Care Representative
2004-2008	Olympic Medical Center, Washington State	Chair, Olympic Quality Institute

SEARCH COMMITTEES CHAIRED

Date	Position	Department
2016-2018	Child Abuse Pediatrician, M.D.	Pediatrics, Geisel/DHMC
2015	Primary Care Pediatrics, APRN	Primary Care Pediatrics, Geisel/DHMC
2014	Primary Care Pediatrics, APRN	Primary Care Pediatrics, Geisel/DHMC

LICENSURE AND CERTIFICATION

DATE	LICENSURE/CERTIFICATION
2015-Present	American Board of Pediatrics, Recertification
2005	American Board of Pediatrics, Recertification
1996	American Board of Pediatrics, Certification
2008-Present	New Hampshire Medical License
2000-2008, 1993-1996	Washington State Medical License
1996-2000	Massachusetts Medical License

Hospital Appointments

DATES	INSTITUTION	POSITION/TITLE
2011-Present	Dartmouth Hitchcock Medical Center	Senior Staff Membership
2008-Present	Dartmouth Hitchcock Medical Center	Staff Physician
2000-2008	Olympic Medical Center, Washington State	Senior Staff
2004-2008	Olympic Medical Center, Washington State	Chair, Olympic Quality Institute

TEACHING ACTIVITIES

UNDERGRADUATE EDUCATION

2018-9 Mentor, Eichler Fellowship

GRADUATE EDUCATION

CLASSROOM TEACHING:

DATES	INSTITUTION	COURSE TITLE	ROLE	HOURS/YEAR
2012-2014	TDI/Tuck Masters of Healthcare Delivery Science	Population Health: Vulnerable Populations and Workforce Reform	Pediatric Faculty	30

UNDERGRADUATE MEDICAL EDUCATION

CLASSROOM TEACHING

DATE	INSTITUTION	COURSE	ROLE	HOURS/YR
2010-Present	Geisel Medical	From The Other Side Of The Stethoscope	Facilitator	12
2010-Present	Geisel Medical	Careers in Medicine	Pediatric Lecturer	2
2012-2014	Geisel Medical	Population Health Lecture	Lecturer, Family Medicine 3rd years	3

CLERKSHIP TEACHING

DATES	INSTITUTION	COURSE TITLE	ROLE	HOURS/YEAR
2008-Present	Geisel	Pediatrics	Lead Preceptor	60
2012-Present	Geisel	On Doctoring	Lead Preceptor	20

GRADUATE MEDICAL EDUCATION

DATES	INSTITUTION	COURSE TITLE	ROLE	HOURS/YEAR
2018 - Present	Geisel/DHMC/Pediatric Residency, Community Pediatrics Training Initiative of the AAP	Child Legislative Advocacy – Scholarship to DC to work with NH Legislators	Director	30
2008-Present	Geisel/DHMC/Pediatric Residency	Continuity Clinic	Lead Preceptor	220
2008-Present	Geisel/DHMC/Pediatric Residency	Ambulatory Rotation	Faculty Preceptor	80
2010-Present	Geisel/DHMC/Pediatric Residency	Community Pediatrics	Course Director	21 Resident Rotations each year
2010-Present	Geisel/DHMC Pediatric Residency	Adolescent Medicine	Faculty Preceptor	20
2009-Present	Geisel/DHMC/Pediatric Residency	Advocacy Elective	Course Director	30
2009-Present	Geisel	Schweitzer Fellowship	Advisor/Selection Committee	4
2011-Present	Geisel	From the Other Side of the Stethoscope (FOSS)	Co-Director, Facilitator	10

2010-Present	Geisel	Career Roadmap Series	Pediatrics Presenter	2

Curricular Programs Developed

DATES	INSTITUTION	COURSE TITLE	ROLE
2018-Present	Dartmouth, UVM, Maine Medical Center,in collaboration with State AAP Chapters	Pediatric Legislative Advocacy at the State and Local Level	Medical Director
2011-Present	Dartmouth Pediatric Residency Program	Windshield Survey—Social Determinants of Health Community Needs Assessment	Community Pediatrics Course Director, Content Developer
2011-Present	Dartmouth/Geisel School of Medicine	From the Other Side of the Stethoscope – Compassionate Care workshop with Family Faculty	Co-Developer of Content and Format, with Todd Poret and Toni Lamonica
1991-Present	University of Pennsylvania School of Medicine	Bridging the Gap: Interdisciplinary Community Health Internship Program	Co-Founder, Content and Format Developer

ADVISING/MENTORING

UNDERGRADUATES/GRADUATE STUDENTS

Not Applicable

MEDICAL STUDENTS

DATES	STUDENT'S NAME	PROGRAM NAME
July 2018-Present	Ashley Hamel	Outpatient Follow up of infants affected by Neonatal Abstinence Syndrome
December 2018-Present	Emma Hanlon	Outpatient Follow up of infants affected by Neonatal Abstinence Syndrome
6/2014- June 2017	Christina Jaramillo	Qualitative Research: FOSS (From the Other Side of The Stethoscope)
12/2014 – June 2017	Bianca Williams	Patient Voices – Qualitative Data on the Patient Experience, Adolescent Substance Misuse Screening

2016- 17	Simrun Bal	Neonatal Abstinence Syndrome (NAS) – Babies Born Addicted, and Supports for Parents After Nursery Discharge

RESIDENTS/FELLOWS

DATES	MENTEE'S NAME	SPECIALTY
7/18 - Present	Meghan Reynolds	Pediatric Resident – Academic Advisor
7/15 – 6/18	Carrie Schulmeister	Pediatric Resident – Academic Advisor
7/14 - Present	Aimee Beaton	Pediatrics Oral Health Fluoride Varnish Project
4/15 – June 2017	Hallie Baucher	Pediatrics Homeless Healthcare Project
5/12-6/15	Sam McWilliams	Pediatrics – Homeless Healthcare Project
2011-13	Brendan Gilligan	Pediatrics
2010-2012	Diana Baker	Pediatric Advocacy

FACULTY

Date	Mentee's Name	Specialty
2015-2016	Susan Pullen MSW	Behavioral Health – SBIRT and Substance Abuse in Adolescents

RESEARCH TEACHING/MENTORING

UNDERGRADUATE, GRADUATE, FACULTY

Date	Mentee's Name	Specialty
2018-9	Aishwarya L. Sritharan	Eichler Fellowship Dartmouth Undergraduate

RESIDENTS -- Advocacy Projects as Scholarly Activity

DATE	MENTEE'S NAME	SPECIALTY
2018-19	Rob Murray, Jessica Trulove	Pediatric Oral Health Promotion in a Family Homeless Shelter - American

		Academy of Pediatrics CATCH Grant
2017-2018	Christina Marmeola	Mothers in Recovery pediatric continuity project; Drug Court Advocacy
2014-2017	Aimee Beaton	Pediatrics - Oral Health in Underserved Children. SBIRT – Substance Abuse in Adolescents
2015-Present	Sam Ogden	Parents Together – Parents and Recovery Support in Families with Young Children
2015-2017	Hailee Baucher	Health Education and Parent Coaching in a Homeless Population
2013-2015	Sam McWilliams	Child Homeless Healthcare Project
2012	Ryan Johnson	It Happens Here Too; Rural Homelessness and Health in Northern New England
2010-2012	Diana Baker	Child Oral Health – The Opportunity of Fluoride Varnish in Medical Settings

COMMUNITY SERVICE, EDUCATION, AND ENGAGEMENT

DATES	INSTITUTION	COURSE TITLE/ACTIVITY	ROLE	HOURS/YEAR
2015-Present	CHaD/The Family Place/Second Growth	Parents Together, Parenting and Substance Misuse Support Course	Faculty Director	20
2011-Present	DHMC/Upper Valley Haven	Bridges Out of Poverty	Course Coordinator	8
2009-Present	Dresden School Board		School District Physician	30
2010-Present	Child Focus Forum		Physician Lead	4
2014- Present	NH Oral Health Coalition		Physician Lead	20

2013-Present	Community Pediatric Grand Rounds	Community agency-based seminar series	Medical Director	6
2013-Present	NH Children's Alliance/Kids Count	Pediatric Advisor	Board Member	15
2014-Present	Let's Grow Kids Vermont		Campaign Ambassador	4

RESEARCH FUNDING

DATES	PROJECT	ROLE	%EFFORT	SPONSOR	ANNUAL
2018-2019	Advancing MAT and perinatal outpatient supports in rural NH settings	Director of Child Health (CARPP, Center for Addiction, Pregnancy and Parenting)	30%	21st Century Cures Grant – through NH BDAS	
September 2017 -19	Advancing the Standard of Care for Women and Children Affected by Substance Use Disorders (Planning Grant)	Co-PI	10%	NH Charitable Foundation	PLANNING GRANT FOR 'CENTER OF EXCELLENCE' PERINATAL SUBSTANCE ABUSE CARE
September 2017 Onward	Regional Consult Network – Perinatal Substance Abuse Care	Core Pediatric Lead	5%	NH Charitable Foundaton	
2015-Present	NIDA CTN Northeast Node	Core-Investigator	5%	NIDA CTN	
July 2017-Dec 2018	AAP Healthy People 2020 Chapter Grant "The Earlier the Better, Supporting Families in Early Opiate Recovery"	PI	10% (in kind; grant supports program expenses)	American Academy of Pediatrics	
July 2017-July 2018	Family Engagement Grant	Co-PI	In Kind, funds to support family advisory infrastructure	American Academy of Pediatrics Friends of Children Fund	

May 2014-May 2017	Adolescent Substance Abuse - - SBIRT	Co-Director	10%	NH Charitable Foundation – Hilton Family Foundation	
2013- 2015	Compassionate Care Initiative	Co-PI	10% (in kind)	Dolan Family Foundation	
2015 – Present (Funded through 2020)	Adolescent Substance Abuse Research Node	Co-PI	5%	National Institute of Drug Abuse (NIDA)	

CURRICULUM/PROGRAM DEVELOPMENT

DATES	Program	Description
2018-Ongoing	Northern New England Advocacy Collaborative (NH, Maine, Vermont Pediatric Residency Programs)	Multi-State collaborative among pediatric residencies, State AAP Chapters, legislators and medical schools to teach and engage in legislative advocacy. First Annual Summit held at Dartmouth Hitchcock October, 2018
2015-Present	Parents Together – Boyle Community Pediatrics Program, in partnership with 3 community agencies.	Three parenting/recovery groups in partnership with The Family Place, Second Growth, and Perinatal Addiction Treatment program. Pediatric residents involved in program evaluation as well as providing pediatric care to children in the program.
2013-Present	Faculty Development Seminars for Pediatric Family Faculty and Community Faculty	The Boyle Program uses non-traditional faculty for teaching medical students and residents. This series explores development of skills and pedagogical techniques for both Family Faculty (parents of children with special health care needs) and Community Faculty (community agencies and organizations that work with children).
2012-Present	Boyle Community Forum Series: "How Can We Be a Stronger, Healthier Community?"	Presentation and moderated panel discussion on population health issue, held 3 times a year. Topics include Gun Violence, Childhood Obesity, Adolescent Suicide, and Adolescent Opioid Addiction.
2012-Present	Bridges Out of Poverty	Co-Sponsored with The Upper Valley Haven; A joint DHMC –Community seminar on the culture of poverty, and approaches to compassionate care.

2011-Present	Boyle Fund Grant Program	$3-18K grants given to community partners for programs providing care and support to children with special healthcare needs. Past areas of focus have included childhood obesity, and supporting substance abuse recover in parents with young children. Pediatric Residents are involved in the execution of these programs.
2010-Present	Pediatric Resident Advocacy Elective	Defining advocacy as 'speaking for those whose voice is not heard' this is a month long elective involving project work using an 8-step advocacy framework, including need assessment, attainable goals and objectives, working with collaborative partners, measurement, and evaluation.
2011-Present	Community Needs Assessment 'Windshield Survey'	Incoming pediatric interns are each assigned a town to visit and conduct a health needs assessment, and report back to the residency in written form, and conference presentation.
2009-Present	From the Other Side of The Stethoscope	All Third year Geisel pediatric clerkship students write a reflection on a case of theirs, share with other students and Family Faculty (Parents of children with special healthcare needs who are trained to teach medical learners), and participate in a group discussion on the elements of compassionate care.
1991-Present	Bridging the Gaps – Co-Founder	Developed at the University of Pennsylvania, this Interdisciplinary Community Health Summer Internship program has spread to all medical schools in Philadelphia and Pittsburgh, and has trained over 4000 medical, social work, nursing, and dental students, with all presenting posters at an Annual Symposium. **www.med.upenn.edu/*btg***

ENTREPRENEURIAL ACTIVITIES

Not Applicable

MAJOR COMMITTEE ASSIGNMENTS

NATIONAL/INTERNATIONAL

DATES	COMMITTEE	ROLE	INSTITUTION
2017-2020	AAP District I Executive Committee	NH President	American Academy of Pediatrics
2009-Present	Committee on Oral Health	NH State Champion	American Academy of Pediatrics
2014-Present	AAP National Leadership Forum	NH President/Vice President	American Academy of Pediatrics
2013-Present	Community Pediatrics Training Initiative	NH AAP/Geisel Representative	American Academy of Pediatrics
2014-Present	National Health Service Corp Alumni Recruitment	NHSC Ambassador/Geisel Liaison	National Health Service Corp

REGIONAL

2017-8	Senators Shaheen and Hassan NH Health Leaders Advisory Group	NH AAP Representative	U.S. Senate
2012-Present	Region I District Leadership Council	NH Representative	American Academy of Pediatrics
2014-Present	NH Pediatric Improvement Partnership	Steering Committee	CHaD/University of New Hampshire
2012-Present	NH Oral Health Coalition	Physician Liaison	AAP, NH Oral Health Coalition, NH Dental Society

LOCAL/INSTITUTIONAL

2016-2017	Substance Misuse Initiate	Lead, Adolescent SBIRT, Member Perinatal Addiction	DHMC
2011-Present	Child Focus Forum	Pediatric Lead	DHMC – 12 Community Organizations/Govt Agencies

2014-Present	Bridges Out of Poverty Collaborative	Boyle Director	Boyle Program, United Way, Upper Valley Haven,
2017-Present	NH Pediatric Society Executive Committee	Chair	American Academy of Pediatrics

MEMBERSHIPS, OFFICE AND COMMITTEE ASSIGNMENTS IN PROFESSIONAL SOCIETIES:

DATES	SOCIETY	ROLE
2017-2020	NH Pediatric Society	President
2017-Present	Child Abuse Council, American Academy of Pediatrics	Member
2014-Present	NH Pediatric Society	Vice President
2008-Present	NH Pediatric Society	Executive Committee Member
2009-Present	Community Pediatrics Council- American Academy of Pediatrics	Faculty Member

EDITORIAL BOARDS/JOURNAL REFEREE ACTIVITIES

Not Applicable

AWARDS AND HONORS:

DATE	AWARD
2019	Pediatric Academic Society's Health Delivery Science Award (along with Drs. Whalen, Frew, Holmes, and Nurse Midwife Daisy Goodman for the creation of the Center on Addiction, Recovery, Pregnancy and Parenting)
2016	American Academy of Pediatrics Special Achievement Award for "His valuable work educating residents and medical students on substance misuse in children, and addressing poverty in children"
2016	First Place Award, Value Institute DHMC Patient Safety and Quality Award: Adolescent SBIRT

2015	University of Pennsylvania Bridging The Gaps 25th Anniversary -- Community Health Lifetime Recognition
2014	Pediatric Residency Teaching Award
2005	Hero of Health Award – Washington State Department of Health
2003	Bridging The GAP Founders Award – University of Pennsylvania
2000	Faculty Excellence Award – Teacher of the Year (Lawrence Family Medicine Residency)
1991-2000	Public Health Service National Health Service Corp Scholarship
1993	CIBA-Geigy Award for Outstanding Community Service
1993	Alpha Omega Alpha Honor Society
1992	Paul Stolley International Clinical Epidemiology Travel Award

INVITED PRESENTATIONS:

DATE **TOPIC/TITLE** **ORGANIZATION** **LOCATION**

NATIONAL

*^ 2019 May	"Building Collaboration: Novel Approaches to Improving Resident Advocacy Training through Partnerships Across States"	Pediatric Academic Society Annual Meeting, Scholarly Session	Baltimore, MD
*^ 2018 Dec	"Integrating Screening, Brief Intervention, and Referral to Treatment in Pediatrics"	Center for Technology and Behavioral Health at Dartmouth	Geisel School of Medicine, NH
*^ 2018 May	"A Multidisciplinary Approach to the Care of Pregnant Women with Opiate use Disorders"	Psychiatry Grand Rounds, DHMC/Geisel	Lebanon, NH
*^ 2017 June	"SBIRT in Adolescence"	Substance Abuse Mental Health Services Administration (SAMHSA)	Providence, RI
*^ 2017 May	"SBIRT in Primary Care Pediatrics: Lessons and Opportunities Beyond Implementation"	National Drug Abuse Treatment Clinical Trials Network Science Series	Bethesda, MD Lebanon, NH (Webex Talk, live and archived)

*^ 2017 April	"The Earlier the Better: Developing a System of Integrated Care for Childbearing Families with Substance Use Disorders"	Pediatric Academic Society Annual Meeting	San Francisco, CA
*^ 2017 April	"SBIRT Implementation in Primary Care; What Happens After Screening?"	Pediatric Academic Society Annual Meeting Poster	San Francisco, CA
*^ 2017 April	"Systematic Tablet-Based Adolescent Screening Improves Practice" Susanne Tanski MD Presenter	Pediatric Academic Society Annual Meeting Platform Presentation	San Francisco, CA
*^ 2017 March	"Management of Adolescent Substance Use Disorder: An Overview and Next Steps"	National Institute on Drug Abuse, Clinical Trials Network Annual Scientific Meeting	Bethesda, MD
*^2016 December	"Beyond Screening and Brief Intervention with Adolescents"	National Drug Abuse Treatment Clinical Trials Network (CTN) Youth Special Interest Group	Bethesda, MD (WebEx)
*^2016 October	"SBIRT in Pediatric Primary Care"	Hilton Foundation Annual Retreat	Washington D.C.
*^2016 October	"Parenting and Substance Abuse: Preventing Adverse Childhood Experiences"	The Northeast Node of the National Drug Abuse Treatment Clinical Trials Network (CTN) Annual Meeting	Hanover, NH
*^2016	Families as Teachers: From the Other Side of the Stethoscope in Third Year Medical Student Clerkships	Pediatric Academic Society, Workshop	Baltimore, MD
*^2016	Addressing Substance Misuse in Adolescents: the SBIRT Model in Primary Care	Academic Pediatric Association, Platform Presentation	Baltimore, MD
*^2016	Tooth or Consequences: Fluoride Varnish Medical Settings	Dartmouth Annual Mount Washington Pediatric Conference, Lecture and Workshop	Mount Washington Lodge, NH
#^2015	Family Faculty Teaching Compassionate Care: From The Other Side of The Stethoscope	Academic Pediatric Association	San Diego, CA
*2015	From The Other Side of The Stethoscope: Compassion Care in Pediatric Clerkship	Counsel on Medical Student Education in Pediatrics	New Orleans, LA
*2012	"Bringing Compassionate Care to Life with Schwartz Center Rounds"	Schwartz Center; Press Ganey	Washington DC

*^2008	Overcoming Fluorophobia In a Rural Western Town By Building Strong Community Partnerships	AAP National Conference	Washington, DC
*^2000	Searching For the Evidence – Use Of Electronic Databases & Internet In Research & Clinical Decision Making Workshop	Academic Pediatric Association National Conference	Boston, MA
*1995	Creating A Road Map For The Future: Workshop	National Health Service Corp	Washington, DC
*^1991	"The West Philadelphia Improvement Corp (WEPIC) Community Health Watch: A School Based Education and Screening Initiative"	Prevention 91: Buiilding an Economic Framework	Baltimore, MD

REGIONAL/LOCAL

*^2019 January	"Plan of Safe Care Summit"	Governor's Task Force on Perinatal Substance Misuse	Manchester, NH
*^2018 December	"Plans of Safe Care in NH"	NH Behavioral Health Summit	Manchester, NH
*^2018 October	The Brief Intervention with Adolescents: The Power of our Relationships in Primary Care	Vermont Child Health Improvement Program (CHIP) 2018 Learning Session	Burlington, VT
*^2018 October	"Identifying and Addressing Adolescent Substance Risk: SBIRT"	DHMC/Governor's Council on Substance Misuse	Manchester, NH
*^ 2018, August	Supporting Recovery in Mothers and their Children affected by Opiate Use Disorders	NH WIC Directors Annual Forum, Keynote	Manchester, NH
*^ 2017 November	Supporting the Mother-Infant Dyad: Integrated Care for Pregnant and Parenting Women with Substance Use Disorders	2017 NH Behavioral Health Conference & Public Policy Summit	Manchester, NH
*^ 2017 June	"Parents Together: An Integrated System of Support for Parents of Young Children in Early Recovery"	DHMC APRN CME Retreat	Lebanon, NH
*^ 2017 June	"SBIRT in Pediatric Primary Care"	DHMC "No Health Without Mental Health" Evening CME Symposium	Lebanon, NH
*^10/2015	"Ripples in the Pond: Implementing Substance Abuse Screening in NH"	NH Center for Excellent, Region SBIRT Summit	Concord, NH

*^10/2015	"Fluoride Varnish in Medical Office Settings"	NH Oral Health Coalition Annual Summit	Concord, NH
*9/2015	The Raising of America -- Moderator	Boyle Community Forum Series	Lebanon, NH
*7/2015	Brief Intervention: Effective Response To a Positive Substance Abuse Screen	Family Medicine Faculty	Lebanon, NH
*7/2015	Community Needs Assessment: Conducting a Windshield Survey	Pediatric Residency	Lebanon, NH
*6/2015	Third Year Medical Student Clerkship Reflections with Family Faculty: From the Other Side of The Stethoscope	Pediatric Academic Society Meeting, Platform Presentation	San Diego, CA
*6/2015	Brief Intervention: Effective Response To a Positive Substance Abuse Screen	Pediatrics Primary Care Faculty	Lebanon, NH
*5/2015	SBIRT in Primary Care	DHMC Value Institute	Manchester, NH
* 4/2015	Addressing Substance Misuse: Lessons from the NH Youth SBIRT Initiative	Dartmouth Seminar Series	Dartmouth College, Hanover NH
* ^ 2/2015	Adolescent Substance Abuse Screening and Intervention	Dartmouth Research Cooperative	Annual Retreat, North Conway, NH
*^ 10/2014	Implementing a Tablet Based Substance Abuse Screener	NH Center For Excellence	Concord, NH
*10/2014	Healthy Eating Active Living: Community Translation	Boyle Community Forum Series	Lebanon, NH
*9/2014	Barrel To The Head: Firearms and Suicide Risk -- Moderator	Boyle Community Forum Series	Lebanon, NH
*3/2014	The Hungry Heart – Adolescent Substance Abuse	Boyle Community Forum Series	Lebanon, NH
*6/2013	Medical Dental Partnerships: Risk Assessment and Fluoride Varnish	NH Oral Health Coalition	Concord, NH
*2/2013	Working Toward The Sandy Hook Promise" -- Moderator	Boyle Community Forum Series	Lebanon, NH
*1/2013	Testimony, Oral Health Access	NH Senate Bill 284	Concord, NH
1/2012	Testimony, Fluoride Regulation	NH House Bill 186	Concord, NH

PUBLICATIONS

ARTICLES

Steven H. Chapman M.D. and Ashley Lamb, M.D, New Hampshire Chapter Battles Opioid Epidemic with "The Earlier the Better" Initiative, *Developmental and Behavioral Pediatrics Newsletter* Fall, 2018

Aimee Beaton, MD, Catherine Shubkin, MD, **Steven Chapman, MD** Addressing Substance Misuse in Adolescents: A Review of the Literature on the SBIRT (Screening, Brief Intervention, and Referral to Treatment) Model. *Current Opinions In Pediatrics* 2016 Apr;28(2):258-65 PMID: 26867164

Robert D. Newman MD, **Steven H. Chapman MD**, Catherine D. Shubkin MD, Douglas Diekema MD A Wilderness Medicine Curriculum for Pediatric Residents. . *Pediatric Emergency Care*, Vol 14, No. 1, 1998

Mitchell P. LaPlante Ph.D., **Steven H. Chapman**, Gail R. Wilensky Ph.D., Life Expectancy and Health Status of the Aged, Social Security Administration, 1986

Glinda S. Cooper, **Steven H. Chapman**, Gail R. Wilensky Ph.D., An Evaluation of The Eastern Caribbean Regional Training Program for Allied Health Professionals US Agency for International Development, 1985

Louis Garrison, Jr. Ph.D., **Steven H. Chapman**, The Potential Revenue of A State Run Lottery in Jamaica, Report to the Jamaican Ministry of Health, 1985

BOOK CHAPTERS

Gail R. Wilensky Ph.D., **Steven H. Chapman,** in Indicators and Trends of Health and Healthcare, D. Schwefel M.D. *Demographic Indicator Systems of Health Care Needs ed*, Springer Press (1986) pp. 34-40.

ON LINE PUBLICATIONS

Steven H. Chapman M.D., Julie Frew, M.D., Hendree Jones Ph.D., Adam Bisaga, M.D. Pregnancy and Opioids: What Families Needs to Know About Opioid Misuse and Treatment During Pregnancy , Partnership for Drug Free Kids May, 2018
https://drugfree.org/parent-blog/how-to-help-a-woman-who-is-using-opioids-and-becomes-pregnant/

Andrew Aligne MD, Deborah Best MD, **Steven H. Chapman** MD, Cappy Collins MD, Lisa Ayoub-Rodriguez MD, Julie Linton MD, Michele Lossius MD, Jerri Rose MD, Benjamin Hoffman The Community Pediatrics Training Initiative Project Planning Tool: A Practical Approach to MD .Community-Based Advocacy *MedEdPortal*, September, 2017
https://www.mededportal.org/publication/10630/

Journal Guest Editor

Gail R. Wilensky Ph.D., **Steven H. Chapman** (Guest Editors) Medicare Physician Payment Alternatives: Assessing the Options. *Medical Care Review* Vol 43, No 1, 1986

Letters to the editor:

Op-Ed: Don't Harm Children and Call It Reform – Co-Authored with Senator Jean Shaheen	Concord Monitor, Portsmouth Gazette, Keene Sentinel, Valley News	June, 2017
Op-Ed Community Water Fluoridation and Ethics	Peninsula Daily News	October, 2015
Op-Ed – Charleston SC – Race and Violence	Valley News	July, 2015
Letter -- Fluoridation as public health	Valley News	September, 2014
Letter -- Sandy Hook and Gun Violence	Valley News	January, 2012

MARTHA SUE "SUZY" CATALONA

WORK EXPERIENCE:

Management

* Stabilized systems and staffing in the Weight and Wellness Center, Sleep Medicine service and Addiction Treatment Programs after reorganizations.

* Collaborated with Primary Care administrative teams to implement and expand behavioral health service integration in Primary Care.

* Developed and maintained the infrastructure, systems and procedures to support the mission and promote the overall function of the Department of Psychiatry.

* Implemented a Corporate Compliance Program for the Department of Psychiatry including developing the plan, coordinating and facilitating medical record compliance audits with an outside consultant, organizing and leading the Compliance Committee and providing compliance training for all Department faculty and staff.

* Developed documentation templates for all services provided within the Department.

* Led administrative efforts associated with the initial implementation of an electronic medical record and appointment scheduling system and with the conversion to a new system several years later.

* Created and maintained master schedules for 65 providers.

* Negotiated and administered service contracts with outside facilities and agencies.

* Administered Training Affiliation Agreements for the Child and Adolescent Psychiatry Fellowship Training Program.

* Served as Department's Complaints Officer.

* Served as a resource to the Department on regulatory matters.

* Participated in the formation of a formal quality improvement program for the Department of Psychiatry

* Monitored day-to-day work flow and allocated resources to maximize productivity and insure timely task completion.

* Monitored and distributed monthly faculty productivity reports.

* Hired, trained, and managed department support staff.

* Assumed responsibility for UM program development, implementation, maintenance, evaluation, and improvement.

* Collaborated with clinicians in system-wide UM activities for those clients receiving services across the continuum of care in an integrated care delivery system.

* Collaborated with all involved individuals/departments to develop specific policies/guidelines for admission, utilization review, and care management processes.

* Developed and defined Access Office roles and functions.

* Established and maintained relationships with referral sources and third party payors.

* Managed intake and utilization review/case management functions for Inpatient, Partial Hospital, and Outpatient Psychiatry Services.

* In-serviced staff on utilization review process.

* Counseled and evaluated performance of professional nurses based on stated expectations and conducted annual appraisal interviews.

* Scheduled fifty staff to provide twenty-four hour coverage of Inpatient Psychiatry Services.

* Planned and coordinated assignments and activities to ensure safe patient care.

* Assumed responsibility for maintaining staffing budget demands while responding to widely fluctuating patient acuity and census.

* Participated in Nursing Department committees and task forces including the Acuity Steering Committee, Medication Process Task Force, Procedure Committee and Quality Assurance Committee.

* Functioned as liaison between Inpatient Psychiatry Services and Pharmacy.

* Monitored patient medication delivery as part of hospital quality assurance monitoring program.

* Consulted with architect and various hospital personnel to plan a psychiatric unit in a new facility and assisted with planning and coordinating Inpatient Psychiatry Services move to a new facility.

* Assisted with JCAHO reviews.

Clinical

* Provided initial and ongoing clinical review and authorization of services for all capitated clients.

* Conducted intake assessments on all inpatient psychiatry referrals.

* In-serviced and implemented a new multidisciplinary treatment plan.

* Counseled, supported and instructed psychiatric patients undergoing diagnostic evaluation and treatment on an acute psychiatric unit.

* Assessed, delivered and evaluated care provided to critically ill patients in an intensive care unit.

* Utilized sophisticated equipment in the evaluation and treatment of critically ill patients.

* Participated in multidisciplinary team approach to the development and evaluation of plans of care in the gerontological setting.

* Demonstrated clinical competence through use of the nursing process in medical-surgical nursing.

WORK HISTORY:

1/18 – present	Department of Psychiatry Dartmouth-Hitchcock Clinic Addiction Treatment Center Position: Sr. Practice Manager
1/17 – 12/17	Department of Medicine Dartmouth-Hitchcock Clinic Position: Interim Practice Manager Weight and Wellness Center and Sleep Medicine
	Department of Psychiatry Dartmouth-Hitchcock Clinic Position: Sr. Practice Manager
10/16 – 1/17	Department of Psychiatry Dartmouth-Hitchcock Clinic Position: Sr. Practice Manager
7/16 – 10/16	Department of Psychiatry Dartmouth-Hitchcock Clinic Position: Practice Manager
7/01 – 6/16	Dartmouth-Hitchcock Psychiatric Associates, Department of Psychiatry, Geisel School of Medicine at Dartmouth Position: Administrative Director
7/98 – 6/01	Dartmouth Hitchcock Behavioral Healthcare Position: Care Management Coordinator
10/97 – 7/98	Dartmouth-Hitchcock Medical Center Position: Coordinator Inpatient Psychiatry Access Services
10/95 - 10/97	Dartmouth-Hitchcock Medical Center Position: Clinical Coordinator Inpatient Psychiatry Services Responsible for the management of Access Services, Psychiatry-Medicine Unit, and General Psychiatry Unit
7/93 - 9/95	Dartmouth-Hitchcock Medical Center Position: Coordinator Inpatient Psychiatry Access Services
9/89 - 6/93	Dartmouth-Hitchcock Medical Center Position: Clinical Coordinator

Psychiatry-Medicine Unit/Short Term Unit

4/83 - 9/89	Dartmouth-Hitchcock Medical Center Position: Assistant Head Nurse General Psychiatry Unit Acting Head Nurse 11/87 - 7/88
5/81 - 4/83	Dartmouth-Hitchcock Medical Center Position: Staff Nurse General Psychiatry Unit
5/80 - 4/81	Hanover Terrace Health Care Position: Charge Nurse Skilled Care Unit
6/78 - 12/79	Dartmouth-Hitchcock Medical Center Position: Staff Nurse Intensive Care Unit
1/77 - 3/78	Frederick Memorial Hospital Position: Staff Nurse Medical-Surgical Unit
7/71 - 8/72	Dr. Herbert Glick Position: Medical Assistant Pediatric Office

EDUCATION:

1972 -1976	University of Maryland Bachelor of Science in Nursing Sigma Theta Tau and Phi Kapa Phi honor societies
1986	University of New Hampshire Course work toward Masters in Nursing Administration

LICENSURE:

Registered Nurse
License No. 021135-21
State of New Hampshire

COMMITTEE MEMBERSHIP:

Compliance Committee Coordinator, DHPA

Quality Improvement Committee, DHPA

TERI BISHOP LAROCK

[redacted]

LICENSE #
New Hampshire LICSW # 1847
Massachusetts LICSW #1021146
Vermont LICSW # 0890055650

EDUCATION

Boston University School of Social Work, Boston, MA	MSW, May 1990
University of Vermont, Burlington, VT	BA Psychology, May, 1988

PROFESSIONAL EXPERIENCE

Dartmouth Hitchcock Medical Center (DHMC)
Lebanon, New Hampshire

Clinical Director; Moms in Recovery; Psychiatry 2018-Present

*Management of a team of clinicians providing psychosocial assessment, counseling and treatment to pregnant and parenting women in an integrated care clinical setting.

* Facilitation of and assistance with development, design and training of agency programs.

*Clinical supervision to candidates for MSW licensure. Clinical supervision of peer support recovery coaches in Emergency Department setting.

Behavioral Health Clinician; Moms in Recovery; Psychiatry 2016-2018

*Evaluation, diagnosis and treatment of women with substance use disorder and co-occurring mental health diagnoses such as anxiety and mood disorders in an integrated care clinical setting.

*Establishment and documentation of treatment goals utilizing appropriate psychotherapy including group and individual, trauma sensitive cognitive behavioral therapy, crisis intervention and supportive cognitive therapy. Trained facilitator of Circle of Security Parenting curriculum.

*Communication and collaboration with interdisciplinary team and community partners to assure proactive and successful integrated care with a high risk population facing significant resource insecurities and marginalization.

Behavioral Health Clinician; Behavioral intervention Team; Psychiatry 2014-Present

*Comprehensive and targeted proactive primary mental health assessment and intervention with medically hospitalized patients experiencing mental health related symptoms. Timely follow-up and

targeted behavioral health interventions including cognitive behavioral therapy, motivational interviewing, guided visual imagery, crisis intervention and therapeutic supportive counseling.

*Development of strategies with the healthcare team to advocate for patients psychiatric and behavioral needs. Work with team to negotiate complex systems to remove barriers and limitations in accessing appropriate disposition plans. Participation in complex care and ethics meetings. Consultation and professional support to interdisciplinary team members. Education of mental health education with medical staff. Teaching with and support of primary MSWs on units regarding behavioral and mental health patient care and interventions.

Continuing Care Manager: Child Advocacy and Protection Program; Pediatrics 2007-2017

*Perform comprehensive assessment with families of children suspected to be victims of neglect, physical, sexual abuse and intimate partner violence. Evaluation of health and functional status, cognitive capability, support systems, biopsychosocial functioning, finances and health/wellness status

*Development and implementation of plan of care to include family strengths and challenges. Supportive trauma informed and trauma focused counseling with family. Collaboration with involved child protection, law enforcement and mental health agencies. Testimony in court as needed. Non-offender support group.

*Teaching with pediatric residents, nursing and allied health service staff about trauma informed mental health assessment, diagnosis and psychosocial care of at risk children and families. Supervision of MSW interns from Boston University, University of Vermont, University of New Hampshire, and Simmons College

Pediatric Nephrology Social Worker 2012-Present

*Coordinated caseload of children and families diagnosed and coping with kidney disease as part of a multidisciplinary team. Case management and collaboration with community resources including Partners in Health, Children with Special Health Needs, Team Impact, Camp Sunshine and primary care offices

Pediatric Social Worker 2006-2007

*Assessment, supportive counseling and referrals to and collaboration with community agencies for families of children admitted to pediatric and pediatric intensive care units for treatment of illness and injury. Crisis intervention and bereavement counseling. Member of interdisciplinary care team. Psychosocial and mental health education with Dartmouth medical students, residents and nursing.

Per Diem Social Worker 2004-2006

Clinical social work coverage on adult and pediatric units throughout the 400 bed medical center. Assessment and brief intervention with individuals and families. Facilitation of processes including

guardianship, placement, and residential settings. Coordination of care with existing resources and referrals to community supports.

Community Health Link/University of Massachusetts (aka The Herbert Lipton Center) Fitchburg, MA

Clinical Social Worker 1998-2004

Provided both long term and brief individual weekly therapy to clients with mental health and complex psychosocial challenges in a multicultural, low socioeconomic clinical setting. Modalities of counseling included cognitive behavioral therapy, crisis intervention, motivational interviewing and supportive counseling. Individual counseling with women transitioning from Framingham State Prison system to home/community environment who were working with child protection to re-establish custody of their children. Development and implementation of treatment plans and collaboration with community agencies.

Clinical Social Worker 2002-2004

School based counseling at Leominster High School, a large suburban high school, via Community Health Link. Assessment and crisis intervention with adolescents and families. Wrote comprehensive evaluations and developed treatment plans for adolescents engaging in self harming behaviors and substance use. Collaboration and referral to community based services. Member of interdisciplinary team working with Department of Youth Services, Department of Social Services and Department of Mental Health.

Boston Children's Hospital
Boston, MA
Clinical Social Worker Emergency Department 1995-1998

*Child abuse and neglect assessment, collaboration with Department of Social Services and other collateral agencies. Crisis intervention counseling and intervention. Referrals to local community resources and health centers.

Clinical Social Worker 1991-1995

*Psychosocial assessment, crisis intervention, brief treatment and case management with families on three inpatient medical and surgical units. Individual, family and group counseling. Collaboration with interdisciplinary team and community resources.

*Supervision responsibilities; summer staff social work position, Boston University, Simmons College and Boston College MSW students. Emergency room coverage. Co-leader of weekly Parent Support Group and Adolescent Cystic Fibrosis Group.

Waltham Weston Hospital and Medical Center
Waltham, MA
Clinical Social Worker 1990-1991

*Assessment of individual and family psychosocial situations on Birthing/GYN, Pediatric and Medical/Surgical adult units. Development of Family/Child High Risk Criteria. Provided crisis intervention, short term and group therapy. Rotating Emergency Department coverage. Facilitator of community based Gulf War Family Support Group.

Boston Children's Hospital
Boston, MA
Social Work Intern 1989-1990

Provided individual and group counseling to hospitalized children and families. Referrals to relevant community counseling agencies, support groups, shelters, IPV resources and economic agencies. Collaboration with hospital based Child Protective Team and Massachusetts Child Protection.

Mary Curley Middle School
Jamaica Plain, MA
Social Work Intern 1988-1989
Provided individual counseling and brief treatment to teenage adolescents in an urban middle school environment. Facilitation of multicultural seventh grade girls Peer Support and Leadership Groups with focus on societal challenges of poverty, oppression and ethnic difference. Co-facilitator of drug, alcohol and sexual health education psych-educational groups.

CONTRACTOR NAME

Key Personnel

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Julia Frew, MD	Medical Director	$251,222	10%	$25,122
Daisy Goodman, APRN	Women's Health Director	$127,962	20%	$25,592
Steve Chapman, MD	Pediatric Director	$213,200	10%	$21,320
Teri LaRock, LLICSW	Clinical Director	$94,723	40%	$37,889
Suzy Catalona	Program Manager	$108,826	75%	$81,620

These are the key personnel on the leadership team, critical to the successful implementation and management of this program.

8 mar

Jeffrey A. Meyers
Commissioner

Katja S. Fox
Director

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

105 PLEASANT STREET, CONCORD, NH 03301
603-271-6110 1-800-852-3345 Ext. 6738
Fax: 603-271-6105 TDD Access: 1-800-735-2964
www.dhhs.nh.gov

December 27, 2017

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

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division for Behavioral Health, Bureau of Drug and Alcohol Services, to enter into an agreement with Mary Hitchcock Memorial Hospital, Vendor #177160, One Medical Center Drive, Lebanon, NH 03756, for the provision of integrated obstetric, primary care, pediatric, and Medication Assisted Treatment (MAT) for pregnant and postpartum women with opioid use disorder in an amount not to exceed $2,755,443, effective upon date of Governor and Executive Council approval, through June 30, 2019. 100% Federal Funds.

Funds are available in the following account(s) for SFY 2018 and SFY 2019, with authority to adjust amounts within the price limitation and adjust encumbrances between State Fiscal Years through the Budget Office if needed and justified, without approval from Governor and Executive Council.

05-95-92-920510-25590000 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION FOR BEHAVIORAL HEALTH, BUREAU OF DRUG AND ALCOHOL, OPIOID STR GRANT

SFY	Class/Account	Class Title	Job Number	Total Amount
2018	102-500731	Contracts for Program Services	92052559	$ 862,630
2019	102-500731	Contracts for Program Services	92052559	$1,892,813
			Total	$2,755,443

EXPLANATION

The purpose of this request is to provide integrated obstetric care, primary care, pediatric care and Medication Assisted Treatment for pregnant and postpartum women with opioid use disorder and any co-occurring mental health disorders. Medication Assisted Treatment services will be integrated with prenatal and postpartum care, and provided with parenting support and education at eight (8) sites across New Hampshire, including sites in

the high need areas of Belknap and Coos Counties where opioid use disorder treatment services are limited.

The Contractor will deliver these services through both a Perinatal Addiction Treatment Program in Lebanon, NH that is integrated with obstetrics/gynecology and pediatric care on-site and at seven (7) other sites which are obstetrical/gynecological practices that are enhanced with Medication Assisted Treatment services and pediatric care.

The State of New Hampshire was awarded funding authorized through the 21st Century CURES Act by the Substance Abuse and Mental Health Services Administration which is overseeing the process for states to receive federal funding through the State Targeted Response to the Opioid Crisis Grants Program. New Hampshire's application is a joint effort by several state agencies and proposes to use evidence-based methods to expand treatment, recovery and prevention services to targeted populations. These critical funds will strengthen established programs that have had a positive impact on the opioid crisis as well as expanding the capacity for programs that have shown promise in helping individuals battling a substance misuse issue and combatting the epidemic in New Hampshire.

In 2016, the State of New Hampshire experienced four hundred eighty-five (485) deaths from drug overdoses. At present, the State is experiencing an increase in the need for population-specific Substance Use Disorder Treatment and Recovery Support Services for pregnant women due to a rise in Neonatal Abstinence Syndrome in infants born to mothers who have used opioids. Babies with this syndrome experience symptoms of drug withdrawal and require special treatment prior to leaving the hospital. It is critical that providers develop integration of services, approaches to meet individual client needs, and approaches to maximize State and Federal dollars to meet the public's demand for these specific services. The services provided by the Contractor will be comprehensive and focused not only on the mother's recovery, but also on ensuring that the infant is receiving the necessary health and social supports and services to mitigate risk associated with maternal opioid use.

Mary Hitchcock Memorial Hospital was selected for this project through a competitive bid process. A Request for Proposals was posted on The Department of Health and Human Services' web site from August 28, 2017 through September 25, 2017. The Department received one (1) proposal. The proposal was reviewed and scored by a team of individuals with program specific knowledge. The review included a thorough discussion of the strengths and weaknesses of the proposals/applications. The Score Summary is attached.

As referenced in the Request for Proposals and in Exhibit C-1, Revisions to General Provisions, of this contract, the Department reserves the option to extend contract services for up to two (2) additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties and approval of the Governor and Executive Council.

Should the Governor and Executive Council not authorize this request, pregnant and postpartum women in New Hampshire diagnosed with opioid use disorder may not receive the support necessary to overcome their addiction which could negatively impact their health and the health of their newborn child(ren).

Area served: Statewide

Source of Funds: 100% Federal Funds from DHHS, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. CFDA #93.788. FAIN TI080246.

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

Respectfully submitted,

Katja S. Fox
Director

Approved by:
Jeffrey A. Meyers
Commissioner

New Hampshire Department of Health and Human Services
Office of Business Operations
Contracts & Procurement Unit
Summary Scoring Sheet

Integrated Medication Assisted Treatment for Pregnant and Postpartum Women
RFP Name

RFP-2018-BDAS-05-INTEG
RFP Number

Reviewer Names

1. Jamie Powers, Clinical & Recovery Serv Unit Administrator II, BDAS
2. Rhonda Siegel, Administrator II, DPHS Health Mgmt Ofc
3. Abby Shockley, Senior Policy Analyst, Substance Use Servcs,
4. Laurie Heath, Business Adminstr III, DBH/BDAS Finance
5. Don Hunter, Planning and Review Analyst, BDAS

Bidder Name	Pass/Fail	Maximum Points	Actual Points
1. Mary Hitchcock Memorial Hospital		575	444
2. 0		575	0
3. 0		575	0

STATE OF NEW HAMPSHIRE
DEPARTMENT OF INFORMATION TECHNOLOGY
27 Hazen Dr., Concord, NH 03301
Fax: 603-271-1516 TDD Access: 1-800-735-2964
www.nh.gov/doit

Denis Goulet
Commissioner

January 3, 2018

Jeffrey A. Meyers, Commissioner
Department of Health and Human Services
State of New Hampshire
129 Pleasant Street
Concord, NH 03301

Dear Commissioner Meyers:

This letter represents formal notification that the Department of Information Technology (DoIT) has approved your agency's request to enter into a contract with Mary Hitchcock Memorial Hospital, of Lebanon NH as described below and referenced as DoIT No. 2018-047.

This is a request to enter into a contract with Mary Hitchcock Memorial Hospital to provide integrated obstetric, primary care, pediatric, and medication assisted treatment for pregnant and postpartum women with substance use disorder (SUD). This will also include utilizing the State's Prescription Drug Monitoring Program (PDMP) database to mitigate prescription drug diversion or harmful interactions.

The amount of the contract is not to exceed $2,755,443.00, and shall become effective upon the date of Governor and Executive Council approval through June 30, 2019.

A copy of this letter should accompany the Department of Health and Human Services' submission to the Governor and Executive Council for approval.

Sincerely,

Denis Goulet

DG/kaf
DoIT #2018-047

cc: Bruce Smith, IT Manager, DoIT

Subject: Integrated Medication Assisted Treatment for Pregnant and Postpartum Women (RFP-2018-BDAS-05-INTEG)

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 NH 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 Dartmouth-Hitchcock One Medical Center Drive Lebanon, NH 03756	
1.5 Contractor Phone Number 603-650-8960	1.6 Account Number 05-95-92-920510-25590000	1.7 Completion Date June 30, 2019	1.8 Price Limitation $2,755,443
1.9 Contracting Officer for State Agency E. Maria Reinemann, Esq. Director of Contracts and Procurement		1.10 State Agency Telephone Number 603-271-9330	
1.11 Contractor Signature Edward J Merrens		1.12 Name and Title of Contractor Signatory Edward Merrens Chief Clinical Officer	

1.13 Acknowledgement: State of New Hampshire, County of Grafton

On 12/15/17, before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.

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

(Seal) FAITH B. JOHNSTON MY COMMISSION EXPIRES SEPT. 21, 2021 NOTARY PUBLIC NEW HAMPSHIRE

1.13.2 Name and Title of Notary or Justice of the Peace

1.14 State Agency Signature Date: 12/28/17	1.15 Name and Title of State Agency Signatory Katja S Fox, Director

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

By: Director, On:

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

By: Megan A. Lenox, Attorney On: 1/3/18

1.18 Approval by the Governor and Executive Council *(if applicable)*

By: On:

2. EMPLOYMENT OF CONTRACTOR/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 A 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 1.18, 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 1.14 ("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, and 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 terminate this Agreement immediately upon giving the Contractor notice of such termination. The State shall not be required to transfer funds from any other account 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 B 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 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 opportunity laws. This may include the requirement to utilize auxiliary aids and services to ensure that persons with communication disabilities, including vision, hearing and speech, can communicate with, receive information from, and convey information to the Contractor. In addition, the Contractor shall comply with all applicable copyright 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 If this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all the provisions of Executive Order No. 11246 ("Equal Employment Opportunity"), as supplemented by the regulations of the United States Department of Labor (41 C.F.R. Part 60), and with any rules, regulations and guidelines as the State of New Hampshire or the United States issue to implement these regulations. The Contractor further 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

Contractor Initials
Date 12.15.17

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

8. EVENT OF DEFAULT/REMEDIES.
8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"):
8.1.1 failure to perform the Services satisfactorily or on schedule;
8.1.2 failure to submit any report required hereunder; and/or
8.1.3 failure to perform any other covenant, term or condition of this Agreement.
8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:
8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely remedied, 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 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 treat the Agreement as breached and pursue any of its remedies at law or in equity, or both.

9. DATA/ACCESS/CONFIDENTIALITY/ PRESERVATION.
9.1 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.
9.2 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.
9.3 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.

10. TERMINATION. In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall 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 A.

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. The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written notice and consent of the State. None of the Services shall be subcontracted by the Contractor without the prior written notice and consent of the State.

13. INDEMNIFICATION. The Contractor shall defend, indemnify and hold harmless the State, its officers and employees, from and against any and all losses suffered by the State, its officers and employees, and any and all claims, liabilities or penalties asserted against the State, its officers and employees, by or on behalf of any person, on account of, based or resulting from, arising out of (or which may be claimed to arise out of) the acts or omissions of the Contractor. 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 maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:
14.1.1 comprehensive general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $1,000,000per occurrence and $2,000,000 aggregate ; and
14.1.2 special cause of loss coverage form covering all property subject to subparagraph 9.2 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.

Contractor Initials
Date 12.15.17

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

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. 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. WAIVER OF BREACH. 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.

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

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

19. CONSTRUCTION OF AGREEMENT AND TERMS. This Agreement shall be 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.

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 provisions set forth in the attached EXHIBIT C 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 relating hereto.

Contractor Initials BM

Date 12·15·17

Scope of Services

1. Provisions Applicable to All Services

1.1. The Contractor shall submit a detailed description of the language assistance services they will provide to persons with limited English proficiency to ensure meaningful access to their programs and/or services within ten (10) days of the contract effective date.

1.2. The Contractor agrees that, to the extent future legislative action by the New Hampshire General Court or federal or state court orders may have an impact on the Services described herein, the State Agency has the right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance therewith.

2. Scope of Services

2.1. The Contractor shall provide comprehensive Medication Assisted Treatment (MAT) for pregnant and postpartum women diagnosed with opioid use disorder (OUD) and co-occurring mental health disorders, integrated with prenatal and postpartum care, and provide parenting support and education for parents at eight (8) sites across the State of New Hampshire, including sites in Belknap and Coos Counties.

2.2. The Contractor shall deliver the required services in Lebanon through the Dartmouth Hitchcock (D-H) Perinatal Addiction Treatment Program (PATP), a comprehensive addiction treatment service with integrated obstetrical/gynecological (OB/Gyn) services and pediatric care offered on-site.

2.3. The Contractor shall ensure delivery of the required services at the seven (7) other sites where services shall be offered by OB/Gyn practices that are enhanced with integrated addiction services and pediatric support.

2.4. The Contractor's Center for Addiction Recovery in Pregnancy and Parenting shall develop an implementation plan with each site to include, but not be limited to:

2.4.1. Training and implementing new practices, using a combination of Contractor staff and the local site to fill key roles.

2.4.2. Migrating the required core staffing to the practice while the Contractor provides ongoing coaching and consultation for complex situations.

2.4.3. Providing or developing, locally, the adjunct services including, but not limited to child supervision, transportation, and case management as required.

2.5. The Contractor shall provide project management, program consultation, and clinical consultation through their D-H Center for Addiction Recovery in Pregnancy and Parenting team to each site.

2.6. The Contractor shall provide services at all eight (8) sites including, but not limited to:

2.6.1. On-site family support for children.

2.6.2. Peer recovery coaches.

2.6.3. Resource/Employment specialists.

2.6.4. Case management/Care coordination.

2.6.5. Parenting education groups.

2.6.6. Health education.

2.6.7. Social supports including, but not limited to access and/or referrals to food, housing, and transportation services.

2.7. The Contractor shall collaborate with Coos County Family Health Services and implement two (2) of the seven (7) enhanced programs in OB/Gyn practices in Laconia and Littleton by providing intensive support to facilitate the development of an integrated perinatal MAT program at each practice.

2.8. The Contractor shall employ a licensed behavioral health clinician whose responsibilities shall include, but not be limited to:

2.8.1. Conducting weekly visits to each practice for the first six (6) months of the contract.

2.8.2. Providing direct clinical services at all sites.

2.8.3. Supporting and mentoring for weekly MAT visits.

2.8.4. Leading group therapy for participating women.

2.8.5. Collaborating with each site to identify or develop behavioral health resources in the local community.

2.9. The Contractor shall ensure each site identifies at least one (1) provider willing to become waivered to prescribe buprenorphine before the project launch and shall provide initial on-site mentoring to waivered providers at each practice, followed by consultative phone calls over a twelve (12)-month period in a frequency determined necessary by the providers and the Contractor.

2.10. The Contractor shall provide services through the D-H PATP which include, but are not limited to:

2.10.1. Collaborating with the Family Resource Centers, whose services include, but are not limited to:

2.10.1.1. Home visiting.

2.10.1.2. Lactation support.

2.10.1.3. Case management.

2.10.2. Providing parent education groups to program participants on a regular basis which integrate the parenting education curriculum with addiction treatment, so that participants have the opportunity to learn about the impact of substance use on family functioning and healthy child development.

2.10.3. Providing educational sessions to all pregnancy groups which include, but are not limited to "The Period of Purple Crying," safe sleep practices, and car seat safety and are integrated with newborn nursery and outpatient pediatric follow up.

2.10.4. Collaborating with Continuum of Care Coordinators as part of Region 1 Integrated Delivery Network (IDN).

2.10.5. Participating in the Boyle Program, which co-sponsors and facilitates the Child Focus Forum, a bi-monthly collaborative of medical, governmental and community agencies serving parents and children.

2.10.6. Offering co-located child "play time," which provides supportive child engagement that allows women to participate fully in group therapy and receive care without distraction.

2.10.7. Sponsoring co-location of resources such as a food pantry, infant books, and diaper bank through active partnerships with community agencies such as The Upper Valley Haven and The Family Place.

2.11. The Contractor shall ensure patient-centered, effective, integrated care and attention to overdose prevention by employing educational materials which include, but are not limited to:

2.11.1. Center for Disease Control (CDC) opioid prescribing guidelines.

2.11.2. Substance Abuse and Mental Health Services Administration's (SAMHSA's) Opioid Overdose Prevention Toolkit.

2.11.3. State-published Guidance Document on Best Practices: Key Components for Delivering Community Based Medication Assisted Treatment Services for Opioid Use Disorders in New Hampshire.

2.11.4. Care guidelines for OB/GYN providers and delivery hospitals developed by the Northern New England Perinatal Quality Improvement Network (NNEPQIN).

2.12. The Contractor shall provide interim OUD treatment services when the needed treatment services are not available to the participant within forty-eight (48) hours of referral.

2.13. The Contractor shall provide OUD treatment services that support the Resiliency and Recovery Oriented Systems of Care (RROSC) by operationalizing the Continuum of Care Model. (More information can be found at http://www.dhhs.nh.gov/dcbcs/bdas/continuum-of-care.htm.)

2.14. The Contractor shall ensure that participants are able to easily transition between levels of care within a group of services which includes, but is not limited to:

2.14.1. Working with the Continuum of Care Facilitator(s) in the development of a resiliency and recovery oriented system of care (RROSC) in the region(s).

2.14.2. Participating in the Regional Continuum of Care Workgroup(s).

2.14.3. Participating in the Integrated Delivery Network(s) (IDNs).

2.15. The Contractor shall ensure ongoing communication and care coordination with entities involved in the participants' care including child protective services, treatment providers, home visiting services, and pediatric providers.

2.16. The Contractor shall actively participate in the Regional Continuum of Care and IDN Region 1, and maintain good relationships with relevant community partners.

2.17. The Contractor shall assist enhanced sites with creating and hiring for a Recovery Coach position to help participants locate community resources including, but not limited to local recovery centers, peer support meetings, and transitional housing.

2.18. The Contractor shall assist enhanced sites with collaborating with their local/regional Continuum of Care Facilitators and leaders of their regional Integrated Delivery Networks to ensure alignment and coordination across these service networks.

2.19. The Contractor shall collaborate with each enhanced site to modify workflows and electronic records processes to ensure screening and required data collection.

2.20. The Contractor shall modify the obstetrics office electronic health record (EHR) and clinical work flow to ensure required screening activities by OB staff and appropriate required data collection by care coordinators.

2.21. The Contractor shall utilize the State's Prescription Drug Monitoring Program (PDMP) database to mitigate prescription drug diversion or harmful interactions and shall assess each enhanced site's use and support them to develop protocols to monitor the PDMP regularly.

2.22. The Contractor shall develop and implement outreach activities, which may include marketing designed to engage pregnant women with an OUD in the community. The Contractor and Contractor's sites are not required to market themselves publicly as substance use disorder treatment centers.

2.22.1. The Contractor shall ensure that their staff at the Center for Addiction Recovery in Pregnancy and Parenting collaborate with the appropriate D-H department to develop appropriate materials and methods to promote the program throughout our service areas.

2.22.2. The Contractor shall collaborate with each implementing site to ensure marketing materials, if any, and outreach methods used, are consistent with the Contractor's standards and policies in its discretion.

2.22.3. The Contractor shall actively engage with referral networks in the service areas to increase awareness of the program with pregnant women with OUD and to enable the program to be utilized to its greatest capacity.

2.23. The Contractor shall maintain formal and effective partnerships with behavioral health, OUD specialty treatment and Recovery Support Services (RSS), and medical practitioners to meet the needs of the target population and the goals of MAT Expansion.

2.24. The Contractor shall ensure meaningful input of consumers in program assessment, planning, implementation, and improvement which includes, but is not limited to:

2.24.1. Using their Patient Advisory Board which meets quarterly and is composed of participants in long-term recovery.

2.24.2. Engaging participants in all stages of recovery in the development of key program elements through focus groups and targeted interviews.

2.25. The Contractor shall ensure that treatment is provided in a child-friendly environment with childcare support available to participants which includes, but is not limited to:

2.25.1. Developmentally-appropriate childcare support as well as integration with pediatric and developmental services at all enhanced sites.

2.25.2. Co-located child "Play Time" where children engage in developmentally appropriate play while their mothers participate in group treatment and receive care in both Lebanon and Keene.

2.25.3. On-site well-child care at D-H Lebanon PATP.

2.26. The Contractor shall ensure participants' transportation needs are met to maintain participant involvement in the program by utilizing a Resource Specialist whose duties related to transportation may include, but not be limited to:

2.26.1. Assisting participants to enroll in Medicaid transportation services.

2.26.2. Developing a network of support to help with transportation needs.

2.26.3. Helping participants to attain a valid driver's license or an affordable car loan.

2.26.4. Collaborating with Good News Garage or similar programs.

2.26.5. Finding housing in close proximity to social services.

2.27. The Contractor shall use data to support quality improvement including, but not limited to:

2.27.1. Developing, disseminating, and implementing best practices for pregnant and parenting women with OUD, including, but not limited to hosting monthly webinars related to topics such as screening and treatment of co-occurring psychiatric disorders.

2.27.2. Collecting data on participant demographics and more than thirty (30) key perinatal, neonatal, and treatment outcomes for all program participants, using a REDCap database designed for this purpose.

2.27.2.1. REDCap allows de-identified, participant-level data to be entered remotely by sites.

2.27.2.2. Data shall be entered for each participant from the time of entry into the program until three (3) months postpartum. For example, a participant entering care in the late first trimester, data would entered at entry to care, at 24-28 weeks of pregnancy, at delivery, and at three (3) months postpartum.

2.27.2.3. Data shall be utilized for quality improvement purposes and program evaluation, as well as development of targeted services at all sites.

2.27.3. Collecting data on key measures identified by the Department and the Contractor's multidisciplinary stakeholder group and using the data to track performance.

2.27.3.1. The existing REDCap database shall be expanded as needed to include additional measures identified by the Department.

2.27.3.2. Site specific data shall be reviewed quarterly.

2.27.4. Reporting data to sites quarterly and addressing areas flagged for improvement both directly through discussion and process improvement at the individual practice level and through learning collaborative sessions with multiple practices.

2.27.5. Employing a research assistant to support sites with data entry challenges and ensure data quality.

2.27.6. Analyzing the data and promoting quality improvement efforts.

2.28. The Contractor shall maintain the infrastructure necessary to achieve the goals of MAT Expansion for the target population, to meet SAMHSA requirements, and to deliver effective medical care to pregnant and postpartum women with an OUD.

2.29. The Contractor shall participate in the State-funded "Community of Practice for MAT" along with other State-funded projects which include, but are not limited to:

2.29.1. Project-specific trainings.

2.29.2. Quarterly web-based discussions.

2.29.3. On-site Technical Assistance (TA) visits.

2.29.4. Ad hoc communication with expert consultants on MAT clinical care topics such as Hepatitis C Virus (HCV) and Human Immunodeficiency Virus (HIV) prevention, diversion risk mitigation, and other relevant issues.

2.30. The Contractor shall participate in the development of a Safe Plan of Care with birth attendants and the New Hampshire Division of Children, Youth, and Families (DCYF) for each infant affected by illegal substance use, withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder.

2.30.1. The Contractor shall employ a social worker with experience in the Contractor's Child Advocacy and Protection Program.

2.30.2. The Contractor shall ensure that planning and communication regarding the Safe Plan of Care will also involve other community agency supports including, but not limited to home visitation, WIC, housing, and other services central to recovery and parenting.

2.31. The Contractor shall establish formal agreements with hospitals to aid in preparing the hospital system with the clinical policies and procedures necessary to address neonatal abstinence syndrome in the newborn while supporting the mother's recovery.

2.31.1. The Contractor shall engage with the NNEPQIN learning collaborative, the organization that has developed policies and procedures to effectively address neonatal abstinence syndrome while supporting the mother's recovery.

2.32. The Contractor shall have billing capabilities which include, but are not limited to:

2.32.1. Enrolling with Medicaid and other third party payers.

2.32.2. Contracting with managed care organizations and insurance companies for MAT and delivery of prenatal care.

2.32.3. Having a proper understanding of the hierarchy of the billing process.

2.33. The Contractor shall assist the participant with obtaining either on-site or off-site RSS's including, but not limited to:

2.33.1. Transportation.

2.33.2. Childcare.

2.33.3. Peer support groups.

2.33.4. Recovery coach.

2.34. The Contractor shall use the New Hampshire Alcohol and Drug Treatment Locator (http://www.nhtreatment.org) to identify specific services that are available by location, population, and payer to enable patient choice.

2.35. The Contractor shall establish agreements with specialty treatment organizations that can provide higher levels of OUD treatment and co-occurring mental health treatment.

2.36. The Contractor shall deliver parenting and personal development education using evidence-based curriculum including, but not limited to:

2.36.1. Marsha Linehan's Dialectical Behavior Therapy approach to treatment and Lisa Najavits' Seeking Safety curriculum to increase emotion regulation skills in participants to address Post-Traumatic Stress Disorder (PTSD) symptoms and decrease emotional vulnerability that could lead to relapse.

2.36.2. SAMHSA materials, 12-Step information, and other materials that the program has developed to increase participants' knowledge of the disease model of addiction and to enhance understanding of biological vulnerability and the progression of addiction.

2.36.3. Cognitive Behavioral Therapy (CBT), SAMSHA materials, 12-Step materials, and mindfulness-based stress reduction approaches to bolster relapse prevention strategies and improve resiliency.

2.36.4. Duluth Model Domestic Abuse Intervention Programs and Dialectical Behavior Therapy (DBT) to promote healthy relationships and decrease risk of interpersonal violence.

2.36.5. Circle of Security and the Nurturing Program for Families in Substance Abuse Treatment and Recovery curricula to increase parent-child attachment and increase parents' knowledge of healthy child development.

2.37. The Contractor shall improve participants' access to a sober network of support and increased resiliency to relapse which includes, but is not limited to.

2.37.1. Utilizing an on-site Recovery Coach who participates in group therapy sessions and engages one-on-one with participants to provide additional support between sessions.

2.37.2. Inviting representatives from 12-Step groups and peer-run recovery groups on a regular basis to speak to participants.

2.38. The Contractor shall refer relapsing participants to residential or intensive outpatient care and provide support for accessing appropriate services including, but not limited to follow-up care after intensive treatment services are completed.

2.39. The Contractor shall provide parenting supports to participants including, but not limited to:

2.39.1. Parenting groups.

2.39.2. Childbirth education.

2.39.3. Safe sleep education.

2.40. The Contractor shall collaborate with other providers that offer services to pregnant women with an OUD including, but not limited to programs funded by the Cures Act resources for similar populations.

2.41. The Contractor shall ensure compliance with confidentiality requirements, which include, but are not limited to:

2.41.1. Applicable federal and state laws.

2.41.2. HIPAA Privacy Rule.

2.41.3. 42 C.F.R Part 2.

2.41.3.1. The D-H PATP shall be required to follow 42 C.F.R Part 2 rules.

2.41.3.2. The OB/Gyn programs that will be enhanced with integrated addiction services are not required to follow 42 C.F.R. Part 2.

2.42. The Contractor shall participate in all evaluation activities associated with the funding opportunity, including national evaluations.

2.43. The Contractor shall develop and submit a work plan to the Department for review and approval, which describes the process for ensuring the completion of all aspects of the Scope of Services (Section 2), Staffing (Section 3), and Training (Section 4) as outlined in this Contract within thirty (30) days of Governor and Executive Council approval of the Contract. The Contractor shall use four (4) phases when designing the work plan.

2.43.1. Phase 1: The Contractor shall engage in an intensive planning process and simultaneous development of the infrastructure of the Center for Addiction Recovery in Pregnancy and Parenting which will include hiring key staff such as a project manager and gathering more information about the current state at implementation sites.

2.43.2. Phase 2: The Contractor shall solidify services at the D-H Lebanon PATP and D-H Keene so that they fully meet the service requests of this Contract. The Contractor shall also begin the data collection process.

2.43.3. Phase 3: The Contractor shall plan and implement enhanced services at three (3) new sites (Berlin, Manchester, and Nashua).

2.43.4. Phase 4: The Contractor shall use lessons learned from previous implementations to plan and implement enhanced services at the final three (3) sites (Laconia, Littleton, and Dover).

2.44. The Contractor shall maintain policies and procedures and have regular required employee training (at least annually) in the areas of ethical conduct, confidentiality, compliance, cyber security, and conflict of interest.

3. Staffing

3.1. The Contractor shall meet the minimum MAT team staffing requirements to provide the Scope of Services which includes, but is not limited to at least one (1):

3.1.1. Waivered prescriber.

3.1.2. Masters Licensed Alcohol and Drug Counselor (MLADC) or behavioral health provider with addiction training.

3.1.3. Obstetrician or midwife.

3.1.4. Care coordinator.

3.1.5. Non-clinical/administrative staff.

3.2. The Contractor shall ensure that all unlicensed staff providing treatment, education, and/or recovery support services are under the direct supervision of a licensed supervisor.

3.3. The Contractor shall ensure that no licensed supervisor oversees more than eight (8) unlicensed staff, unless the Department has approved an alternative supervision plan.

3.4. The Contractor shall ensure that at least one Certified Recovery Support Worker (CRSW) is available for every fifty (50) participants or portion thereof.

3.5. The Contractor shall ensure that unlicensed staff providing clinical or recovery support services must hold a CRSW within six (6) months of hire or from the effective date of this contract, whichever is later.

4. Training

4.1. The Contractor shall make available initial and on-going training resources to all staff including, but not limited to buprenorphine waiver training for physicians, nurse practitioners, and physician assistants. The Contractor shall develop a plan for Department approval to train and engage appropriate staff.

4.2. The Contractor shall participate in training and technical assistant activities as directed by the Department including, but not limited to the Community of Practice for MAT which may include, but is not limited to:

4.2.1. Project-specific trainings.

4.2.2. Quarterly web-based discussions.

4.2.3. On-site technical assistance visits.

4.2.4. Ad hoc communication with expert consultants regarding MAT clinical care topics including, but not limited to:

4.2.4.1. HCV and HIV prevention.

4.2.4.2. Diversion risk mitigation.

4.2.4.3. Other relevant issues.

4.3. The Contractor shall train staff on relevant topics which may include, but are not limited to:

4.3.1. Integrated care.

4.3.2. Trauma-informed care.

4.3.3. MAT (e.g. prescriber training for buprenorphine).

4.3.4. Care coordination.

4.3.5. Trauma-informed wrap around care/RSS delivery best practices.

4.3.6. Evidence-Based Practices (EBPs) such as Screening, Brief Intervention, and Referral to Treatment (SBIRT).

4.3.7. Buprenorphine waiver trainings, available locally and at websites including, but not limited to:

4.3.7.1. https://www.samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training

4.3.7.2. https://www.asam.org/education/live-online-cme/buprenorphine-course

4.3.7.3. https://aanp.inreachce.com/Details?groupId=714cb0a9-73b2-4daf-8382-27cbdb70ef5a

4.3.8. Cognitive behavioral therapy, dialectical behavior therapy, motivational enhancement therapy, mindfulness, and relapse prevention.

4.4. The Contractor shall provide ongoing supervision for buprenorphine prescribers with access to consultation from experienced providers.

4.5. The Contractor's Center for Addiction Recovery in Pregnancy and Parenting shall offer online training, CME/CNE events, and monthly learning collaboratives to each practice including, but not limited to:

4.5.1.1. Two (2) hour initial in-service training in preparation for opening clinic regarding providing trauma-informed and recovery-friendly care.

4.5.1.2. Toolkit of training materials.

4.5.1.3. Weekly team meetings on day of clinic facilitated by the behavioral health clinician.

4.5.1.4. Monthly webinar learning collaboratives for all participating practices with rotating topics

4.5.1.5. Quarterly in-person gatherings for all participating practices, focused on relationship building and sharing of experiences, hosted at rotating locations to maximize participation.

4.5.1.6. Annual CME event aimed at all staff involved in this model of care.

4.6. The Contractor shall provide assistance to all sites regarding training and logistics for the distribution of naloxone kits to patients and family members.

4.7. The Contractor shall assist practice staff in attending the following externally provided formal trainings:

4.7.1. CRSW training for prospective Recovery Coaches

4.7.2. Circle of Security training for BHCs and Recovery Coaches

4.7.3. Buprenorphine training for MDs/PAs/ARNPs

4.7.4. Smoking cessation training for any interested staff

4.7.5. Motivational Interviewing training for any interested staff

4.7.6. Additional trainings on trauma-informed care and other evidence based treatment strategies as indicated

5. Reporting

5.1. The Contractor shall gather, monitor, and submit data to the Department monthly. Participant data will be submitted in de-identified, aggregate form to the Department using a Department-approved method. The data being collected includes all data points required in the Treatment Episode Data for Admissions which includes, but is not limited to:

5.1.1. Treatment Setting

5.1.2. Number of prior treatment episodes

5.1.3. Primary source of referral

5.1.4. Age at admission

5.1.5. Pregnancy status

5.1.6. Race/Ethnicity

5.1.7. Education

5.1.8. Employment status

5.1.9. Primary substance

5.1.10. Route of administration

5.1.11. Frequency of use

5.1.12. Age at first use

5.1.13. Co-Occurring Substance Abuse and Mental Health Status

5.1.14. Veteran status

5.1.15. Living arrangements

5.1.16. Primary source of income

5.1.17. Health insurance status

5.1.18. Primary source of payment

5.1.19. Details for those not-in-labor-force

5.1.20. Marital status

5.1.21. Days waiting to enter treatment

5.1.22. Number of arrests in past 30 days

5.1.23. Frequency at self-help programming 30 days prior to admission

5.2. The Contractor shall report on federally-required data points specific to this funding opportunity quarterly and send the results in de-identified, aggregate form to the Department using a Department-approved method. The required data points include, but are not limited to:

5.2.1. Number of participants with OUD's:

5.2.1.1. In total.

5.2.1.2. Receiving integrated MAT with prenatal care.

5.2.1.3. Receiving care coordination/case management.

5.2.1.4. Receiving peer recovery support services.

5.2.1.5. Participating in parenting education programming.

5.2.1.6. Referred to or placed in recovery housing.

5.2.1.7. Referred to higher levels of care.

5.2.2. Number of providers in the program implementing MAT.

5.2.3. Number of OUD prevention and treatment providers trained by the program including, but not limited to Nurse Practitioners, Physician's Assistants, physicians, nurses, counselors, social workers, and case managers.

5.2.4. Numbers and rates of opioid overdose-related deaths within population served.

5.2.5. Number of children receiving childcare services by MAT program.

5.2.6. Number of infants in the program born with NAS not attributable to the mother taking prescribed MAT medications.

5.2.7. Number of referrals made to DCYF for substance-exposed infants not attributable to the mother taking prescribed MAT medications.

5.3. The Contractor shall require that all MAT-providing implementation sites report on the data points specified by the Department, utilizing a standardized protocol.

5.3.1. Each site will have exclusive access to protected health information for its own participants, and REDCap will be used to facilitate reporting of de-identified, aggregated data.

5.3.2. The Contractor shall provide a research assistant to help sites develop and implement appropriate site-specific data collection strategies to ensure compliance with reporting protocols.

5.4. The Contractor shall provide a final report to the Department within thirty (30) days of the termination of the contract which will include the following de-identified information based on the work plan progress, but shall not be limited to:

5.4.1. Policies and practices established.

5.4.2. Outreach activities.

5.4.3. Demographics of participants.

5.4.4. Outcome data (as directed by the Department).

5.4.5. Participant satisfaction.

5.4.6. Description of challenges encountered and action taken.

5.4.7. Other progress to date.

5.4.8. A sustainability plan to continue to provide MAT services to the target population beyond the completion date of the contract, subject to approval by the Department.

6. Performance Measures

6.1. The following aggregate performance indicators are to be annually achieved and monitored monthly to measure the effectiveness of the agreement:

6.1.1. The Contractor shall ensure that fifty percent (50%) of women referred to the program who consent to treatment and qualify based on clinical evaluation will enter OUD treatment as reported by the Contractor.

6.1.2. The Contractor shall ensure seventy-five percent (75%) of women identified by ASAM criteria as in need of a higher level of care will be referred to treatment services in order to increase referral of pregnant and postpartum women to OUD treatment providers as reported by the Contractor.

6.1.3. The Contractor shall attempt to ensure that NAS rates of infants born to mothers served in this program not attributable to the mother taking MAT medications as prescribed will decline by five percent (5%) from SFY18 to SFY19 as reported by the Contractor.

6.1.4. The Contractor shall attempt to lower positive urine drug screens for illicit substances for pregnant women served in this program by five percent (5%) from SFY18 to SFY19 as reported by the Contractor.

6.1.5. The Contractor shall seek to help lower reports to DCYF of substance-exposed infants born to mothers served in this program, not attributable to the mother taking MAT medications as prescribed by five percent (5%) from SFY18 to SFY19. This performance measure will be reported by the Contractor and through the use of collected hospital and DCYF data.

6.2. Annually, the Contractor shall develop and submit to the Department, a corrective action plan for any performance measure that was not achieved.

Methods and Conditions Precedent to Payment

1. The State shall pay the Contractor an amount not to exceed the Form P-37, Block 1.8, Price Limitation for the services provided by the Contractor pursuant to Exhibit A, Scope of Services.
2. The Contractor agrees to provide the services in Exhibit A, Scope of Service in compliance with funding requirements. Failure to meet the scope of services may jeopardize the funded contractor's current and/or future funding.
3. This contract is funded with funds from the US Department of Health and Human Services, Substance Abuse and Mental Health Administration, Catalog of Federal Domestic Assistance (CFDA #) 93.788, Federal Award Identification Number (FAIN) TI080246.
4. Payment for said services shall be made monthly as follows:
   - 4.1. 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.
   - 4.2. The Contractor will submit an invoice in a form satisfactory to the State by the twentieth (20th) working day of each month, which identifies and requests reimbursement for authorized expenses incurred in the prior month. The invoice must be completed, signed, dated, and returned to the Department in order to initiate payment. The Contractor agrees to keep records of their activities related to Department programs and services.
   - 4.3. 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. Contractors will keep detailed records of their activities related to DHHS-funded programs and services.
   - 4.4. The final invoice shall be due to the State no later than forty (40) days after the contract Form P-37, Block 1.7 Completion Date.
   - 4.5. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to:

     Department of Health and Human Services
     Division of Behavioral Health
     129 Pleasant Street
     Concord, NH 03301
     Email addresses: laurie.heath@dhhs.nh.gov AND abby.shockley@dhhs.nh.gov
   - 4.6. Payments may be withheld pending receipt of required reports or documentation as identified in Exhibit A, Scope of Services, and in this Exhibit B.
5. Notwithstanding paragraph 18 of the General Provisions P-37, changes limited to adjusting amounts between budget line items, related items, amendments of related budget exhibits within the price limitation, and to adjusting encumbrances between State Fiscal Years, may be made by written agreement of both parties and may be made without obtaining approval of the Governor and Executive Council.

Exhibit B-1
Budget for SFY 2018

New Hampshire Department of Health and Human Services

Bidder/Program Name: Mary Hitchcock Memorial Hospital

Budget Request for: Integrated Medication Assisted Treatment for Pregnant and Postpartum Women

Budget Period: January 1, 2018 - June 30, 2018

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct Incremental	Indirect Fixed	Total	Direct Incremental	Indirect Fixed	Total	Direct Incremental	Indirect Fixed	Total
1. Total Salary/Wages	$ 336,926	$ 98,719	$ 435,645	$ -	$ -	$ -	$ 336,926	$ 98,719	$ 435,645
2. Employee Benefits	$ 87,361	$ 25,597	$ 112,958	$ -	$ -	$ -	$ 87,361	$ 25,597	$ 112,958
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:		$ -	$ -	$ -	$ -	$ -		$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Educational		$ -	$ -	$ -	$ -	$ -		$ -	$ -
Lab	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medical	$ 60,000	$ 17,580	$ 77,580	$ -	$ -	$ -	$ 60,000	$ 17,580	$ 77,580
Office	$ 16,500	$ 4,835	$ 21,335	$ -	$ -	$ -	$ 16,500	$ 4,835	$ 21,335
6. Travel	$ 10,000	$ 2,930	$ 12,930	$ -	$ -	$ -	$ 10,000	$ 2,930	$ 12,930
7. Occupancy		$ -	$ -	$ -	$ -	$ -		$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Telephone		$ -	$ -	$ -	$ -	$ -		$ -	$ -
Postage	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subscriptions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Audit and Legal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ 4,000	$ 1,172	$ 5,172	$ -	$ -	$ -	$ 4,000	$ 1,172	$ 5,172
Board Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ 50,000	$ 14,650	$ 64,650	$ -	$ -	$ -	$ 50,000	$ 14,650	$ 64,650
11. Staff Education and Training	$ 40,000	$ 11,720	$ 51,720	$ -	$ -	$ -	$ 40,000	$ 11,720	$ 51,720
12. Subcontracts/Agreements	$ 73,315	$ 7,325	$ 80,640	$ -	$ -	$ -	$ 73,315	$ 7,325	$ 80,640
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 678,102	$ 184,528	$ 862,630	$ -	$ -	$ -	$678,102	$184,528	$862,630
Indirect As A Percent of Direct		27.2%							

Contractor Initials

Date 9.15.17

Exhibit B-2
Budget for SFY 2019

New Hampshire Department of Health and Human Services

Bidder/Program Name: Mary Hitchcock Memorial Hospital

Budget Request for: Integrated Medication Assisted Treatment for Pregnant and Postpartum Women

Budget Period: July 1, 2018 -June 30, 2019

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct Incremental	Indirect Fixed	Total	Direct Incremental	Indirect Fixed	Total	Direct Incremental	Indirect Fixed	Total
1. Total Salary/Wages	$ 866,506	$ 253,886	$ 1,120,392	$ -	$ -	$ -	$ 866,506	$ 253,886	$ 1,120,392
2. Employee Benefits	$ 229,427	$ 67,222	$ 296,649	$ -	$ -	$ -	$ 229,427	$ 67,222	$ 296,649
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Educational		$ -	$ -	$ -	$ -	$ -		$ -	$ -
Lab		$ -	$ -	$ -	$ -	$ -		$ -	$ -
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medical	$ 5,000	$ 1,465	$ 6,465	$ -	$ -	$ -	$ 5,000	$ 1,465	$ 6,465
Office	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6. Travel	$ 40,000	$ 11,720	$ 51,720	$ -	$ -	$ -	$ 40,000	$ 11,720	$ 51,720
7. Occupancy		$ -	$ -	$ -	$ -	$ -		$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Telephone	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Postage	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subscriptions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Audit and Legal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ 4,000	$ 1,172	$ 5,172	$ -	$ -	$ -	$ 4,000	$ 1,172	$ 5,172
Board Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ 1,500	$ 440	$ 1,940	$ -	$ -	$ -	$ 1,500	$ 440	$ 1,940
11. Staff Education and Training	$ 7,500	$ 2,198	$ 9,698	$ -	$ -	$ -	$ 7,500	$ 2,198	$ 9,698
12. Subcontracts/Agreements	$ 378,803	$ 21,975	$ 400,778	$ -	$ -	$ -	$ 378,803	$ 21,975	$ 400,778
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 1,532,736	$ 360,077	$ 1,892,813	$ -	$ -	$ -	$1,532,736	$360,077	$1,892,813
Indirect As A Percent of Direct		23.5%							

Contractor Initials
Date 9/5/17

SPECIAL PROVISIONS

Contractors Obligations: The Contractor covenants and agrees that all funds received by the Contractor under the Contract shall be used only as payment to the Contractor for services provided to eligible individuals and, in the furtherance of the aforesaid covenants, the Contractor hereby covenants and agrees as follows:

1. **Compliance with Federal and State Laws:** If the Contractor is permitted to determine the eligibility of individuals such eligibility determination shall be made in accordance with applicable federal and state laws, regulations, orders, guidelines, policies and procedures.

2. **Time and Manner of Determination:** Eligibility determinations shall be made on forms provided by the Department for that purpose and shall be made and remade at such times as are prescribed by the Department.

3. **Documentation:** In addition to the determination forms required by the Department, the Contractor shall maintain a data file on each recipient of services hereunder, which file shall include all information necessary to support an eligibility determination and such other information as the Department requests. The Contractor shall furnish the Department with all forms and documentation regarding eligibility determinations that the Department may request or require.

4. **Fair Hearings:** The Contractor understands that all applicants for services hereunder, as well as individuals declared ineligible have a right to a fair hearing regarding that determination. The Contractor hereby covenants and agrees that all applicants for services shall be permitted to fill out an application form and that each applicant or re-applicant shall be informed of his/her right to a fair hearing in accordance with Department regulations.

5. **Gratuities or Kickbacks:** The Contractor agrees that it is a breach of this Contract to accept or make a payment, gratuity or offer of employment on behalf of the Contractor, any Sub-Contractor or the State in order to influence the performance of the Scope of Work detailed in Exhibit A of this Contract. The State may terminate this Contract and any sub-contract or sub-agreement if it is determined that payments, gratuities or offers of employment of any kind were offered or received by any officials, officers, employees or agents of the Contractor or Sub-Contractor.

6. **Retroactive Payments:** Notwithstanding anything to the contrary contained in the Contract or in any other document, contract or understanding, it is expressly understood and agreed by the parties hereto, that no payments will be made hereunder to reimburse the Contractor for costs incurred for any purpose or for any services provided to any individual prior to the Effective Date of the Contract and no payments shall be made for expenses incurred by the Contractor for any services provided prior to the date on which the individual applies for services or (except as otherwise provided by the federal regulations) prior to a determination that the individual is eligible for such services.

7. **Conditions of Purchase:** Notwithstanding anything to the contrary contained in the Contract, nothing herein contained shall be deemed to obligate or require the Department to purchase services hereunder at a rate which reimburses the Contractor in excess of the Contractors costs, at a rate which exceeds the amounts reasonable and necessary to assure the quality of such service, or at a rate which exceeds the rate charged by the Contractor to ineligible individuals or other third party funders for such service. If at any time during the term of this Contract or after receipt of the Final Expenditure Report hereunder, the Department shall determine that the Contractor has used payments hereunder to reimburse items of expense other than such costs, or has received payment in excess of such costs or in excess of such rates charged by the Contractor to ineligible individuals or other third party funders, the Department may elect to:
   7.1. Renegotiate the rates for payment hereunder, in which event new rates shall be established;
   7.2. Deduct from any future payment to the Contractor the amount of any prior reimbursement in excess of costs;

7.3. Demand repayment of the excess payment by the Contractor in which event failure to make such repayment shall constitute an Event of Default hereunder. When the Contractor is permitted to determine the eligibility of individuals for services, the Contractor agrees to reimburse the Department for all funds paid by the Department to the Contractor for services provided to any individual who is found by the Department to be ineligible for such services at any time during the period of retention of records established herein.

RECORDS: MAINTENANCE, RETENTION, AUDIT, DISCLOSURE AND CONFIDENTIALITY:

8. **Maintenance of Records:** In addition to the eligibility records specified above, the Contractor covenants and agrees to maintain the following records during the Contract Period:
   8.1. Fiscal Records: books, records, documents and other 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 during the Contract Period, said records to 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.
   8.2. Statistical Records: Statistical, enrollment, attendance or visit records for each recipient of services during the Contract Period, 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.
   8.3. Medical Records: Where appropriate and as prescribed by the Department regulations, the Contractor shall retain medical records on each patient/recipient of services.

9. **Audit:** Contractor shall submit an annual audit to the Department within 60 days after the close of the agency fiscal year. It is recommended that the report be prepared in accordance with the provision of Office of Management and Budget Circular A-133, "Audits of States, Local Governments, and Non Profit Organizations" and the provisions of Standards for Audit of Governmental Organizations, Programs, Activities and Functions, issued by the US General Accounting Office (GAO standards) as they pertain to financial compliance audits.
   9.1. Audit and Review: 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.
   9.2. Audit Liabilities: 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.

10. **Confidentiality of Records:** All information, reports, and records maintained hereunder or collected in connection with the performance of the services and the Contract shall be confidential and shall not be disclosed by the Contractor, provided however, that pursuant to state laws and the regulations of the Department regarding the use and disclosure of such information, disclosure may be made to public officials requiring such information in connection with their official duties and for purposes directly connected to the administration of the services and the Contract; and provided further, that the use or disclosure by any party of any information concerning a recipient for any purpose not directly connected with the administration of the Department or the Contractor's responsibilities with respect to purchased services hereunder is prohibited except on written consent of the recipient, his attorney or guardian.

Notwithstanding anything to the contrary contained herein the covenants and conditions contained in the Paragraph shall survive the termination of the Contract for any reason whatsoever.

11. **Reports:** Fiscal and Statistical: The Contractor agrees to submit the following reports at the following times if requested by the Department.
    11.1. Interim Financial Reports: Written interim financial reports containing a detailed description of all costs and non-allowable expenses incurred by the Contractor to the date of the report and containing such other information as shall be deemed satisfactory by the Department to justify the rate of payment hereunder. Such Financial Reports shall be submitted on the form designated by the Department or deemed satisfactory by the Department.
    11.2. Final Report: A final report shall be submitted within thirty (30) days after the end of the term of this Contract. The Final Report shall be in a form satisfactory to the Department and shall contain a summary statement of progress toward goals and objectives stated in the Proposal and other information required by the Department.

12. **Completion of Services:** Disallowance of Costs: 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.

13. **Credits:** 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:
    13.1. 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.

14. **Prior Approval and Copyright Ownership:** All materials (written, video, audio) produced or purchased under the contract shall have prior approval from DHHS before printing, production, distribution or use. The DHHS will retain copyright ownership for any and all original materials produced, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports. Contractor shall not reproduce any materials produced under the contract without prior written approval from DHHS.

15. **Operation of Facilities: Compliance with Laws and Regulations:** In the operation of any facilities for providing services, the Contractor shall comply with all laws, orders and regulations of federal, state, county and municipal authorities and with any direction of any Public Officer or officers pursuant to laws which shall impose an order or duty upon the contractor with respect to the operation of the facility or the provision of the services at such facility. If any governmental license or permit shall be required for the operation of the said facility or the performance of the said services, the Contractor will procure said license or permit, and will at all times comply with the terms and conditions of each such license or permit. In connection with the foregoing requirements, the Contractor hereby covenants and agrees that, during the term of this Contract the facilities shall comply with all rules, orders, regulations, and requirements of the State Office of the Fire Marshal and the local fire protection agency, and shall be in conformance with local building and zoning codes, by-laws and regulations.

16. **Equal Employment Opportunity Plan (EEOP):** The Contractor will provide an Equal Employment Opportunity Plan (EEOP) to the Office for Civil Rights, Office of Justice Programs (OCR), if it has received a single award of $500,000 or more. If the recipient receives $25,000 or more and has 50 or

more employees, it will maintain a current EEOP on file and submit an EEOP Certification Form to the OCR, certifying that its EEOP is on file. For recipients receiving less than $25,000, or public grantees with fewer than 50 employees, regardless of the amount of the award, the recipient will provide an EEOP Certification Form to the OCR certifying it is not required to submit or maintain an EEOP. Non-profit organizations, Indian Tribes, and medical and educational institutions are exempt from the EEOP requirement, but are required to submit a certification form to the OCR to claim the exemption. EEOP Certification Forms are available at: http://www.ojp.usdoj/about/ocr/pdfs/cert.pdf.

17. **Limited English Proficiency (LEP)**: As clarified by Executive Order 13166, Improving Access to Services for persons with Limited English Proficiency, and resulting agency guidance, national origin discrimination includes discrimination on the basis of limited English proficiency (LEP). To ensure compliance with the Omnibus Crime Control and Safe Streets Act of 1968 and Title VI of the Civil Rights Act of 1964, Contractors must take reasonable steps to ensure that LEP persons have meaningful access to its programs.

18. **Pilot Program for Enhancement of Contractor Employee Whistleblower Protections:** The following shall apply to all contracts that exceed the Simplified Acquisition Threshold as defined in 48 CFR 2.101 (currently, $150,000)

CONTRACTOR EMPLOYEE WHISTLEBLOWER RIGHTS AND REQUIREMENT TO INFORM EMPLOYEES OF WHISTLEBLOWER RIGHTS (SEP 2013)

(a) This contract and employees working on this contract will be subject to the whistleblower rights and remedies in the pilot program on Contractor employee whistleblower protections established at 41 U.S.C. 4712 by section 828 of the National Defense Authorization Act for Fiscal Year 2013 (Pub. L. 112-239) and FAR 3.908.

(b) The Contractor shall inform its employees in writing, in the predominant language of the workforce, of employee whistleblower rights and protections under 41 U.S.C. 4712, as described in section 3.908 of the Federal Acquisition Regulation.

(c) The Contractor shall insert the substance of this clause, including this paragraph (c), in all subcontracts over the simplified acquisition threshold.

19. **Subcontractors**: DHHS recognizes that the Contractor may choose to use subcontractors with greater expertise to perform certain health care services or functions for efficiency or convenience, but the Contractor shall retain the responsibility and accountability for the function(s). Prior to subcontracting, the Contractor shall evaluate the subcontractor's ability to perform the delegated function(s). This is accomplished through a written agreement that specifies activities and reporting responsibilities of the subcontractor and provides for revoking the delegation or imposing sanctions if the subcontractor's performance is not adequate. Subcontractors are subject to the same contractual conditions as the Contractor and the Contractor is responsible to ensure subcontractor compliance with those conditions.
When the Contractor delegates a function to a subcontractor, the Contractor shall do the following:
    19.1. Evaluate the prospective subcontractor's ability to perform the activities, before delegating the function
    19.2. Have a written agreement with the subcontractor that specifies activities and reporting responsibilities and how sanctions/revocation will be managed if the subcontractor's performance is not adequate
    19.3. Monitor the subcontractor's performance on an ongoing basis

19.4. Provide to DHHS an annual schedule identifying all subcontractors, delegated functions and responsibilities, and when the subcontractor's performance will be reviewed

19.5. DHHS shall, at its discretion, review and approve all subcontracts.

If the Contractor identifies deficiencies or areas for improvement are identified, the Contractor shall take corrective action.

DEFINITIONS

As used in the Contract, the following terms shall have the following meanings:

COSTS: Shall mean those direct and indirect items of expense determined by the Department to be allowable and reimbursable in accordance with cost and accounting principles established in accordance with state and federal laws, regulations, rules and orders.

DEPARTMENT: NH Department of Health and Human Services.

FINANCIAL MANAGEMENT GUIDELINES: Shall mean that section of the Contractor Manual which is entitled "Financial Management Guidelines" and which contains the regulations governing the financial activities of contractor agencies which have contracted with the State of NH to receive funds.

PROPOSAL: If applicable, shall mean the document submitted by the Contractor on a form or forms required by the Department and containing a description of the Services to be provided to eligible individuals by the Contractor in accordance with the terms and conditions of the Contract and setting forth the total cost and sources of revenue for each service to be provided under the Contract.

UNIT: For each service that the Contractor is to provide to eligible individuals hereunder, shall mean that period of time or that specified activity determined by the Department and specified in Exhibit B of the Contract.

FEDERAL/STATE LAW: Wherever federal or state laws, regulations, rules, orders, and policies, etc. are referred to in the Contract, the said reference shall be deemed to mean all such laws, regulations, etc. as they may be amended or revised from the time to time.

CONTRACTOR MANUAL: Shall mean that document prepared by the NH Department of Administrative Services containing a compilation of all regulations promulgated pursuant to the New Hampshire Administrative Procedures Act. NH RSA Ch 541-A, for the purpose of implementing State of NH and federal regulations promulgated thereunder.

SUPPLANTING OTHER FEDERAL FUNDS: The Contractor guarantees that funds provided under this Contract will not supplant any existing federal funds available for these services.

REVISIONS TO GENERAL PROVISIONS

1. Subparagraph 4 of the General Provisions of this contract, Conditional Nature of Agreement, is replaced as follows:

   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, in whole or in part, under this Agreement are contingent upon continued appropriation or availability of funds, including any subsequent changes to the appropriation or availability 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 of Services provided in Exhibit A, Scope of Services, in whole or in part. In no event shall the State be liable for any payments hereunder in excess of appropriated or available funds. In the event of a reduction, termination, or modification of appropriated or available funds, the State shall have the right to withhold payment until such funds become available, if ever. The State shall have the right to reduce, terminate, or modify services under this Agreement immediately upon giving the Contractor notice of such reduction, termination or modification. The State shall not be required to transfer funds from any other source or account into the Account(s) identified in block 1.6 of the General Provisions, Account Number, or any other account, in the event funds are reduced or unavailable.

2. Subparagraph 10 of the General Provisions of this contract, Termination, is amended by adding the following language;

   10.1 The State may terminate the Agreement at any time for any reason, at the sole discretion of the State, 30 days after giving the Contractor written notice that the State is exercising its option to terminate the Agreement.

   10.2 In the event of early termination, 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, including but not limited to, identifying the present and future needs of clients receiving services under the Agreement and establishes a process to meet those needs.

   10.3 The Contractor shall fully cooperate with the State and shall promptly provide detailed information to support the Transition Plan including, but not limited to, any information or data requested by the State related to the termination of the Agreement and Transition Plan and shall provide ongoing communication and revisions of the Transition Plan to the State as requested.

   10.4 In the event that services under the Agreement, including but not limited to clients receiving services under the Agreement are transitioned to having services delivered by another entity including contracted providers or the State, the Contractor shall provide a process for uninterrupted delivery of services in the Transition Plan.

   10.5 The Contractor shall establish a method of notifying clients and other affected individuals about the transition. The Contractor shall include the proposed communications in its Transition Plan submitted to the State as described above.

3. Extension:

   The Department reserves the right to renew the Contract for up to two (2) additional years, subject to the continued availability of funds, satisfactory performance of services and approval by the Governor and Executive Council.

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

This certification is required by the regulations implementing Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.). The January 31, 1989 regulations were amended and published as Part II of the May 25, 1990 Federal Register (pages 21681-21691), and require certification by grantees (and by inference, sub-grantees and sub-contractors), prior to award, that they will maintain a drug-free workplace. Section 3017.630(c) of the regulation provides that a grantee (and by inference, sub-grantees and sub-contractors) that is a State may elect to make one certification to the Department in each federal fiscal year in lieu of certificates for each grant during the federal fiscal year covered by the certification. The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment. Contractors using this form should send it to:

Commissioner
NH Department of Health and Human Services
129 Pleasant Street,
Concord, NH 03301-6505

1. The grantee certifies that it will or will continue to provide a drug-free workplace by:
   1.1. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
   1.2. Establishing an ongoing drug-free awareness program to inform employees about
      1.2.1. The dangers of drug abuse in the workplace;
      1.2.2. The grantee's policy of maintaining a drug-free workplace;
      1.2.3. Any available drug counseling, rehabilitation, and employee assistance programs; and
      1.2.4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
   1.3. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by 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.

Contractor Name:

12.15.17
Date

Edward Merrens
Name:
Title: Chief Clinical Officer

CERTIFICATION REGARDING LOBBYING

The Contractor 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.

Contractor Name:

12.15.17
Date

Edward J. Menezes
Name:
Title:

CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Executive Office of the President, Executive Order 12549 and 45 CFR Part 76 regarding Debarment, Suspension, and Other Responsibility Matters, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

INSTRUCTIONS FOR CERTIFICATION

1. By signing and submitting this proposal (contract), the prospective primary participant is providing the certification set out below.

2. The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. If necessary, the prospective participant shall submit an explanation of why it cannot provide the certification. The certification or explanation will be considered in connection with the NH Department of Health and Human Services' (DHHS) determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.

3. The certification in this clause is a material representation of fact upon which reliance was placed when DHHS determined to enter into this transaction. If it is later determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, DHHS may terminate this transaction for cause or default.

4. The prospective primary participant shall provide immediate written notice to the DHHS agency to whom this proposal (contract) is submitted if at any time the prospective primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

5. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549: 45 CFR Part 76. See the attached definitions.

6. The prospective primary participant agrees by submitting this proposal (contract) that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by DHHS.

7. The prospective primary participant further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions," provided by DHHS, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

8. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or involuntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List (of excluded parties).

9. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and

Contractor Initials EM

Date 12.15.17

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.

Contractor Name:

12.15.17
Date

Edmund J Mercer
Name:
Title:

CERTIFICATION OF COMPLIANCE WITH REQUIREMENTS PERTAINING TO FEDERAL NONDISCRIMINATION, EQUAL TREATMENT OF FAITH-BASED ORGANIZATIONS AND WHISTLEBLOWER PROTECTIONS

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

Contractor will comply, and will require any subgrantees or subcontractors to comply, with any applicable federal nondiscrimination requirements, which may include:

- the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. Section 3789d) which prohibits recipients of federal funding under this statute from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act requires certain recipients to produce an Equal Employment Opportunity Plan;

- the Juvenile Justice Delinquency Prevention Act of 2002 (42 U.S.C. Section 5672(b)) which adopts by reference, the civil rights obligations of the Safe Streets Act. Recipients of federal funding under this statute are prohibited from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act includes Equal Employment Opportunity Plan requirements;

- the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, which prohibits recipients of federal financial assistance from discriminating on the basis of race, color, or national origin in any program or activity);

- the Rehabilitation Act of 1973 (29 U.S.C. Section 794), which prohibits recipients of Federal financial assistance from discriminating on the basis of disability, in regard to employment and the delivery of services or benefits, in any program or activity;

- the Americans with Disabilities Act of 1990 (42 U.S.C. Sections 12131-34), which prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation;

- the Education Amendments of 1972 (20 U.S.C. Sections 1681, 1683, 1685-86), which prohibits discrimination on the basis of sex in federally assisted education programs;

- the Age Discrimination Act of 1975 (42 U.S.C. Sections 6106-07), which prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance. It does not include employment discrimination;

- 28 C.F.R. pt. 31 (U.S. Department of Justice Regulations – OJJDP Grant Programs); 28 C.F.R. pt. 42 (U.S. Department of Justice Regulations – Nondiscrimination; Equal Employment Opportunity; Policies and Procedures); Executive Order No. 13279 (equal protection of the laws for faith-based and community organizations); Executive Order No. 13559, which provide fundamental principles and policy-making criteria for partnerships with faith-based and neighborhood organizations;

- 28 C.F.R. pt. 38 (U.S. Department of Justice Regulations – Equal Treatment for Faith-Based Organizations); and Whistleblower protections 41 U.S.C. §4712 and The National Defense Authorization Act (NDAA) for Fiscal Year 2013 (Pub. L. 112-239, enacted January 2, 2013) the Pilot Program for Enhancement of Contract Employee Whistleblower Protections, which protects employees against reprisal for certain whistle blowing activities in connection with federal grants and contracts.

The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment.

In the event a Federal or State court or Federal or State administrative agency makes a finding of discrimination after a due process hearing on the grounds of race, color, religion, national origin, or sex against a recipient of funds, the recipient will forward a copy of the finding to the Office for Civil Rights, to the applicable contracting agency or division within the Department of Health and Human Services, and to the Department of Health and Human Services Office of the Ombudsman.

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this proposal (contract) the Contractor agrees to comply with the provisions indicated above.

Contractor Name:

12.15.17
Date

Name:
Title:

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, Part C - Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 per day and/or the imposition of an administrative compliance order on the responsible entity.

The Contractor identified in Section 1.3 of the General Provisions agrees, by signature of the Contractor's representative as identified in Section 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this contract, the Contractor agrees to make reasonable efforts to comply with all applicable provisions of Public Law 103-227, Part C, known as the Pro-Children Act of 1994.

Contractor Name:

12.15.17
Date

Name:
Title:

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:

12.15.17
Date

Name:
Title:

FORM A

As the Contractor identified in Section 1.3 of the General Provisions, I certify that the responses to the below listed questions are true and accurate.

1. The DUNS number for your entity is: 06-99102-97

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: _____

DHHS INFORMATION SECURITY REQUIREMENTS

1. Confidential Information: In addition to Paragraph #9 of the General Provisions (P-37) for the purpose of this RFP, the Department's Confidential information 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 Personal Health Information (PHI), Personally Identifiable Information (PII), Federal Tax Information (FTI), Social Security Numbers (SSN), Payment Card Industry (PCI), and or other sensitive and confidential information.

2. The vendor will maintain proper security controls to protect Department confidential information collected, processed, managed, and/or stored in the delivery of contracted services. Minimum expectations include:

   2.1. 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.).

   2.2. Maintain appropriate authentication and access controls to contractor systems that collect, transmit, or store Department confidential information where applicable.

   2.3. Encrypt, at a minimum, any Department confidential data stored on portable media, e.g., laptops, USB drives, as well as when transmitted over public networks like the Internet using current industry standards and best practices for strong encryption.

   2.4. 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.

   2.5. Provide security awareness and education for its employees, contractors and sub-contractors in support of protecting Department confidential information

   2.6. Maintain a documented breach notification and incident response process. The vendor will contact the Department within twenty-four 24 hours to the Department's contract manager, and additional email addresses provided in this section, of 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.

      2.6.1. "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations. "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.

      Breach notifications will be sent to the following email addresses:

      2.6.1.1. DHHSChiefInformationOfficer@dhhs.nh.gov

      2.6.1.2. DHHSInformationSecurityOffice@dhhs.nh.gov

   2.7. If the vendor will maintain any Confidential Information on its systems (or its sub-contractor systems), the vendor will maintain a documented process for securely disposing of such data upon request or contract termination; and will obtain written certification for any State of New Hampshire data destroyed by the vendor or any subcontractors as a part of ongoing, emergency, and or disaster recovery operations. When no longer in use, electronic media containing State of New Hampshire data shall be rendered unrecoverable via a secure wipe program in accordance with industry-accepted standards for secure

deletion, or otherwise physically destroying the media (for example, degaussing). The vendor will document and certify in writing at time of the data destruction, and will provide written certification to the Department upon request. The written certification will include all details necessary to demonstrate data has been properly destroyed and validated. Where applicable, regulatory and professional standards for retention requirements will be jointly evaluated by the State and vendor prior to destruction.

2.8. If the vendor will be sub-contracting any core functions of the engagement supporting the services for State of New Hampshire, the vendor will maintain a program of an internal process or processes that defines specific security expectations, and monitoring compliance to security requirements that at a minimum match those for the vendor, including breach notification requirements.

3. The vendor 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 vendor and any applicable sub-contractors prior to system access being authorized.

4. If the Department determines the vendor is a Business Associate pursuant to 45 CFR 160.103, the vendor will work with the Department to sign and execute a HIPAA Business Associate Agreement (BAA) with the Department and is responsible for maintaining compliance with the agreement.

5. The vendor will work with the Department at its request to complete a survey. The purpose of the survey is to enable the Department and vendor to monitor for any changes in risks, threats, and vulnerabilities that may occur over the life of the vendor engagement. The survey will be completed annually, or an alternate time frame at the Departments discretion with agreement by the vendor, or the Department may request the survey be completed when the scope of the engagement between the Department and the vendor changes. The vendor will not store, knowingly or unknowingly, any State of New Hampshire or Department data offshore or outside the boundaries of the United States unless prior express written consent is obtained from the appropriate authorized data owner or leadership member within the Department.